

3

DELIVERY OF PUBLIC HEALTH

Summary and Implications

Many organisations have roles in the delivery of public health and many individuals, carrying out a broad range of tasks, are part of the wider public health workforce. The Specialist public health workforce is an essential, but small, component of the public health function and to achieve greatest impact they must engage with and harness the resources of contributors across all sectors.

Despite the committed efforts of these many individuals, there are systematic barriers to the successful delivery of a “fully engaged” scenario. The complexities of the delivery chain, the gaps in and duplication of functions, and the lack of levers for those who provide advice or set targets all work against the translation of policy into practice on the ground.

There are a number of challenges that the forthcoming Public Health White Paper and DH review of arm’s length bodies should address:

- # DH needs to re-orientate its role from caring for the sick to promoting good health. This needs to be reinforced by clear leadership in setting national priorities, backed up by organisations with responsibilities for developing the evidence base on cost-effective interventions, evaluating and disseminating best practice, and improving “health literacy” in the population at large.
- # Objectives to improve health outcomes and tackle key risk factors, such as smoking and obesity, need to be given equal weight in the NHS performance management and inspection systems to waiting times. These need to impact both on PCT managers and, through the new opportunities created by PMS and the GMS contract, on front line professionals.
- # Recognising that the NHS is only one contributor to delivering the public health agenda, there needs to be an alignment of targets between the Planning and Priorities Framework for the NHS and the Comprehensive Performance Assessment for local government.

Capacity needs to be developed at the local level, whether through nurturing evolving networks, combining expertise and sharing good practice across PCTs, or buying in expertise on risk and disease management. Rather than further structural change or top down imposition, the focus should be on setting clear outcome goals and facilitating local solutions to achieving them.

INTRODUCTION

3.1 This chapter describes and analyses the organisation and delivery of public health in England. The following areas are discussed:

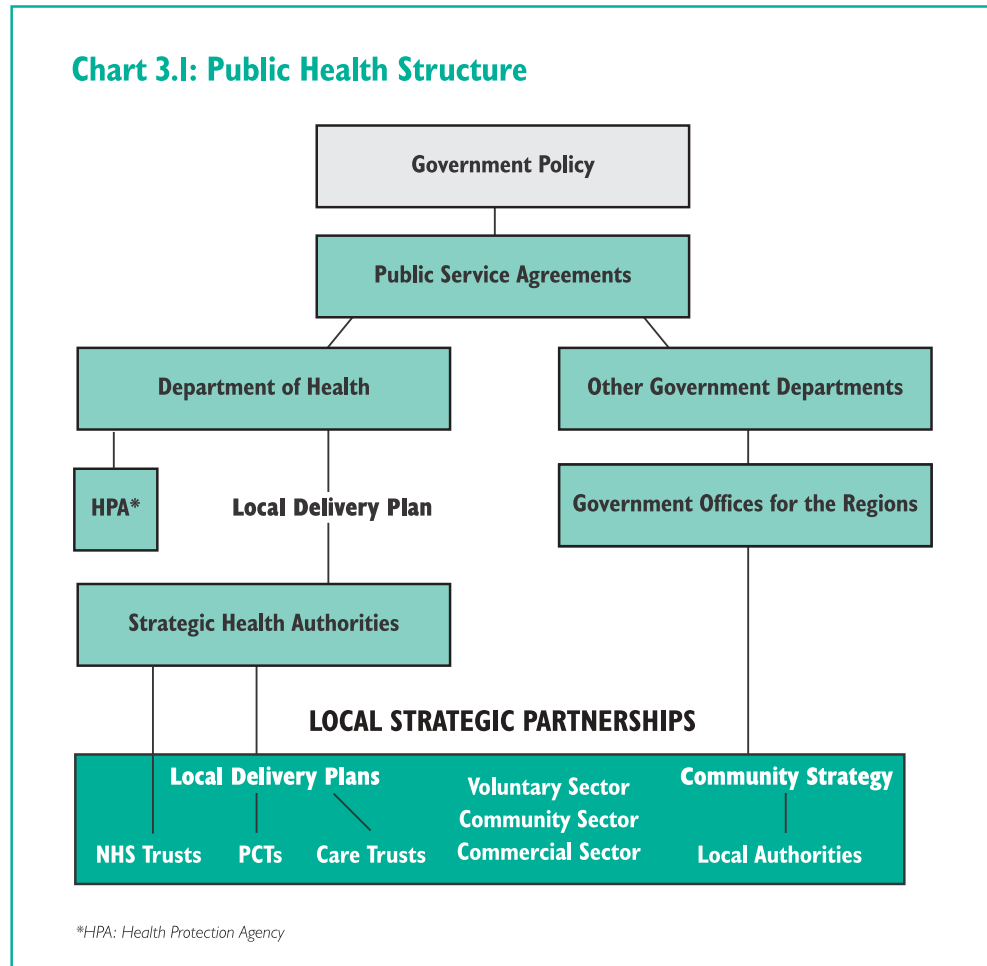
- ☞ organisations responsible for public health;
- ☞ performance management of the public health function;
- ☞ partnership arrangements for improving health;
- ☞ public health activity at a local level;
- ☞ ministerial responsibility for public health;
- ☞ public health leadership and the public health workforce;
- ☞ development of public health capacity; and
- ☞ levers available to strengthen public health delivery in primary care.

3.2 The chapter is illustrated with examples of practice gathered from submissions to the Review and from evidence gathered through visits to a range of government offices, strategic health authorities, primary care trusts, county councils and local authorities across England.

ORGANISATIONS RESPONSIBLE FOR PUBLIC HEALTH

3.3 As discussed in *Population Health Trends*, health and well-being are influenced by many factors including past and present individual behaviour, health care provision and ‘wider determinants’ including social, cultural and environmental factors. Therefore, responsibility for public health lies with individuals and a range of organisations, across Government (by setting national policy on health services and factors that affect the wider determinants of health), local government, the NHS and regional and local agencies, voluntary and private sector bodies.

3.4 This section provides an overview of statutory organisations and their responsibilities and non-statutory players with a potential role in relation to public health. The relationships between these organisations are illustrated in chart 3.1.



The Department of Health

3.5 In the 2002 Spending Review the aim of the Department of Health (DH) was stated as 'to transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities'. Specific objectives and targets were set out in the DH Public Service Agreement (PSA)¹. The main themes of the PSAs are to improve service standards, to improve health and social care outcomes for everyone and to improve value for money (Annex B).

The NHS

3.6 Public health within the NHS is active under four main headings:

- # improving health and addressing inequalities;
- # providing services for prevention, treatment and care;
- # health protection (including the control of communicable diseases); and
- # contributing to corporate leadership across all levels of the NHS.

3.7 The DH delivers its functions through Primary Care Trusts (PCTs), Strategic Health Authorities (SHAs) and NHS Healthcare and Hospital Trusts.

¹ The Government introduced Public Service Agreements (PSAs) following the 1998 Comprehensive Spending Review, setting out publicly clear targets showing what departments aimed to achieve in terms of public service improvements. Progress against those targets has been reported every year in Departmental reports. The Government publishes its updated targets for improved performance every two years in the spending review White Paper. The most recent PSAs are for the period 2003 – 2006.

PCTs 3.8 In 2001, the White Paper *Shifting the Balance of Power*² set out a programme of change aiming to devolve decision-making and budgetary control to frontline staff and patients in the NHS. It established Primary Care Trusts (PCTs) as local organisations responsible for 75 per cent of the NHS budget.

3.9 There are now 303 PCTs in England covering populations ranging from 60,000 (Central Derby) to 368,000 (Merton and Sutton)³. Since April 2002, all PCTs have been required to appoint a Director of Public Health as a member of the PCT Board.

3.10 The main statutory functions of a PCT are:

- ⌘ improving (and reducing inequalities in) the health of the community;
- ⌘ developing primary and community health services; and
- ⌘ commissioning secondary care⁴.

Care Trusts 3.11 A Care Trust is an NHS organisation to which local authorities can delegate health-related functions. Care Trusts carry the statutory functions of a PCT but in addition provide integrated health and social care for selected services to their local communities. There are currently 8 Care Trusts in England providing integrated health and social care for a range of services including Older People, Disabled Adults, Mental Health and Learning Disability and Physical Disability.

NHS Healthcare and Hospital Trusts 3.12 NHS Trusts have responsibility for providing health care to meet local need. A greater emphasis on the role of NHS Trusts in relation to population health was outlined in *Shifting the Balance of Power*. NHS Trusts were expected to work in partnership with PCTs and other local partners to ‘develop strategies to reduce health inequalities and improve the health of the population’.

Strategic Health Authorities 3.13 The creation of Strategic Health Authorities (SHAs) was also announced in *Shifting the Balance of Power*. There are now 28 SHAs in England responsible to the Secretary of State for Health. Population served averages around 1.5 million, ranging from 1.13 million (County Durham and Tees Valley) to 2.59 million (Trent).

3.14 The main remit of SHAs is the performance management of all the NHS organisations (PCTs and NHS Trusts) in their area. They are responsible for supporting local NHS services to work together to achieve common goals.

3.15 The three key statutory functions of a SHA are:

- ⌘ creating a coherent strategic framework for their area;
- ⌘ agreeing annual performance agreements and performance management of the NHS against agreed priorities and targets; and
- ⌘ building capacity and supporting performance improvement⁵.

Health Protection Agency 3.16 Health protection encompasses the surveillance and control of communicable diseases, the protection of the public from health risks caused by environmental hazards, and the response to emergencies and disasters. In April 2003, a new national

² *Shifting the Balance of Power*, DH, 2001

³ *Census Key Statistics*, ONS, 2001.

