Are we choosing health?

The impact of policy on the delivery of health improvement programmes and services

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**Front cover:** the ‘MOT health check’ programme in action in the pubs of Southwark, London in 2007: an initiative of Southwark Health and Social Care, which combines Southwark Primary Care Trust and Southwark Council social care services.
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Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission’s role relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare. In this work, we collaborate closely with the Healthcare Inspectorate Wales.

Website: www.healthcarecommission.org.uk

Audit Commission

The Audit Commission is an independent watchdog, driving economy, efficiency and effectiveness in local public services to deliver better outcomes for everyone.

Our work across local government, health, housing, community safety and fire and rescue services means that we have a unique perspective. We promote value for money for taxpayers, covering £180 billion spent by 11,000 local public bodies.

As a force for improvement, we work in partnership to assess local public services and make practical recommendations for promoting a better quality of life for people.

Website: www.audit-commission.gov.uk
Summary
The challenges for people to be healthy and stay healthy are considerable. A person’s health is determined by a range of factors, including socioeconomic, cultural and environmental factors as well as individual lifestyle behaviours and genetic make-up. While Government does not control all these factors, it has a key role to play. The levers available to Government include taxes, subsidies, service provision and regulation.

Improving health and tackling inequalities in health have been at the centre of Government policy throughout the 10-year period from 1997 to 2007. In 1998, the Independent Inquiry into Inequalities in Health signalled the importance of improving people’s health and the need to tackle inequalities in health. This, along with Securing Good Health for the Whole Population (2004) and Our Future Health Secured? A review of NHS funding and performance (2007) have emphasised the importance of public health in relation to the affordability of health services, and provided the additional impetus for a number of challenging and ambitious Government targets to improve health and reduce inequalities.

During this time, national health policy focused on public service agreement (PSA) targets for the ‘big killers’ – cancer, heart disease and stroke – along with targets to tackle some of the causes of disease, including obesity and smoking. Other key targets across the 10-year period included teenage conceptions and health inequalities.

**Aims of the study**

The aim of this report is to understand the impact of Government policies that sought to improve the health of people and tackle inequalities, and to assess whether these policies have achieved their objectives.

The Department of Health’s white paper Choosing health and subsequent action plans brought together policy themes that have been important throughout the period, and we have used these to shape the study:

- Tackling inequalities in health
- Reducing the numbers of people who smoke
- Tackling obesity
- Improving sexual health
- Improving mental health and wellbeing
- Reducing harm and encouraging sensible drinking
- Helping children and young people to lead healthy lives
- Promoting health and active life among older people.

We have also covered other health issues, including unintentional injury to children.

It is difficult to directly attribute change to a single factor, particularly in relation to the health of the population, where a range of elements can contribute to changes in health outcomes. To be able to draw broad conclusions about the impact of policy, we analysed a range of information in relation to Government policy between 1997 and 2007. The particular contribution we bring to this discussion is our analysis of information held by the Healthcare Commission and Audit Commission, generated through assessments of performance and inspections of local healthcare organisations and councils. We also looked at changes in health outcomes and inequalities in health over the 10-year period within the longer-term context.
Box 1: Key health issues of today

‘Big killers’: Cancer and circulatory disease have been the most common causes of death in England in the last decade... however, deaths from circulatory disease in people under 75 have reduced by 45% since 1995. Premature deaths from cancer have fallen by around 15% over the same period.

Smoking is England’s single greatest cause of preventable illness and early death from a wide range of illnesses, including cancer, respiratory disease and heart disease... however, since 1998, the prevalence of smoking has decreased among all adults – including those from manual groups, who are known to have the highest prevalence. A ban on smoking in public places has now been introduced.

The UK has the highest rates of teenage pregnancy in Western Europe – associated with poorer health and economic outcomes for both teenage parents and their children... although rates of teenage conceptions in England are now the lowest since the early 1980s.

Sexually transmitted infection rates continue to rise in the UK, especially among young people... but access to genitourinary medicine services within 48 hours has improved.

The UK has the highest prevalence of obesity among adults in Western Europe. In 2006, almost a third of children were overweight or obese. Obesity is related to a number of conditions, including coronary heart disease, stroke and diabetes... and yet the obesity strategy for England was published only in 2008. However, systems for collecting data are now in place to measure progress.

Inequalities in health persist between people from different occupational groups... between 1972 and 2001, the gap in life expectancy between men from manual and non-manual groups increased from 2.1 to 3.8 years although this has since reduced to 3.3 years. Since 1997-2001, the gap in life expectancy between women from manual and non-manual groups has remained fairly constant at 2.8 years, increasing slightly to 2.9 years in 2002-2005.

In 2007, alcohol misuse and related harm were estimated to have cost England’s economy £55.1 billion, including £2.8 billion for public health services and care services... although strategies are now in place to tackle alcohol misuse and related harm.

Also, in the summer of 2007, we held a series of roundtable discussions with over 150 experts in health improvement, working in national, regional and local organisations. Analysis of these roundtables has fed into our findings.*

A key element of policy over the past 10 years has been the use of targets to drive improvement. The report explores this approach and considers the extent to which targets for improving health and tackling

* Details of the roundtable discussions on Choosing health priority areas held during the summer of 2007 can be found on www.healthcarecommission.org.uk and wwwaudit-commission.gov.uk.
inequalities have been successful. We examine the impact of incentives, both in terms of performance assessment and performance management, and at levels of resources and capacity.

We also look at changes in systems between 1997 and 2007 in relation to local government and, in particular, the NHS, covering issues from increased focus on independent assessment of performance and inspection, to devolution of decision-making to local areas. While a range of wider issues also impact on health and health inequalities – such as tax, education and environment – our focus is on a more specific range of policy and practice related to improving people’s health. Our recommendations reflect that focus.

As a broad framework for the report, we looked at the main components of an effective approach to the delivery of better outcomes, including:

- Clear, consistent, ambitious and measurable objectives
- Relevant, reliable and up-to-date information
- Consistent focus across the NHS and Government
- Putting the evidence of ‘what works’ into practice
- Resources, capability and capacity
- Commissioning for local need
- Clear accountabilities for commissioning and delivery.

The report contributes to the emerging debate about the effectiveness of efforts to improve health and tackle inequalities. It is aimed at all those with responsibility for the health of the public, including planners and commissioners in primary care trusts (PCTs) and local councils, as well as local healthcare organisations and council services. It is also for those in Government Offices, strategic health authorities and Government departments.

