CHAPTER 2

Enabling health, independence and well-being
This chapter on health, independence and well-being includes the following commitments:

- developing an NHS ‘Life Check’ starting in Primary Care Trust (PCT) spearhead areas;
- better support for mental health and emotional well-being: promoting good practice; demonstration sites for people of working age, as part of our action to help people with health conditions and disabilities to remain in, or return to, work; access to computerised cognitive behaviour therapy;
- local leadership of well-being: improving commissioning and joint working through defining and strengthening the roles of Directors of Public Health (DPHs) and Directors of Adult Social Services (DASSs);
- better partnership working in local areas: a new outcomes framework; aligning performance measures, assessments and inspection; aligning planning and budget cycles for the NHS and local authorities;
- stronger local commissioning: shifting towards prevention and early support; expanding the evidence base through Partnerships for Older People Projects (POPPs); National Reference Group for Health and Well-Being; re-focusing the Quality and Outcomes Framework (QOF);
- national leadership: stronger leadership for social care within the Department of Health; a new Fitter Britain campaign.
Introduction

2.1 People want to stay as healthy, active and independent as possible. We each have a responsibility for our own health and well-being throughout our lives.

2.2 At the same time, the Government – as well as the citizen – has a role in promoting healthier, longer lives lived to the full. In our society, not everyone has the same opportunities or capacity to take action to improve their own health and well-being. We will build on and strengthen the opportunities for improving the health of the population set out in Choosing Health. Public bodies can and should do more to support individuals and give everyone an equal chance to become and stay healthy, active and independent.

2.3 People in the Your health, your care, your say consultation reflected this view strongly. They said that they wanted to take responsibility for their health and to be helped to do that. This echoed the strong messages in Independence, Well-being and Choice where people wanted services to support their independence, put them in control and focus on the prevention of ill-health and promote well-being at all stages of their lives.

2.4 These are not idle aspirations. As a nation, we are faced with the real possibility that – due to lifestyle changes – our children will not live as long as their parents unless there is a shift towards healthier living. Millions of working days are lost each year through ill-health, with mental health problems and stress now the most frequent causes of this. Services also must respond to the needs of the ageing population, supporting people to continue to live full, healthy and independent lives as they grow older.

2.5 People also felt strongly that those at greatest disadvantage need more help than others. The two Wanless reports highlighted the need for citizens to be fully engaged with their health and for their health service to deliver better health outcomes for the poorest in our communities and to ease pressures and costs for the NHS in the long-run. Choosing Health outlined a cross-government strategy for delivering this, in partnership with local services, and Independence, Well-being and Choice set out proposals for promoting social inclusion for all those needing support to maintain their independence.

2.6 Preventing ill-health and enabling people to play a full role in their local communities are also key parts of the Government’s work on regeneration and building sustainable communities. And the quality of the environment, for example of our air and water, is vital to health and an important aspect of health protection. Access to green spaces, clean and safe open air spaces where people can meet and exercise informally, and planning and design that encourage walking and cycling are all important factors in supporting health and well-being.
Childhood

2.7 Healthy living starts before we are born. The evidence is unmistakable. Health later in life is influenced by such factors as whether mothers smoke or breastfeed their babies. The children of overweight parents are more likely to grow up overweight. What food and drinks we see as desirable and healthy are determined at an early age. Early relationships may affect later resilience and mental well-being. Healthy living must therefore start at the earliest opportunity and should continue as part of schooling.

2.8 *Every Child Matters* set out our aspirations to maximise the health and well-being and achievement of all children. We are working to achieve this through a major reform programme which includes the integration of local services in children’s trusts, the implementation of the *National Service Framework for Children, Young People and Maternity Services* and better support for parents and carers.

2.9 Because health and development in early childhood are crucial influences on health and other outcomes throughout life, we have made a major investment in transforming the life chances of the most disadvantaged children aged under five through the Sure Start local programmes. The intention is for parents, from the time they know they are expecting a baby, to be supported by integrated health, childcare, early education and family support services that target those most at risk of poor outcomes.

2.10 In the current Childcare Bill, the Government is proposing a new duty on local authorities, working with their partners, to improve the outcomes of all young children under school age and to reduce inequalities in these outcomes. The main delivery vehicle for the strategy will be the development of Sure Start Children’s Centres in every community, bringing together health, family and parenting support, childcare and other services. There are currently about 400 Children’s Centres and the number is set to rise to 1,000 by September 2006, 2,500 by 2008 and to 3,500 by 2010.

2.11 Following *Choosing Health*, we are also improving support for school-age children. All schools should promote the physical health and emotional well-being of children and young people, including through access to nutritious, well-balanced food, personal, social and health education, and to opportunities for
physical activity and sport. We are working with schools, through our Healthy Schools programme and other initiatives, to achieve this, and we are investing £840 million over five years in order to expand the range of services – including healthy living advice and support services – on offer to children and local communities through extended schools.

---

**CASE STUDY**

**Peer mentoring in Warrington**

Starting at a new school can be daunting. In Warrington, one school has hit on the solution of pairing older pupils with new entrants.

Year 8 pupils at William Beaumont School have been discussing issues such as the secondary school culture, healthy eating, bullying and sport with Year 6 pupils at local primary schools. The Year 8 mentors are given training in advance. They then work on a one-to-one basis with primary school pupils who may struggle to cope with the move from a small primary school to a much larger secondary school.

Everyone has benefitted from the scheme. The mentors say they have become more confident, felt responsible and are enjoying their own lessons more, while the mentees say they are less anxious and happier about their impending move.