⁴ *Primary Care Trusts: establishment, the preparatory period and their functions*, DH, 1999

⁵ *Shifting the Balance of Power: the next steps*, DH, 2002

'Health Protection Agency' (HPA) was established as a Special Health Authority⁶ to provide national expertise for health protection and health emergency planning in England and Wales.

3.17 The HPA has representation at regional level and through a network of 'field services' (each one covering a strategic health authority area) provides a health protection function for the local population.

Public Health Observatories

3.18 A recent development has been the creation of nine public health observatories⁷ in England as set out in *Our Healthier Nation*. As part of the NHS, their main tasks are to support local bodies by:

- ⌘ monitoring health and disease trends and highlighting areas for action;
- ⌘ identifying gaps in health information;
- ⌘ drawing together information from different sources in new ways to improve health;
- ⌘ advising on methods for health and health inequality impact assessments;
- ⌘ carrying out projects to highlight particular health issues;
- ⌘ evaluating progress by local agencies in improving health and reducing inequalities; and
- ⌘ looking ahead to give early warning of potential future public health problems.

Other National Agencies with a Public Health Role

3.19 In addition to the organisations listed above, there are a number of other national agencies that have a public health role. Box 3.1, while not exhaustive, gives some examples.

⁶ A Special Health Authority is a health authority that provides services to the whole population of England and not just to a local community

⁷ www.pho.org.uk

Box 3.1 Other National Agencies and Committees with a Public Health Role

The Health Development Agency (HDA). The HDA was created in 2000 to establish and maintain an evidence base of what works in public health practice and to provide guidance on the translation of this evidence into practice.

National Institute of Clinical Excellence (NICE). NICE was established in 1999 and is charged with establishing guidance for the Government, the NHS and patients on best practice in relation to drugs, treatments and services.

National Screening Committee (NSC). The NSC provides advice to Ministers on all aspects of screening policy, drawing on the latest research evidence. The NSC assesses proposed new screening programmes against a set of internationally recognised criteria⁸. In 1996, the NHS was instructed not to introduce any new screening programmes until the NSC had reviewed their effectiveness.

Food Standards Agency (FSA). Established in 2000, the FSA is charged with protecting the public's health and consumer interests in relation to food. Priorities set by the FSA include helping people to improve their diet and reducing food borne illness.

The organisation of the public health function within the NHS

3.20 *Shifting the Balance of Power* was a major structural change to the NHS and the organisation of the public health function. It has had a large impact on the delivery of public health. The policy has strengthened the potential of the NHS to address public health issues, particularly to address locally identified needs through PCTs, but in some areas the disruptive impact of re-organisation is still being felt.

3.21 Particular problems relate to the size of PCTs and capacity and the dispersal of the workforce, including public health Specialists, health promotion staff and senior management. In some areas Chief Executives and Directors of Public Health (DsPH) report insufficient 'critical mass' to fulfil responsibilities.

3.22 Some areas are attempting to address this by sharing functions, for example joint DPH posts between PCTs or joint management posts such as Finance Directors. In other areas the co-location of PCTs (for example South Cambridgeshire and Cambridge City PCT) has allowed public health professionals to continue working as a team and share activities across the larger area.

⁸ *Criteria for Appraising the Viability, Effectiveness and Appropriateness of a Screening Programme*, UK National Screening Committee, 2003

3.23 In relation to the Specialist public health function, the creation of 303 PCTs from 95 Health Authorities has led to a small public health resource in most PCTs, comprising just the DPH and a few other people. In addition, the creation of a DPH post in each PCT, whilst a welcome recognition of the importance of public health to PCTs, has resulted in an increase in the corporate responsibilities of the Public Health Specialist workforce, and a reduction in their ability to undertake and practice public health work. As a result, activities such as needs assessment and engagement with partners to develop programmes targeted at local public health needs are, in some cases, weak. The dispersal is impacting on the capacity of PCTs to provide training for trainee Specialists, public health practitioners and the wider public health workforce, which in the long term could have a detrimental effect.

3.24 Public health teams within PCTs are much smaller than previously, and some posts remain vacant, including DPH posts (8 per cent vacancy rate in January 2003 with a further 11 per cent filled on an 'acting' basis). Of the 280 PCTs with a current DPH, 31 share their DPH with another PCT. This includes 14 individuals acting as a DPH for 2 PCTs, and one individual acting as DPH for 3 PCTs.

3.25 A survey commissioned by the DH in 2002/3 to identify the capacity and development needs of PCT and SHA Specialists in public health found that the Specialist public health workforce was thinly distributed and unequally spread, with its present distribution largely attributable to a combination of history and the presence of a 'public health friendly' organisational environment, particularly at Board level. The report concluded that 'the size of the specialist public health workforce in any location seems to bear little, if any, relationship to the needs of the population it serves'.

3.26 **Given the newness of PCTs and the negative impact of restructuring, structural change is not recommended, although where it is deemed locally appropriate and is supported, the combination of PCT public health functions should not be discouraged.**

Public Health Networks

3.27 Creation of public health networks is one way the problems created by the dispersal of the public health workforce are being tackled. These were introduced in *Shifting the Balance of Power* as a means of ensuring the best use of scarce Specialist public health resources. In principle networks could achieve the 'critical mass' required for the public health function, and indeed, in some areas, networks are showing great strengths and maximising opportunities. For example, in Cambridgeshire and Peterborough the public health network has appointed joint posts with the County Council research unit to share public health analytical and epidemiological skills.

3.28 However, it must also be recognised that development of a network function takes time and effort, and commitment is needed both from individuals and their organisations. The early stages of network development may actually absorb rather than release resources.

3.29 The membership and 'core functions' of public health networks vary between areas. A survey of thirteen public health networks undertaken in 2002/3 found that the size of networks varied from three to fifteen PCTs. Only some PCTs had committed funding to the networks and only some networks had a dedicated co-ordinator⁹.

⁹ *Capacity and Development Needs of Specialists and Consultants in PCTs and SHAs: Final report to the Department of Health*, Chapman et al., Queen Mary's School of Medicine and Dentistry, 2003

Additionally, only 47 per cent of public health specialists reported in 2003 that they had a strong relationship with the networks¹⁰.

3.30 The establishment by the DH of 'learning sets' for public health network leaders and co-ordinators is a positive contribution. However, PCTs and SHAs need to recognise the importance of strong local PH networks and the possible need to allocate resources.

3.31 Further evaluation of PH networks should be undertaken and guidance developed to enable networks to work out:

- # the optimal local membership (in relation to both organisation or individuals);
- # the resourcing; and
- # the specific roles and the functions that the PCT should expect from its local public health network.

3.32 A further major change to the organisation of the public health function has been the creation of the Health Protection Agency and the transfer of Consultants in Communicable Disease Control and their teams to the new Agency. The HPA has a valuable role in providing expertise on health protection issues, particularly at a national level. At a local level, PCTs continue to have statutory responsibility for the health protection of their population and have 'memoranda of understanding' with the HPA to deliver this function on their behalf through the 'field services' network. However concern has been expressed by DsPH and Chief Executives of PCTs that although health protection teams have been transferred to the HPA, PCTs are still expected to perform some of the functions previously undertaken by these teams (for example in relation to emergency planning and Section 47 of the National Assistance Act 1948).

3.33 The roles of the HPA and PCTs in relation to health protection should be clarified and further guidance on the interpretation of 'memoranda of understanding' should be provided.

Performance management of the NHS

3.34 The PSA targets for the Department of Health set out Departmental aims. Based on these PSA targets, the DH has set more specific priorities and targets for the delivery of health and social care by the NHS in the 2003-6 Priorities and Planning Framework (PPF) (box 3.2)¹¹.

¹⁰ *Mapping Public Health Networks: a report to the Health Development Agency*, S Abbot et al., Queen Mary's School of Medicine and Dentistry, 2003

¹¹ *Improvement, Expansion and Reform: the next three years, Priorities and Planning Framework 2003-2006*, DH, 2002

Box 3.2 The main priorities of the PPF

1. Improving access to all services through:
 - # better emergency care; and
 - # reduced waiting, increased booking for appointments and admission, and more choice for patients.
2. Focusing on improving services and outcomes in:
 - # cancer;
 - # coronary heart disease;
 - # mental health; and
 - # older people.
3. Improving life chances for children.
4. Improving the overall experience of patients.
5. Reducing health inequalities.
6. Contributing to the cross-government drive to reduce drug misuse.

Local Delivery Plans

3.35 PCTs and SHAs currently set out priorities and objectives through the local delivery plan (LDP). This is a three yearly document based on the 2003-6 PPF. The LDP should set out the timescale, milestones and delivery mechanism by which PCTs and SHAs will achieve the targets in the PPF. Strategic Health Authorities are expected to develop a comprehensive LDP for their area, bringing together the NHS Trust Plans and LDPs of each constituent PCT.

Commission for Health Improvement

3.36 The Commission for Health Improvement (CHI) is an independent inspection body for the NHS. CHI undertakes routine inspections (clinical governance reviews) of NHS providers and investigates serious service failures. It also reviews the implementation of National Service Frameworks and National Institute for Clinical Excellence guidance. CHI publishes performance ratings based on the findings of their clinical governance reviews. Performance is assessed against a range of indicators that are primarily based on the targets and priorities of the DH Priorities and Planning Framework.