Our findings

An ambitious programme

The Government is to be commended for setting an ambitious programme to improve health and tackle inequalities. There was often joint responsibility across two or more Government departments and across sectors at regional and local levels. This approach – set early in the 10-year period – has continued to be a focus of national policy, covering a broad range of health improvement issues. Policy and targets, along with increased management of performance and independent assessment of health improvement, have been significant and positive measures.

Many of the targets set by Government have an end date in 2010, so in some cases it is too early to assess their ultimate effect. It will not be until 2010/2012 or beyond that the full impact of interventions will be known, although a number are not on course to be achieved.

However, to date there has been significant improvement, for example in deaths from the ‘big killers’ – cancer and coronary heart disease – where rates have been cut among people in both the most and the least deprived populations, although the gap between the most and the least deprived areas has not changed in terms of cancer and has widened in terms of circulatory diseases. There have been reductions in smoking and teenage conceptions, and improved access to genitourinary medicine services, as well as...
improved access to screening for chlamydia. Sixty-one per cent of schools have achieved Healthy School status, a programme seeking to improve the health of children and young people across a range of physical and mental health areas.

Inequalities in health
However, while there has been improvement, it has not been universal across health topics, geographical areas and populations, despite tackling inequalities having been a main focus of policy across this period. The gap between the most and least deprived populations in terms of life expectancy is a key measure for examining the success of policy, programmes and services aimed at improving health and tackling inequalities.

Between 1972-1976 and 1997-2001, the gap in life expectancy between men from manual and non-manual groups increased from 2.1 to 3.8 years – virtually doubling. A decrease in the period up to 2002-2005 resulted in the gap reducing to 3.3 years, although it is not yet clear if this represents an underlying change in the pattern of inequalities. There has been less change between women from manual and non-manual groups, with an increase between 1972-1976 and 1997-2001 from 2.5 years to 2.8 years, and a further slight increase to 2.9 years in 2002-2005. In both cases, those in non-manual groups live longer. It is well known that women – internationally – tend to live longer than men. But, if trends continue, men from non-manual groups in this country could surpass women from manual groups in life expectancy within the next 10 years. These results challenge the health sector to increase its targeted approach to improving health.

Models for delivery
A key focus of policy over the past 10 years has been the use of targets to drive improvement. Our study shows that clear, consistent objectives are critical. However, unless part of a coherent model of delivery, targets alone have been found to be insufficient to drive improvement. Our analysis suggests that areas that have shown greater progress – such as reducing teenage pregnancy, the 48-hour access target for genitourinary medicine clinics, and four-week stop smoking services – have so far been characterised by a combination of: clear and consistent objectives; detailed guidance on actions required; investment in programmes and dedicated staff at national, regional and local level, including training and development; research on effectiveness; better data; and strong management and assessment of performance.

Alcohol and obesity – two areas identified as potentially having a profound effect on individuals, service delivery and the cost to broader society – did not have national strategies until 2004 and 2008 respectively. The target for obesity set in 1992 by the previous Government was dropped as a priority in 1997 and did not reappear as a PSA until 2004.

Even within health topics where there has been progress [such as teenage pregnancy or four-week smoking quit rates], it has not always been consistent, with some local areas not on course to achieve targets. Since 2006, PCTs at risk of not achieving their targets have received further support from the Department of Health’s national support teams. In sexual health, there was significant progress in reducing waiting times for access to genitourinary medicine clinics, as well as progress in the uptake of screening for chlamydia, but little evidence of progress in relation to contraceptive services.
Wider factors
Related measures such as cross-governmental policy and several reconfigurations of the NHS have not consistently contributed to – indeed have sometimes hindered – progress. A sustained focus on delivery, rather than the development of further national policy or changes in structure, would have been beneficial to support consolidation and coherent implementation.

Central Government is now moving towards a more devolved approach, with greater responsibility for decision-making at a local level. Local strategic partnerships, made up of local councils and PCTs and other local organisations, will develop local area agreements using the new national indicator set. From April 2008, upper tier local councils and PCTs are required to undertake a joint strategic needs assessment to inform local priorities, through an appraisal of local health-related need across a range of health topics.

Devolution is welcomed for its potential to ensure that local councils, healthcare organisations and their partners address local need in relation to both health and the wider issues that impact on health.

The Government has produced 198 indicators in the new national indicator set, relating to crime, economic development and other key issues. Forty-two of these relate to health. Each local strategic partnership will choose up to 35 indicators for their local area agreements that are best suited to promote improvement for their local population, based on findings of the joint strategic needs assessment.

For PCTs’ local operational plans, the Department of Health has produced national planning guidance and its own indicator set that includes relevant indicators from the 198 national ones (“vital signs”). To support this shift to a greater focus on local action, performance management and inspection and assessment frameworks will need to work in tandem on improving people’s health and tackling inequalities in health, to ensure that health issues continue to be prioritised and to benefit fully from a joined-up approach.

Recommendations
Over the last decade, good progress has been made in improving life expectancy and health outcomes in a number of priority areas. However, further progress in achieving a healthier nation – and more equal health outcomes for all – requires renewed drive and focus from Government, local councils and healthcare organisations, wider society and from individuals taking more responsibility for their own health.

Local strategic partnerships will play a critical role in health improvement and tackling health inequalities, with responsibilities for local councils, healthcare organisations and their statutory partners in relation to health and the wider factors impacting on health.

It will be important both to continue to build on successes to date – for example, in relation to cancer and circulatory diseases, smoking cessation, access to genitourinary medicine services, and teenage conceptions – and to ensure areas that have had less focus to date – such as obesity, alcohol misuse, mental health promotion and unintentional injury – are tackled through programmes that take into account all the components identified as contributing to better outcomes.

Our national recommendations for improving the development and delivery of health
improvement programmes and services are set out below. We also make recommendations that apply at a regional and local level, and these are shown in appendix B alongside the national recommendations.

**Clear, consistent, ambitious and measurable objectives**

Organisations and partnerships at all levels, led by central Government policy, should ensure that they have clear, consistent, ambitious and measurable objectives for all policies for improving people’s health. In particular:

- National objectives should be more ambitious in terms of the contribution that organisations can make to health and the broader aspects of health improvement. For example, this would include mental health services helping people to lead more independent lives and get back into work, or alcohol services helping to cut antisocial behaviour and crime.