Thirteen-year-old Beth Caddick was mentored when she was in Year 6 and is now a mentor herself: “It’s great being able to help others and it makes you feel good about yourself. You can answer all their questions and problems. It was years ago when the teachers were at school, wasn’t it, so we probably have more of an idea what it’s like.” Her mother, Maxine, is really pleased with how the programme has helped her gain confidence. “It’s enabled her to participate in other activities that she wouldn’t have had the confidence to do in the past. It makes her feel a better person and she’s achieved a lot. She has come out of herself and I’m really proud of her.”

Teachers have seen the benefits, with one primary school teacher remarking that: “Self-esteem has improved and children are much more prepared for the move.” The William Beaumont school has seen a dramatic decline in the number of Year 7 pupils having difficulty with the change of schools.
2.12 We know that the transition between primary and secondary education can be particularly testing for some young people. Difficulties encountered at this pivotal stage can have profound consequences for future social and educational progress, so support at this life stage is crucial. The peer mentoring pilot projects in 180 secondary schools announced in Support for parents: the best start for children will provide additional support for vulnerable young people throughout secondary education.

2.13 The Youth Matters Green Paper recognised the inseparable link between good emotional and physical health and success in learning and achievement. Support for both emotional and physical health is a core part of the Green Paper's proposals to promote more integrated, multi-disciplinary support for young people. Thirteen pilots for these new integrated forms of support are now under way. Life skills and emotional resilience acquired in childhood and adolescence help people cope with challenges throughout their lives. Youth Matters set out a range of proposals for making health services more responsive to young people's needs, and the Government will shortly publish its response to the consultation and next steps.

2.14 Improving the way key individuals and organisations safeguard and promote the welfare of children is crucial to improving outcomes for children. Section 11 of the Children Act 2004 places a duty on key people and bodies, including Strategic Health Authorities (SHAs), PCTs, NHS Trusts and Foundation Trusts, to make arrangements to ensure that their functions are carried out with regard to the need to safeguard and promote the welfare of children and young people. Effective information sharing by professionals is central to safeguarding and promoting the welfare of children. The Government is expected to publish further guidance on this during 2006.

**People of working age**

2.15 Health and well-being also matter in adult life. In particular, work is an important part of people's adult lives. There is good evidence that someone who is out of work is more likely to be in poor health and use services more frequently. People who are out of work for longer periods are at greater risk of losing their sense of well-being and confidence, which may lead to longer-term mental health problems and long-term detachment from the labour market. There is a strong link between unemployment, social exclusion and health inequalities in this country.

2.16 Health conditions and disabilities, if not appropriately managed and supported, can lead to job loss and long-term benefit dependency, with all the associated consequences not just for individuals but for their families. Equally, good health and emotional well-being can assist people to enter work and maintain fitness for work.

2.17 The Department of Health is working with the Department for Work
and Pensions and the Health and Safety Executive to address these issues through *Health, work and well-being – caring for our future.* This strategy seeks to break the link between ill-health and inactivity, to advance the prevention of ill-health and injury, and to encourage good management of occupational health issues. It also aims to transform opportunities for people to recover from illness, while at work, maintaining their independence and sense of worth. By ensuring equal rights and opportunity for all, not only will individuals benefit, but employers and the economy as a whole will gain from the huge potential that people have to offer.

2.18 The Government’s planned welfare reforms will take the health, work and well-being agenda forwards. We have already seen great success from local partnership working, led by PCTs, in the Pathways to Work pilots. Over 19,500 people with a health condition or disability have been helped by the pilots to make a return to work.

2.19 As the first point of contact for people with health conditions, GPs and primary care teams play a key role in providing the support to patients that allows them to remain in work or to return to work quickly. The Department for Work and Pensions is developing a range of initiatives to provide the support necessary for GPs to offer this help to their patients. Initiatives include training in fitness for work issues, piloting access to employment advice and support, and

---

**CASE STUDY**

**Improving mental health in London**

Pioneering work in mental health is going on across the capital. In South London the NHS is working with local voluntary and community services to help people back to work as part of the New Deal for Disabled People. South West London and St George’s Mental Health Trust runs an exemplary employment service which uses employment advisers to place referred clients. In 2004/05 it managed to place 922 clients in jobs and 90 per cent remained in employment.

North East London and the East London and The City Mental Health Trusts are also developing an NHS Live project which focuses on employment for people with a mental illness. Rita Dove, a mental health user development co-ordinator in East London, says: “We get a range of issues that I have to help with. Often it’s a question of just trying to build up someone’s confidence and at other times someone might not be aware of what they are entitled to beyond their direct mental health problems. People who come here are very vulnerable but I try to encourage them to have responsibility for themselves, even in the smallest way. One person now does the washing up here and gets paid £5 and that has started to help them build their confidence.”
piloting an occupational health helpline for GPs. The proposals contained in this White Paper will further enhance this process.

Older people

2.20 Our aims for promoting health and well-being in old age are:

- to promote higher levels of physical activity in the older population;
- to reduce barriers to increased levels of physical activity, mental well-being and social engagement among excluded groups of older people;
- to continue to increase uptake of evidence-based disease prevention programmes among older people.

2.21 Choosing Health, the National Service Framework for Older People and the Green Paper, Independence, Well-being and Choice set out our vision for promoting health, independence and well-being for older people, as well as describing some of the levers for effecting change.

2.22 A cross-government group will drive the broad health and well-being agenda forwards with involvement of key stakeholders from the National Coalition for Active Ageing. Detailed plans will be set out in the forthcoming National Clinical Director for Older People’s report Next Steps for Older People’s National Service Framework.