Commission for Healthcare Audit and Inspection

3.37 In April 2004 the newly created Commission for Healthcare Audit and Inspection (CHAI) will come into operation. CHAI has been created to improve and bring coherence to the regulation of health organisations¹². It will take over the following roles:

- # the work of CHI and the Mental Health Act Commission;
- # the national NHS value for money work of the Audit Commission; and
- # the independent healthcare work of the National Care Standards Commission.

¹² *Statement of Purpose, The Commission of Healthcare Audit and Inspection (CHAI) and the Commission for Social Care Inspection*, DH, 2003

3.38 Unlike the Commission for Health Improvement, CHAI will have a particular remit to ensure appropriate arrangements are in place to promote and protect public health, as set out in the standards in the current DH consultation document *Standards for a Better Health*¹³. The standards include a specific domain for public health. CHAI will publish annual performance ratings for all NHS bodies in England, and has indicated that these will cover comprehensively the activity of each body, including its contribution to public health.

The performance management of PCTs and the public health function

3.39 The DH holds SHAs and PCTs to account for delivering the targets set out in the Priorities and Planning Framework, articulated through local delivery plans. Overall there are thirty three PPF targets, of which eleven can be considered to have a specific public health remit, including a 4 week smoking cessation target. While the number of public health related targets is a significant proportion and gives greater emphasis to public health than ever achieved before, the overall emphasis within the PPF is on access and waiting times, which are repeatedly referred to by DsPH and Chief Executives alike as 'hanging targets' which take precedence over all other priorities. It is clear that public health targets are not considered to be equally important.

3.40 While national guidance on priorities and performance improvement is important, this can be to the detriment of addressing local priorities.

3.41 A survey of all PCT DsPH in post in May 2003¹⁴ found that 76 per cent of DsPH felt that national work programmes displaced local priorities completely or to a large extent, with waiting lists being the most commonly identified factor. The most common areas of 'foregone' priorities from the final LDP were health promotion and public health (26 per cent of PCTs) and primary care development (24 per cent of PCTs), which included areas such as expansion of practice nursing for chronic disease management and diabetes identification and care. This perception was strong but not universal, and one DPH commented 'generally I feel there is a fairly strong concurrence between national priorities (especially as reflected in NSFs) and what would be the local priorities if they were set on a national needs basis'.

3.42 The survey also identified financial pressures as a key problem, although the additional resources allocated in SR2002 are a welcome step towards addressing this. Where PCTs are struggling to achieve financial balance, additional resources to address public health issues outside the PPF may not be available.

¹³ *Standards for Better Health: health care standards under the NHS – a consultation*, DH, 2003

¹⁴ *Setting Priorities for Health, experience of Directors of Public Health in PCTs*, A Brown and P Littlejohns, NICE, Submission to the Wanless Review, 2003

3.43 A further problem is that public health targets are based on what can be measured rather than what should be measured. For example in relation to smoking there are three targets that reflect what can reasonably be measured at PCT level – the 4 week quit rate through smoking cessation services, reduction in smoking in pregnancy and practice based registers of those at risk of coronary heart disease, including smoking status. However the 4 week quit data are generally perceived to be an insufficient record of success in reducing smoking prevalence in an area. The target does not take account of those who quit smoking through other means and does not provide an accurate reflection of trends in smoking prevalence in the area. As one DPH reported 'it's easy to make quick wins by cleaning up the data rather than improving the service or targeting hard to reach groups'.

3.44 The ideal would be organisational level (for example, PCT, SHA) data on smoking prevalence which would give the full picture of progress towards smoking reduction, but currently this information is not available.

3.45 The importance attached to achieving targets and the way in which this is implemented can also have a distorting effect on activity at a local level. While smoking cessation targets are widely welcomed, in some cases the methods used to achieve the target are far from ideal. For example, one PCT reported that they offered a financial incentive to GPs for completing a 'smoking cessation form' for patients who had quit smoking in order to build up numbers to achieve their target. For every form completed the GP is paid £15.

3.46 In addition to performance management of PCTs in relation to achieving targets set out in the PPF, it is important that mechanisms are in place for the performance management of the public health function as a whole, including the public health capacity of PCTs, partnership working to improve health, and the impact of PCTs and partners on the overall health of the population. Potential players to fulfil this remit include SHAs, Regional Public Health Groups and CHAI.

3.47 DsPH within some PCTs have reported that the support provided by SHAs in relation to the performance management and development of the public health function within PCTs is variable. This may reflect the initial impact of *Shifting the Balance of Power*, with the capacity of SHAs to undertake this role only just beginning to emerge. Evidence of good practice in relation to the performance management of the public health function within PCTs was demonstrated to the Review. Box 3.3 gives an example of one such approach.

Box 3.3 Performance Management

In Cheshire and Merseyside SHA a new performance management framework for 'health improvement, health protection and tackling health inequalities' has been developed. The 33 acute and primary care trusts in the area are divided into nine local health communities. Each community has undergone a performance review in each of the above three themes. Public health indicators were used relating to improving life expectancy, reducing infant mortality, health protection and access for disadvantaged groups. Performance is assessed against these indicators. The performance framework has proved successful in engaging PCTs and NHS Trusts to work together to achieve public health goals and tackle health inequalities.

3.48 The Department of Health should reinforce the role of SHAs in relation to the performance management of the public health function within PCTs, and an evaluation of existing practice should be undertaken from which a framework can be developed and adapted for local use.

3.49 In 2003, the Chief Medical Officer commissioned the Association of Public Health Observatories to produce a series of reports presenting indicators of public health for the English Regions¹⁵. The indicators reflect the structure, process and outcomes in public health practice and are based on five themes:

- ☞ population health status;
- ☞ priority public health interventions;
- ☞ effectiveness of partnerships;
- ☞ risk factors and determinants; and
- ☞ public health capacity.

3.50 The first analysis of the indicators was published in December 2003. The indicators act as a screening tool to identify areas that are worthy of further investigation, either as areas of potential good practice, or areas of concern, and will provide a useful resource for development of the public health function.

3.51 While the above steps to monitor the public health function are welcome, it is important that the approach is applied consistently across England and that performance management is used as a tool to strengthen the public health function at both regional and local level.

3.52 CHAI should develop a robust mechanism for the performance assessment of the public health role of PCTs and SHAs, drawing on lessons learned from the Regional Public Health Indicators, the NatPact PCT competency framework (see box 3.21) and the evaluation of current practice within SHAs in relation to the performance management of PCTs.

The role of National, Regional and Local Government in relation to public health

Government Departments

3.53 In addition to the DH, the policies of other government departments impact on the health of the population, primarily by affecting the ‘wider determinants’ as discussed in Chapter 2. Departments’ policies seek to deliver Public Service Agreements. Annex C describes PSAs related to health inequalities. Examples of current cross-departmental activity to address public health issues include:

- ☞ a draft Food and Health Action Plan: co-ordinated by the DH, the Food and Health Action Plan draws together all food and health activity across 9 departments, and involves key players from industry, non-governmental organisations and local authorities;
- ☞ a strategy to increase levels of physical activity and sport in England, developed jointly between the DH and DCMS;
- ☞ the Health Inequalities *Programme for Action*;

¹⁵ *Indicators of Public Health in the English Regions, Volume 1 Number 1*, APHO, 2003

- # the Government's Drug Strategy, led by the Home Office and strongly supported by DH and DfES;
- # action to address alcohol-related problems, led by DH and Home Office; and
- # accident prevention.

3.54 Box 3.4 describes a range of area-based initiatives arising from a number of Government Departments that have a potential impact on health.

Box 3.4 Area Based Initiatives with a potential impact on health¹⁶

Health Action Zones: cross cutting partnerships to improve health and address health inequalities between the better off and the most deprived.

Healthy Living Centres (New Opportunities Fund): community led partnerships in the UK to improve the quality of life for people, especially the most disadvantaged.

Sure Start: aims to support the physical, emotional, intellectual and social development of young children through the integration of early education, childcare, and health and family support services.

Sure Start Plus: partnerships to support teenagers who become pregnant when they are aged 17 or under, or who may be at risk of becoming pregnant, to improve health, well-being and learning for teenage parents.

Children's Fund: education, health and social care partnership to support the well-being of school age children and their parents.

Connexions: partnerships to guide, inform and advise young people on training and other opportunities.

Healthy Schools: education and health partnerships to improve the health of the school community and enable children to make healthier choices and improve their educational achievement.

New Deal for Communities: regeneration partnerships to improve job prospects, reduce levels of crime, and improve educational achievement and health in some of the poorest areas.

Sports Action Zones: aim to bring the benefits of sport to deprived communities.

Employment Zones: aim to help long term unemployed people into sustainable work and independence.

Education Action Zones: aim to raise educational standards through partnerships with local businesses, parents and the community.

Neighbourhood Renewal: the Neighbourhood Renewal Fund aims to enable the 88 most deprived local authorities to improve services, narrowing the gap between deprived areas and the rest of England.

Regional Government

3.55 At a regional level the Regional Development Agencies (RDA), regional chambers (commonly called Regional Assemblies) and the Government Offices for the Regions all have roles in relation to population health.

¹⁶ This list is not exhaustive and further details on area-based initiatives can be found at www.rcu.gov.uk

3.56 The RDAs and regional chambers were established in the 8 English Regions in 1999. The elected Greater London Assembly and London Development Agency were established in 2000.

3.57 The role of the RDA is to improve the economic performance of the region and deliver the Regional Economic Strategy. The RDAs are public bodies directly accountable to Government Ministers and to Parliament.