- Objectives at all levels must be backed up by effective delivery plans. These plans need to be developed with local partners and communities, based on evidence of effectiveness, with identified resources and investment in building capacity and capability. They must have clear accountabilities for delivery and appropriate information systems to track and report on progress.

**Relevant, reliable and up-to-date information**

The Department of Health should continue to work with the Information Centre, public health observatories and others to provide information systems that enable local public services to prioritise health improvement programmes and enhance delivery. In particular:

- The Department should build on the work of *Informing Healthier Choices* to support the capacity of local organisations to improve local data collection. Data collection should include information such as ethnicity and disability in line with the public health observatory data set, and include more information at a neighbourhood level.

- The Department of Health should further develop systems for healthcare organisations that allow clear identification of expenditure on health improvement programmes. The existing work on ‘programme budgeting’ provides a good foundation for this, and should be developed to cover specific health improvement areas.

**Consistent focus across the NHS and Government**

Across Government, all policies should be analysed at an early stage to ensure that negative health impacts are minimised and positive impacts maximised in relation to health and health inequalities, that policies are aligned, and that roles are identified and maximised across statutory, private and third sectors. For example, sex and relationship education should be mandatory to support achievement of the under-18 conception target.

**Putting the evidence of ‘what works’ into practice**

The Department of Health should continue to support identification of evidence of what works and increase focus on identifying value for money. The Department should ensure that information and support are available to healthcare organisations on how best to deliver programmes that improve health and tackle inequalities in health.

Support should be aligned with that given to local councils and should complement the
work of the National Institute for Health and Clinical Excellence (NICE) and the national support teams. Approaches can be learned from the Care Services Improvement Partnership (CSIP) and the Improvement and Development Agency for local government (IDEA). Of particular importance will be support for effective action to prevent alcohol misuse and obesity.

**Resources, capability and capacity**
The Department of Health should provide sufficient economic and other incentives to support the delivery of health improvement programmes and services, with a particular concentration on issues that have had least focus, such as obesity, alcohol, mental health promotion and unintentional injury.

When considering use of the GP payment system known as the quality and outcomes framework (QOF) as an incentive, the Department of Health should ensure that health promotion is taken into account.

**Commissioning for local need**
Through the world class commissioning programme, the Department of Health should strengthen the capability of PCTs and local councils as commissioners, and ensure a strong focus on health improvement that addresses local health needs.

**Clear accountabilities for commissioning and delivery**
Independent assessment by an independent body of the performance of PCTs and local councils as commissioners is an important component in improving local public accountability. The Health and Social Care Bill gives the new health and adult social care regulator this function in relation to PCTs and social services. Comprehensive Area Assessment, the framework for the future assessment of public services working together in a given locality, should emphasise the potential for improving people’s health.

- In-depth reviews undertaken of both commissioners and providers should include health improvement and tackling inequalities in health.
- Commissioning: The new health and adult social care regulator’s assessment should include the performance of healthcare organisations in relation to commissioning of services. This should cover improving health and tackling health inequalities and issues such as access to services for people from different ethnic groups, disabled people and older people, and those living in deprived areas. All appropriate aspects of assessments should contribute to the wider Comprehensive Area Assessments.
- Providers: The Department of Health should ensure that requirements in the registration system for health and social care providers include responsibilities for improving health and tackling inequalities in health. Improvement standards should be set to drive up the level and breadth of performance (including, for example, effectiveness of services and programmes, the integration of health improvement along the care pathway, partnership working and the health of staff).
Chapter 1
Introduction
Chapter 1
Introduction

“Health is not valued,” wrote 17th century author Thomas Fuller, “til sickness comes”. The challenges for people to be healthy and stay healthy are considerable, and the role of Government is crucial. Since 1997, the Government has issued numerous policies that have sought to improve the health and wellbeing of people, and reduce inequalities in health. The aim of this report is to understand the impact of those policies, and to assess whether they have achieved their objectives.

Health matters

The term ‘public health’ describes a set of practices that seek to understand and improve the health of the population. These include efforts to ensure the quality, accessibility and effectiveness of health and social care, and to improve and protect people’s health.

In this report, we focus on health improvement and tackling inequalities in health. The other elements of public health practice, notably health protection and the quality of health and social care, are not considered. For clarity, we use the term ‘health improvement’ throughout the report, unless specifically referring to public health in its wider sense. We cover all the activities in box 2, except number 6 (responding to disasters) and number 7 (assuring the quality, accessibility and accountability of medical care).

A person’s health is affected by many factors. Broad issues such as the environment and the economy, the conditions in which people live and work, the social networks they have and how much they feel a part of their neighbourhood all have an impact. Many public services – not only health services but also education, social care and housing – figure strongly in maintaining and improving health. Personal attributes, genetics and life experiences also have an impact.

In many areas of health, there is an inequalities gap and it is not narrowing. Some groups are

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Box 2: The core activities of public health

| 1. Preventing epidemics                        |
| 2. Protecting the environment, workplaces, food and water |
| 3. Promoting healthy behaviour                |
| 4. Monitoring the health status of the population |
| 5. Mobilising community action                |
| 6. Responding to disasters                   |
| 7. Assuring the quality, accessibility and accountability of medical care |
| 8. Reaching out to link high risk and hard-to-reach people to needed services |
| 9. Researching to develop new insights and innovative solutions |
| 10. Leading the development of sound health policy and planning |
more at risk than others. To take one example, higher proportions of people in deprived groups smoke compared with those in more affluent groups. There are also different ethnic and cultural attitudes to tobacco.

Improving the health and wellbeing of the nation is a huge challenge and needs a range of approaches. Some interventions aimed at individuals can bring about direct personal improvement, for example increasing physical activity. Others are effective when implemented on a national basis, such as the ban on smoking in public places. Therefore, the changes that are needed to improve the health of the population and reduce inequalities across the country demand coordinated efforts at national, regional and local level.

Are we choosing health?

This study looks at national policies over the period 1997 to 2007 that sought to improve health and tackle inequalities. It aims to add to the wider debate about health improvement policy that includes Sir Derek Wanless’ 2007 report, Our Future Health Secured? A review of NHS funding and performance. We look particularly at the delivery and performance of services over the period.