2.23 This work fits within wider cross-government policy for older people, described in Opportunity Age.\(^\text{10}\) It links to our recently published report on older people and social exclusion, A Sure Start to Later Life: Ending Inequalities for Older People,\(^\text{11}\) which announced the £10 million programme Link-Age Plus. This will include a network of one-stop centres developed and controlled locally and containing services such as health, social care, housing, leisure, education, volunteering and social opportunities.

Disabled people and people with high support needs

2.24 These strategies complement the 20-year strategy Improving the life chances of disabled people,\(^\text{12}\) which focuses on independent living, choice and control for all disabled adults.

2.25 The Supporting People programme, launched in April 2003, enables the provision of housing-related support services that help people with a wide range of needs to live independently and to avoid unnecessary or premature hospitalisation or use of institutional care. The programme covers a broad
range of vulnerable groups, including people with disabilities and older people. Through Creating Sustainable Communities: Supporting Independence, the Government is consulting on how best to build on and take forward the programme, including through improving co-ordination and integration of care and support services for those who receive both.

2.26 This chapter now sets out what more the Government will do to support people to look after their own health and well-being: joining up local services better, shifting the system towards prevention and providing effective national leadership.

Helping people to look after their own health and well-being

2.27 People want to keep themselves well, and take control of their own health. This came through clearly in our consultation. People asked for more help to do this, through better information, advice and support. In particular, people strongly supported the idea of regular check-ups as a way of helping them to look after themselves, and reduce demand on conventional health and care services. Avoidable illness matters to individuals and their families but it also matters to society and the economy. We all bear the costs of days lost at work and expenditure on avoidable care. Regular check-ups was voted the top ‘people’s priority’ at the national Citizens’ Summit.

2.28 There is, however, clear evidence that simply offering routine physical checks, such as cholesterol testing, to everyone in the population is not an effective way of identifying people at risk of disease and ill-health. Nor would it be a good use of the considerable resources which would have to go into developing such a global screening programme.

NHS ‘Life Check’

2.29 The best way of empowering people to take charge of their own health and well-being is to focus on the major risk factors that may affect their health:

• Higher obesity rates are predicted to lead to a rise in strokes, heart attacks and Type 2 diabetes. Only 37 per cent of men and 25 per cent of women are achieving recommended physical activity targets. Rates of obesity are rising steadily.
Smoking is the single greatest cause of illness and premature death in England today, killing an estimated 86,500 people a year, accounting for a third of all cancers and a seventh of cardiovascular disease. A significant proportion of the population still smokes. Smoking disproportionately affects the least well-off. Some 31 per cent of manual groups smoke, compared with 20 per cent in non-manual groups.

Between 15,000 and 22,000 deaths and 150,000 hospital admissions each year are associated with alcohol misuse. A significant proportion of the population drinks more than the maximum recommended weekly amounts (14 units for women and 21 units for men) and many young people are taking increased risks by binge drinking.
Figure 2.2 Predicted growth in obesity-related disease by 2030

Source: Living in Britain 2004: Results from the 2002 General Household Survey; National Food Survey 2000 Table B1

Figure 2.3 Obesity rates in England

Source: Health Survey for England 2004
Figure 2.4 Smoking rates in England

Source: Health Survey for England 2004

Figure 2.5 Population drinking more than maximum recommended weekly amount

Source: Health Survey for England 2004
• Mental illness and stress-related conditions are now the most common cause of sickness absence and are a common cause of social exclusion among older people. One in four consultations with a GP concern mental health problems.

• Sexually transmitted infections continue to rise. Up to one in ten young people aged under 25 may be infected with chlamydia, leading to pelvic inflammatory disease, ectopic pregnancy and infertility.

2.30 We will therefore develop a new NHS ‘Life Check’ service to help people – particularly at critical points in their lives – to assess their own risk of ill-health. The NHS ‘Life Check’ will be based on a range of risk factors, such as those outlined above, and on awareness of family history. The service will be developed and evaluated in 2007, with a view to wider roll-out thereafter.

2.31 The NHS ‘Life Check’ will be a personalised service in two parts:
• an initial assessment for people to complete themselves;
• offers of specific advice and support on the action people can take to maintain and improve health and, if necessary, referral for more specialist diagnoses for those who need it.

2.32 The NHS ‘Life Check’ will be available on-line as part of Health Direct Online, or locally on paper. Where people complete the self-assessment on-line, they will be able to store it in their own personal HealthSpace, as part of a life-long personal health plan. They will have the option to share their assessment electronically with their general practice surgery. It can then be held as part of their electronic care record to help inform health professionals about the lifestyle risks and family history factors that may affect their long-term health and well-being.

2.33 People whose initial self-assessment indicates that they are at significant risk of poor health will be able to discuss the outcome with a health trainer. The discussion will include looking at what action they can take to improve their own health, for example through diet or exercise. It will also cover the further help they might want to seek from local services, including, where appropriate, referral to seek medical advice and follow-up from more specialist services and the development of a personal health plan. Follow-up action may involve a range of health and social care services. For example, for young children this may involve services provided at Children’s Centres, including parental advice; and for adults in work, support may be provided in the workplace through occupational health services.

2.34 We will develop the approach to take account of the changing needs of people in their early years, childhood, early adulthood, working and later years. The Department of Health will
start by working jointly with the Department for Education and Skills to test the approach for children at key ages, including within the first year and at the transition from primary to secondary education. Self-assessment by parents will be included as an integral part of considering the health of their children. For the youngest children we will look at how the ‘Life Check’ is part of the child health promotion programme, linking it to the routine developmental assessments and other support currently provided to parents to ensure a joined-up approach. For adults we will initially develop the approach for people around the age of 50, then move on to test at other key ages. We will help parents, children and other key carers understand and engage in behaviour changes to reduce the risks of binge drinking, smoking, poor sexual health, poor diet, and low levels of physical exercise, all of which can have negative effects on future adult health.