3.58 The regional chambers are voluntary, multi-sector partnerships that bring together local government and the social, economic and environmental sectors in their region into a single partnership to contribute to regional economic strategies and to scrutinise the implementation of the strategy. A strengthened role for the regional chambers was outlined in the White Paper *'Your region: your choice'* which envisaged regional chambers as the formal regional planning bodies to integrate regional strategies (including transport and waste strategies) and to scrutinise the work of the RDAs¹⁷. It is expected that the regional chambers will work closely with the Government Offices for the Regions, although there is no formal accountability relationship between them.

3.59 The White Paper also established a role for elected Regional Assemblies in those regions that vote in their favour in a referendum¹⁸. The Regional Assemblies will have executive powers and functions that will be largely drawn from central government bodies such as the Government Offices. Regional Assemblies have the potential to play a strong role in improving health and reducing inequalities in the health of their population. The relevant functions of elected Regional Assemblies will be:

- ☞ promoting the health of the region and scrutinising policies to ensure they have a positive impact on health;
- ☞ developing and implementing a health strategy with other partners;
- ☞ appointing the regional director of public health as an advisor; and
- ☞ strengthening the public health function in their region.

Box 3.5 North West Regional Health Partnership

In the North West (NW) region a Health Partnership has been established bringing together the NW Regional Assembly, the NW Development Agency (with its associated Regional Intelligence Unit), the NW Public Health Observatory, the Government Office for the NW and the NHS. The partnership has developed an 'Integrated Impact Assessment Tool' to assess the health, social inclusion and sustainability of any new projects in the Region, and is now developing training and piloting the use of the tool.

The role of the NHS as a corporate citizen is also being developed in the North West and is recognised within the Regional Economic Strategy. For example, programmes and pilots are underway which focus on the NHS as a major regional player in recruitment, employment and training, and as an important player in the procurement of goods and services and capital developments.

¹⁷ *Your Region, Your Choice: revitalising the English regions*, ODPM, 2002

¹⁸ Work undertaken by the ODPM has identified strong support for an elected Regional Assembly in the North East, North West and Yorkshire and Humber. These regions will be the first to progress towards holding a referendum.

Government Offices for the Regions

3.60 The interests of Government are represented at regional level through the 9 Government Offices for the Regions (GORs) that were set up in 1994 to co-ordinate and ensure the delivery of Government policy at a local level.

3.61 The GORs bring together the English regional services for a number of Government Departments including:

- # Office of the Deputy Prime Minister;
- # Department of Trade and Industry;
- # Department for Education and Skills;
- # Department for Transport;
- # Department for Environment, Food and Rural Affairs;
- # Home Office;
- # Department for Culture, Media and Sport; and
- # Department for Work and Pensions.

3.62 Since April 2003, the DH has been represented in the GORs by Regional Public Health Groups that include staff from the DH, the local Public Health Observatory, the National Treatment Agency and Cancer Intelligence Service. Each group is led by a Regional Director of Public Health (RDPH) and is responsible for the development of regional partnerships to improve health and reduce health inequalities. This provides additional opportunities for public health to work across Government Departments at a regional level to tackle the wider determinants of health, at the same time as retaining connections with the NHS.

Box 3.6 Responsibilities of Regional Public Health Groups

- # The development of cross-government and cross-sector approaches to tackling the wider determinants of health;
- # Informing regional work on economic regeneration, education, employment and transport;
- # Ensuring there is a proper health contribution to local strategic partnerships;
- # Accountability for the protection of health across the region;
- # Making sure the public health function is properly managed at local level;
- # Emergency and disaster planning and management; and
- # Being the main point of contact for serious concerns about clinical standards and associated public health priorities.

3.63 The role of public health groups within the GORs is viewed very positively by Directors of Public Health, PCT and SHA Chief Executives, and Local Authority members. Although public health groups have been located within the GORs for less than a year, most show strong signs of partnership working with public health influencing strategies to address the 'wider determinants'.

Local Government **3.64** Local government has a key role to play in improving and reducing inequalities in population health, primarily through the provision of services which impact on the wider determinants, local action to address these determinants and through the provision of social care services. Additionally, the Local Government Act 2000 gives local authorities the discretionary power to do whatever they consider likely to promote or improve the social, economic or environmental well-being of their area¹⁹.

3.65 In England there are 34 county councils, 238 district councils, 47 unitary councils, 36 metropolitan councils and 33 London boroughs.

Performance management of local government

National PSAs for local government **3.66** The Public Service Agreements of a number of Government Departments are delivered through local government. The 2002 Spending Review drew together these PSAs and established National PSAs for local government which set targets within themes: health and social services, education, employment, housing, transport, crime, and improving service delivery and value for money. Health and social care performance targets are outlined in box 3.7.

Box 3.7 Local Government Health And Social Services PSAs²⁰

1. Improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively to live at home to 30 per cent of the total being supported by social services at home or in residential care.

2. Improve life chances for children, including by:

- ⌘ improving the level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75 per cent of those achieved by all young people in the same area;

- ⌘ at least 15 per cent of children in care attain five good GCSEs by 2004;

- ⌘ narrowing the gap between the proportions of children in care and their peers who are cautioned or convicted; and

- ⌘ reducing the under-18 conception rate by 50 per cent by 2010.

3. Increase the participation of problem drug users in drug treatment programmes by 55 per cent by 2004 and by 100 per cent by 2008, and increase year on year the proportion of users successfully sustaining or completing treatment programmes.

4. By 2010 reduce inequalities in health outcomes by 10 per cent as measured by:

- ⌘ infant mortality; and

- ⌘ life expectancy at birth.

Best Value **3.67** The Local Government Act 1999 established a duty of continuous improvement on local authorities. Best Value Performance Indicators were set by central government against which improvement is assessed. Every year, each local authority conducts a Best Value Review against these indicators and on the basis of this develops a Best Value

¹⁹ *Power to Promote or Improve Social, Economic or Environmental Well-being: guidance to local authorities*, DTLR, 2001

²⁰ *PSA National Targets*, ODPM, 2003

Performance Plan which details current performance levels, future activity to secure continuous improvement in services and future performance standards. In respect of the independence of local government, the Best Value Performance Indicators are not used to manage local authorities but rather provide a framework through which local authorities identify their own strengths and weaknesses and set priorities for action.

Comprehensive Performance Assessment

3.68 In 2001, a new performance management framework for local government – the Comprehensive Performance Assessment (CPA) was initiated²¹. CPA is undertaken by the Audit Commission and is intended to deliver a balanced and wide ranging assessment of local government performance against clearly defined priorities. The next round of CPA (due to begin in 2005) will consider action by local authorities to address health inequalities.

Local PSAs

3.69 Local PSAs are voluntary agreements between principal local authorities and government. The first round of local PSAs were developed and piloted in 20 local authorities in 2000/01. Subsequently almost all shire counties and unitary authorities, metropolitan districts and London boroughs have agreed PSAs with government²².

3.70 The aim of local PSAs is to incentivise and reward local authorities for improving services. Under these arrangements, a local authority agrees with government twelve performance targets which are set to achieve a better level than the original performance required by the authority's Best Value obligations. The council is given a 'pump priming' grant to help achieve the target, greater freedom in the means of delivery and a performance reward grant is paid as progress is made towards achieving these 'stretch targets'.

3.71 In the first round of local PSAs, local authorities were obliged to select a minimum of seven targets from the National PSAs for local government. The remaining targets could be determined locally. Currently, a second round of PSA targets is being developed and piloted. In the second round there is greater flexibility to provide a more local focus and there is no longer an obligation to include some of the National targets. Guidance indicates that local PSAs should be developed in agreement with partners and based on the Best Value Review, CPA findings and Community Strategy (see below).

Box 3.8 Case study of Kent County Council 'mini PSA targets'

Kent County Council has developed 'mini-PSAs' with a number of local bodies including district councils, PCTs and schools. These mirror the PSA Kent Council has with government. The council offers financial rewards for the achievement of 'stretch targets' and has used the local PSA process as a means to address local priorities, including health improvement.

Community Strategy

3.72 The Local Government Act 2000 places a duty on principal local authorities to promote the social, economic and environmental well-being of their area to achieve sustainable development. All local authorities are required to develop a community strategy for their locality which co-ordinates the actions of the council and public, voluntary, community and private sectors. A community strategy should aim to enhance the quality of life of local communities through action to improve the economic, social and environmental well-being of an area and its inhabitants.

²¹ *Strong Local Leadership – Quality Public Services*, ODPM, 2001

²² *Building on Success: a guide to the second generation of local public services agreements*, ODPM, 2003

The performance management of local government

3.73 In contrast to the NHS, the performance management of local government provides greater flexibility for local authorities to identify and address local priorities. The Community Strategy is not a performance assessment tool, but rather facilitates partnership working between the local authority and other stakeholders to share common priorities and to co-ordinate action to address these, including action to improve health and reduce inequalities. The local PSAs provide an additional incentive for local authorities to improve performance, by rewarding councils for performance over and above their obligations. **The inclusion of health targets and health inequalities targets within the local PSAs should be encouraged. Additionally, the potential inclusion of public health and health inequalities targets within the next round of CPA is an important step in relation to strengthening the public health role of local government, and should be a key element of all future CPA processes.**

The role of non-statutory bodies in relation to public health

3.74 In addition to the statutory sector, a wide range of voluntary, community and private sector bodies have a potential role in relation to public health, acting at a national or local level. Their main impact can be to address the wider determinants of health including community support and development, training, employment opportunities and regeneration. Additionally, a number of non-statutory bodies provide leadership, advocacy for public health and research. Examples of such bodies are presented in box 3.9.