In Choosing health, the Department of Health brought together policy themes over the previous 10 years. We have used these to shape the study:

- Tackling inequalities in health
- Reducing the numbers of people who smoke
- Tackling obesity
- Improving sexual health
- Improving mental health and wellbeing
- Reducing harm and encouraging sensible drinking
- Helping children and young people to lead healthy lives
- Promoting health and active life among older people.

We also cover other health issues where there are strong inequalities, for example unintentional injury to children.

In researching this report, we analysed health improvement and related policies, the performance of local healthcare organisations and councils, and the views and opinions of over 150 experts in the field through roundtable events.

A key element of policy over the past 10 years has been the use of targets to drive improvement. The report explores this approach and considers the extent to which targets for improving people’s health and tackling inequalities have been successful. We examine the impact of incentives, both in terms of performance assessment and performance management, and at levels of resourcing and capacity. We also look at changes in systems between 1997 and 2007 in local government and, in particular, the NHS, covering issues from service reconfiguration and increased focus on inspection and assessment and management of performance to the devolution of decision-making to local areas.

In conducting our analysis, we identified a number of consistent components that contribute to the delivery of better outcomes, including:

- **Clear, consistent, ambitious and measurable objectives:** stretching goals that are clearly set out and capable of being measured
• **Relevant, reliable and up-to-date information:** nationally available and standardised data and information systems in place to prioritise programmes and measure progress

• **Consistent focus across the NHS and Government:** consistent working across national Government, with policies that complement each other, associated targets and incentives, and joined-up working at a local level

• **Putting the evidence of ‘what works’ into practice:** effective – and cost effective – methods used by service providers, including through support for commissioners and providers to deliver effectively

• **Resources, capability and capacity:** adequate financial resources and appropriately skilled staff are available to deliver programmes

• **Commissioning for local need:** commissioning effective and efficient services that are based on local need

• **Clear accountabilities for commissioning and delivery:** performance management together with inspection, performance assessment and audit can be important levers to drive improvement and ensure delivery.

Policy throughout the 10-year period has pointed to the need for increased joint working across sectors to improve health outcomes. Reviews carried out jointly by the Audit Commission and Healthcare Commission have identified the need for sectors – statutory and independent, including private and third sector – at all levels to work together to improve people’s health and tackle inequalities in health.*

At a local level, councils working with healthcare organisations and other partners have the potential to make a significant impact. To ensure this impact is maximised, the Healthcare Commission and Audit Commission have worked together on this report. As part of this work, we have considered the performance of local councils and healthcare organisations. We look forward to the increased focus on local area agreements and the assessment of progress, and the prospect through Comprehensive Area Assessment for providing opportunities for further systematic approaches to joint review.

Chapter 2
The health of the population in England
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The health of the population in England

In this chapter, we examine the health, life expectancy and quality of life of people in England. We look at factors affecting health and wellbeing, such as smoking, obesity and alcohol misuse. We consider specific areas, including cancer and circulatory diseases, sexual health, mental health and unintentional injury in children.

Health and life expectancy

Continuing the trend set in the 20th century, the health of people in England has improved over the past 10 to 20 years. In some cases, the improvement has been dramatic. Average life expectancy at birth for boys born in 2004-2006 was 77.2 years; for girls born over the same period, it was 81.5 years. Between 1991-1993 and 2004-2006, life expectancy for men increased by 3.1 years; for women, it rose by 2.4 years.4,5

Premature deaths* from circulatory diseases fell by 45% between 1995 and 2006, while premature deaths from cancer fell by around 15% in the same period.6

Figure 1 shows that both men and women now have lower premature death rates from circulatory diseases than cancer. This transition happened in 2000 for women and around 2003 for men.

However, these improvements are not universal. There are differences in relation to factors such as geographical area, ethnicity, age, sex and sexual orientation. These differences can be formally considered as health inequalities.†

Figure 1: Premature deaths from cancer and circulatory diseases in England, 1993-2006

![Graph showing premature deaths from cancer and circulatory diseases in England, 1993-2006](image)

Source: Compendium of clinical and health indicators, January 2008’

* Premature or avoidable deaths are those that could have been prevented through public health measures or medical intervention. Most deaths of people under the age of 75 are considered avoidable.

† Health inequalities are defined as the gap in health status and in access to health services between people from different social classes and ethnic groups and between people living in different geographical areas.
There have been slower increases in life expectancy since 1995-1997 (the baseline year) in the spearhead areas (those in the lowest fifth of areas for health and deprivation indicators) compared with the rest of the population. This was reflected in recently published findings on progress towards the 2010 target of a minimum 10% reduction in the difference between the two groups. While the average life expectancy at birth continued to increase for both England and the spearhead groups, so did the gap between the two groups. In 2004-2006, the measured difference for those living in spearhead areas and the rest of England was two years for men (1.9 years in the baseline year), while it was less for women at 1.6 years (1.4 years in the baseline year).

Overall, changes from the baseline year suggested that reducing these differences is a more challenging task in women.\textsuperscript{8}

Inequality in life expectancy is even more pronounced between different parts of the country – in some cases, a difference of over 10 years. In 2004-2006, life expectancy for men was lowest in Manchester at 73.0 years and highest in the Royal Borough of Kensington and Chelsea at 83.1 years. Similarly, life expectancy for women was lowest in Liverpool and Hartlepool at 78.3 years and highest in Kensington and Chelsea at 87.2 years.\textsuperscript{9}

Differences become even more stark when comparing estimated life expectancy between the 25 most and least deprived wards.\textsuperscript{10} In the most deprived wards, life expectancy for men is around 65 years, compared with 85 years in the least deprived – a difference of 20 years. For women, the gap is 23 years, with life expectancy ranging from 72 to 95 years.

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**Figure 2: Life expectancy at birth by manual and non-manual occupations, England and Wales, 1972-2005**

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Note: figures show difference in years

Source: Office for National Statistics: Trends in life expectancy by social class 1972-2005 \textsuperscript{11}
As figure 2 shows, between 1972–1976 and 1997–2001, the gap in life expectancy between men from manual and non-manual groups increased from 2.1 to 3.8 years – virtually doubling. A decrease in the period up to 2002–2005 resulted in a gap of 3.3 years, although it is not yet clear if this represents an underlying change in the pattern of inequalities. There has been less change in the corresponding gap among women – an increase between 1972–1976 and 1997–2001 from 2.5 years to 2.8 years and a further slight increase to 2.9 years in 2002–2005. In both cases, those in non-manual groups live longer. It is well known that, internationally, women tend to live longer than men, but figure 2 shows that if trends continue, men from non-manual groups in this country could surpass women from manual groups in life expectancy within 10 years.

