A G E N D A

Health & Care Partnership

Date: **Monday, 11th April, 2005**

Time: **10.30 a.m.**

Place: **Council Chamber, Brockington**

Notes: Please note the **time, date** and **venue** of the meeting.

For any further information please contact:

Heather Donaldson, Room 20, Brockington, 35 Hafod Road, Hereford

Tel: 01432 261829;
Email: hdonaldson@herefordshire.gov.uk

County of Herefordshire District Council

HEREFORDSHIRE COUNCIL

AGENDA

for the Meeting of the Health & Care Partnership

To: **Herefordshire Council:**
Councillors: Mrs. L.O. Barnett, Mrs. M.D. Lloyd-Hayes, R.J. Phillips, D.W. Rule MBE, R.V. Stockton
Officers: Ms S. Fiennes (Director of Social Care and Strategic Housing and Director of Children's Services)

Herefordshire Primary Care Trust:
Mr. P. Bates (Chief Executive of Herefordshire PCT), Ms Frances Howie (Associate Director of Public Health), Dr I. Tait (Chairman of the Executive Committee), Mr T. Willmott (Vice-Chair of Health and Care Partnership and Chair of Herefordshire PCT)

Hereford Hospitals Trust:
Mr D. Rose (Chief Executive), Mrs. C. Moore (Chair)

Hereford and Worcester Ambulance Service:
Mrs J. Newton (Chair), Mr R. Hamilton (Chief Executive)

Voluntary Sector/Others:
Ms J. Francis (Alliance Chair), Ms H. Horton (Alliance Chief Executive), Mr W. Lyons (H&W Chamber of Commerce), Ms A. Stokes (Chair of PCT PPI Forum), and Chair of HHT PPI Forum

		Pages
1.	**APOLOGIES FOR ABSENCE** To receive apologies for absence.	
2.	**NAMED SUBSTITUTES (IF ANY)** To receive details of any Member nominated to attend the meeting in place of a Member of the Board.	
3.	**DECLARATIONS OF INTEREST** To receive any declarations of interest by Members in respect of items on this agenda.	
4.	**MINUTES** To approve and sign the minutes of the meeting held on 13th January 2005.	1 - 40
5.	**JOINT HEALTH AND CARE COMMISSIONING GROUP BRIEFING NOTES** To note the attached report of the Assistant Director of IMPACT in respect of items dealt with by the Joint Health and Care Commissioning Group on 17th March 2005 *(Report by Jean Howard)*.	41 - 42

6. THEME FOR THE MEETING: "CHOOSING HEALTH: MAKING HEALTHY CHOICES EASIER" 43 - 68

To consider the attached papers and receive a presentation in respect of the Public Health White Paper published on 16th November 2004. *(Presentation by Mr P. Bates, Chief Executive of the PCT)*

7. WINTER STRATEGY 2005/06

To consider plans to deal with the increased pressure on services during the forthcoming winter period.

8. CHILDREN'S SERVICES UPDATE

To receive a progress report on matters relating to Children's Services.

9. HEREFORD AND WORCESTER AMBULANCE SERVICE UPDATE

To receive a progress report on matters relating to the Hereford and Worcester Ambulance Service.

10. DATE OF NEXT MEETING

To agree the date of the next meeting.

MINUTES of the meeting of the Health and Care Partnership held at Brockington, 35 Hafod Road, Hereford on 13th January, 2005 at 10.30 a.m.

Present:

Herefordshire Council:
Councillors: P.E. Harling, Mrs M D Lloyd-Hayes, R. J. Phillips, D W Rule, R.V. Stockton

Ms S Fiennes (Director of Social Care and Strategic Housing),
Ms A Heath (For Dr E Oram, Director of Education)

Herefordshire Primary Care Trust:
Mr P Bates (Chief Executive), Mr T Willmott (Vice-Chair in the Chair)(Chair of PCT)

Hereford Hospitals Trust:
Mrs C. Moore (Chair) and Mr D. Rose (Chief Executive)

Hereford & Worcester Ambulance Service:
Mrs J. Newton (Chair)

Other Member Representatives:
Mr W. Lyons (Chamber of Commerce) ,Ms A Stoakes (Primary Care Trust PPI Forum)

In attendance: **Ms J. Bruce (PCT), Mrs Y. Clowsley (PCT), Ms L. Davies (Trainee Solicitor, Herefordshire Council), Ms J. Howard (PCT), Mr H. Lewis (Head of Social Care (Children), Herefordshire Council), Councillor W J S Thomas.**

21. APOLOGIES FOR ABSENCE

Apologies were received from Councillor Mrs L.O. Barnett, Mr S. Hairsnape, Mr R. Hamilton and Dr I. Tait.

22. NAMED SUBSTITUTES

Ms A. Heath for Dr. E. Oram.

23. DECLARATIONS OF INTEREST

There were no declarations of interest.

24. MINUTES

RESOLVED: that the minutes of the meeting held on 25th October, 2004 be approved as a correct record and signed by the Chair, subject to the following amendment:

- **The names of Ms C. Moore and Mr D. Rose be added to the list of those giving their apologies.**

25. JOINT HEALTH AND CARE COMMISSIONING GROUP BRIEFING NOTES

The Partnership received a report on issues dealt with by the Joint Health & Care Commissioning Group, and the report indicated where further information could be obtained.

During the ensuing discussion, the following key points were raised:

- **Single Assessment Progress:** The Assistant Director (IMPACT) reported that Single Assessment was progressing steadily. It was apparent that most Health Authorities had experienced problems with introducing electronic systems to operate the process and were behind schedule with implementation. Herefordshire also required considerable work in relation to staff attitude and training, and the PCT was researching examples of best practice, such as Lincolnshire, in order to address this. In addition a Trainer had been appointed.

  The Chief Executive of the PCT added that the next step beyond Single Assessment Herefordshire would be a total integration of all services. This would involve major changes at organisational level. The Director of Social Care and Strategic Housing reported that the national expectations for this framework had been ambitious, given the resources, making the local targets difficult to achieve. She emphasised that Herefordshire had made above average progress, however.

- **Voluntary Sector Alliance:** The Partnership heard a report on an event that had been held for non-Alliance members, and had produced some very positive feedback. A further meeting had been arranged for 10:30 a.m. on 27th January 2005 at College Hall, Hereford Cathedral.

RESOLVED: That the report be noted.

26. REPORT ON THE HEALTH AND SOCIAL CARE COMMISSIONING ORGANISATIONAL STRUCTURE

The Head of IMPACT presented a verbal report about proposed changes to the Health and Social Care Commissioning Organisational Structure, and said that a written report would follow in due course. Members also noted that Cabinet was going to discuss some of the issues later today, which were particularly complex, due to the vast changes that had been proposed in respect of Children's Services.

The NHS Plan had driven the need for change, and in particular advocated joint working, which Central Government believed would bring improvements by creating Health Services that were tailored to local needs. In Herefordshire, this meant finding a way to standardise decision-making, which was currently undertaken via various Boards, LITs, Groups and Section 31 arrangements. There was also a need to improve service planning, which was sometimes fragmented and piecemeal, with gaps and overlaps.

The Head of Impact proposed that a review be conducted, and the Partnership would then consider the resulting report at a future meeting. During the discussion, the following key points were made about the proposed review:

- The review of Children's Services was fundamental to the review of all Health Services, and would need to be in place first. Councillor R. Phillips stated

that one of the greatest challenges would be the integration of Social Services with Children's Services.

- The Director of Social Care and Strategic Housing said that the review of Health Services would be focussed on meeting the needs of the Public, on service development and filling gaps in service provision, and on change and modernisation.

- The review would also address the issue of membership of decision-making and commissioning bodies, ensuring that the optimum mix of people's qualifications, skills and experience were put to use in the right areas. Currently, some of the groups had influence, but no decision-making powers, whilst others had influence, decision-making powers and budgetary responsibility. It would be necessary to define these, reduce bureaucracy and make their terms of reference clearer and simpler. The Chief Executive of the PCT added that the Section 31 Boards in particular needed to become more effective through stronger constitutional and membership powers.

- Those delivering Single assessment would need the Partnership's support, to develop an environment where professional knowledge was readily and easily shared, and the teamwork already apparent could be built further upon.

RESOLVED: That a review of the health and social care commissioning organisational structure be undertaken, and a report be considered by the Health and Care Partnership at a future meeting.

27. THEME FOR THE MEETING: CHILDREN'S SERVICES

The Partnership received the following presentations on the principal issues in respect of Children's 'Services in Herefordshire:

Change for Children – Herefordshire Programme (Presentation by Ms S. Fiennes of Herefordshire Council):

The Director of Social Care and Strategic Housing's presentation is attached at Appendix A.

The new arrangements in respect of requirements of the Children's Act 2005 would commence from April 2005, and would affect the Governing and Commissioning functions of Local Authorities. A number of reviews in connection with Children's Services would take place, namely: 1.) 3 Children's Services inspections were currently taking place in the areas of Services for 14-19 year-olds, Herefordshire and Worcestershire Youth Offending Service, and the second round of the Fostering Service inspection; 2.) the Audit Commission's Joint Area Review of Children's Services, scheduled for Autumn 2005; 3.) joint inspections in the areas of Probation, Health and Care Commissioning, and Social Care; 4.) a regulation inspection of Adoption Services; 5.) Comprehensive Performance Assessment in Autumn 2005.

Members recognised that the number of assessments was unprecedented this year, and would place staff under considerable pressure. IN addition, the inspections would take away capacity to deliver services because staff would be assigned to the inspection process at various stages, and there would also be a financial cost to the Local Authority.

The Director of Social; Care and Strategic housing circulated 3 documents from the DfES in connection with the Children's Act 2005, namely: "Change for Children in Health Services", "Change for Children in Schools" and Change for Children in Social Care". She said that she would be circulating a paper to the Hospital Trust, the Ambulance Trust, the PCT the Voluntary Sector and to the Section 31 Boards on the implications of these documents.

Children's Services – Local Practice (Presentation by Mr H. Lewis and Ms A. Heath, Herefordshire Council):

The Head of Social Care (Children) reported on progress made with the implementation of the Herefordshire Child Concern Model. He explained that the development of a Common Assessment Framework would be a key element of safeguarding children, as would working closely with the Area Child Protection Committee (shortly to be replaced by a Statutory Board).

A Joint Service Manager would have particular responsibility to children with disabilities, bringing together colleagues from the PCT, Child development Centres and Social Services.

The Head of Children's Services reported on the measures that would be put in place to support children with Special Education Needs, in line with the document "Change for Children in Schools", and said that funding was accessible now.

In addition, she reported that Joint Agency Meetings had been established to build on good practice amongst Health and Education professionals, and to make decisions about how to use their joint budget.

Children's National Service Framework (Presentation by Ms Y. Clowsley and Ms M. Colwell):

The Head of IMPACT's Presentation is attached at Appendix B.

Councillor Mrs M. Lloyd-Hayes and Councillor W.J.S. Thomas emphasised the need to address health issues (such as obesity) in children as early as possible, so that they would continue to be healthy for as long as possible in adult life, and the Chief Executive of the PCT reported that these issues had been addressed in a White Paper on Public Health, and woiulod be considered in greated detail. It was noted that the Act did not allow for Schools and General Practitioners to provide input easily, although the excellent relationships already established amongst professionals in Herefordshire would help to ensure that they would be included. The creation of the Children's Services Directorate and 2 new posts within Herefordshire Council, Children's Services Director and Children's Services Cabinet Member, would be a significant strategy in meeting the more challenging next steps of implementation.

The Partnership agreed that Herefordshire was well placed to deal with the significant changes imminent in Children's Services. The Chief Executive of the PCT reported that services would be delivered through a Children's Trust, and although this was not ideal because of its status as a Statutory Organisation, it was likely to prove the best way forward in terms of assessment and achieving recognised targets.

RESOLVED: That

That (i) the reports be noted;

(ii) a progress report on Children's Services be given at each Partnership meeting for the remainder of the year;

(iii) the Public Health White Paper be considered at a furute Partnership meeting; and

(iv) the Children's NSF be considered in greater detail at a future Partnership meeting.