2.35 The NHS ‘Life Check’ will be developed in areas with the worst health and deprivation (the spearhead areas), in consultation with groups of people who are least likely to access advice provided through conventional services. It will be led by health trainers who are already being recruited in those spearhead areas.

2.36 Development work will include looking at how NHS ‘Life Check’ should link into wider local strategies, particularly action on neighbourhood renewal and tackling inequalities.

In 2007/08, as the technology to deliver rolls out, the NHS ‘Life Check’ will become more widely available in formats and languages to meet everyone’s needs. The approach will be tested to ensure that it works for the many different groups in our society, particularly those at greatest disadvantage and those who may need assistance in completing the self-assessment, and it will take account of the needs of carers.

**Mental health and emotional well-being**

2.37 Emotional well-being and resilience are fundamental to people’s capacity to get the most out of life, for themselves and for their families. In the consultation people made it clear that they wanted action to help them maintain mental and emotional well-being just as much as physical health and fitness. There is much that can be done to reduce the frequency of the more common illnesses such as anxiety and depression, and the widespread misery that does not reach the threshold for clinical diagnosis but nevertheless reduces the quality of life of thousands of people. Helping people in these situations will help them to lead happier, more fulfilled and productive lives.

2.38 Straightforward positive steps that everyone can take were set out in *Making it possible* – a good practice guide to improving people’s mental health and well-being. They include:

- keeping physically active;
- eating well;
I think that being mentally healthy is more than just having medical treatment, it’s about quality of life.

**RESPONDENT TO INDEPENDENCE, WELL-BEING AND CHOICE**

### CASE STUDY

**Keeping Healthy in Hull**

In Hull, the Looking Good, Feeling Good programme is helping people understand how to live healthy lives. The scheme is the brainchild of Christine Ebeltoft, community health development worker, and Tracy Taylor and June Carroll, two local practice nurses.

The programme has been run in five different locations throughout Eastern Hull in church halls, community centres and the local Women’s Centre. This enables health workers to reach out to people who might not use traditional health services, and it is helping people stay well.

The content of the ten-week programme to encourage lifestyle change was developed with the people who would use it. They wanted a programme that offered exercise, weight management and looked at various other issues such as smoking, food labelling, stress and nutrition.

Christine said: “It’s very much about prevention rather than cure. We are not here to dictate to people about their lifestyle, just to give them information on other options and advice. It’s not about putting people on a diet. It’s all about lifestyle change.”

- if you do drink, drink in moderation;
- valuing yourself and others;
- talking about your feelings;
- keeping in touch with friends and loved ones;
- caring for others;
- getting involved and making a contribution;
- learning new skills;
- doing something creative;
- taking a break;
- asking for help.

2.39 We will take steps to make these simple messages more widely known by ensuring that mental well-being is included in the social marketing strategy currently being developed to support *Choosing Health.*
2.40 As well as helping people to increase their own positive mental health and resilience, we also need to address external factors such as violence and abuse or workplace stress which may pose a risk to their well-being. Each local area needs to have a mental health promotion strategy which addresses these issues as well as the issues of individual lifestyles.

2.41 *Making it possible* identified the criteria that could be used to identify good practice in local mental health promotion strategies. Good practice demonstrated:

- local needs assessment;
- cross-sector ownership, governance and resourcing;

---

**CASE STUDY**

*Westbury Fields for ever*

Mildred and Norman Jenkins were the first residents to move in to Westbury Fields Retirement Home, a residential village for older people in Bristol, run by the charity St Monica Trust. Both are in their seventies.

“My husband’s been a paraplegic for almost 18 years, I’d had a couple of bouts of cancer and we were getting older, so when we read about Westbury Fields in the local paper we thought it would be a good move for us. It’s a question of security. If there are any problems we can press the emergency button and someone will come to help us and my husband has care and support. It means we’ve been able to keep our independence, but it has also taken a lot of pressure off both of us, and our daughters. They know that if there is an emergency there’s someone on hand.

“The surroundings here are very nice, and there’s plenty to do. I go to art classes, there are poetry readings, a library and clubs, and a minibus for outings or shopping. We have the companionship of people our own age and we can join in with activities or not, it’s up to us. We’re very happy we decided to come here.”

Westbury Fields is home to more than 200 older people who occupy 150 retirement/sheltered apartments and a 60-bed care home. The aim of the village is to encourage a lively, balanced community ranging from active independent residents to those requiring a high degree of support.
• links to wider initiatives to improve health and social care outcomes;
• clear statement of what success would look like and how it should be measured;
• evidence-based interventions;
• building public mental health/mental health promotion capacity;
• developing public mental health intelligence.

2.42 Sometimes, however, people are reluctant to accept that they have mental health needs, and may be unwilling to talk about feelings or ask for help due to fear and lack of understanding. **We will strengthen our efforts to improve public understanding of mental health issues, building on the existing Shift campaign to counteract stigma and discrimination.**

2.43 We do not yet know how to prevent the most severe forms of mental illness such as schizophrenia and bipolar disorder. However, we do know that early intervention can reduce the length of episodes of ill-health and prevent some of the longer-term health and social consequences of severe mental illness.

2.44 Universal services, such as transport, housing and leisure services, including access to sports, arts and culture, can play a crucial role in facilitating social contacts and supporting social inclusion. Older people living alone are particularly vulnerable to isolation and loneliness. A number of pilots are currently testing approaches to support for older people, including promoting good mental health. The recently published Social Exclusion Unit’s report *A Sure Start to Later Life* on excluded older people also sets out proposals for support for this group.