Quality of life

Increased life expectancy is, of course, a positive outcome. However, as people age, the risk of disease and disability increases, which can impair a person’s quality of life.

Figure 3 shows that in 1994–1999, total life expectancy for men in the most deprived areas of England was six years less than for those in the least deprived areas. It also shows that men in the least deprived areas had on average 12.5 more disability-free years compared to those in the most deprived areas.

This pattern had increased by 1999–2003 (the latest figures available) where the men in the least deprived areas lived an average of seven years longer than those in the most deprived areas, and had 13 more years free of disability. A similar, but less marked, pattern was evident for women.

Inequalities in health and life expectancy are also evident between different groups such as homeless people, travellers, refugees and asylum seekers, people with disabilities and prisoners, as well as black and minority ethnic groups. These people can have poor access to the full range of public services, further compounding health inequalities.

As with many other industrialised countries, England has an ageing population. The population is projected to grow from 51 million in 2007 to almost 59 million by 2027. Despite the contribution of immigration towards growth in the working age population, the greatest increase remains in the proportion of
people aged 65 or over. This is expected to rise from 16% of the population in 2007 to 18% by 2017, and 21% by 2027 – an overall increase of about four million people aged 65 or over.15

This increase is mainly due to the ageing of the large numbers of people born during the baby boom after the Second World War and in the 1960s. Given these changing demographics, it is particularly important that health improvement programmes and services ensure that people are healthier for longer, with an improved quality of life and reduced healthcare costs.

Infant mortality

Infant mortality is a good indicator of overall health in an area or population group. Since the mid-1970s in the UK, there has been a downward trend in infant deaths* – from 14.3 per 1,000 live births in 1976 to about 5.3 per 1,000 in 2003, a reduction of about 62% (see figure 4), with a further reduction in 2006 to 5.0 per 1,000.16

Internationally, the UK has the highest infant mortality rate in Western Europe, at 5.1 deaths per 1,000 live births in 2005, whereas France had 3.8 deaths per 1,000.† The UK rate is lower than the OECD average of 5.4 deaths per 1,000. There are regional inequalities in England – there were reductions of about 43% between 1997 and 2006 in the South West and slower decreases in the East Midlands (5.1%) and the North East (6.9%).

Recent findings from the Office for National Statistics show that there is higher infant mortality for very low birth weight babies, babies of teenage mothers and mothers over 40 years of age, and babies of Pakistani and Caribbean mothers. Although the gap in infant mortality between routine manual groups and the population as a whole has narrowed in recent years, a concerted effort will be required to reach the public service agreement target of a minimum 10% reduction in the gap by 2010.

Wider factors affecting health and wellbeing

Many factors affect the health of an individual and therefore the health of the wider population. Predetermined factors include age, sex and genetic make-up. There are also lifestyle behaviours, such as diet, exercise, smoking and alcohol intake. Wider determinants include social networks, education, employment, poverty, physical environment and housing.

* Defined as deaths of babies under one year old.
† It should be noted that differences in registration and coding practices mean that data are not necessarily truly comparable.
Chapter 2 The health of the population in England

Smoking

Smoking is England's single greatest cause of preventable illness and early death, responsible for a wide range of illnesses including cancer, respiratory disease and heart disease.\(^{18}\)

England has a relatively high adult smoking population compared to the rest of Europe. In 2005, it was estimated that about 82,000 deaths in England (17% of all deaths of adults aged 35 and over) were caused by smoking, with a larger proportion of men (23%) than women (13%). The proportion of adults in England who smoked was 24% (25% of men and 22% of women)\(^{19}\), a decrease from 1974 when 45% of adults smoked (51% of men and 41% of women).\(^{20}\) Smoking in pregnancy has also gone down, from 23% in 1995 to 17% in 2005.\(^{21}\)

The proportion of adults in manual socioeconomic groups who smoke decreased from 33% in 1998 to 28% in 2006. However, people in manual groups continue to be more likely to smoke than those in non-manual groups (28% and 17% of adults respectively).\(^{22}\)

Of those adults living in the most deprived wards, 38% are smokers, while only 17% of adults living in the least deprived areas smoke. Among ethnic groups, smoking was found to be more common in Bangladeshi men, with an estimated 40% prevalence. The highest smoking rates in women in England are found in Irish communities (26%), followed closely by Caribbean women (24%).

Underage smoking is a concern in England. Children who smoke are at a higher risk of continuing to smoke into adulthood, further increasing the risk of respiratory problems, particularly lung cancer and heart disease. It is also illegal. Smoking in boys aged 11 to 15 decreased from about 12% in the early 1980s to 7% in 2003 and has remained at a similar rate since. Smoking in girls, however, increased from 11% in 1982 to 15% in 1996 and then slowly fell to 10% in 2006, 3% higher than in boys of the same age.\(^{23}\) The number of people who managed to quit smoking by attending NHS stop-smoking services has risen, from 119,834 people in 2001-2002 to 319,720 in 2006-2007.

Obesity

Being overweight or obese increases the risk of heart disease, hypertension, cancer in later life and type 2 diabetes in children and adults.

Comparisons with Western Europe show that obesity in children is rising fastest in England. England has the highest rates of obesity in Western Europe, with around 23% of the adult population classified as obese (see figure 5). About a third of children aged two to 15 were estimated to be overweight or obese in 2006, with a higher proportion of boys obese than girls. In 2006, 17.3% of boys and 14.7% of girls were obese, compared with 10.9% and 12.0% in 1995 respectively.\(^{24}\)

Between 1993 and 2006, the proportion of obese men rose from 13.2% to 24.9%. The percentage of obese women increased from 16.4% to 25.2% over the same period.\(^{25}\) Women in lower socioeconomic groups are more likely to be obese. This is not the case for men, where obesity is less prevalent for those in lower supervisory and routine occupations, possibly because of increased physical activity at work. Children in deprived areas in school reception year and year 6 are more likely to be obese.\(^{26}\)

Obesity rates also differ between ethnic groups. For example, prevalence of obesity is particularly high among South Asian and African Caribbean women.\(^{27}\)
Alcohol misuse

Alcohol misuse can result in ill health, including liver disease, high blood pressure, pancreatitis, coronary heart disease and stroke, cancers and mental health problems. It is also known to contribute to crime and antisocial behaviour. Deaths associated with alcohol consumption have risen (see figure 6). In men, the death rate doubled from 9.1 deaths per 100,000 in 1991 to 18.3 in 2006. For women, the rate increased from 5.0 to 8.8 deaths per 100,000 over the same period, a rise of around 80%.