28. HEREFORD AND WORCESTER AMBULANCE SERVICE

The Chair of the Hereford and Worcester Ambulance Service reported that there had been significant challenges in meeting some of its targets over the last few weeks, with target ambulance response times being achieved in 70% of cases overall. This figure dropped to and in only 44% of cases over the Christmas period, when additional complications had arisen. The Chief Executive of Hereford Hospitals Trust reported that this had been mirrored in the A&E Department which had seen a 16% rise in patients over the same period. He added that the health system usually felt under particular strain over Christmas and at times it had been particularly challenging, in spite of strong working relationships between the services. It was noted that a significant number of calls to the PCT had been abandoned, raising questions about whether they needed to call in the first place.

The Chief Executive of the PCT reported that this was a growing problem nationwide, and that there had been record levels of demand for beds over Christmas. He also cited the previous evening as an example of when serious acute bed shortages had been reported in some parts of England which had led to emergency requests for additional beds from other regions.

Members felt that there were indications of changes in the way that people were using emergency and acute services, and it was suggested that this might be related to underlying permanent changes in society, and in people's expectations of the Health Service through creating a patient-driven system. The Chief Executive of the PCT said that it would be useful to analyse the situation in order to identify trends and find ways to better allocate resources.

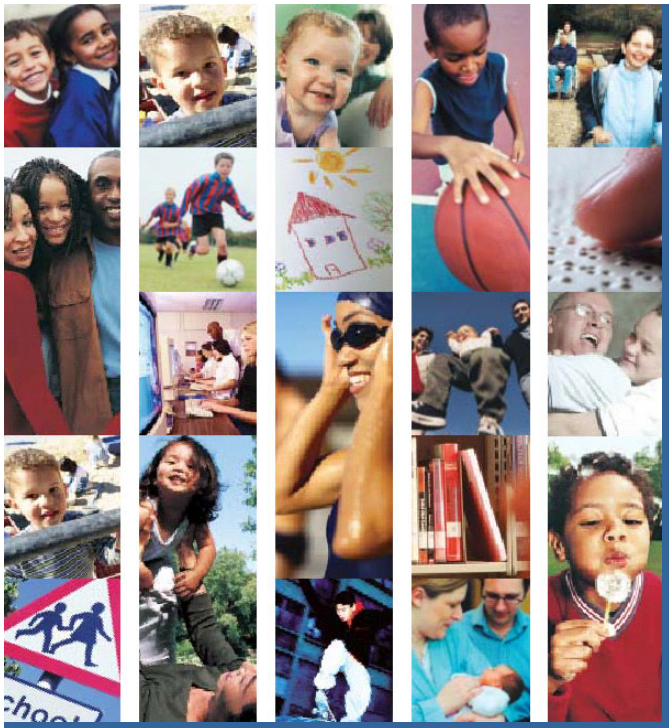
Members noted that a significant proportion of calls to the Primary Care Trust

RESOLVED: That the report be noted.

29. DATE OF NEXT MEETING

It was noted that the next meeting of the Health and Care Partnership would be held at **10:30 a.m.** on **Monday 11th April, 2005** at **Brockington, 35 Hafod Road, Hereford**.

The meeting ended at 12.03 p.m. **CHAIRMAN**



Every Child Matters: Change for Children

Sue Fiennes
Director of Children's Services
Herefordshire Council
13th January, 2005

Every Child Matters…the vision

Radical improvement in opportunities and outcomes for children, driven by whole-system reform of the delivery of children's services.

Systemic change to

- Build services around the child, young person and family
- Support parents and carers
- Develop the workforce, changing culture and practice

and to integrate

- Universal and targeted services
- Services across the age range 0-19

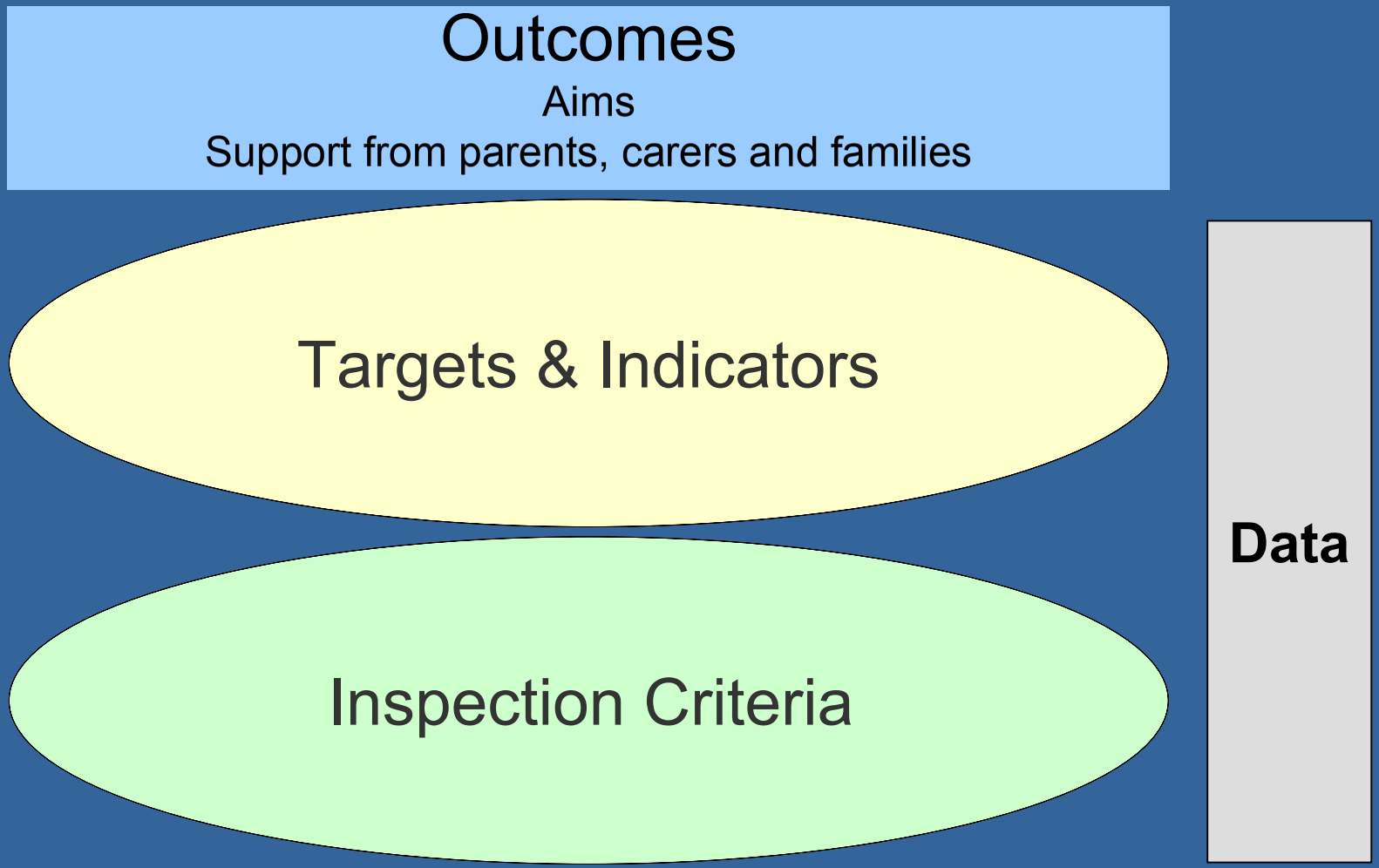
Every Child Matters…progress so far

- Legislative foundation: the Children Act 2004
- Outcomes Framework
- Cross-government change programme
- Building a national framework for 150 local change programmes

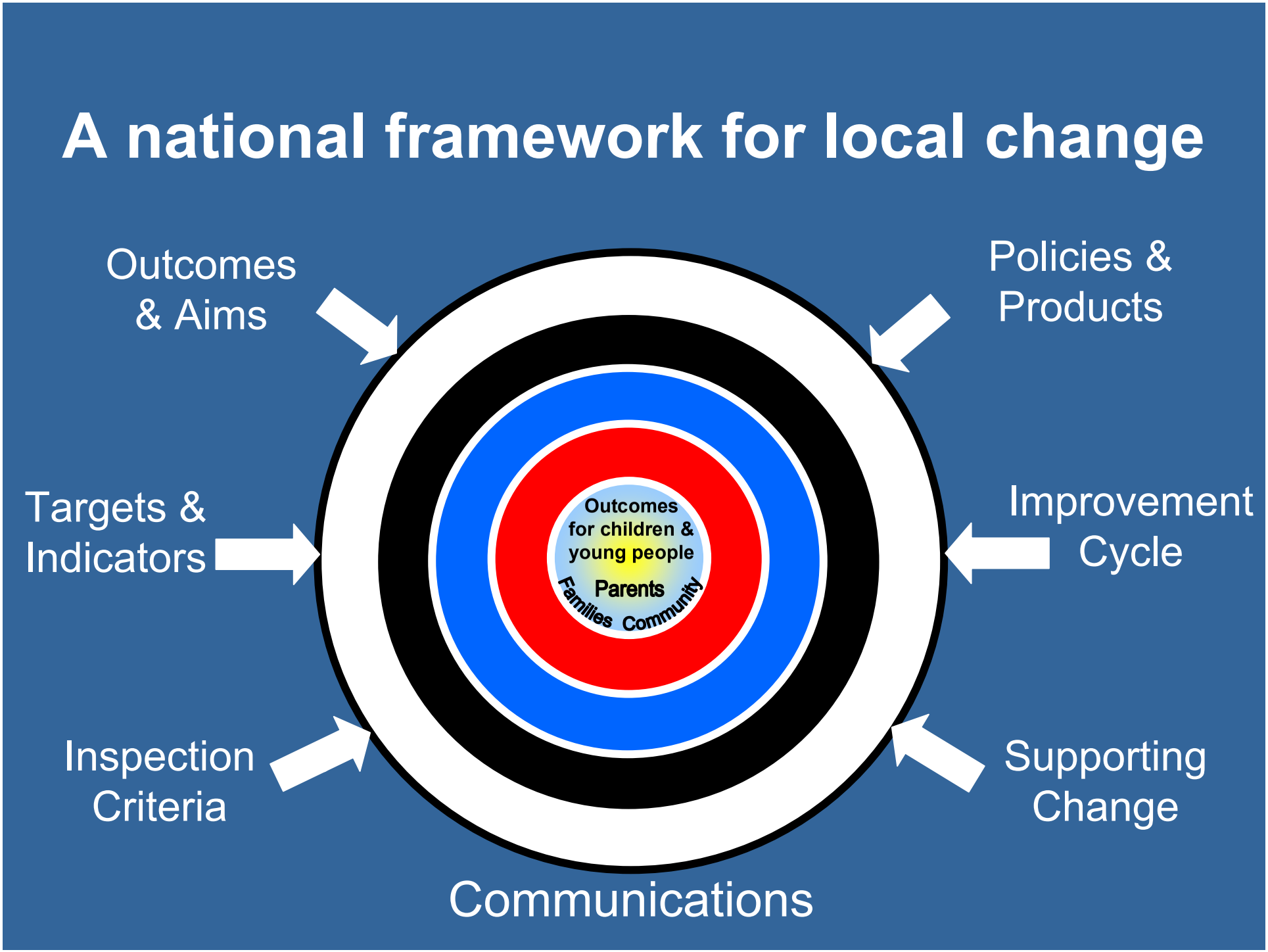
Children Act 2004

- Children's Commissioner
- Duty to cooperate (April 2005)
- Duty to safeguard and promote welfare of children
- Duty to set up Local Safeguarding Children Boards
- Provision for indexes or databases to enable better sharing of information
- Single statutory Children and Young People's Plan
- Director / Lead Member for Children's Services
- Joint Inspection Framework / Joint Area Reviews
- Provisions on foster care and private fostering
- Duty to promote educational achievement of looked after children