Box 3.9 Examples of non statutory organisations with public health roles

The National Forum of Non-Governmental Public Health Organisations (PHorum)²³: Supported by government and chaired by the DH, the PHorum seeks to improve the active engagement of non-governmental organisations in developing policies, strategies and plans relevant to public health and to promote the contribution of non-governmental bodies and the voluntary sector to improving health and reducing inequalities.

National Heart Forum (NHF)²⁴: The NHF is an alliance of over 40 national organisations representing the medical and health services, professional bodies, consumer groups and voluntary organisations. Members also include many individual experts in cardiovascular research. Government departments have observer status on the Forum. The NHF co-ordinates action to reduce the risk of coronary heart disease in the UK through information, education, research, policy development and advocacy.

Action on Smoking and Health (ASH)²⁵: ASH is a campaigning public health charity working for a comprehensive societal response to tobacco aimed at achieving a sharp reduction, and eventual elimination, of the health problems caused by tobacco. ASH works by formulating the best information and analysis of the tobacco problem and credible responses, then communicates that to the public, opinion-formers and decision makers in order to generate the public and political impetus for measures to reduce tobacco use.

Faculty of Public Health (FPH)²⁶: The FPH aims to promote, for the public benefit, the advancement of knowledge in the field of public health and to develop public health with a view to maintaining the highest possible standards of professional competence and practice, and to act as an authoritative body for consultation in matters of education or public interest concerning Public Health.

UK Public Health Association (UKPHA)²⁷: The UKPHA is a multidisciplinary independent voluntary organisation of individuals and organisations from all sectors who share a common commitment to promoting the public's health. The UKPHA seeks to promote the development of healthy public policy at all levels of government and across all sectors.

The Independent Advisory Group on Sexual Health: The group is made up of a wide range of stakeholders across the full panoply of sexual health issues. It plays an important role in advising the Government on how to tackle the rising rates of sexually transmitted disease, how to spread good practice and how to learn from other countries. It also helps to draw other groups' attention to the issues that government needs to tackle in delivering its Sexual Health and HIV strategy.

3.75 Improvement of the population's health will require the co-ordinated activity of a range of players at a local level (including individuals, statutory and non-statutory partners) and between local, regional and national agencies.

²³ <http://194.83.94.91> (PHorum website)

²⁴ www.nhf.org.uk

²⁵ www.ash.org.uk

²⁶ www.fph.org.uk

²⁷ www.ukpha.org.uk

PARTNERSHIP ARRANGEMENTS FOR IMPROVING HEALTH

3.76 A broad interpretation of the concept of health and the recognition that this goes far beyond the reach of the NHS and social services to wider social, environmental and economic factors highlights the need for effective partnership working at a local level. There is a growing body of evidence that good partnership working improves service outcomes for users and communities²⁸ and it is therefore a key element of the Health Inequalities delivery plan²⁹.

3.77 The importance of partnership working and community engagement is articulated in national policy outlining the roles of both the NHS and local government. The *NHS Plan* set out a stronger role for the NHS in reducing inequalities through joint working with local authorities and other regional agencies. Guidance to local government is that 'to tackle our most challenging problems on health, crime, education, transport, housing and the local environment, we need to marshal the contributions of the public, private and voluntary sectors, and of communities themselves'³⁰.

Legislative Drivers

3.78 A number of legislative changes have facilitated partnership working to improve health. These include the Health Act 1999, which imposes a duty of partnership and enables NHS organisations and local authorities to come to new arrangements for the transfer of money for a health related function, and The Health and Social Care Act 2001, which gives local authorities specific powers to scrutinise local health services and health organisations.

Local Strategic Partnerships

3.79 In recent years a plethora of partnerships has developed at a local level. Some are broad and cross-cutting. Others are issue based addressing themes such as teenage pregnancy, drugs and crime or area based like Sure Start and New Deal for Communities (see box 3.4).

3.80 Local Strategic Partnerships (LSPs) were introduced into the 88 Neighbourhood Renewal Areas to draw local agencies together and bring coherence to partnership arrangements and strategies. Although LSPs are not statutory in other areas, almost all local authorities have now established an LSP³¹. Those in Neighbourhood Renewal areas are monitored and accredited by their regional Government Office.

3.81 LSPs are intended to be partnerships bringing together all key players (public, private, community and voluntary) to rationalise and simplify existing partnerships, plans and initiatives (chart 3.1). The LSP aims to identify local priorities and to devise and implement strategies to address them.

²⁸ *Practical Partnerships for Health and Local Authorities*, D Plamping et al., BMJ, 2000

²⁹ *Tackling Health Inequalities: programme for action*, DH, 2003

³⁰ *Strong Local Leadership: Strong Local Services*, ODPM, 2001

³¹ *Evaluation of Local Strategic Partnerships: report of a survey of all English LSPs*, ODPM, 2003

3.82 National evaluation of LSPs in 2003 found that the majority include a subgroup or 'themed partnership' dedicated to the health strand of their local community and/or neighbourhood renewal strategies³¹. Additionally, a survey by the HDA found that in most areas health was seen as a key element of the community strategy with LDPs being used to inform the development of community strategies³². Although local authorities are expected to take the lead in developing the LSP they do not 'own' the partnership and LSPs themselves decide who leads.

Partnership working at a local level

3.83 Partnership working seems essential to improve the health of the population. In some areas there are signs of strong partnership working between PCTs and local government. In Jan 2003, 33 DPH posts (12 per cent) were joint appointments with the local authority. Other areas have developed 'Joint Health Units' between the PCT and local authority to bring together public health and community development skills.

3.84 Evaluation should be undertaken of the emerging ways in which PCTs and LAs are working together in relation to public health including the effectiveness of joint DPH appointments and Joint Health Units.

3.85 However a particular problem in many areas can be the lack of co-terminosity between local authority and PCT boundaries and the relationships between PCTs and two-tier authorities. When the geographical boundaries (and hence populations served) are not aligned, it is more difficult to co-ordinate activity and increases the number of partnerships with which PCTs and local authorities must engage. Box 3.10 illustrates the complexity of the problem.

Box 3.10 Cheshire and Merseyside SHA

The Cheshire and Merseyside SHA covers fifteen PCTs and eight local authority areas. Only four local authorities are coterminous with their PCT. One local authority shares the same boundary with two PCTs, one with three PCTs and one with four PCTs.

3.86 Currently, only a minority of PCTs are coterminous with a single unitary authority and historically co-terminosity between NHS services and local government has never been fully realised; indeed any attempt to achieve this would require re-organisation that is unlikely to be beneficial on a widespread scale.

3.87 The important issue is the recognition that developing partnerships and joint planning or service delivery with a range of organisations can be complex and requires sufficient expertise and capacity. Different approaches are being taken to facilitate partnership working. In some areas clusters of PCTs are organising themselves around local authority boundaries to reduce the planning burden and improve co-ordination³².

3.88 Partnership working in relation to public health should be included within the performance management of PCTs and LAs. Performance management and inspection of partnership arrangements should recognise the complexity of partnerships working in areas where the number of partner organisations is large due to the lack of co-terminosity.

³² *Planning With a Purpose: local authorities and the NHS planning together to improve health and well-being across the local strategic partnership*, HDA, 2003

3.89 The local strategic partnership acts to bring coherence to the range of plans and initiatives in an area and should provide a framework through which public health activity is co-ordinated locally. However the extent to which they do this in practice is variable. First, LSPs vary in their membership, organisation and activities and some are still at an early stage of development. They do not have a specific health remit, and their performance management arrangements are determined locally.

3.90 Although NHS strategic planning should be aligned with local authority Community Strategies, a survey by the HDA identified a number of problems that limited this including³²:

- ⚡# the large number of different priorities and targets between agencies;
- ⚡# the lack of flexibility over local interpretation of targets;
- ⚡# the different planning timetables and cycles of each agency;
- ⚡# different funding streams for different agencies;
- ⚡# increasing numbers of specific grants funds and the associated audit burden;
- ⚡# difficulty in combining funds from different initiatives in the same area;
- ⚡# many LSP partners are focusing on writing recovery plans for their own organisations; and
- ⚡# health planning guidance has focused on NHS service planning rather than joint health plans.

3.91 One particular difficulty relates to the accountability frameworks of PCTs and local government and guidance for developing the LDP and Community Strategy. The LDP is a relatively inflexible document based on guidance issued in the PPF. Accountability runs to the DH in a hierarchical fashion. The performance management of PCTs and SHAs is focused on achieving PPF targets. In contrast, the format and content of the Community Strategy is largely a matter for local discretion. Accountability is through the political process at a local level. Such differences can make it very difficult for both people and plans to relate to one another.

3.92 **PCTs, local authorities and others partners should determine shared local objectives based on national objectives and their local needs. Local objectives should be considered in the planning and performance management of both PCTs and local government – through the Priorities and Planning Framework and the Comprehensive Performance Assessment.**

PUBLIC HEALTH ACTIVITY AT A LOCAL LEVEL

3.93 At a local level, a wide range of activity is taking place to address public health issues. This includes activity to address the wider determinants of health, led primarily by local government, and activity focusing on prevention, screening and treatment of specific disease areas (such as those described in the NSFs), primarily led by the NHS. This section describes examples of initiatives to improve diet, to increase physical activity and to reduce obesity, as illustrations of partnership working at a local level to improve population health.

Box 3.11 Obesity and Nutrition Programme in Newcastle PCT

Newcastle PCT established a Specialist Weight Management Service (SWiMS) following a survey undertaken by Newcastle University that identified high prevalence of obesity among Newcastle residents (41 per cent of men and 54 per cent of women).

Funded by Neighbourhood Renewal, the service is staffed by a programme manager, fitness instructor, psychologist, dietician and community nutrition assistant together with administrative support.