Alcohol-related hospital admissions have more than doubled in the last 10 years. In 1995/1996, 93,459 adults aged 16 or over were admitted to hospital with either a primary or secondary diagnosis related to alcohol. By 2006/2007, this number had risen to 207,788. This increase is true for all regions, but it is greater in the more deprived areas. For example, the rate of admissions to hospital in the North West in 2006 for alcohol-specific conditions was more than twice as high as in the East of England. In addition, the North East experienced a disproportionately high health burden from alcohol misuse.
While the majority of people drink alcohol in moderation, a significant proportion drink above the sensible drinking limits.* In 2004, it was estimated that 38% of men and 16% of women (aged 16 to 64) had a drinking disorder – approximately 8.2 million people in England.\textsuperscript{33} Alcohol consumption is not universal across all population groups.\textsuperscript{34} Men, younger people aged 16 to 24, those from white ethnic groups and those living in higher income households are more likely to drink above the sensible drinking guidelines.\textsuperscript{35}

In 2006, the proportion of pupils aged 11 to 15 reported drinking in the previous week was around 20%, continuing a trend that has been decreasing since 2001. In contrast to this, the average consumption among pupils who had drunk alcohol in the previous week was 11.4 units, the highest ever recorded in the survey.\textsuperscript{36}

The 2006 General Household Survey\textsuperscript{37} and publications by the British Beer and Pub Association\textsuperscript{38} both contain indications that alcohol consumption in the UK has fallen in recent years. However, research suggests this could be a result of under-reporting, changes in research and survey methodology, illegal sales or alcohol importation from the EU that is not systematically monitored\textsuperscript{39,40}

### Specific conditions

#### Cancers and circulatory diseases

Cancers and circulatory diseases (heart disease and stroke) were the most common causes of death in England in the last decade. However, between 1995 and 2006, deaths from these diseases declined for both men and women, and more quickly than in a number of other European countries, especially for men.\textsuperscript{41}

Government targets are in place to reduce death rates from cancer and circulatory disease in people under 75 by at least 20% and 40% respectively by 2010. Mortality target monitoring data uses three-year average rates, and shows considerable progress towards the target for both diseases.\textsuperscript{42}

For example, in 1995-1997 the overall mortality for cancers in people under 75 in England was 141.2 deaths per 100,000 people. In 2004-2006, the rate had fallen to 117.0 deaths per 100,000, a reduction of 17.1%. If this trend continues, the 2010 target of a 20% reduction will be met.

Mortality rates from all circulatory diseases in the under-75s had fallen from 141.0 deaths per 100,000 in 1995-1997 to 84.2 per 100,000

\* A maximum of two to three units per day for women and no more than 14 units per week. A maximum of three to four units per day for men and no more than 21 units per week. Pregnant women should avoid alcohol altogether in the first three months of pregnancy. If they choose to drink during pregnancy, women are advised to drink no more than one to two units once or twice a week.
in 2004-2006, effectively meeting the target of a 40% reduction in deaths five years early.

Although inequalities in deaths from these diseases persist, there have been significant reductions in the gaps between the spearhead areas and the population as a whole. Between 1995-1997 and 2004-2006, the gap in mortality for heart disease in people under 75 between England and the spearhead group fell from 36.7 deaths per 100,000 people in 1995-1997 to 24.9 in 2004-2006 – a reduction of about 32%.

Differences are also evident between ethnic groups. For example, rates of death from circulatory diseases in 1999-2003 were higher in certain black and minority ethnic groups in England and Wales – in particular in Bangladeshi, Pakistani and Indian communities. However, the lack of routinely available data on mortality by ethnicity makes monitoring access to services and outcomes difficult. For example, ethnicity does not appear on death certificates.

Sexual health in the UK
Under-18 conception is associated with poor outcomes for both teenage parents and children. While teenage conception rates are now at the lowest level in 20 years, Britain’s rate is still among the highest in Europe and, as recent statistics show, abortion rates for this age group remain too high. Large inequalities are apparent, with teenage conceptions in the most deprived 10% of wards being four times higher than the 10% least deprived wards.

Chlamydia is a sexually transmitted infection that increases the risk of a number of conditions, including ectopic pregnancy and infertility in both men and women. The known incidence of chlamydia increased by more than 300% (from 35,840 to 109,958) between 1996 and 2005, although increased detection through screening could explain some of this increase. Incidence of gonorrhoea has stayed relatively static.

The number of new diagnoses of HIV reported annually in the UK increased by 182% (from 2,764 in 1997 to 7,800 in 2006). The 2007 estimate of new diagnoses was 6,840. Although this estimate remained high, it is lower than the figures for 2005 (an estimated 7,900 new diagnoses) and 2006, suggesting that the annual number of new diagnoses may be stabilising.

Men and women between 16 and 24 years of age are most at risk of contracting non-HIV sexually transmitted infections, although rates of HIV infection are highest among those aged 20 to 40. The number of new diagnoses of HIV is higher among people from more deprived areas, and there are more cases among men who have sex with men and in people who have been exposed to HIV while abroad. Ethnicity has an impact on the risk of sexual ill health between particular groups of people. There is a higher prevalence of sexually transmitted infections among African Caribbean people and a lower prevalence among Asian people, when compared with the British population as a whole.

Mental health
The World Health Organisation predicts that depression will be the second leading cause of disability internationally by 2020. Mental health problems are associated with significant burdens of physical ill health. In the UK, people with a severe mental illness are: five times as likely to suffer from diabetes; four times as likely to die from cardiovascular or respiratory disease; and up to 20 times as likely to have HIV or hepatitis C.
Mortality rates for people with a severe mental illness are two and a half times higher than the average.\textsuperscript{50}

Already, stress-related sickness counts for half of all absences from work, and mental illness is the most common factor for people on incapacity benefit in the UK. The rates of hospital admission for conditions such as schizophrenia remain high in comparison to other mental health and physical conditions, and this is likely to have a significant impact on the ability of these people to retain control over their personal affairs and remain connected to their local community.