Outcomes Framework



A national framework for local change



The children's trust in action

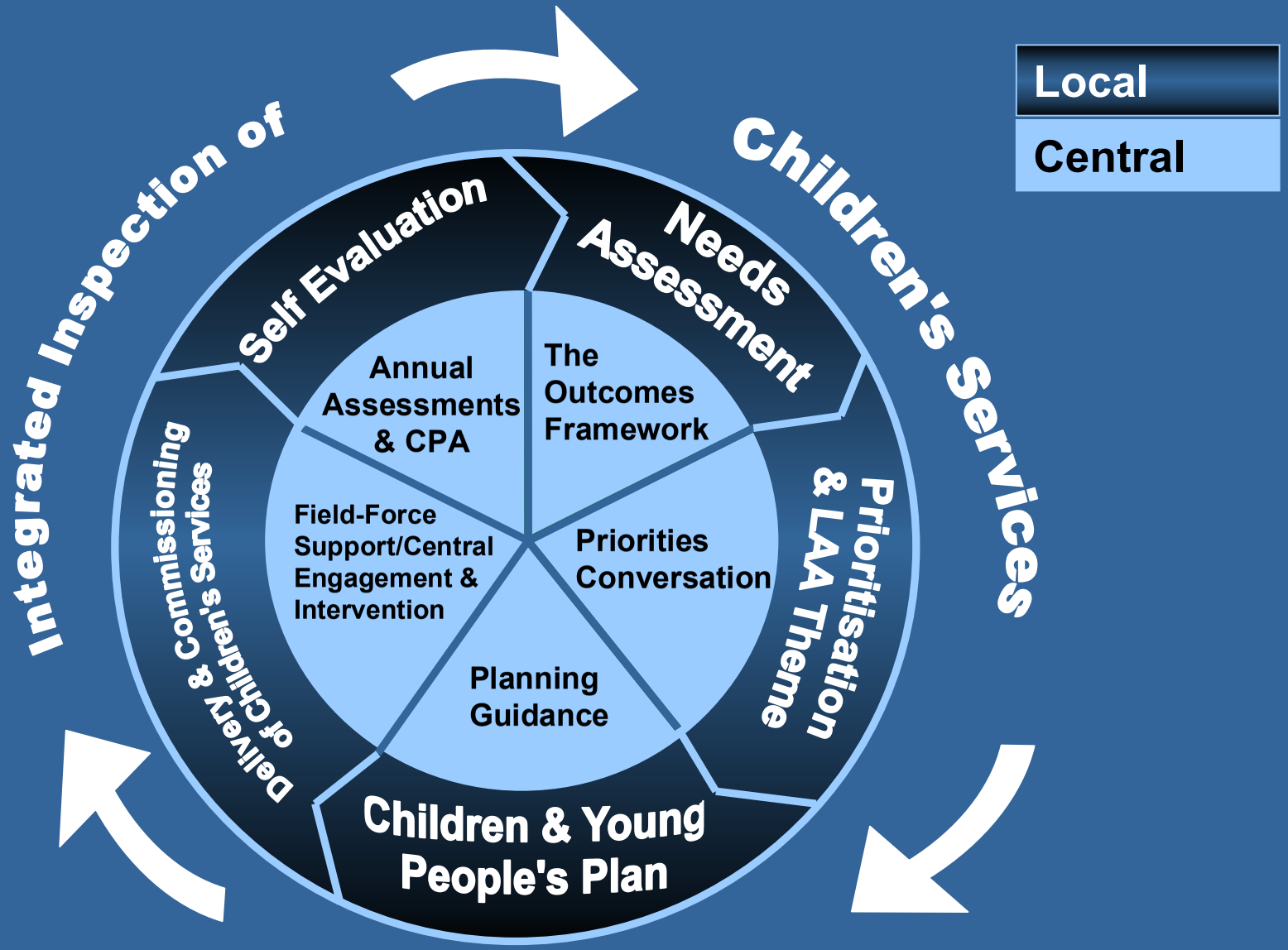
Children's trusts driving change

- Arrangements for working together to improve outcomes for all children and young people through:
  - the front line staff providing integrated services, including children's centres and extended schools
  - the processes to support these services
  - the planning which sets their direction
  - the governance arrangements which sustain them

Support for local change

- Regional Change Advisers in GOs
- Leadership support and development
- Sharing emerging / good practice
- Monitoring the impact of policies
- Resources for change
- Statutory and non-statutory guidance and other communications

Improvement Cycle for Children's Services

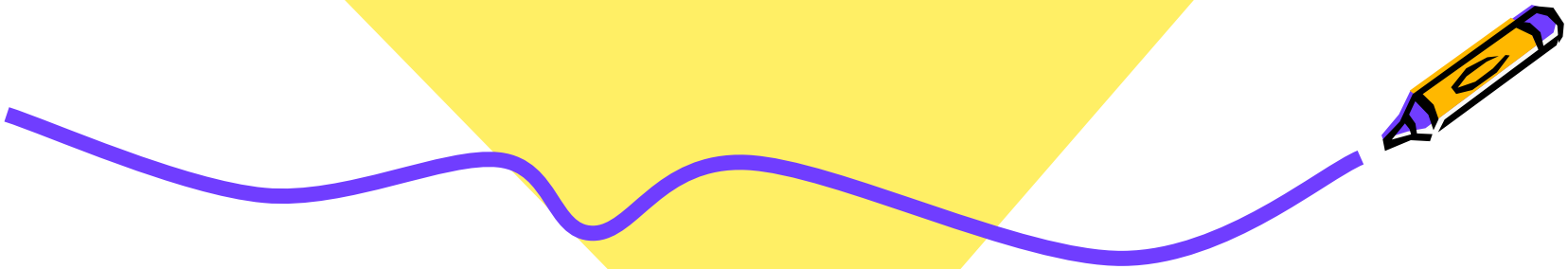


What Does Every Child Matters: Change for Children mean for me?

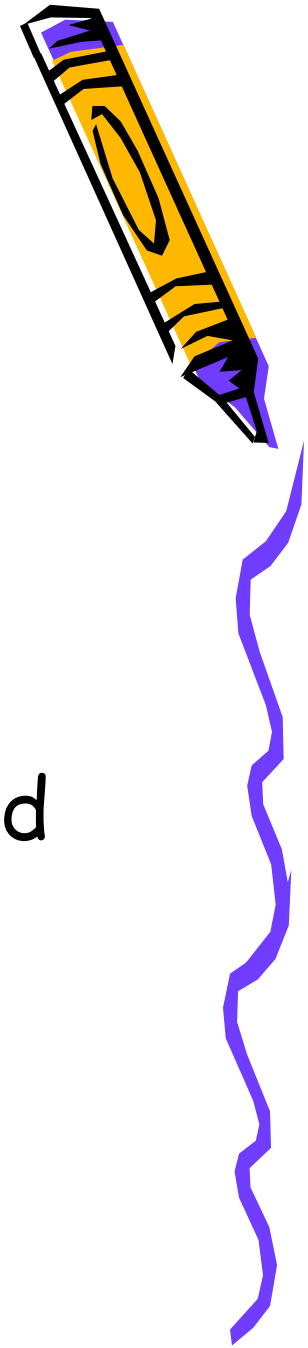
- How will it benefit the children and young people I work with?
- What do I need to do to deliver it successfully?
- What progress has my organisation already made?
- What barriers have we overcome, and how?
- What advice would I offer to others?
- Who will I need to work with?

National Service Framework for Children, Young People and Maternity Services

NSF

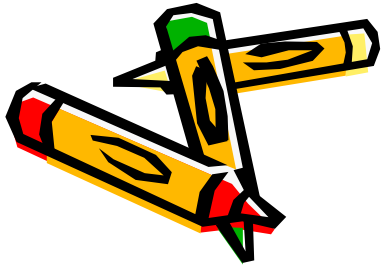


Policy Overview

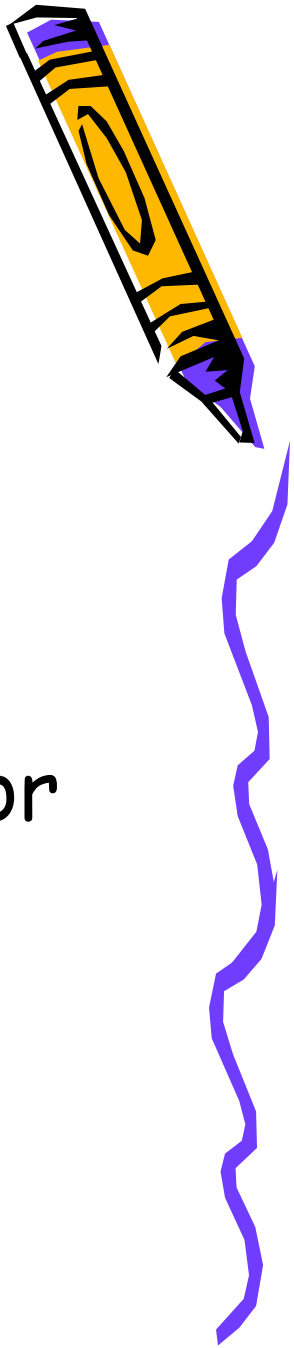


Kennedy + Laming Inquiries =

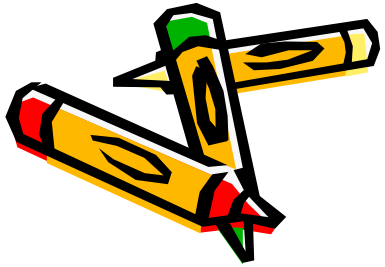
- Every Child Matters
- Children's Bill
- NSF for Children, Young People and Maternity Services



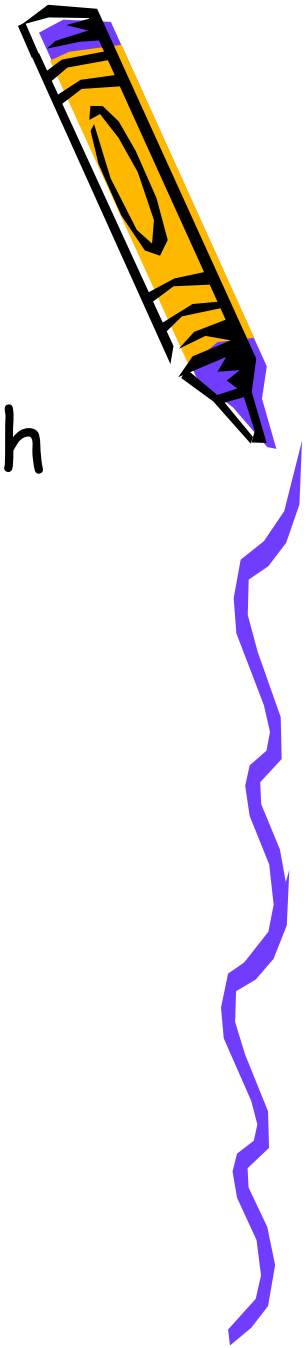
Policy Links



- NHS Plan
- Choosing Health – Making healthy choices easier
- Valuing People : A New Strategy for Learning Disability for the 21st Century

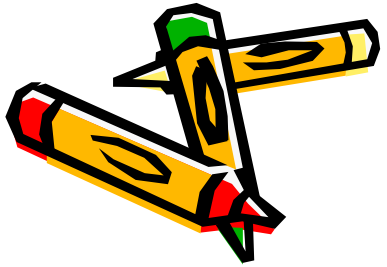


Children's NSF Overview;