The service links with primary, secondary and tertiary care (including diabetes and cardiac rehabilitation services), with physiotherapy and with council funded and private leisure facilities. Referral to SWiMS can be from any of these routes or clients can self-refer.

The service offers 3 levels of provision depending on BMI:

Level 1 services are those that were already in existence prior to the development of SWiMS and include primary care advice and management of overweight and obesity, and leisure services.

Level 2 services provide weekly groups sessions over a 12 week period offering dietary advice, physical activity and psychological support to those with a BMI >25.

Level 3 services are provided for the house bound or those with morbid obesity (BMI >40). Individual or small group interventions are provided with a programme tailored to the individual. This involves a range of activity including physiotherapy, dietary advice and psychological support.

For those with morbid obesity the service has links with tertiary care services and can refer directly for assessment of the need for gastric surgery.

Follow-up at 6 and 12 months is provided for all clients.

Evaluation of clients at one year follow-up demonstrated sustained physical activity and weight loss together with a reported increase in self-esteem and confidence.

An independent evaluation of the service has been commissioned from Northumbria University.

Box 3.12 Food Mapping in Sandwell

In Sandwell, Health Action Zone funding was used to undertake a 'food mapping exercise' to determine the accessibility of 'healthy food options' for residents³³. A survey of neighbourhood shops demonstrated that most residents did not have access to affordable, healthy food within walking distance. In contrast, access to cigarettes, chocolate and biscuits was relatively good. Interviews with shop owners found that the reason why they had little fresh produce was because such products were highly perishable and difficult to 'manage' and generated little income for the shelf space. Following on from this a 'sale or return' scheme was piloted in three shops as part of Sandwell's National Five a Day pilot site. This demonstrated that residents were willing to purchase such produce and the 'sale or return' scheme allowed shopkeepers to 'take a risk' with stocking fruit and vegetables. Neighbourhood Renewal funding is now being sought to pilot a 'complete fresh produce service' within local shops. The pilot scheme aims to provide small retailers with support and guidance in establishing a fresh fruit and vegetable service within their business. The scheme has been developed with support from a local fresh produce consultant, a local retail improvement consultant, local shopkeepers and Sandwell Traders Association.

Box 3.13 Community Workers in Newcastle

In Newcastle local community nutrition assistants have been developed. These are local people who have been trained by members of the community dietics team. They are involved in a wide range of projects including cooking classes and healthy eating sessions, and now work in a range of community based projects including the Sure Start Programmes and Community Kitchen (a local programme teaching cooking and healthy eating skills in a deprived area of the city). The community workers also support School Breakfast Clubs where some have taken the role of running the breakfast clubs to provide a link between the community and the school and providing employment for members of the community. The breakfast clubs have included oral health interventions (toothbrushing projects).

Additional local trained community workers are also involved in the family safety scheme where local people are trained to visit people in their homes and assess safety and risk.

³³ *Measuring Access to Healthy Foods in Sandwell: final report*, D Dowler et al., Warwick University, 2001

Box 3.14 Action to promote physical activity in Kirklees

In Kirklees, a 'Physical Activity and Health' Action Plan has been developed by Kirklees Metropolitan Council, Primary Care Trusts, Kirklees Active Leisure and the University of Huddersfield.

The plan aims to address the local PSA target of 'reducing the proportion aged over 65 who are sedentary by at least 900 people and the proportion of 18 to 65 years olds on low incomes who are sedentary by 1200 people by 2005'.

A needs assessment was undertaken to inform development of the plan. This identified 4 main objectives:

- # to increase knowledge, awareness and understanding of physical activity;
- # to increase the number of physical activity opportunities particularly for children and young people, older people, people from South Asia, especially women, and those living in poverty and socially excluded communities;
- # through motivation and support, to increase the proportion of sedentary or occasionally active people who want to increase their level of physical activity; and
- # to increase the profile of physical activity in key policy and strategies.

A range of action is being undertaken to meet these objectives. This includes:

- # training to NHS staff to give advice on how to increase levels of physical activity;
- # Active Sport programme for young people involving 60 local clubs;
- # Energise: a project in 90 schools which aims to increase physical activity for young people who are obese, diabetic or asthmatic;
- # upgrading of 9 play areas every year to increase play opportunities;
- # Practice Activity and Leisure Scheme – an 'activity on prescription scheme' aimed at adults and older people who are not currently active and would benefit from taking part in some regular physical activity;
- # Making Tracks – a programme of free walks, cycle rides, orienteering and practical countryside tasks across Kirklees;
- # the establishment of new walking groups and training for leaders through Kirklees Walk Leaders Network;
- # promotion of cycling through the development of safe cycling routes and the provision of 'Families on Wheels' courses, 'Returners to Cycling' courses, 'Bike Fix' courses and the 'Right Way to Work' scheme; and
- # Local Exercise Action Pilot (LEAP). LEAP is a national DH programme of local physical activity pilots designed to assess what practical interventions on the ground will deliver sustained increases in physical activity. Both national and local evaluation is built into the programme. The Kirklees LEAP project pilots a range of interventions targeted at young people at risk of CHD, South Asian girls, and adults and older people with diabetes. The pilot will run for two years with a 6 month evaluation period following completion.

3.94 Evidence submitted to the Review demonstrated a wide range of activity to address public health issues, including the major behavioural and lifestyle risk factors for future disease, through co-ordinated actions of partners at a local level. However, a key problem remains the evaluation of such activities. Evaluations are frequently built upon process measures, or short-term outcomes with little consideration of long-term health gain or the comparative cost-effectiveness of interventions. Lessons need to be learned about the effectiveness and cost-effectiveness of all activity and fed back into policy formation. These issues are discussed further in Chapters 5 and 6.

3.95 The consideration of effectiveness and value for money should be an essential element to determine the allocation of specific funding streams. Where such evidence does not exist, a pre-requisite of funding should be the demonstration of a robust evaluation strategy to gather the information needed to evaluate the interventions.

3.96 A consistent framework (such as the methodology developed by NICE) should be used to evaluate the cost-effectiveness of interventions and initiatives across both health care and public health.

3.97 A commitment of adequate resources for monitoring and feedback should be an integral part of the planning of any national programme of action to tackle the key determinants of health.

3.98 Although a great deal of partnership activity is taking place to address public health issues across England, much of this is taking place on an 'ad hoc' basis or using non-sustainable funding streams, such as New Opportunities Funding or Neighbourhood Renewal Funding. These sources cannot provide long-term sustainability to projects and there is a danger that when funding ceases the initiative will end (see box 3.15).

3.99 However, some public health initiatives such as the 5 A Day community pilots and the Local Exercise Action Pilots have gathered baseline and follow-up data on consumption and activity levels as part of their evaluation. Additionally, sustainability has been a key feature of both these DH funded projects.

Box 3.15 Fit for the Future in Barnsley

In Barnsley, a partnership has been developed between the PCT, local authority, Barnsley College, Community Partnership, Barnsley Premier Leisure, the Barnsley Chronicle and Barnsley Development Agency. The partnership is developing a long-term strategy to improve health and reduce inequalities 'Fit for the Future'. The aim of the strategy is to move away from short term funded projects to replace this with a systematic large-scale programme based on commissioning and mainstreaming. Existing area-based initiatives will be incorporated into the strategy and mainstreamed where appropriate. Future posts recruited under Fit for the Future will be permanent. Currently £750,000 is invested in the initiative funded through the PCT's health inequalities supplement (Health Action Zone (HAZ) funding) and Neighbourhood Renewal Funding (NRF). However NRF is due to cease in 2006 and HAZ funding to the PCT is not ring-fenced for the initiative. Since the PCT has a budgetary deficit of around £15 million there is a danger that this funding will not be sustainable. The partnership recognises that there is a financial risk with the strategy and none of the partner organisations represented on the steering group will have resources to mainstream everything that 'Fit for the Future' is currently funding.

3.100 An additional problem created by short term funding is that it can lead to lack of coherence and duplication of effort at a local level. However, in many cases the only funding available for partnership public health initiatives is through specific funding streams.

Box 3.16 Sandwell Area Based Initiatives

In Sandwell, in an area covering 3 PCTs and a population of approximately 280,000, there is a multitude of area based initiatives including: Housing renewal zone, Sure Start waves 1 to 5, Urban Regeneration Area, Education Action Zone, single regeneration budget programme, New Deal for Communities, On Track Project and Children's Fund.

Each initiative covers a different geographical area and has its own performance review programme and small packages of funding. Partners have not been permitted to pool funding or combine the performance management of these initiatives into a single framework.

3.101 Where the economic benefits are proven, sufficient funding should be available to develop co-ordinated public health activity which is targeted at addressing the locally identified needs and which is sustainable, if necessary, in the long term.

MINISTERIAL RESPONSIBILITY FOR PUBLIC HEALTH

3.102 The Secretary of State for Health has overall strategic responsibility for NHS improvement, delivery and reform, finance and resources³⁴.

3.103 Five additional Ministers in the Department of Health each have individual responsibility for different aspects of the Department's work. Public Health, to some degree, falls under the remit of all Departmental Ministers. However in 1997 the Government created the post of Minister of Public Health with specific responsibilities for:

- ⌘ Cancer;
- ⌘ Coronary heart disease;
- ⌘ Tobacco policy;
- ⌘ Communicable diseases;
- ⌘ Immunisation;
- ⌘ Health inequalities;
- ⌘ Drug & alcohol misuse;
- ⌘ Sexual health issues;
- ⌘ Food safety and the FSA.