Research regularly shows that there are ethnic variations in the rates of diagnosed mental illness, use of services and pathways to care.\textsuperscript{51} A consistent finding has been the high rates of psychosis, hospital admission and detention under the Mental Health Act among African Caribbean groups. Social and environmental factors such as deprivation, unemployment and family composition are significant contributors, requiring a multi-agency response. This includes measures that actively prevent people developing mental health problems, and measures that help people to stay well after a period of mental illness.

Despite more inclusive social attitudes, and the knowledge that one in six adults will suffer from mental health problems at any one time\textsuperscript{24}, people with mental health problems continue to face exclusion from areas of life such as jobs, family support, community involvement, and choice and decisions about their care and treatment.

There has been progress towards the PSA target of a reduction of 20% in deaths from suicide and undetermined injury by 2010. However, the rate of decline has slowed and, if this trend were to continue, the target would not be met. To reduce deaths by the target amount, an increased rate of decline must be sustained.\textsuperscript{53}

**Unintentional injuries**

Each year in the UK, non-fatal injury results in more than six million visits to A&E departments. Approximately two million of these are children.\textsuperscript{54} Unintentional injury is one of the major causes of death in children. The vast majority of these deaths can be prevented. In 2004, there were about 230 injury-related deaths in children under 15 years in England.\textsuperscript{55} Death rates had decreased to 2.6 per 100,000, a fall of around 45% from 4.4 per 100,000 in 1995. Unintentional injury is also a common cause of hospital admission in children. In England in 2004/2005, unintentional injury resulted in 119,518 admissions to hospital for the 0-14 age group alone.\textsuperscript{54} Rates for 2005/2006 show an increase of 0.2%.\textsuperscript{57}

Children living in the poorest areas are much more likely to have an unintentional injury than children living in more affluent areas.\textsuperscript{58} For example, children of parents who have never worked or who are long-term unemployed are 38 times more likely to die as a result of exposure to smoke, fire or flames than children of parents in higher managerial and professional occupations.\textsuperscript{59} In England, children in the 10% most deprived wards are three times more likely to be hit by a car than children in the 10% least deprived wards.\textsuperscript{60} In addition, fatality is twice as likely in boys as in girls (aged one to 14), a gap that increases with age.\textsuperscript{61}

In 1998, a PSA target was introduced to reduce the death rate from accidents (for all ages) by at least 20% by 2010. Since monitoring of this
target began, deaths from accidents have increased by 1%. If this target is to be met, additional and sustained effort will be required.\textsuperscript{62}

In conclusion

In line with the trend over the past 100 years, the health of people in England has improved over the past decade. The improvement has been particularly notable in a number of areas such as life expectancy and the prevalence of the ‘big killers’. However, the steep rise in the numbers of people who are overweight or obese has the potential to reduce the improvements of recent years in relation to heart disease and cancer, and to increase the prevalence of type 2 diabetes and hypertension. Inequalities still remain in terms of life expectancy and quality of life between people living in the most and least deprived areas. In those health topics where there has been progress, such as teenage conceptions and smoking, it will be important to maintain and build upon progress to ensure ongoing improvement in health outcomes.
Chapter 3
What Government set out to do
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What Government set out to do

Improving people’s health and tackling inequalities in health have been key features of Government policy over the past 10 years. This chapter outlines overall policy since 1997, including key public service agreements (PSAs) and other health-related targets. We identify key policies that sought to improve health and comment on the extent to which they have been successful.

We look at incentives, both in terms of performance assessment and performance management, and resources and capacity. We also examine system change between 1997 and 2007 in relation to local government and the NHS.

This chapter also brings together the views of over 150 public health and health improvement experts, who attended roundtable events in summer 2007 to reflect on the impact of policy on the delivery of health improvement programmes and services.*

Between 1997 and 2007, there was a proliferation of direct policy for improving health, as well as wider policy with the potential to impact on the health of the public (see figure 7). Reviews such as the 1998 Acheson report into inequalities in health63 and the Wanless reports in 2002, 2004 and 2007 on the future of the NHS and health64 increased the profile and importance of health improvement.

Themes were established in The new NHS: modern, dependable and Modern local government: in touch with the people65, which became firm foundations for subsequent policies and remained largely consistent over the following years.

Policy is an important lever in securing better health for people. A clear steer from Government, signalling population-wide changes, is an important component in a whole-system approach to improving health and tackling inequalities. Early health policy identified areas for development, with subsequent strategies and action plans building and refining approaches.

Signalling change

Health improvement policy was well established when the new Labour Government came to office in 1997, providing a strong basis on which to build a renewed commitment. Between 1992 and 1997, the central plank of Government policy had been Health of the Nation, with national priorities and targets for coronary heart disease and stroke, cancer, mental illness, HIV/AIDS and sexual health, and unintentional injuries.64

In 1997, the Government published The new NHS: modern, dependable, a 10-year plan to revitalise the NHS as a modern service for the 21st century, in response to perceived under-funding and organisational concerns.67 It emphasised the importance of partnership working for health improvement, pointing to an NHS that “does not just treat people when they are ill but works with others to improve health and reduce health inequalities”.

The new NHS signalled a range of major reforms that were reflected in policy throughout the following 10 years, including devolution of power to local services, changes to funding structures and management of performance, and major capital investment.

Tackling inequalities in health was a key priority and was reflected in a number of new initiatives, particularly in deprived areas.

* For details of the roundtable discussions, see www.healthcarecommission.org.uk or www.audit-commission.gov.uk
Figure 7: Key policy with impact on the health of the population 1997-2007

- **The new NHS:** modern, dependable
- **Choosing health:** Making healthier choices easier
- **National Standards, Local Action and Standards for Better Health:** Health and social care standards and framework
- **Delivering the NHS plan:** next steps on investment, next steps on reform
- **Delivering Choosing Health**
  - Choosing a better diet
  - Choosing activity
- **Our Future Health Secured:** Sir Derek Wanless
- **Shifting the Balance of Power within the NHS:** Securing delivery
- **Securing Good Health for the Whole Population:** Sir Derek Wanless
- **NHS Improvement Plan:** putting people at the heart of public services
- **Strong and prosperous communities:** The local government white paper
- **Local Government and Public Involvement in Health Act**