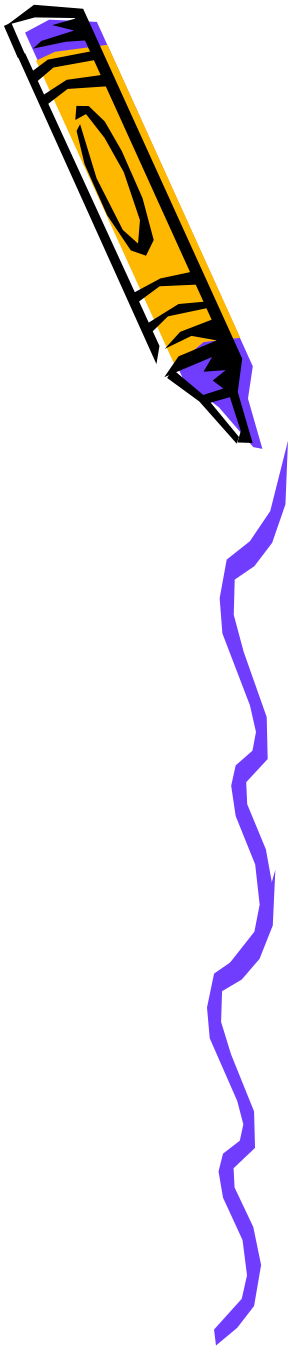


- A 10year plan to reform the Health and Social Care of Children
- There are 11 Standards that are expected to be achieved by 2014
- Standards are divided into

  3 main parts

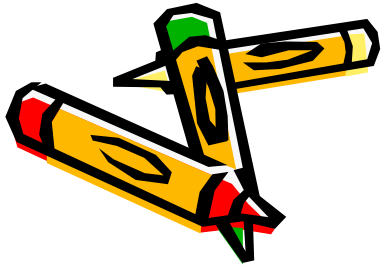


Vision for *all* children



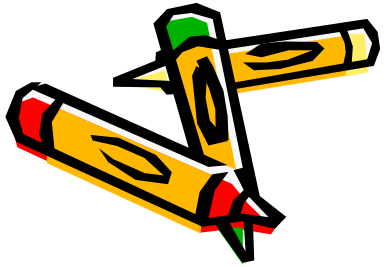
5 Outcomes

- Being healthy
- Enjoying and Achieving
- Staying Safe
- Achieve Economic Well Being
- Make a positive contribution



The Children Act 2004 requires that Local Authorities:

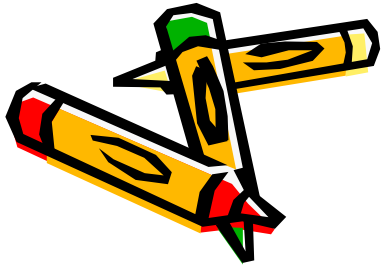
- Work co-operatively
- Appoint a Director of Children's services
- Appoint an Elected Member with Lead responsibility for Children



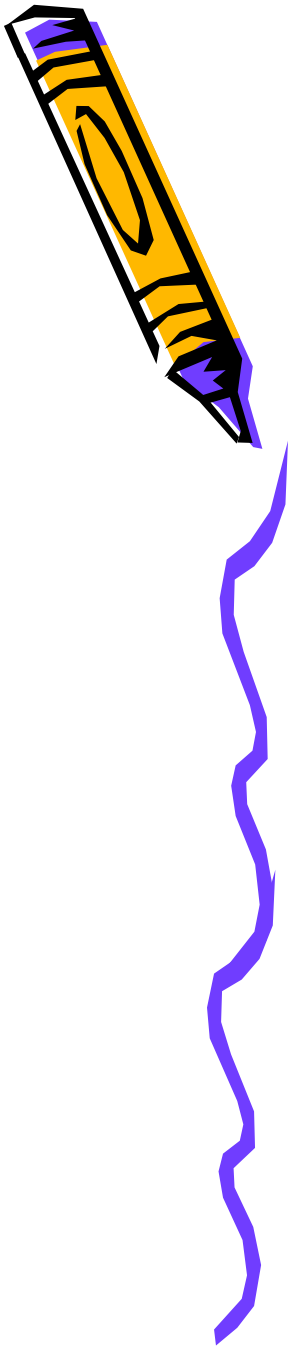
Key Messages of the NSF

Services should:

- Aim for early identification and intervention
- Provide integrated and co-located services that are child and family focused



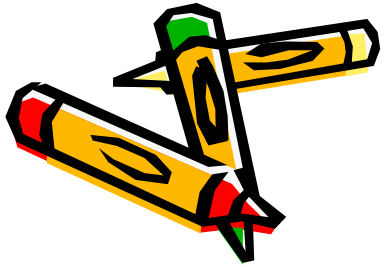
Key Messages of the NSF



This will require services to:

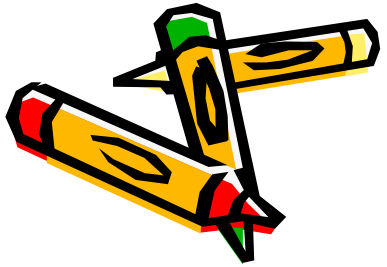
Co-operate to provide

- accessible services
- joint referral systems
- single assessments
- care co-ordination
- share information



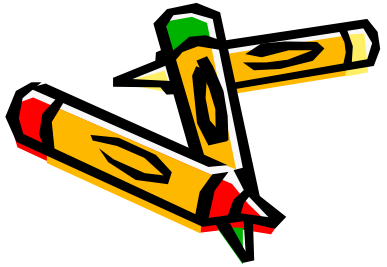
NSF Part One

- Early identification and intervention
- Support for Parents and carers
- Child and family centred services
- Transition into adulthood
- Safeguarding and promoting the welfare of children



NSF Standard 1

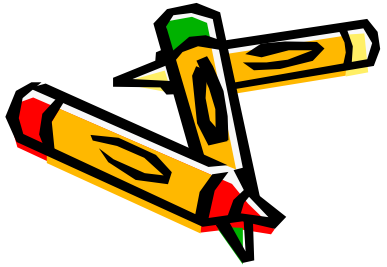
- Promoting Health and Well-Being,
- Identifying Needs
- Intervening Early



NSF Standard 2

- Timely information and support for Parents

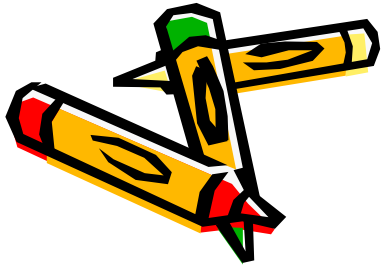
- Equip parents with the necessary skills



NSF Standard 3

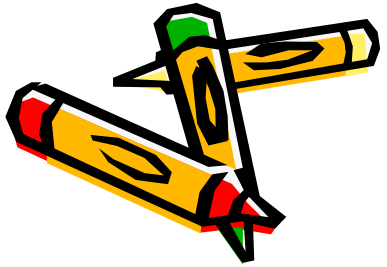
- Improving quality of and access to services

- Co-ordination of services around individual and family needs



NSF Standard 4

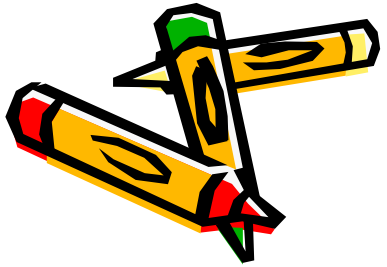
- Services are age appropriate and responsive
- Transition to adult services is planned and co-ordinated



NSF Standard 5

- Safeguarding children

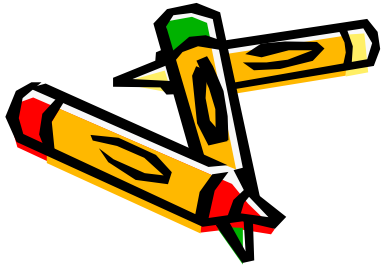
- Promoting the welfare of children and young people



NSF Part Two

Standards 6-10 address children who have particular needs;

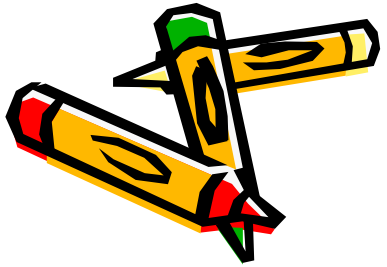
To be implemented in conjunction with Standards 1-5



NSF Standard 6 and 7

All children who are ill will have timely and effective services

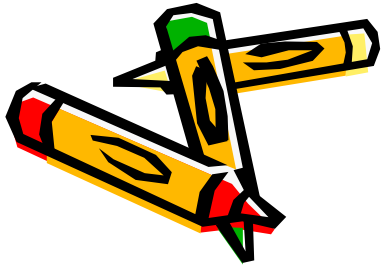
Wherever possible children should be cared for at home



NSF Standard 8

Children who are disabled, or have complex needs, receive care that is;

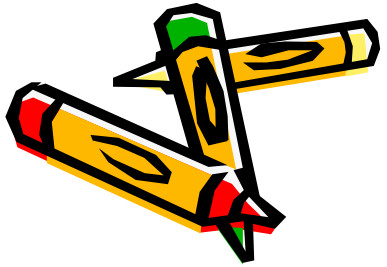
- Co-ordinated
- High quality
- Family centred
- Based upon need



NSF Standard 9

Children and young people with mental health problems are;

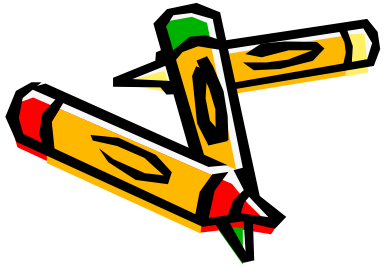
- Identified early
- Offered appropriate, timely intervention
- Receive care from multi agency teams



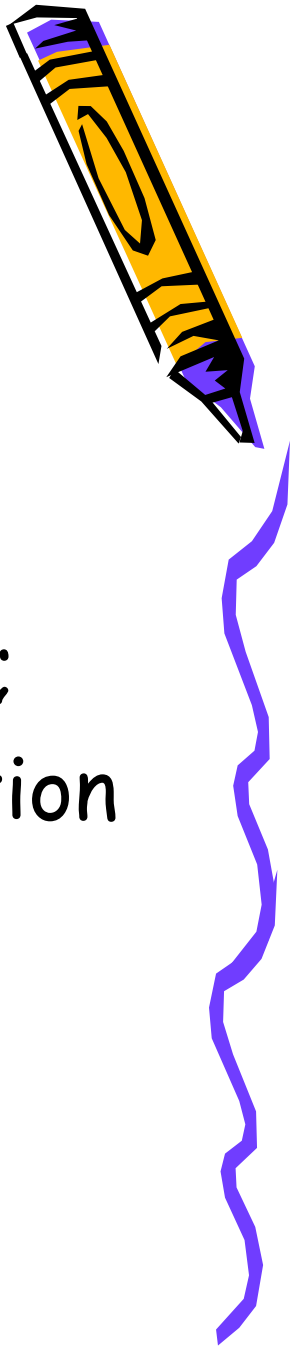
NSF Standard 10

Children will have access to safe and effective medicines

Decisions about prescription medicines are based upon best available evidence

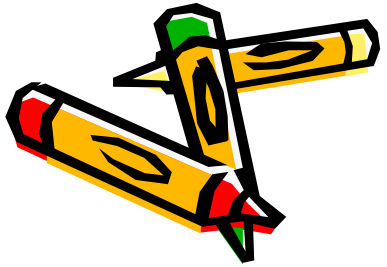


NSF Part Three



Addresses the particular needs and choices of women and their babies;

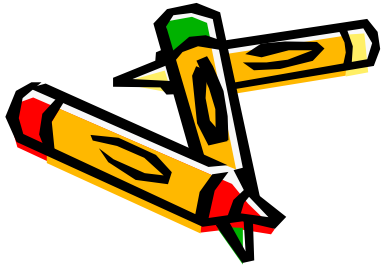
it should be implemented in conjunction with the other standards



NSF Standard 11

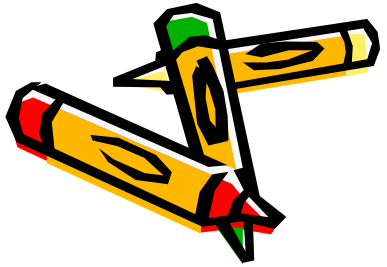
Women have easy access to services around their individual needs

The health of mother and child should be promoted through early identification and intervention



Messages for Local Delivery

- Work in partnership
- Consider the child journey
- Establish a joint commissioning approach
- Set local targets
- Assess outcomes



HEALTH AND CARE PARTNERSHIP **11th APRIL 2005**

JOINT HEALTH AND CARE COMMISSIONING GROUP BRIEFING NOTES

Report By: Jean Howard, Programme Manager, IMPACT

PURPOSE

This paper highlights the issues dealt with by the Health and Care Joint Commissioning Group and gives details about where members of the Partnership can seek additional information on the items discussed and agreed.