2.45 For people who are clearly exhibiting signs of mild depression or anxiety, psychological (‘talking’) therapies offer a real alternative to medication. They can extend choice, reduce waiting times for treatment and help to keep people in work or support them to return to work.

2.46 As part of the Government’s commitment to expand access to psychological therapies, we plan to establish two demonstration sites. These demonstration sites will focus on people of working age with mild to moderate mental health problems, with the aim of helping them to remain in or return to work. They will aim to establish an evidence base for the effectiveness of such therapies and to support the extension to non-working age people and those with moderate to severe mental illness.

2.47 New technology is also increasing the treatment options available in mental health. Computerised cognitive behaviour therapy (CCBT) allows people to take charge of their own treatment. The National Institute for Health and Clinical Excellence (NICE) will publish a full appraisal of five
specific packages for the delivery of CCBT in February 2006. Where this guidance, on the basis of clinical and cost effectiveness, recommends the use of a particular package in surgeries, clinics and other settings, such as community centres and schools, the Department of Health will consider how PCTs can best be supported in accessing the packages.

2.48 In the past, GPs have sought to respond appropriately to the needs of people with complex social, physical and psychological care needs. This role has been extremely challenging because these groups' needs often cannot be managed confidently by GPs within existing primary care services, nor can they be appropriately referred to secondary care, which tends to be focused on those with severe and enduring mental illness.

2.49 Primary care offers significant opportunities to tackle ill-health, including:

- provision of psychological therapies for mild to moderate mental health problems;
- introduction of the 'stepped care model' of service provision recommended by NICE;
- development of new mental health worker roles in primary care, such as graduate primary workers;
- development of GPs with Special Interests (GPwSIs);
- opportunities to use the QOF to improve the care provided to people with mental health problems.

2.50 People with common mental health problems will be given more control over their lives by providing them with access to evidence-based psychological interventions, including cognitive behaviour therapy (CBT), CCBT, and other talking therapies. These services will be provided in non-stigmatising primary and community locations and will be complemented by access to employment advisers, who will work with people with common mental health problems to help them to stay in or return to work.

2.51 We need to ensure that all these services are of a high quality. However, there are currently no clear standards about who should get which sorts of treatment and what the outcomes should be. In addition, counsellors and therapists are not registered or regulated. We will work with the relevant professions to develop standards and work towards light-touch registration that is not unnecessarily burdensome.

More local focus on health and well-being

2.52 People expect to take responsibility for their health and well-being but they also expect central and local government to play their part by developing services which support them to do this. This starts with local bodies directly based in local communities.
Local leadership

2.53 At the local level, joint action to support health and well-being needs to be driven through strong effective leadership within PCTs and local authorities.

2.54 Our plans to strengthen PCTs will ensure enhanced commissioning for health lies at the heart of their activities. Subject to the outcomes of current local consultations on the proposed reconfiguration of PCTs and SHA boundaries, we expect to see the development of greater co-terminosity between health and local government bodies: both between PCTs and local authorities, and between SHAs and Government Offices for the Regions.

2.55 These changes, to be completed by April 2006, should facilitate better joint working. They need to be backed by strong leadership at chief executive and board level, and by individuals who have clear responsibilities for improving people’s health and well-being. Two changes will be central to this.

2.56 Following the creation of the role of the DASS by the Children Act 2004, guidance has been developed to support local authorities to implement this role. We published this as draft best practice guidance alongside Independence, Well-being and Choice. There was particularly strong endorsement in the consultation process for the proposed focus for the DASS on co-ordination between agencies such as health, housing and transport to promote social inclusion, alongside the DASS’s responsibility for the quality of social care services.

2.57 The proposal for the DASS to play a central role in ensuring that arrangements are in place to support young people during the transition to adult services, working with directors of children’s services, was also welcomed. As a result, it is our intention to issue revised statutory guidance on the role of the DASS, with supporting best practice guidance, during 2006. Some local authorities and PCTs are appointing joint DASS to support integrated working.

2.58 We will redefine and strengthen the role of the DPH so that public health resources are brought to bear across the public sector to promote health and well-being for the whole community, ensuring a clear and strong focus on tackling health inequalities, alongside the DPH’s wider role in protecting health and ensuring clinical safety. In particular, DPHs should ensure that they work closely with local authorities and provide reports directly to local authority overview and scrutiny committees on well-being. Some PCTs and local authorities have already made joint DPH appointments as a mechanism for facilitating this.

2.59 We expect to see more joint appointments of this kind and will promote them in our work to develop the DPH role. Such joint appointments
will be most effective in the context of closer co-operation between organisations, for example by using existing flexibilities to form joint teams and shared accountability arrangements as well as moving towards more devolved and joint budgets to improve inter-agency working.

2.60 The DASS and the DPH will play key roles, with directors of children’s services, in advising on how local authorities and PCTs will jointly promote the health and well-being of their local communities. They will need to undertake regular joint reviews of the health and well-being status and needs of their populations. They will be responsible for a regular strategic needs assessment to enable local services to plan ahead for the next 10 to 15 years, and to support the development of the wider health and social care market, including services for those who have the ability to pay for social care services themselves. We will include responsibility for leading strategic assessment of needs in the statutory guidance on the DASS.

Better partnership

2.61 Good partnerships are built on common aims.

2.62 Setting clear outcomes for services helps partners to focus on what joint working is aiming to achieve for individuals. Every Child Matters has already set five key outcomes for children’s services, which are built into Local Area Agreements (LAAs).

2.63 Responses to the consultation on Independence, Well-being and Choice strongly supported the proposed outcomes which it set out for adult social care services, based on the concept of well-being. These were:

- improved health and emotional well-being;
- improved quality of life;
- making a positive contribution;
- choice and control;
- freedom from discrimination;
- economic well-being;
- personal dignity.