³⁴ www.dh.gov.uk/about/ministers.htm

3.104 Although the creation of the post of Minister of Public Health has highlighted the importance with which the current Government regards public health, evidence submitted to the review from a range of professionals and organisations (both statutory and non-statutory) expressed a concern that leadership and Ministerial responsibility for public health remains within the DH. This is seen as detrimental to public health since it is perceived to indicate a failure of Government to fully consider the importance of all departments in relation to public health, and since the NHS is perceived to focus on treatment activities to the detriment of public health activity.

3.105 Submissions to the review suggested a variety of options to address these perceived failures. Suggested options included:

- ☞ the creation of an independent ‘Commission for the Health of the People’, established by Act of Parliament, to take a wide view of public health and to publish and provide independent advice to Government on public health policy and strategy³⁵;
- ☞ the appointment of a Commissioner for Public Health, accountable to Parliament;
- ☞ the creation of a new Ministerial Department for Public Health; or
- ☞ the appointment of a Minister for Public Health post within Cabinet.

3.106 The Review recognises that the debate around Ministerial and Departmental responsibility for public health, and indeed the location of the public health function at a local level, has been long-standing. The current concerns expressed in submissions to the Review seem to indicate a long-term frustration with a perceived lack of comprehensive, cross-departmental action to address public health issues.

3.107 The forthcoming consultation and Public Health White Paper present an opportunity for Government to consult on these views and develop a comprehensive strategy in relation to long-term population health, which in turn will help to address this frustration. If the recommendations of this Review are acted upon and England moves towards full engagement, DH and the NHS will both move a significant part of their work into promotion of good health.

3.108 **The Secretary of State for Health should be given the role of ensuring that Cabinet assesses the impact on the future health of the population of any major policy development.**

³⁵ *The Case for a New UK Health of the People Act*, S Monaghan et al, The Nuffield Trust, 2003

PUBLIC HEALTH LEADERSHIP AND WORKFORCE

3.109 The Chief Medical Officer (CMO) and his teams, located within the DH, provide leadership of the public health function in England.

The Chief Medical Officer

3.110 The Chief Medical Officer is the UK Government's principal medical adviser and does not change with a change of Government. In addition to providing advice to Ministers, the CMO:

- prepares policies and plans to implement programmes to protect the health of the public;
- promotes and takes action to improve the health of the population and reduce health inequalities;
- leads initiatives within the NHS to enhance the quality, safety and standards in clinical services; and
- prepares or reviews policy in particular areas of health or health care.

3.111 The CMO is part of the DH's management team.

Regional Directors of Public Health

3.112 There are nine Regional Directors of Public Health who are DH employees. The RDsPH are based in the GORs and are responsible for implementing a wide range of strategies to improve health, reduce health inequalities and protect public health in their regions.

The Public Health Workforce

3.113 A wide range of individuals across a variety of organisations can be considered to have a public health role. This was recognised in a report by the CMO on Strengthening the Public Health Function, which highlighted the multi-disciplinary and multi-organisational nature of public health³⁶. In his report, the CMO identified three broad categories of people who contribute to the public health workforce (Box 3.17).

³⁶ *The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function*, DH, 2001

Box 3.17 The Public Health Workforce

Specialists: Consultants in Public Health Medicine and Specialists in Public Health who work at a strategic or senior management level or at a senior level of scientific expertise to influence the health of the whole population or of a selected community. These professionals have specialist knowledge and skills and their core task is public health.

Public Health Practitioners: those who spend a major part, or in some cases all of their time in public health or preventative practice during their hands-on work with individuals or groups of people. Examples include health visitors and environmental health officers.

Wider public health: those who have, by virtue of their job, a role in community or individual health improvement, such as teachers, local business people, housing officers, community development officers and the voluntary sector. This group has been further subdivided into:

- ⌘ 'Key influencers' whose remit has a profound impact on population health such as trust and health authority chief executives, leaders of local authorities, or those who hold senior positions in education such as head teachers;
- ⌘ 'Technical experts' whose specialist knowledge is vital to public health (for example radiation or soil scientists, virologists); and
- ⌘ The wider 'undifferentiated' workforce.

The Specialist public health workforce

3.114 The Specialist public health workforce is primarily located in PCTs. Other public organisations in which Public Health Specialists are employed include Government Offices for the Regions, Strategic Health Authorities, the Health Protection Agency (Consultants in Communicable Disease Control), Academic Departments, Public Health Observatories and the Health Development Agency. A small number of Public Health Specialists are also employed by NHS Trusts.

3.115 A recent survey commissioned by the DH identified a possible 783 Public Health Specialists working in PCTs and SHAs in England, of whom approximately 50 per cent were medically qualified³⁷. However the total Specialist workforce will be much larger than this since the survey did not include other organisations such as the HPA, PHOs or Academic Departments.

Public health practitioners

3.116 Public health practitioners work for a range of organisations including the NHS, local government and voluntary organisations. Box 3.18 describes the public health role of a range of NHS primary and community care staff.

³⁷ *Capacity and Development Needs of Specialists and Consultants in PCTs and SHAs: Final report to the Department of Health*, Chapman et al., 2003

Box 3.18 The role of primary care in relation to public health

Health visitors' roles include child health surveillance, immunisation, family health and health promotion activities with children and families and the wider community

School nurses perform a range of public health related activities including child and family health, immunisation, sexual health and health promotion to children and families.

Practice nurses spend a large part of their time on public health activities, primarily immunisations and screening³⁸. Other public health activity includes health promotion interventions.

Midwives' health promotion activities include advice and support around breastfeeding, diet, smoking and alcohol.

District nurses have opportunities to provide health promotion advice and screening through their contact with patients in the community.

GPs: The time spent by GPs on public health activity is unknown. Relevant interventions include screening, health promotion and risk reduction interventions (for example blood pressure, cholesterol and smoking cessation) and referral to other services, for example exercise on prescription.

Dieticians provide support and advice to improve diet and aid weight loss for the general population and also give specific dietary advice tailored to patient need (for example for those with diabetes). Dieticians are also involved in providing support and training to other NHS staff members or the wider public (for example community workers) in relation to nutrition.

Box 3.19 Examples of nursing activities in relation to public health

Health visitors in Bradford identified that women with weight problems and high risk for Type two diabetes in the local South Asian community were reluctant to access support such as Weight Watchers. They set up a weekly programme of health education and exercise sessions taking into account the cultural and social needs of this group. Evaluation showed a reduction in body mass index among those taking part plus high reported satisfaction, improved social contact and knowledge regarding healthier eating³⁹.

Wider public health workforce

3.117 The wider public health workforce is not easy to define and enumerate. In 2001/2 a survey was undertaken to describe and quantify the public health workforce in London⁴⁰. Organisations included in the survey were wide ranging and included the NHS (SHAs, PCTs, Acute and Mental Health Trusts), local government, the commercial sector, criminal justice and voluntary sector.

3.118 The survey found a workforce in excess of 250,000 in London of whom the majority (98 per cent) were in the 'wider' public health workforce category. The Specialist workforce accounted for only a small proportion of the total (0.37 per cent).

³⁸ *Practice Nurses: what do they do? A study of roles, responsibilities and patterns of work.* R Eve et al., 2000

³⁹ *Liberating the Public Health Talents of Community Practitioners and Health Visitors*, DH and CPHVA, 2003

⁴⁰ *Public Health Workforce Planning for London, mapping the public health function in London, a report to the Department of Health Select Committee*, F Sim et al., DH, 2002

- 3.119** The survey also found that the distribution of the workforce varied by category:
- ☞ the majority of public health Specialists were within the NHS;
 - ☞ the majority of public health practitioners were within the NHS and local government; and
 - ☞ ‘key health influencers’ were from a wide range of bodies, the majority of which are local authority allied bodies such as educational establishments. The NHS also has a significant proportion of ‘key influencers’ predominantly within NHS Trusts.

Development of Public Health Capacity

3.120 Developments to strengthen public health capacity need to address both the knowledge and competence of individual members of the workforce, and the capacity of organisations to support and deliver public health activity.

3.121 An essential element of ‘full engagement’ is the recognition that the greatest contribution to public health is made by individuals in the ‘wider’ public health workforce, many of whom have job titles that do not mention public health, or even health. The Specialist public health workforce is an essential, but small, component of the public health function and to achieve greatest impact must engage with and harness the resources of other contributors across all sectors.

3.122 Recent national policy has indicated a commitment to strengthen the public health function. Box 3.20 outlines some of these policy developments and box 3.21 describes a range of current activities that will strengthen public health capacity. But in order to ensure that capacity is right for the long term, it is necessary to have a clear view of the future development in public health policy and delivery.

Box 3.20 National policy relevant to strengthening the Public Health Function

Shifting the Balance of Power positioned PCTs as the lead organisation to deliver the public health function at a local level. All PCTs are required to have a board level director of public health who may come from a background other than medicine.

Saving Lives: Our Healthier Nation and *The NHS Plan* gave a policy commitment to develop a new post of 'non-medically qualified' public health specialist, which is equivalent in status to a consultant in public health medicine.

'Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and health care' set out a strategy to broaden the remit of the nursing profession in relation to public health⁴¹.

'Liberating the Talents' identified 'public health/health protection and promotion programmes that improve health and reduce inequalities' as one of three core functions to be delivered by nurses, midwives and health visitors³⁹.

A Vision for Pharmacy in the New NHS set out 10 key roles for pharmacy including 'to be a public health resource and provide health promotion, health improvement and harm reduction services'⁴².

Additional guidance issued to the NHS and LA Social Service Departments in 1999 placed a requirement on local organisations to work together to extend training for staff about public health, health inequalities and health promotion⁴³.