The Joint Commissioning Group held on 17th March 2005 addressed the following:

1. Information items

a. Work is continuing on revising Joint Commissioning arrangement following outline agreement of the JCG at the previous meeting in December. Yvonne Clowsley and Jean Howard will present a second draft proposal to the group in June.

b. Simon Hairsnape advised the group the LDP was now available for circulation. Anyone wishing to receive an electronic or paper format should contact Julie Rogers on 01423 363960

c. Madeline Spinks gave a presentation on the State of Herefordshire report which is now available on the Councils web site. The group found the discussion useful and interesting and commended Madeline and her team on the production of this excellent document.

d. Yvonne Clowsley briefly updated the group on the progress of the Joint Health and Care Commissioning Plan. The Partnership Officer who has been working on this has now left to take up a new post and the group agree to the suggestion we should get someone from an agency to take this work forward, as a permanent replacement for the Partnership Officer is unlikely to be in place before the summer. This has now been actioned and the draft Commissioning plan should be available for the June meeting of the JCG.

2. Partnership Fund

Yvonne tabled a paper outlining agreed spend against the main schemes budget. Helen Horton and Jean Howard advised of the arrangements in place this year for the Small Schemes element and advised that five organizations had made application for funding. The JCG agreed them all subject to a further discussion with one particular organisation. This has now taken place and all organisations have been notified. The organisations concerned are Heart Start, Kidz First, Carers Action, Head Way and the Alzheimer's Society.

A copy of the report is available from Yvonne Clowsley on 01432 369389

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3. Partnerships for Older People Projects (POPP)

This is a recently announced Government initiative which invites local councils to bid for pump priming money to fund innovative pilot projects designed to:

provide person centred and integrated care for older people and;

to encourage investment in preventative approaches, which promote health, well-being and independence

It is a requirement that Councils work in partnership with local PCTs and Voluntary Sector partners and a local steering group involving senior officers and practitioners has been set up. Jean Howard will coordinate the stage one bid which will be submitted in outline by the 12th May 2005. Successful authorities will be notified on 10th June; they will than need to submit detailed proposals by 2nd September and the go ahead will be given on 30th September, if successful.

There is potentially £500,000 available to Herefordshire in 2006/7 and a further £500,000 in 2007/8 with the option of applying for one or both years. However, this is not recurring money and we need to ensure any projects can be contained within the two years or sustained investment can be achieved through shifts in current types of service provision to those with a greater emphasis on prevention.

Further information on the grant is available on the DOH website.

4. The Alliance

Helen Horton tabled a paper entitled 'Working collaboratively for improved health and care services in Herefordshire' and gave an update of progress made so far by the Alliance. She reported that steady progress had been made but not as speedily as had been anticipated, due to demands made by the PPI forums, which was taking time away from the main work of the organisation. However the Alliance would be relinquishing this work in August which would free up resources.

Overall the Alliance felt the ambition of the service level agreement was not matched with the capacity to deliver and would welcome a discussion with the funders. It was agreed this discussion should take place and should focus on agreeing priorities, and how to work together to lever in additional resources to support the Alliance.

Further information is available from Helen Horton on 01432 265586.

HM Government

DH Department of Health

CHOOSING HEALTH

Making healthy choices easier

Executive Summary

Working in partnership across government with people, their communities, local government, voluntary agencies and business

NHS

EXECUTIVE SUMMARY

Introduction

1. England has a proud history of improving the health of its people. Over the past three centuries, the combined impact of individuals, families, communities, national and local government, education, business and industry, and voluntary, faith and charitable bodies has seen unthought of progress in the health of the people of England.

2. Some of that progress has been driven by wider social, economic, environmental and cultural trends as England benefited from economic growth, improving education, better housing and better sanitation. In the twentieth century health services also began to make a significant impact, gathering pace after 1948 as the establishment of the NHS enabled free universal provision of immunisation, screening and treatment to make in-roads into ill health and premature death.

3. The role of Government in the prevention of ill-health during this time was often a top-down approach, reflecting the cultural and political relationships of the times. In the post war era of deference in a homogenous society, 'Public Health' was often seen as something that was *done to* the population, for their own good, by impersonal and distant forces in Whitehall and the public bodies and professionals that it directed, with varying degrees of success.

4. As rapid progress was made on the big killer infectious diseases of the past, more intractable issues and conditions such as cancer and coronary heart disease came to the fore. The absence of obvious simple, quick solutions to these diseases and the increasing preoccupation of the NHS in coping with rising demand for treatment, meant that too often public health was diverted into better analyses of the problems they were witnessing rather than practical solutions. With widening health inequalities, a sharp rise in obesity, a slowing in the decline of smoking rates, growing problems with alcohol, teenage pregnancy and sexually transmitted diseases, old ways of thinking about and responding to public health problems were, increasingly being shown to be inadequate.

5. While there were many notable successful public efforts, such as the response to HIV and AIDS, too often work to tackle longstanding, intractable or emerging problems was increasingly caught up in a sterile national debate, disconnected from the real lives of the public, that created a false dichotomy between those proposing a heavy handed nanny state on one hand, and those supporting inactivity bordering on neglect in the name of individual freedom on the other.

6. At the same time, new opportunities have been opening up rapidly. The public is now used to consuming a range of goods and services and enjoy the choices available to them. However, they look to Government to assist them with information about healthy and unhealthy choices. Not to make the decisions for them, but to provide them with clear information. Information technology and the internet have transformed the way in which we can communicate information. At the same time, the NHS is freeing itself from a decades-old crisis focused on waiting for treatment, which is creating the time, space and resources needed for effective action on prevention. Now action to improve health and to provide the practical support to achieve this is needed urgently. Paragraphs 11–33 summarise many of the key actions we are putting into place.

A new approach to the health of the public

7. The time is now right for action. At the start of the twenty-first century England needs a new approach to health of the public, reflecting the rapid and radical transformation of English society in the latter half of the twentieth century, responding to the needs and wishes of its citizens as individuals and harnessing the new opportunities open to it. To sustain and build upon an historic track record of progress and effectiveness, it needs policies and approaches which reflect the realities of people's lives today. That means an approach which respects the freedom of individual choice in a diverse, open and more questioning society; which recognises the realities of the impact of the consumer society on those choices; which addresses the fact that too many people and groups have been left behind or ignored in the past; and which moves forward at the pace which the people of England want and will support.

Reconnecting with people's lives

8. The first and critical stage in that process was to listen to the views of the people in England, to get in touch with their real concerns and to ask what ***they*** wanted and how ***they*** could be helped to realise ***their*** aims. For this White Paper, it is the public who have, for the first time, set the agenda and identified what 'for their own good' means, not Whitehall. They have made clear where they want support, where they want to be left alone by Government and where they want Government to intervene. They have also made clear that they wish to see change. Chapter 1 – the time for action on health and health inequalities – describes the extensive and unprecedented consultation that has gone into reshaping public health policy for the public and by the public.

Underpinning principles

9. That process has enabled us to establish three core principles of a new public health approach. These underpin the whole of this strategy, and are set out in Chapter 1:

(1) Informed choice. People want to be able to make their own decisions about choices that impact on their health and to have credible and trustworthy information to help them do so. They expect the Government to provide support by helping to create the right environment. However, this principle is subject to two qualifications. First, people believe that we need to exercise a special responsibility for children who are too young to make informed choices themselves. Second, people agree that we need special arrangements for those cases where one person's choice may cause harm or nuisance to another, such as exposure to second hand smoke. We need to balance rights and responsibilities, in ways that protect health.

(2) Personalisation. Some people want support in making healthy choices and sticking to them, but, particularly in deprived groups and communities, find current services do not meet their needs or are difficult to use. To be effective in tackling health inequalities, support has to be tailored to the realities of individual lives, with services and support personalised sensitively and provided flexibly and conveniently.

(3) Working together. The public are clear that Government and individuals alone cannot make progress on healthier choices. Real progress depends on effective partnerships across communities, including local government, the NHS, business, advertisers, retailers, the voluntary sector, communities, the media, faith organisations and many others. People look to Government to lead, coordinate and promote these partnerships, and expect that the other players take their health and the health of their families seriously and are prepared to engage constructively in a shared effort.

Overarching priorities

10. The consultation process was also critical in establishing a shared set of priorities for action. These are:

- **Reducing the numbers of people who smoke,** because it leads to heart disease, strokes, cancer and many other fatal diseases; because many people felt this was an area in which they needed more support in addressing the problem; because many people were concerned about the affects of second-hand smoke; and because many parents were concerned about their children taking up smoking.

- **Reducing obesity and improving diet and nutrition,** because the rapid increase in child and adult obesity over the past decade is storing up very serious health problems for the future if it is not addressed effectively now. Effective action on diet and exercise now will help to tackle heart disease, cancer, diabetes, stroke, high blood pressure, high cholesterol and a range of factors critical to our health.
- **Increasing exercise,** because it reduces the risk of major chronic diseases and premature death. Over a third of people are not active enough to benefit their health, and rates of walking and cycling have fallen over the last 25 years.
- **Encouraging and supporting sensible drinking,** because alcohol misuse is associated with deaths from stroke, cancer, liver disease, injury and suicide; because it places a burden on the NHS, particularly on Accident and Emergency departments; and because it is related to absenteeism, domestic violence and violent crime.
- **Improving sexual health,** because risk-taking sexual behaviour is increasing across the population; because diagnoses of HIV, Chlamydia, genital warts and Syphilis have increased in recent years; because sexually transmitted infections can lead to cancer, infertility and death; and because delay in diagnoses and treatment can lead to more people being infected.
- **Improving mental health,** because mental well-being is crucial to good physical health and making healthy choices; because stress is the commonest reported cause of sickness absence and a major cause of incapacity; and because mental ill-health can lead to suicide.

Chapter 2 – Health in the consumer society

11. Many of the choices that affect our health are choices we make as consumers. The consultation generated a debate between producers, retailers, the marketing industry, the media, communities and individuals about how best to make choosing health an easier option for consumers.

12. People get information on health from many different sources including friends and family, product labelling, the media, and national campaigns. Chapter 2 sets out a modern strategy for health that includes action to stimulate both demand for healthier options – through information that people trust – and the availability of those options so that people can take up the choices they want to make.

Marketing health – we will work across government and with other organisations in the

voluntary and independent sector, through a strategy to bring together messages that raise awareness of health risks with information about action that people can take themselves to improve their health – for example by changing their diet, taking more exercise or seeking advice through telephone help lines, local health improvement services or clinics. Action will be linked to activities in communities, schools and workplaces. The focus will be on:

- **sexual health** – with a new national campaign targeted particularly at younger men and women to ensure that they understand the real risk of unprotected sex and to persuade them of the benefits of using condoms to avoid the risk of sexually transmitted infections or unplanned pregnancies;
- **obesity** – a new cross-government campaign to raise awareness of the health risks of obesity, and the steps people can take through diet and physical activity to prevent obesity;
- **smoking** – a boosted campaign to reduce smoking rates and motivate smokers in different groups to quit supported by clear information about health risks, reasons not to smoke and access to NHS support to quit, including Stop Smoking Services and nicotine replacement therapy; and
- **alcohol** – working with the Portman Group to cut down binge drinking.

Food labelling – the Government will work with the food industry to develop better information on the nutrition content of packaged food. Our goal is, by early 2006, for there to be:

- a clear straightforward coding system
- that is in common use
- that busy people can understand at a glance which foods can make a positive contribution to a healthy diet, and which are recommended to be eaten only in moderation or sparingly.

Information for the public – we will commission a new service – Health Direct – to provide easily accessible and confidential information on health choices. Health Direct will be set up from 2007. It will include links to existing services where they exist – for example, information on diet and nutrition (provided by the Food Standards Agency) and support for parents (provided by Sure Start and other agencies).