2.64 These outcomes are important to all of us, whether or not we receive social care services. The Commission for Social Care Inspection (CSCI) is already developing indicators to support these outcomes in social care. We endorse them as outcomes towards which social care services should be working, with their partners. We will build on them to develop outcomes that apply both to the NHS and social care. We will also use this set of outcomes measures to structure our goal-setting for health, social care and related activity in the LAAs negotiated over the next two years.

2.65 If we want services to work together to deliver common outcomes, we need to ensure that performance measures for services reinforce and help deliver health and well-being outcomes. The current Public Service Agreement (PSA) targets for local services do include some measures to drive joint work in key areas, for
example between the NHS and social care on support for people with long-term conditions, and help for people to be supported at home. But we need to go further to align performance measures. **We will therefore take forward the development of performance assessment regimes to achieve this, reinforced through inspection.**

2.66 Subject to the current wider regulatory review of health and social care arm’s-length bodies, we have already made public our aim to merge the Commission for Social Care Inspection with the Healthcare Commission by 2008. As these two organisations join, we will ask them to work together to ensure that their assessment and inspection arrangements complement each other in support of these outcomes. They will also continue to work with the Audit Commission to ensure that the relationship between social services and wider local government functions is properly recognised.

2.67 The assessment arrangements will measure how well commissioners ensure delivery against their locally agreed plans to promote health and well-being. This work will be undertaken jointly with our partners across and outside Government, including the Better Regulation Executive and the Audit Commission. It will parallel the current work on a joint inspection framework for children’s services.

2.68 Good partnership working requires clarity about what each partner will contribute to joint work towards agreed targets and goals, and mechanisms that help them plan to achieve them. In *Local Strategic Partnerships: Shaping Their Future*, local Strategic Partnerships (LSPs) are positioned as the ‘partnership of partnerships’ that draw up Sustainable Community strategies for the economic, social and environmental well-being of their areas. These strategies bring together the views, needs and aspirations of communities and businesses; local service data and trends; and national, regional, local and neighbourhood priorities.

2.69 Sustainable Community strategies set the local priorities for LAAs. LAAs simplify funding streams, targets and reporting arrangements to enable local partners to deliver better public services. LSPs add value by bringing diverse partnerships together with their mainstream and area-based funding to commission services that will deliver the Sustainable Community strategy and LAA.

2.70 Proposals in *Local Strategic Partnerships: Shaping Their Future* are an important part of an ongoing and open debate with local government and other stakeholders on the vision for the future of local government which will be drawn together in the form of a White Paper in summer 2006. Central to this long-term vision are the principles of devolution and decentralisation.
2.71 We believe that LAAs are a key development in helping to achieve good partnership working. They provide a framework for local services including social care and PCTs to deliver improved health and social care outcomes for people in communities, whether provided by public, voluntary or private bodies.

2.72 LAAs are made up of outcomes, indicators and targets aimed at delivering a better quality of life for people by improving performance of local services. LAAs are being rolled out across the country over the next two years. The first 20 pilot agreements were signed in March 2005 and plans are in place for all local authorities to be included by 2006/07. The experience of the current LAA pilots has shown that they have the potential to facilitate integrated service planning and delivery across all those who provide services in a locality. As well as delivering national priorities, they also allow the necessary space for local priorities and can provide an effective way of involving the voluntary and community sectors and the local business community.

2.73 The Office of the Deputy Prime Minister has published a toolkit based on the lessons learnt from these areas and highlighting some of the challenges that will arise as an LAA develops, and how these might be addressed. We will build on the experience of the LAA pilots to develop them as a key mechanism for joint planning and delivery.

2.74 At the moment there are practical barriers that get in the way of joint planning to deliver common aims. The different organisations that need to work together to meet these outcomes have different planning and budgeting cycles, created in part by Whitehall. These should be brought in line with each other.

2.75 Therefore, working across departments, the Government will align the planning and budgeting cycle for the NHS with the timetable for local government planning and budget-setting, making a start in 2007/08.

**Stronger local commissioning – getting the best out of public resources to improve local people’s well-being and independence**

2.76 The main responsibility for developing services that improve health and well-being lies with local bodies: PCTs and local authorities. They have a vital role in making sure public resources are used effectively to promote health and well-being and to support high-quality services. This range of functions is generally referred to as ‘commissioning’ (see paragraphs 1.44–45). Good local commissioning will help local people to stay well and independent and tackle health inequalities.

2.77 In Chapter 7 we set out our proposals for strengthening local commissioning and ensuring that it is more responsive to local needs, as well as our plans for a new joint
commissioning framework covering health and social care services.

The legal framework

2.78 Local bodies’ responsibilities are defined in law. One of the three main statutory purposes of a PCTs is to promote the health of its population. Local authorities have the power to promote social and economic well-being, and there are duties on both local authorities and PCTs to co-operate in promoting the well-being of children which were introduced by the Children Act 2004. Local bodies will also be guided by the statutory obligations under the public sector duties on race, disability (from December 2006) and gender equality (from April 2007) to ensure that service delivery is improved.

2.79 The consultation paper Local Strategic Partnerships: Shaping Their Future has already asked for views on whether a duty should be placed on all partners in an LSP to co-operate with local authorities in producing and implementing community strategies. Subject to the outcome of that consultation, we see a strong case

Respect: partnership in action

The Government’s recently published Respect Action Plan illustrates partnership in action, at the national and local level. Respect is a cross-government programme, led by the Respect Task Force, setting out measures which bear down down on anti-social behaviour, and the wider culture of disrespect within society. Strong partnership between national and local government, between local services and with people and communities is at the heart of the Respect Action Plan. The main aims of the Plan are to:

- support families;
- bring a new approach to dealing with the most challenging families;
- improve behaviour and attendance in schools;
- increase activities for children and young people;
- strengthen communities;
- ensure effective enforcement and community justice.