⁴¹ *Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and health care*, DH, 1999

⁴² *A Vision for Pharmacy in the New NHS*, DH, 2003

⁴³ *Modernising Health and Social Care Services: developing the workforce*, HSC 1999/111 and LAC 1999/018

Box 3.21 Examples of activity to strengthen the Public Health Function

Voluntary Register: In 2003 a Voluntary Register of Public Health Specialists was established under the auspices of the Tripartite Group (Faculty of Public Health, the Royal Institute of Public Health and the Multidisciplinary Public Health Forum). 'Top up' training is being funded by the DH for Public Health Specialists to access training to fill competency gaps, in order to become Registered Public Health Specialists.

National Public Health Leadership Programme: Established in 1998, the Leadership Programme aims to develop leaders who can ensure that population health considerations are included in all decisions involving health and social policy at local, regional and national level board level or equivalent. The Programme is open to 'key influencers' in public health including the NHS, academic, local authority, prison services, voluntary and independent sectors.

PCT Competency Framework: The National Primary Care Trust Development Programme, part of the DH sponsored Modernisation Agency, has developed a self-assessment Competency Framework as a support tool for PCTs. Public Health is one of nine domains included within the Framework.

Public Health Learning Sets: Learning sets for Public Health Network Leads and Co-ordinators have been established by the DH.

Standards for Public Health Practice: National public health practice standards have been developed by Skills for Health (Sector Skills Council for Health). These will be used by PCTs to identify and plan to fill skills gaps, by individuals to identify their own learning needs, and by academic institutions to develop courses that deliver these competencies.

Nursing and Midwifery Council Register for Public Health: The Nursing and Midwifery Council (NMC) has recently consulted on their intention to establish a third part of the NMC Register for Public Health.

Health Visitor and School Nurse Public Health Resource Packs: Developed by the DH, the resources packs have been distributed to all health visitors and school nurses in England to provide information and knowledge in developing their public health skills.

3.123 In 2000, Workforce Development Confederations (WDCs) were created to lead workforce planning for local health and social care communities. In July 2003 they were integrated with SHAs. Although the WDCs have the responsibility for long-term workforce planning including training and education, some have been criticised by Public Health Specialists for paying insufficient attention to developing public health capacity, in particular to supporting the development of Academic Public Health.

3.124 Despite the number of policies and activities seeking to strengthen the public health function that recognise the broad range of players, there remains a need to have a long-term vision of the public health workforce.

3.125 A strategic plan at national level should be produced to implement a co-ordinated approach to developing the public health workforce. It is important that the competencies required to play new roles (for example, smoking cessation officers) are identified. This strategy should build on current activities but in particular, the potential contribution of the 'wider' public health workforce must be fully realised and the skills and capacity of the Specialist and practitioner workforce to engage with this wider public health community must be strengthened.

LEVERS CURRENTLY AVAILABLE TO STRENGTHEN PUBLIC HEALTH DELIVERY IN PRIMARY CARE

3.126 A number of recent developments have given PCTs greater flexibility in the provision of primary care medical services allowing them to develop services according to local need and to improve population health through primary care. Options available are:

- ⌘ Personal Medical Services;
- ⌘ General Medical Services;
- ⌘ PCT provided Primary Medical Services; and
- ⌘ Alternative provided Primary Medical Services (for example, through a commercial organisation or a voluntary organisation).

Personal Medical Services (PMS)

3.127 The NHS (Primary Care) Act 1997 allowed for the introduction of 'PMS pilots'. Pilot providers can be an individual GP practice (which could be nurse led), a group of practices, GPs employed by an NHS Trust, or a PCT. For an agreed sum of money, the pilot provider agrees to provide a range of primary care medical services to a defined population. The aim of PMS is to give greater flexibility to PCTs to commission or provide services that are better tailored to local need. Under PMS, the PCT and providers can agree to vary the quality framework to tackle specific issues.

3.128 At present about 40 per cent of general practices in England are PMS. Although PMS pilots vary widely in their configuration and services provided, national evaluations suggest that PMS has led to a number of improvements in patient care, including:

- ⌘ improved services for disadvantaged groups;
- ⌘ filling previously hard-to-fill clinical posts; and
- ⌘ expanding primary care services to include those usually provided in hospital.

Box 3.22 Examples of PMS Pilots⁴⁴

North Peterborough PCT: The PMS pilots have clear targets linked to local health improvement priorities, especially coronary heart disease and diabetes, but also asthma and mental health, as well as broader targets linked to improving access.

North Yorkshire Health Authority established a doctor-led drug rehabilitation clinic at a surgery adjacent to a bail hostel where a large number of residents suffered from drug abuse problems. A key objective of the pilot was to provide a comprehensive substitute prescribing and detoxification service.

Sunderland Health Authority identified that it had significantly fewer GPs than the national average and, since it was a relatively deprived area, also had greater health needs. The HA used PMS growth funding to recruit additional doctors to the area. It also focused pilots' targets on NSFs that are especially relevant to the local community, particularly heart diseases.

The New General Medical Services Contract

3.129 Historically, GPs have been self-employed 'independent contractors' to the NHS, running their own businesses and receiving payment under 'General Medical Services' through the 'Statement of Fees and Allowances'. This system has been cumbersome and inflexible, and poorly equipped to address issues such as primary care vacancies in deprived areas. Additionally, GMS provided few incentives to improve clinical quality or develop services adapted to local need.

3.130 Beginning in April 2004 a new GMS contract will be implemented. The contract provides flexibility for practices to determine the range of services they wish to provide and establishes a 'quality and outcomes' framework through which practices will be rewarded for clinical and organisational quality.

3.131 Under the contract, services provided by a primary care practice are categorised into essential (such as management of patients with acute or chronic diseases), additional (such as cervical screening, contraceptive services, vaccinations and immunisations) and enhanced services (such as minor injury services and enhanced care of the homeless).

3.132 All GMS practices will provide essential services but may choose to 'opt out' of additional services, in which case the money for that service will be retained by the PCT and used to secure alternative provision from other providers. Payment to GMS practices for essential and additional services will be through a 'Global Sum' allocated to PCTs.

3.133 A separate stream of protected money will be allocated to PCTs for the commissioning of 'enhanced services'. PCTs are free to commission whatever enhanced services they consider appropriate to meet local health needs. This creates many opportunities, including the potential to target services at a specific population group (for example drug misuse services) or to provide more primary care services at the boundary of primary and secondary care (for example provision of near patient testing and specialised care of patients with depression).

⁴⁴ *Personal Medical Services*, Audit Commission, 2003

3.134 A new Quality and Outcomes Framework⁴⁵ has been established which will reward practices for delivering quality care. The quality framework sets out indicators within four domains: clinical standards, organisational standards, the patient experience and additional services. Box 3.23 gives some examples of quality indicators. Practices are free to choose which areas of the quality framework to focus on and are rewarded for achieving set targets within this framework. The framework will be reviewed in two years time to take into account lessons learned from both GMS and PMS.

Box 3.23 Examples of Quality Indicators within the new GMS contract

The practice can produce a register of patients with established hypertension.

The per cent of patients with hypertension in whom the last blood pressure (measured in the last 9 months) is 150/90mmHg or less.

The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 55 per cent of patients.

The practice supports smokers in stopping smoking by a strategy that includes providing literature and offering appropriate therapy.

The percentage of patients with asthma who smoke, and whose notes contain a record that smoking cessation advice or referral to a specialist service, if available, has been offered within the last 15 months.

3.135 An additional provision of the GMS contract is that PCTs will fund the costs of practice IM&T systems that have been accredited against UK wide standards. This provides potential for the development of practice and PCT based patient registers that could be developed to record information on disease, medication and risk factors. Such knowledge could be used not only to improve chronic disease management, but to guide local activity aimed at health improvement and the primary prevention of disease.

3.136 An experiment should be established across primary care to assess the benefits of additional resource in information systems, in monitoring risk, and in services. It would also produce evidence about the effectiveness of information to assist personalised risk management and disease prevalence in local populations. The experiment should be directed towards areas of inequality, given that access to services there is a crucial issue, which must be resolved.

⁴⁵ *Quality and Outcomes Framework Guidance*, NHS Confederation, 2003

CONCLUSIONS

3.137 This chapter has illustrated the breadth of individuals and organisations responsible for improving, and reducing inequalities in, the population's health and the relationships between these partners. The NHS, whilst a major contributor, is only one element of the public health delivery system.

3.138 While recent policy and activity has been directed at strengthening the public health role of the NHS and local government, and facilitating partnership working to improve population health, in some areas difficulties remain due to capacity problems, the impact of recent organisational changes, and the lack of alignment of performance management mechanisms between partners.

3.139 The Review found a need to establish shared targets for public health, which are agreed locally between partners following national objectives, and which are included in the performance management and inspection processes of all partners.

3.140 The Review has found a clear need to prioritise and adequately resource public health activities at a local level in order to develop long-term sustainable action to improve population health, and has found a need to evaluate existing activities against a common framework (including their cost-effectiveness).

3.141 The greatest contribution to public health is made by individuals in the 'wider' public health workforce, many of whom have job titles that do not mention public health, or even health. The Specialist public health workforce is an essential, but small, component of the public health function and to achieve greatest impact must engage with and harness the resources of contributors across all sectors. There is a need to develop public health capacity recognising the potential resource within this wider public health workforce.

3.142 Primary care trusts, as the main NHS organisations responsible for improving population health, need appropriate incentives and performance management to enable them to prioritise public health issues and to work in partnership with local players to achieve this. The potential of PMS and the new GMS contract to improve population health must be fully utilised.