Information for the media – we will expand the existing programme of expert briefings provided by the Chief Medical Officer and support the development of an independent national centre for media and health.

13. Chapter 2 also sets out action to address inequalities in health that focuses particularly on getting information across to people in different groups and securing better access to healthier choices for people in disadvantaged groups or areas.

Tackling inequalities – we will help providers of local services to:

- tailor information and advice to meet people's needs, and support staff to communicate complex health information to different groups in the population; and
- provide practical support for people who lack basic skills to help them use health information, including signposting them to extra support through programmes such as *Skilled for Health*.

14. Where demand for healthier choices is increasing – for example following the national campaigns on 5 A DAY and on salt – industry is already responding. However, the Government has a role in taking the lead on issues where strong national and public concern about health indicates the need to do more to increase awareness of the benefits and supply of healthy options – in particular, maintaining a balance between exercise and a healthy diet.

Partnership with industry – the Government intends to discuss with the food industry how it might contribute to funding national campaigns and other national initiatives to promote positive health information and education.

Health Ministers and the Food Standards Agency are leading discussions with industry aimed at:

- increasing the availability of healthier food, including reducing the levels of salt, added sugars and fat in prepared and processed food and drink, and increasing access to fruit and vegetables;
- reversing the trend towards bigger portion sizes;
- adopting consistent and clear standards for information on foods including signposting;
- introducing long-term and interim targets for reducing sugar and fat levels in different categories of foods; and
- developing guidance on portion sizes to reduce fat, sugar and salt intake.

Coordinated action – we will work with the farming and food industries to coordinate action through a Food and Health Action Plan to be published in early 2005.

15. Responses to the consultation indicated that while people felt it was generally right to leave lifestyle choices up to each individual, Chapter 2 sets out the steps that the Government will take to protect children and help them to make healthier choices about what food to eat, and about alcohol and smoking.

Food promotion to children – the Government is committed to securing, by 2007, a comprehensive and effective strategy for action to restrict the advertising and promotion to children of foods and drinks that are high in fat, salt and sugar covering through both broadcast and non-broadcast media, sponsorship, vending machines and packaging.

Social responsibility scheme for alcohol – we will also work with industry to develop a voluntary social responsibility scheme for alcohol producers and retailers, to protect young people by:

- placing information for the public on alcohol containers and in alcohol retail outlets;
- including reminders about responsible drinking on alcohol advertisements; and
- checking identification and refusing to sell alcohol to people who are under 18.

Restrictions on tobacco advertising – by the end of the year, the size of tobacco advertising still allowed in shops will be restricted, and in 2005 we will end internet advertising and brand-sharing.

Chapter 3 – Children and Young People – Starting on the Right Path

16. Chapter 3 sets out action to support children and young people, as well as their parents, families, carers and staff in the public and voluntary sectors.

17. Services will be coordinated to meet needs and increasingly brought together in one location as part of an integrated service delivery through children's trust arrangements that involve everybody working together locally to improve outcomes for children.

Integrated planning and delivery of services – we are recommending that all areas should have a children's trust by 2008 and we will work with local authorities to establish over 2,500 children's centres by March 2008. We will also encourage more schools to develop as extended schools, working with other local agencies to offer opportunities to pupils, their families and the local community both for activities and classes out of school hours, and for accessible health and social care.

School nursing services – we will modernise and promote school nursing services, expanding the number of qualified staff working with primary and secondary schools so that, by 2010, every cluster of schools will have access to a team led by a qualified school nurse.

18. There will be new sources of information guidance and practical support for parents, children (particularly those who are disadvantaged in early years) and young people, provided in ways that are designed to meet their individual needs and accessible to everyone.

Personal health guides – Children's Health Guides are being introduced as part of the new Child Health Promotion Programme. As they grow up, each child will take on responsibility for developing their own health goals with help from their parents or carers, school staff and health professionals, including health visitors and school nurses. These plans will be the foundation for personal health guides for life.

Support for parents and carers – we will develop better access to information on all aspects of growing up, through more accessible services that are tailored to local needs.

Nutrition – from 2005, a new scheme – Healthy Start – will provide disadvantaged pregnant women and mothers of young children with vouchers for fresh food and vegetables, milk and infant formula.

Local support – *Sure Start* will develop new programmes in 2005 to improve support for parents in understanding the things that impact on their children's social, emotional and physical development in the early years. By 2007, nine out of 10 areas will provide home volunteer visiting programmes through *Home Start* for families under stress.

Looked-after children – new guidance for carers to be published in 2005 will help carers engage looked-after children to improve their self-esteem, social skills and emotional well-being.

Support and information for young people – we are developing a new *youth offer* that will be the subject of a forthcoming cross-government Green Paper. This will include specific new proposals to improve health and provide alternatives to risk-taking behaviour. We are also developing new sources of information about health – for example, a new magazine *FIT* will be designed to get health information across to young men aged 16 to 30, targeted information for young people on sexual health and developing responsible sexual relationships. From 2006, we will pilot health services specifically targeted at meeting young people's needs.

19. The components of good health will be a core part of children's experience in schools through a coordinated 'whole school' approach to health – in lessons, sport, provision of food, personal advice and support, and travel arrangements.

Healthy schools – the *National Healthy Schools* programme encourages schools to foster better health in everything that schools provide – including a healthy environment with policies on smoking, healthy and nutritious food, time and facilities for physical activity and sport both within and beyond the curriculum, and a comprehensive programme of personal, social and health education. Our aim is that half of all schools will be healthy schools by 2006, with the rest working towards healthy school status by 2009.

Standards and inspections – from 2005, all relevant inspections of services for children will be carried out under a single overall inspection framework focusing on how services contribute towards improving the well-being of children and young people, including their physical and mental health.

Food in schools – by the end of 2004, all 4–6 year olds in LEA-maintained schools in England will be eligible for free fruit or vegetables. We are investing to improve nutrition in schools through revision in standards for school meals and, subject to legislation, extension of the standards to cover vending machines and tuck shops, and through improved training and support for catering staff. We will seriously consider introducing nutrient-based standards. From early 2005, a new *Food in Schools* package will support implementation of the 'whole school' approach to healthy eating.

School travel – by 2010, building on existing progress, all schools in England should have active travel plans.

Support for cycling – we will drive forward the new National Standard for cycle training across England by 2006, through new support for instructor training schemes and advice to local communities on implementation.

20. There will be new initiatives to promote physical activity and sport inside and outside school.

PE and school sport – we are significantly increasing investment in PE and school sport as part of the *National Strategy for PE, School Sport and Club Links* to promote sport in schools and lifelong participation in sport via out-of-school-hours learning, inter-school sport and school-clubs links for all children and young people – focusing particularly on those who do not traditionally take part in sport. In 2006, all maintained schools will be in a school sports partnership and we aim to

have at least 400 sports specialist schools and academies with a sports focus.

21. We will strengthen measures to protect children and young people and help them understand and manage risk – including risks in sexual activity and smoking.

Underage tobacco sales – we will develop a communications programme to support local authority enforcement of underage tobacco sales and we propose to bring forward legislation to strengthen powers in this area.

Teenage pregnancy – we will support implementation of the *Teenage Pregnancy Strategy*, in particular through action in neighbourhoods with high teenage conception rates.

Chapter 4 – Local Communities Leading for Health

22. Chapter 4 sets out how the environment we live in, our social networks, our sense of security, socio-economic circumstance, facilities and resources in our local neighbourhood can affect our experience of health. There are unacceptable differences in people's experience of health between different areas and between different groups of people within the same area. Action by local authorities working with local communities, business and voluntary groups to tackle local health issues makes a difference to the opportunities for both adults and children to choose healthier lifestyles.

23. This chapter sets out action to maximise the positive impact of the local community setting with measures that will mean successful community-based models for improving local health can be more confident of sustained support.

- We will support new community 5 A DAY initiatives in deprived communities – from 2006, more primary care trusts (PCTs) will provide support for cookery clubs and food co-ops to encourage fruit and vegetable consumption. From 2006, we will extend healthy community collaboratives to new areas and we will use collaborative techniques to support action through local partnerships.
- A new National Strategic Partnership Forum is being set up to help promote health through cooperation between the NHS and the voluntary sector, and revised guidance on health and neighbourhood renewal will be published in 2005.
- Beginning in spring 2005 we will pilot a new approach in 12 localities, *Communities for Health*, to promote action on locally chosen

priorities for health across the local voluntary sector, the NHS, local authorities, business and industry.

- From 2006, through the Public Health Observatories, we will publish new reports for local communities, and a national composite report, based on a standard set of local health information that can be linked to other local data sets.

24. Local authorities and PCTs will have more flexibility to develop local targets through local partnership, in response to local needs.

- Working with local government and other partners, including PCTs and children's trusts, from 2005 we will pilot *Local Area Agreements* in 21 areas to secure local delivery of national priorities, reinforce joint working and bring together different funding streams in ways that reflect local priorities. From April 2005, PCTs will develop targets to meet the needs of people living in their area that are agreed with local partners to meet national targets set by *Choosing Health* and the *NHS Improvement Plan*.

25. Football and other sports have a huge reach and engagement and a strong community base, alongside other forms of active recreation they make a significant contribution to overall physical activity levels in the population. There will be new opportunities for people who want to be more active through cycling, walking, and easier access to sports facilities.

- We will use lessons learned from the 27 local authority pilots on improving parks and public places to invest through the new *Safer and Stronger Communities Fund* and will build on the *Sustainable Travel Towns* pilot to develop new guidance on 'whole town' approaches to walking, cycling and public transport.
- By 2006, local authorities, working with the transport charity Sustrans, are forecast to build over 7,000 miles of new cycle lanes and tracks, and we are also providing new investment to link more schools into the existing National Cycling Network.
- New initiatives will encourage the use of pedometers to promote awareness of the benefits of physical activity among pupils in schools and in clinical practice. And building on the success of the *Local Exercise Action Pilots*, we are setting up new initiatives to promote and coordinate local roll-out of evidence-based physical activity interventions and guidance on best practice for local authorities, PCTs and voluntary bodies.

- We will also publish new guidance in 2005 on best practice in local development of free swimming and other sports initiatives and on fostering links between PCTs and sports clubs.

26. Organisations, including NHS organisations, will increasingly use their corporate power in ways that promote the health and well-being of their local communities, and people across all sectors of society will be encouraged to work together to improve health.

- We will work with others to develop a network of local health champions – including people in local government, voluntary organisations and individuals – to share good practice and celebrate success.
- We will invite national and local organisations to develop their role as corporate citizens by making their own pledges on improving health to their workforce, local community or customers.
- We will sponsor development of good practice for action across the public and private sectors to improve the health of employees and the wider community. And, building on work being taken forward by the Food Standards Agency and others for schools, the NHS and the armed forces, we will develop nutritional standards for the public sector.
- Building on the Sustainable Development Commission's *Healthy Futures* programme, we will develop new guidance for the NHS on food procurement and on capital development and building programmes.

27. Smoking is a major cause of ill-health. Balancing the rights of people who choose to smoke against the interests of the majority who object to being exposed to second-hand smoke at work and in public places was one of the most controversial issues in the consultation. This is an area where campaigns and public demand for change have not done enough to achieve national targets to reduce prevalence in smoking. We therefore intend to shift the balance significantly in favour of smoke-free environments.

By 2006, all government departments and the NHS will (subject to limited exceptions) be smoke-free.

We will consult on detailed proposals for regulation with legislation where necessary, so that by the end of 2008, all enclosed public places and workplaces will be smoke-free except those specifically exempted.

Chapter 5 – Health as a way of life

28. The consultation made clear that people are ambitious for their health and the health of their families, but often found it difficult to turn good

intentions into sustained action. People wanted support both in making the right decisions for their own health and help to carry them out in practice. This chapter sets out new proposals to provide that support.