Health and social care services have key roles to play, working with local partners, in taking forward the Action Plan, including through drug treatment, alcohol and mental health services, and working with other services to deliver better support for children and young people at risk.

“We are committed to providing community-focused health services to address those health problems which cause anti-social behaviour” – Patricia Hewitt, Secretary of State for Health.
for clarifying the duties on the NHS and local authorities to co-operate in exercising their functions. We will look carefully at the responses to the consultation when deciding on whether we need to bring forward measures, in addition to those outlined in this White Paper, to strengthen partnership working to support the health and well-being of local communities, and to tackle disadvantage and inequality.

Shifting the system towards prevention

2.80 In their consultation responses, people told us that they want services not only to support them in maintaining their health and well-being, but to do more to prevent problems.

2.81 Prevention begins by building good health and a healthy lifestyle from the beginning of an individual’s life. We are strengthening the provision of antenatal, postnatal and health and early years services, including through our proposals for the new NHS ‘Life Check’.

2.82 There is also a growing evidence base showing that preventative measures involving a range of local authority services, such as housing, transport, leisure and community safety, in addition to social care, can achieve significant improvements in well-being. Chapter 6 sets out proposals for shifting resources into prevention.

2.83 Integrated health and social care services, and better links with occupational health advice, can help prevent inappropriate use of specialist or acute health care. For example well-...
timed interventions and greater social inclusion can prevent or reduce the severity of episodes of mental illness or homelessness.

2.84 We intend to expand the evidence base through our investment in a number of areas, in particular the Partnerships for Older People Projects (POPPs). Ring-fenced funding of £60 million has already been earmarked for 2006/07 to 2007/08 in order to facilitate a series of pilots.
Operational from 1 May 2006, the POPPs will provide examples of how innovative partnership arrangements can lead to improved outcomes for older people, particularly with respect to reduced hospital admissions and residential care stays. They bring together a range of interventions, which have been chosen because of their combined potential to provide a sustainable shift of resources and culture towards prevention across the whole health and care system.

The economic case for primary and secondary disease prevention has been made. The task now is to develop local services that translate this evidence into service delivery.

The accessibility and use of the evidence base for interventions that support health and well-being will be overseen through a new National Reference Group for Health and Well-being. The National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) will play key roles. Building on the Choosing Health information strategy, a central database will also be developed as a resource for commissioners.

In future, healthy living services will be provided by a range of people in different settings including local surgeries, community pharmacies, voluntary sector organisations, leisure/community centres, healthy living centres, sheltered housing, children’s centres and schools. Building on local social capital will help develop community skills and provide employment opportunities across communities that have the greatest needs. Chapter 6 sets out plans for monitoring the development of preventative services in PCTs’ local delivery plans.

Innovative primary care services are already working to identify at-risk patients on their lists and target interventions and advice to them. The new primary medical services contracts include a powerful set of incentives, through the QOF, for practices to identify patients with long-term conditions or lifestyle risk factors such as smoking, and manage their care effectively.

The QOF now covers 10 disease areas including mental health, diabetes, heart disease, asthma and chronic obstructive pulmonary disorder; and from 2006/07 it will have 7 new areas including obesity, learning difficulty, chronic kidney disease and palliative care. The QOF will drive health improvement in two ways.

First, practices will be rewarded for managing the care of patients effectively and in line with the best evidence available. As the QOF evolves we intend that by 2008/09 it will include new measures which provide a clear focus on wider health and well-being outcomes. The National Reference Group for Health and Well-Being will have a key role in development of the QOF, providing...
expert advice to NHS and social care employers who will consult primary care representative groups in the normal way.

2.92 Second, the QOF means that every practice now has a register of patients with long-term needs. These registers provide a clinical database that is unparalleled anywhere else in the world. It is essential that such a unique database is used to improve local decisions on meeting needs. **We will ensure that commissioning decisions use QOF data about the local population.**

**CASE STUDY**

Fitness friends are FAB

Having a few understanding friends can make a huge difference when you’re trying to make some big changes in your life. Fit Active Braunstone (FAB) has around 200 members from the Braunstone housing estate in Leicester, supporting and encouraging each other as they change their lifestyle for the better. Since joining FAB, 42-year-old Gary Buncher has lost four stone, is much fitter and is secretary of FAB’s Calorie Killers group.

“Before FAB all I did was go to work, watch telly and have a few beers. I was hugely overweight. Now I swim for two hours five times a week. Every Wednesday evening I go to Calorie Killers, our exercise and nutrition group. We have 45 minutes of exercise and 45 minutes on healthy eating. It’s had a big impact – one guy who’s diabetic has massively reduced his insulin since joining. We’re starting training courses in badminton, football and basic food hygiene. I’ve also done a course qualifying me to give nutritional advice to people like diabetics.

“My family says I’m a better person to live with. I feel better about myself and actually enjoy getting up in the mornings.”
While only one year of data exists, the QOF has been an undoubted success. Quality scores have hit 958 points on average out of 1050, that is, over 91 per cent achievement.

**Coronary heart disease**
- 1.5 million people with coronary heart disease (CHD) had their blood pressure managed at the clinically acceptable level of 150/90 or less;
- 1.2 million people with CHD had their cholesterol levels managed at the clinically acceptable level of 5 mmol/l or less;
- 1.8 million people with both CHD and lower ventricular dysfunction were brought treated with ACE inhibitors (or A2 antagonists).