- First, anyone who wants help to make healthier choices and stick to them will have the opportunity to be supported by a new kind of personal health resource, NHS health trainers. In keeping with a shift in public health approach from 'advice from on high to support from next door', health trainers will be drawn from local communities, understanding the day-to-day concerns and experiences of the people they are supporting on health. They will be accredited by the NHS to have skills appropriate to helping members of their community to make the changes they want. In touch with the realities of the lives of the people they work with and with a shared stake in improving the health of the communities that they live in, health trainers will be approachable, understanding and supportive. Offering practical advice and good connections into the services and support available locally, they will become an essential commonsense resource in the community to help out on health choices. A guide for those who want help, not an instructor for those who do not, they will provide valuable support for people to make informed lifestyle choices. From 2006, NHS-accredited health trainers will be giving support to people who want it in the areas of highest need, and from 2007 progressively across England. We will also consult shortly on proposals to offer disabled people the option of taking up a health-stocktake.
- Everyone who wants to will have the opportunity, starting in the areas of the country with the biggest health challenges, to use a Personal Health Kit to develop their own personal health guide, based on who *they* are, what *they* want and what *their* circumstances are. This tool will help people to identify their own priorities for health and the changes that they feel ready to make, to obtain online guidance about what will make the most impact on their lives, and to receive tailored advice on how to go about making changes and sticking to them. Starting from 2006 in the areas of highest need, and progressively across the country, people, if they want to, will be able to use a variety of different types of support from the NHS to develop their own personal health guides.

Chapter 6 – A health-promoting NHS

29. Chapter 6 sets out how the NHS, as it tackles waiting for treatment successfully, will increasingly become a health improvement and prevention service, supporting individuals in the healthy informed choices that they make. It includes measures to:

- Help local health services to plan and deliver effective action to tackle inequalities and improve health and to ensure that health improvement and prevention services are of a high quality and benefit from the same drive for modernisation and improvement as exists across the rest of the NHS.

We are giving PCTs the means to tackle health inequalities and improve health through funding to give greater priority to areas of high health need, new investment in primary care facilities, with a focus on the most deprived areas, and development of new tools to help PCTs and Local Authorities jointly plan services and check on progress in reducing inequalites.

We are working with the medical, pharmaceutical and dental professions to build on opportunities under the new contractual arrangements to develop health improvement activity in primary care.

The National Clinical Directors with the Deputy Chief Medical Officer will, by March 2005, make recommendations on building a comprehensive and integrated prevention framework across all the areas covered by the National Service Frameworks, focusing particularly on action to tackle health inequalities.

- Make the most of the millions of encounters that the NHS has with people every week and ensure that all NHS staff have training and support to embed health improvement in their day-to-day work with patients.

We will develop training and support for all NHS staff to develop their understanding and skills in promoting health and to foster and expand a comprehensive range of community health improvement services, building on the new health trainers and including more specialist practitioners.

- Address the needs of people at particular risk, such as those with long-term conditions or mental health problems.

By 2008, there will be 3,000 Community Matrons who will take the lead in providing personalised care and health advice for patients with complex problems with support from health trainers. We will also look at ways that independent sector partners can work with PCTs to develop new

approaches to improving the health skills of people with chronic conditions.

We will develop new approaches to helping people with mental illness manage their own care and all aspects of their health, and take forward work on development of a 'whole system' approach to tackling inequalities in the mental healthcare system experienced by people from minority black and ethnic minority communities.

- Ensure that health improvement and prevention services – such as sexual health services, NHS Stop Smoking Services, obesity and alcohol services – benefit fully from the same drive for modernisation and improvement that exists across the rest of the NHS.

Smoking: improving services and disseminating best practice – the Healthcare Commission will assess local progress in reducing smoking prevalence against national standards and indicators. We will establish a national task force to support efficiency and best practice in NHS Stop Smoking Services. We will develop campaigns to raise awareness of Stop Smoking Services linked to national campaigns, pilot use of electronic booking systems in the NHS to trigger advice for smokers on stopping smoking, build stop-smoking advice into surgical care pathways, promote access to nicotine replacement therapy and extend support services for people who want to quit.

Tackling obesity – NICE will prepare by 2007, definitive guidance on prevention, identification, management and treatment of obesity. We will develop a comprehensive care pathway for prevention and treatment of obesity and will support implementation through a range of new initiatives – including support tools for NHS staff in assessing risk of overweight and obesity in their patients, guidance on weight loss, advice on practical action to prevent obesity through diet and physical activity, and work with the independent sector to develop alternative approaches in behaviour change.

Sexually transmitted infections – we are committing new capital and revenue funding to modernise the whole range of NHS sexual health services, communicate better with people about risk, offer more accessible services and provide faster access to treatment. By March 2007, a national screening programme for chlamydia will cover all areas of England, and by 2008 patients referred to a GUM clinic will be able to have an appointment within 48 hours.

Alcohol harm reduction – we will build on commitments in the *Alcohol Harm Reduction Strategy* through guidance and training to ensure

all health professionals are able to identify alcohol problems early: piloting new approaches to targeted screening and brief intervention in the NHS with a particular focus on A&E settings; developing similar approaches in criminal justice settings to reduce repeat offending; and improving alcohol treatment services.

Chapter 7 – Work and Health

30. For people in employment, work is a key part of life. The environment we work in influences our health choices and can be a force for improving health – for individuals and the communities they are part of. Work offers self-esteem, companionship, structure and status as well as income.

31. Chapter 7 sets out the action that employers, employees, Government and others can take to extend healthy choices by:

- reducing barriers to work to improve health and reduce inequalities through employment;
- improving working conditions to reduce the causes of ill-health related to work; and
- promoting the work environment as a source of better health.

It also sets out what the NHS will do to become a model employer in supporting and promoting the health of its 1.3 million staff.

Maintaining health in work and helping people back to work – we will support initiatives to challenge discrimination and improve access to work for people with mental illness, increase the availability of NHS Plus services and develop occupational health services in the NHS to support employers in fostering the health of their workforce. We will work with the medical Royal Colleges and Faculties to ensure that the NHS supports a wider occupational health approach.

Promoting improved health in the workplace – we will work with the cycle industry to promote cycling. We will establish pilots to develop the evidence for effectiveness on promoting health and well-being through the workplace. We are working with Investors in People UK (IiP) to develop a new healthy business assessment, building on existing mechanisms already available to businesses. This work will be incorporated into the IiP Standard when it is next reviewed in 2007. Sport England will work with government departments to encourage and support staff to be more active in the workplace.

Promoting health of NHS staff – we will support NHS organisations in developing as healthier workplaces through development of a better evidence base to assess current practice, new guidance and dissemination of good practice, and initiatives to support leadership development.

Specific initiatives will include: Health Development Agency publication of guidance for NHS organisations on provision of smoke-free buildings; a joint campaign with the Royal College of Nursing to provide a comprehensive programme of support for nurses who want to quit smoking; work with NHS employers organisations to ensure implementation of the *Framework for Vocational Rehabilitation*; and new guidelines on the management of mental illness in the workplace.

Chapter 8 – Making it Happen – National and Local Delivery

32. Chapter 8 sets out the next steps for delivery of the White Paper. It shows how the new Public Health will move on from the debates of the past and move forward from an era of analysis and description to a hard focus on practical action. It introduces the key elements of how the strategy will be delivered – regulation, resourcing, joining up different parts of the system who can play a part, aligning and building partnerships and effective engagement with everyone who can contribute.

33. Annex B sets out in more detail how we will ensure a strong system delivers the commitments we make in this White Paper, and how we can build on the huge support for action to create irreversible momentum for change. These actions fall into three broad areas:

- Information and evidence – to provide the information and research evidence to achieve real-time health surveillance and support cost-effective interventions to improve health, inform commissioning of services and improve practice of front-line staff.

We will be increasing central funding for public health research from April 2006 and establishing a new public health research initiative within the framework of the United Kindgom Clinical Research Collaborative. This will be backed up by projects focusing on effective health interventions to support delivery of this White Paper and a National Prevention Research Initiative, working in collaboration with research funders in the fields of cancer, coronary heart disease and diabetes to develop research on primary prevention of these diseases.

The National Institute for Health and Clinical Excellence (NICE) will appoint an Executive Director for Health Improvement to provide professional leadership in delivering public health across the NHS and partner organisations, and we will provide additional resources to support NICE work on health improvement to deliver specific objectives related to the White Paper.

We will invest in and develop the Public Health Observatories and set up a Health Information and Intelligence Task Force to lead action to develop and implement a comprehensive public health information and intelligence strategy.

We will establish a new innovations fund from 2006–07 to support and test new models of working and promote faster implementation of those that are proven to be effective.

- Capacity and capability, building the workforce – the changes needed to deliver the policies in this White Paper will only occur if the right people with the right skills are in place to deliver them and if barriers to change are broken down.

We will develop new induction, training and professional development modules for NHS staff at all levels to support them in effective practice to improve the health of patients and explore ways of sharing modular training with other sectors. We will invest in workforce development and work with NHS commissioners locally to develop capacity of public health specialists and practitioners and establish a Health Improvement Workforce Steering Group to develop a comprehensive national strategy.

- Systems for local delivery will be achieved: by aligning investment, performance assurance mechanisms, planning guidance, inspection and regulation processes to deliver increased flexibility; by providing greater incentives and rewards for good performance; and by encouraging innovation and enabling strong leadership and management.

A systematic approach for delivering local improvements in health will be supported by a range of organisations working together, including:

- Government departments;
- inspectorates such as the Healthcare Commission, the Audit Commission, Commission for Social Care Inspection and Ofsted;
- regional bodies such as the Government Offices and Regional Development Agencies;
- NHS arm's-length bodies such as the Health Protection Agency, the new National Institute for Health and Clinical Excellence and the NHS Modernisation Agency or its successor; and
- local government organisations such as the IDeA and the Local Government Association.

The key to success will be effective local partnerships led by local government and the NHS working to a common purpose and reflecting local needs.

Conclusion

34. Just as sustained investment and reform is transforming England's NHS, the new approach to public health set out in *Choosing health* will, through sustained investment and fresh thinking, backed by the public, deliver sustained improvement to the health of the people of England. It will do so by responding to people's concerns about their health with practical support on their own terms and by providing the context and environment needed to make real progress. This white paper sets out some very significant changes – on smoking in public places, on advertising to children and on Health Trainers. But it also sets out a large number of other measures which together will have a significant combined effect. The opportunities are now opening up rapidly for everyone to make their own individual informed healthy choices which together will sustain and drive further the improvement in the health of the people of England.

35. This White Paper is the start, not the end of a journey. We will continue to develop ideas and action, learning from experience to help people choose health in the 21st century. It is the next step in our journey towards engaging everyone in choosing health and tackling health inequalities. It is the beginning of a journey to build health into Government policy and ensure that health is everybody's business. We have set ambitious targets for health. The Government is serious about ensuring that these commitments are met and that this time we get sustained and focused action to improve people's health. By working together across society we should achieve this.

CHAPTER 3
MAKING IT HAPPEN: NATIONALLY, LOCALLY AND REGIONALLY

This section outlines how success will be built into the delivery of public services at local, regional and national levels and the ways we shall foster relationships with communities, the voluntary and community sectors, employers and industry. It builds on the chapters in *Choosing Health* that outline the key actions Government will take to ensure delivery.[6]

NATIONAL DELIVERY

Choosing Health identified five ways the Government will support national delivery:

- regulation;
- building partnership and inviting engagement;
- joining up action;
- aligning planning and performance assessment; and
- resourcing.

Regulation

The Government will ask industry, employers, the voluntary sector and professional bodies to hold themselves publicly accountable for delivering change through formal Pledges, Compacts or Voluntary Codes of Practice. These will be backed up by new legislation where *Choosing Health* indicates this is needed or a voluntary approach has not succeeded. Food labelling, advertising, responsible alcohol promotion, and employment practices will all be developed in this way and through the work of Ofcom and the Food Standards Agency which, among other functions, have a role as statutory regulators.

Health Impact Assessments have now been incorporated into the Regulatory Impact Assessment framework. This requires the Government to assess the impact and effectiveness of all new regulatory proposals that are likely to create or remove burdens in the private and public sectors. *Choosing Health* policies that either have a major impact on business or require legislation, or both, have already been subject to partial Regulatory Impact Assessments.