**Stroke**
- almost 600,000 stroke patients had their blood pressure managed at a clinically acceptable level of 150/90 or less;
- 410,000 stroke patients had their cholesterol levels managed to a clinically acceptable level of 5 mmol/l or less;
- over 565,000 stroke patients had a flu jab.

**High blood pressure**
- 5.4 million people with hypertension had their blood pressure monitored in the previous 9 months;
- 4 million people with hypertension had their blood pressure managed at a clinically acceptable level of 150/90 or less.

**Asthma**
- 2.1 million people with asthma had a review in the previous 15 months;
- 1.3 million people with asthma had a flu jab.

**Diabetes**
- 1.4 million people with diabetes had retinal screening in the previous 15 months;
- 1.7 million people with diabetes had their blood pressure monitored in the previous 15 months;
- 1.2 million people with diabetes had their blood pressure managed at a clinically acceptable level of 145/85 or less;
- 1.1 million people with diabetes had their cholesterol levels managed to a clinically acceptable level of 5 mmol/l or less;
- 1.3 million people with diabetes had a flu jab.

**Chronic obstructive pulmonary disease (COPD)**
- over 555,000 patients with COPD had a flu jab.

**Epilepsy**
- over 172,000 patients on drug treatment for epilepsy had been convulsion free for the previous 12 months.
Social prescribing

2.93 Chapter 5 sets out our proposals for introducing information prescriptions for those with long-term conditions, to enable them to access a wider provision of services. A range of different ‘prescription’ schemes, such as exercise-on-prescription projects, have been established or piloted in a number of areas and have often been very successful.

2.94 We would like to see increasing uptake of well-being prescriptions by PCTs and their local partners, aimed at promoting good health and independence and ensuring people have easy access to a wide range of services, facilities and activities.

National leadership

2.95 The Government has a responsibility to promote leadership for health and well-being across and between different services. This chapter has concentrated so far on our proposals to support individuals to take care of their own health and well-being, and to revise the framework within which local services work, in order to drive stronger local partnership working.

2.96 To offer strong leadership to a more integrated system we also need to work much more closely together in Whitehall than previously. We have already identified a number of areas, including the development of LAAs, where work will be taken forwards through strong collaboration.

2.97 The Department of Health performs a leadership function in relation to the health and social care systems. It has recently undertaken a review of its structure and during the spring will be working to develop a more integrated approach to this leadership role. In particular, we will make a new appointment to the Department of Health’s Board focusing on social care. We will develop a more detailed specification for this position, with a view to making a substantive appointment by July 2006.

2.98 Choosing Health described a comprehensive framework for action across Government in England to enable people to make healthy choices. Since its publication, London has been awarded the honour of staging the 2012 Olympic Games. This will provide a unique opportunity to work closely with the devolved administrations to promote a fitter Britain.

2.99 The Department of Health will work with partner organisations, including Sport England and the London Olympic Games Organising Committee, to maximise opportunities for people to take part in recreational and health-promoting activities. A high-profile campaign, building on the health strategies in England, Scotland, Wales and Northern Ireland, will be developed, encouraging everyone to contribute to the drive for a fitter Britain by 2012.
A focus on both physical and emotional health will be part of this drive for fitness, which will be inclusive of all age groups.

References

1 House of Commons Health Committee, Obesity: 3rd report of session 2003–04: (HC 23-1), The Stationery Office, 2004
4 Every Child Matters (Cm 6499), The Stationery Office, September 2003
5 National Service Framework for Children, Young People and Maternity Services, Department of Health, September 2004
6 Evidence from the National Foundation for Educational Research has shown that 40 per cent of pupils lose motivation and make no progress in the year after transfer to secondary school. The precise reasons for this are unclear, although many of those directly involved in the crucial transition years report similar concerns. Communication difficulties, cultural differences between the primary and secondary ‘styles’ and insufficient attention to the emotions of changing schools crop up as possible causes time and again. See: http://www.teachernet.gov.uk/teachingandlearning/library/transitionphase/
7 Support for parents: the best start for children, HM Treasury and Department for Education and Skills, December 2005
8 Youth Matters, Green Paper (Cm 6629), The Stationery Office, July 2005
9 Health, work and well-being – caring for our future, Department for Work and Pensions, Department of Health and Health and Safety Executive, October 2005
11 A Sure Start to Later Life: Ending Inequalities for Older People, A Social Exclusion Unit Final Report, Office of the Deputy Prime Minister, January 2006
12 Improving the life chances of disabled people, joint report, Prime Minister’s Strategy Unit, Department for Work and Pensions, Department of Health, Department for Education and Skills, and Office of the Deputy Prime Minister, January 2005
13 Creating Sustainable Communities: Supporting Independence, Office of the Deputy Prime Minister, November 2005
14 Effective Health Care. Cholesterol and coronary heart disease: screening and treatment, vol 4 (no 1), University of York, NHS Centre for Reviews and Dissemination, 1988: 1–16
15 Health Survey for England 2004. Target: a minimum of five days a week of 30 minutes or more moderate-intensity activity
16 HealthSpace is an on-line service provided by the NHS for patients in England. For more information see: https://www.healthspace.nhs.uk/index.asp
17 *Making it possible: Improving mental health and well-being*, National Institute for Mental Health in England and Care Services Improvement Partnership, October 2005

18 Schedule 2 of the 2004 Children Act removed the duty on local authorities in England to appoint a Director of Social Services and a Chief Education Officer. It also amended the duty to appoint a Director of Social Services under section 6 of the Local Authority Social Services Act 1970, so that CSAs in England are now required to appoint a DASS.

19 *Local Strategic Partnerships: Shaping Their Future*, consultation paper, Office of the Deputy Prime Minister, December 2005