Building partnership and inviting engagement

Choosing Health argues for a commercial and social environment that supports healthier choices. To help deliver this, the Government will draw on the expertise, resources and drive of private sector advertising and marketing organisations.

The Department of Health will explore formal agreements on local priorities for health and well-being with a wide range of national representative bodies. It will spell out the broad policy framework

6 *Choosing Health*, op cit: Chapter 8 and Annex B.

and the agreed priorities to be delivered by local action with the active help and support of the Government and regional bodies.

Joining up action

Action across government to tackle poverty and unemployment and to improve housing and education will also have a positive impact on health, particularly that of the most disadvantaged. Examples include:

- the Department for Work and Pensions' 'Pathways to Work' pilots where the local NHS is working closely with Jobcentre Plus to help people manage their health problems and return to work;
- the cross-government National Strategy for Neighbourhood Renewal;
- the Deputy Prime Minister's programme to bring all social housing into a decent condition;
- action by the Department for Work and Pensions to reduce the proportion of children living in workless households;
- action by the Department for Environment, Food and Rural Affairs to eliminate fuel poverty and to improve air quality.

Delivery across government will be overseen by a Cabinet sub-committee chaired by the Secretary of State for Health, supported by a Health Improvement Board of senior government officials. Other Boards and Steering Groups involving partners outside the Government will be convened to help lead change and to report on progress.

These will ensure that action across government is properly monitored, that risks to delivery are identified and minimised and that interdependencies between programmes are managed effectively. During 2005 the Department of Health will work with other government departments to develop more detailed agreements setting out how they will work together to deliver key *Choosing Health* priorities. The Office of the Deputy Prime Minister (ODPM) and the Department of Health will work together to ensure that government policy reduces health inequalities, and that improving the overall health and well-being of the population does not inadvertently widen health inequalities.

Progress will be measured through:

- improvements in the health of the population;
- increased delivery of high-quality services – data submitted by Strategic Health Authorities (SHAs) and local authorities;
- achieving project milestones;
- delivery partners' progress reports.

During 2005 the Government will set trajectories that allow progress against targets to be regularly reviewed.

Aligning planning and performance assessment

Independent inspection, assessment and review of health improvement will be carried out by the Healthcare Commission, Audit Commission, Ofsted and Commission for Social Care Inspection (CSCI).

The Concordat signed between the main healthcare inspectorates last year committed them to working together to minimise the burden of review on frontline services.[7] The Department of Health is exploring with the Healthcare Commission how best to ensure that the new standards for NHS provision they will publish later this year achieve a balance between prevention and care.

The new NHS Institute for learning, skills and innovation will also be helping the NHS to redesign its services, focussing on a small number of high priority issues in order to derive maximum benefit. The new Institute is expected to be up and running by July 2005 and its priorities will be set in due course. Each of its priority programmes will consider how to maximise associated health benefits and may focus on a specific public health issue, such as obesity.

7 The Concordat between bodies inspecting, regulating and auditing healthcare can be found at www.healthcarecommission.org.uk/assetRoot/04/00742/00/04004200.pdf

Resourcing

The NHS will invest its mainstream budgets to secure improvements in health, well-being and health inequalities and achieve longer-term savings in the cost of treatment and social care.
A significant proportion of the delivery of health improvement will be funded from PCTs' main allocations and will form part of their core business planning. Local Authorities will also prioritise action on health and health inequalities through existing mainstream spending to maximise Government programmes and initiatives such as Local Area Agreements and Neighbourhood Renewal Funding. This is in line with government policy to devolve responsibility and resources to local organisations. PCTs will also need to consider the contribution that local authorities and other partners make to jointly agreed actions in support of national or locally agreed priorities and explore whether funding streams can be aligned and pooled. Over £1 billion of additional NHS funding has been made available to supplement the delivery of *Choosing Health* over the next three years. The extra funding will pump-prime innovations to existing services (such as sexual health, school nurses, health trainers or obesity services) and test new ideas. Around half of the extra funding in 2006/07 and 2007/08 has gone directly to PCTs as part of their annual allocation and will be used to deliver *Choosing Health* commitments through the local delivery planning process.

ENSURING ACTION LOCALLY: A CLEAR SYSTEM FOR DELIVERY

The NHS has a responsibility for taking forward the health improvement agenda. Early detection, health advice and clear pathways for improving the health of patients and the public are all needed to improve health and manage future demands for NHS care. But *Choosing Health* also emphasises the relationship between health, learning and work, leisure and recreation, crime and community cohesion and the key role of local authorities in improving health and well-being.

Local authorities and PCTs share a responsibility to improve health and well-being by:

- leading community partnerships;
- delivering on national priorities and targets;
- identifying local needs and achieving local targets;
- commissioning and delivering services.

Local authorities also have a responsibility to ensure that effective local planning mechanisms are set up to drive improvements in health and well-being, for example, Local Strategic Partnerships (LSPs)[8] emerging children's trust arrangements, Crime and Disorder Reduction Partnerships (CDRPs), Drug and Alcohol Teams and 'Pathways to Work'.[9]

Local needs are identified through:

- planned local information reports from regional Public Health Observatories (PHOs) to each local authority;
- annual reports to councillors by each PCT Director of Public Health;
- local government's scrutiny of health services, as introduced in the Health and Social Care Act;
- health and well-being equity audits and ethnic monitoring;[10]
- consultation and involvement of local communities themselves.

Local services are delivered by:

- primary care and hospital trusts and other NHS organisations;
- children's services, including schools;
- other local authority services, such as housing, social care, leisure and recreation;
- the voluntary sector and community based organisations; and
- private businesses.

8 The Office of the Deputy Prime Minister's recently published five-year plan *Sustainable Communities: People, Places and Prosperity* sets out a view of the future of local government which emphasises its role in community leadership and engagement.

9 The documents Health Development Agency and Local Government Agency, NHS Confederation (2003) *Planning with a Purpose: Health Development Agency (2004) Pooling Resources Across Sectors: A Report for Local Strategic Partnerships* offer useful models for joint delivery at local level.

10 Further information on health equity audits being developed by the NHS is available from the website: www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Healthinequalities/fs/en

Local needs and targets for improving health and well-being are contained within the Local Authority Community Plan.

Roles and responsibilities for delivery are contained in PCT Local Delivery Plans (LDPs) and the local authority's own business plans.

Other ways in which local government, the NHS and their community partners can improve health and well-being include:

- using existing services to raise the awareness and understanding of local communities about how to improve their own health;
- community advocacy – in particular, local elected representatives have an important role in helping people to represent their concerns and views to local policy makers and decision makers;
- increasing the knowledge and understanding of health issues amongst public sector employees, and those working for organisations funded by the public sector. Health awareness should permeate all areas of work so everyone understands how they can contribute to improving health;
- as healthy employers, pledging their organisation to observe healthy employment practices and encouraging staff to make personal pledges to improve their lifestyles; and
- redesigning jobs to widen access to employment and finding more effective ways of delivering health messages to disadvantaged communities.

PCT LOCAL DELIVERY PLANS

Delivery planning for *Choosing Health* is an integral part of PCTs' LDPs, which should be developed in close consultation with local authority partners and other key stakeholders in LSPs. A Planning and Performance toolkit has been circulated to PCTs to support them in planning locally for *Choosing Health*.

Performance levels within LDPs will be agreed between PCTs and SHAs, and PCTs will be held accountable for delivery with the same determined focus at national and local levels that has brought such impressive results in waiting times, cancer and CHD. SHAs will have an important role in ensuring that the spearhead PCTs[11] in their areas are making faster progress than the average of all PCTs in order to reduce health inequalities in line with the national targets.

Within their LDPs, PCTs will agree with relevant partners a number of targets which respond to local needs and help tackle health inequalities by more effective prioritisation and targeting of disadvantaged groups and areas. They will also agree levels of performance to contribute to many of the key aims of *Choosing Health*, including among others:[12]

- better management of blood pressure and cholesterol levels by GPs;
- implementation of National Institute for Health and Clinical Excellence guidance on cancer treatment;
- reducing smoking during pregnancy and adult smoking prevalence as a whole;
- increasing the uptake of breastfeeding;
- tackling childhood obesity;
- reducing under-18 pregnancy and improving access to sexual health services; and
- improving mental health and well-being and reducing suicide rates.

LOCAL AREA AGREEMENTS

The Department of Health is supporting the development of Local Area Agreements (LAAs)[13] as an important new planning process which brings health inequalities and health outcomes to the forefront of local community planning. LAAs are agreed with Government Offices for the Region (GORs) and are based on three 'blocks':

11 The spearhead group is the fifth of areas with the worst health and deprivation indicators. It consists of the 70 local authority areas, mapped across to 88 PCTs, that are in the bottom fifth nationally for three or more of the following five factors: (i) male life expectancy at birth; (ii) female life expectancy at birth; (iii) cancer mortality rate in under-75s; (iv) cardiovascular disease mortality rate in under-75s; (v) Index of Multiple Deprivation 2004 (Local Authority Summary).

12 Full details of the LDP data-monitoring lines against which PCTs will agree levels of performance with their SHAs is included in Annex 1 on government policy and targets.

13 Information on implementation of LAAs can be found at www.odpm.gov.uk/localvision

- children and young people;
- safer and stronger communities; and
- healthier communities and older people.

Outcomes in each block will be negotiated between local authorities (and their partners) and GORs on behalf of central departments. LAAs will reflect both local and national priorities. PCTs in the pilot areas will lead the development and delivery of the health elements of LAAs, with the support and encouragement of SHAs.

In 2005/06, 21 local authority areas will pilot LAAs. These include 10 spearhead PCTs which will set particularly challenging targets to reduce health inequalities in their area. The Government has recently announced a further pilot phase of 40 LAAs which will be in place by April 2006 and may include more local authority areas in the spearhead group. The LAA approach may also be used to firm up action plans for health improvement in spearhead areas that are not included within the LAA pilots.

To encourage and support new ways to improve health:

- the Department of Health will develop a network of 'Health Champions' able to provide advice and support to new services;
- the Improvement and Development Agency's (IDeA's) peer support will recruit and accredit people with experience and skills to provide consultancy, advice and peer review; and
- Communities for Health will pilot new approaches to local action, piloted in at least 12 areas from April 2005.

CHILDREN'S TRUSTS

Children's trusts are being established by local authorities working with colleagues in the health sector and other local stakeholders. They will determine the services needed to drive improvements in children's health and well-being in line with the Children's Outcomes Framework.[14]

This sets expectations on children's and young people's experience as follows:

- be healthy;
- stay safe;
- enjoy and achieve;
- make a positive contribution; and
- achieve economic well-being.

Local services will be held accountable for delivering improved outcomes and the requirements of the Children's National Services Framework through the annual performance assessments of local authorities and the integrated inspection of children's services.

REGIONAL DELIVERY

The GORs, Regional Assemblies and Regional Development Agencies (RDAs) also play an important part in helping to shape the wider economic determinants of health and strategy on transport, employment, the environment and regeneration. GORs bring together the activities of 10 Whitehall departments within a single organisation in the region. These activities include, for example, ODPM's interests in sustainable communities and in deprived neighbourhoods, DfES's interests in children and learners, and Home Office's interests in crime, community safety and community involvement. GORs are ideally placed to make the connections necessary between these activities to improve health and well-being. GORs are already leading the negotiation of LAAs on behalf of central government which wants to strengthen their role and delegate more activities currently carried out in Whitehall.

Regional Directors of Public Health and their Public Health Groups (PHGs) are based within GORs and will support local delivery of health improvement by:

- working with other key regional stakeholders such as RDAs and Regional Assemblies to deliver health improvements;

14 HM Government (2004) *Every Child Matters: Change for Children*. London: The Stationery Office.

- integrating health improvement and activity in supporting local planning and delivery mechanisms within GORs;
- encouraging closer working with GORs and SHAs;
- co-ordinating regional task forces and other action to support the delivery of health improvement PSAs;
- work closely with regional PHOs to track and report performance;
- identifying regional issues and concerns that may need a national policy response; and
- brokering support for local action and facilitating cross-regional learning and development opportunities.