**Timeline:**

- 1997
- 1998
- 1999
- 2000
- 2001
- 2002
- 2003
- 2004
- 2005
- 2006
- 2007

**Policy highlights:**

- **Modern local government:** in touch with the people
- **New Deal for Communities**
- **Independent Inquiry into Inequalities in Health**
  - Sir Donald Acheson
- **A New Commitment to Neighbourhood Renewal:** A national strategy action plan
- **Tackling Health Inequalities:** A programme for action
- **Choosing health:** Making healthier choices easier
- **Changing the Balance of Power within the NHS:** Securing delivery
- **Securing Good Health for the Whole Population:** Sir Derek Wanless
- **NHS Improvement Plan:** putting people at the heart of public services
- **Shifting the Balance of Power within the NHS:** The next steps
- **Local Government and Public Involvement in Health Act**

**Are we choosing health?**
A number of Government units were set up to tackle social exclusion, including initiatives to promote neighbourhood renewal, and to address teenage pregnancy and homelessness. Section 31 of the Health Act 1999 enabled the establishment of joint working arrangements between local councils and healthcare organisations. These partnership arrangements aimed to give councils and healthcare organisations the flexibility and opportunity to develop innovative approaches to user-focused services. However, as can be seen from our analysis in forthcoming chapters, and from the views of experts (see box 7 on page 43), the implementation of such policy was not always easy.

This commitment to improving health through partnership was further strengthened with Modern local government: in touch with the people [1998]. Local health overview and scrutiny committees were given the power and responsibility to scrutinise the work of local healthcare organisations, and councils were given a duty to promote wellbeing in local people. Some commentators have noted the uneven development of overview and scrutiny committees across England. However, despite some poor performance, there are examples of good practice where scrutiny of health improvement programmes resulted in greater focus and improved performance.

New Deal for Communities, also introduced in 1998, focused on neighbourhood-level multi-agency partnerships involving local people, to address health as an integral part of a wider regeneration agenda. Other area-based initiatives, such as Sure Start, also sought to improve the health of families in disadvantaged areas. Similarly, Health Action Zones were developed to target interventions where need was greatest. The ambition of area-based initiatives was welcomed and improvements were often seen. The money allocated to these became, on occasion, a lifeline for the delivery of health improvement in the absence of sustained mainstream funding. Local and national evaluations and leading experts (see box 7 on page 43) have identified the factors that contributed to success, including local leadership and the robustness of local governance in planning, delivering and evaluating programmes.

Developing targets to focus action on improving health and tackling inequalities

Public service agreements

In 1998, following the Treasury’s Comprehensive Spending Review, which stated that radical changes were needed to modernise public services, Treasury and central Government departments agreed a rolling programme of public service agreement (PSA) priority targets, subject to three-yearly review.

PSAs aim to encourage improvement in the delivery of public services, and to provide the public with information that they can use to hold Government departments and local services to account.

Table 1 outlines a number of key PSAs for improving health, released in planning rounds between 1998 and 2004. These targets created considerable opportunities and had ambitious objectives. They identified overall resources for delivery and set frameworks for whole-system approaches. The table shows how different priorities were identified over the years, within the framework of ongoing commitment to improving health and tackling inequalities.
### Table 1: Selected health-related public service agreement targets 1998-2007

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<tr>
<td>Improving health</td>
<td>Improve the health and wellbeing of the people of England</td>
<td>Improve health outcomes for everyone</td>
<td>Transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities</td>
<td>Improve the health of the population. By 2010, increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women</td>
<td>By 2010, increase the average life expectancy at birth in England to 78.6 years for men to 82.5 years for women monitored using mortality rates as a proxy</td>
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<tr>
<td>Tackling inequality in health</td>
<td>Reduce premature deaths and avoidable illness, disease and injury, and reduce inequalities in health</td>
<td>Narrow the health gap between socioeconomic groups and between the most deprived areas and the rest of the country in childhood and throughout life.</td>
<td>By 2010, to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth</td>
<td>By 2010, to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth</td>
<td>By 2010, to reduce inequalities in health outcomes by 10% as measured by infant mortality and Life expectancy at birth</td>
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**Improve health and wellbeing of the people of England**

   - Improve the health and wellbeing of the people of England

   - Improve health outcomes for everyone
   - Transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities

   - Transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities

   - Improve the health of the population. By 2010, increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women

   - By 2010, increase the average life expectancy at birth in England to 78.6 years for men to 82.5 years for women monitored using mortality rates as a proxy

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**Tackling inequality in health**

1. **Infant mortality**
   - Reduce premature deaths and avoidable illness, disease and injury, and reduce inequalities in health
   - Infant mortality not featured in this round of PSA targets

2. **Narrow the health gap between socioeconomic groups and between the most deprived areas and the rest of the country in childhood and throughout life.**

3. **Specific national targets published in 2001 to become fully operational by the beginning of 2002-2003**

4. **By 2010, to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth**

5. **By 2010, to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth**

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**Are we choosing health?**
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<tr>
<td>Cancer, heart disease and stroke</td>
<td>Reduction in the death rate from cancer among people aged under 65 of 20% by 2010</td>
<td>Reduce substantially the mortality rates from major killers by 2010: from heart disease by at least 40% in people under 75; from cancer by at least 20% in people under 75</td>
<td>Reduce substantially the mortality rates from major killers by 2010: from heart disease by at least 40% in people under 75; from cancer by at least 20% in people under 75</td>
<td>Substantially reduce mortality rates by 2010: • From heart disease and stroke and related diseases by at least 30% in people under 75, with at least a 49% reduction in the inequalities gap • From cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6%</td>
<td>Reducing the mortality rate by 2010 for cancer by at least 20% in people under 75, with a reduction in the inequalities gap by at least 6% Reducing the mortality gap by 2010 for heart disease, stroke and related diseases by at least 40% in people under 75, with a reduction the inequalities gap by at least 40%</td>
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<tr>
<td>Smoking</td>
<td>Not featured in this round of PSA targets</td>
<td>Not featured in this round of PSA targets</td>
<td>Not featured in this round of PSA targets</td>
<td>Reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less</td>
<td>Reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less</td>
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Table 1: Selected health-related public service agreement targets 1998-2007 (continued)

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<tr>
<td>Obesity</td>
<td>Not featured in this round of PSA targets</td>
<td>Not featured in this round of PSA targets</td>
<td>Not featured in this round of PSA targets</td>
<td>Halting the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole</td>
<td>Reduce the proportion of overweight and obese children to 2000 levels by 2020 in the context of tackling obesity across the population</td>
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</table>
| Mental health   | Reduction in the death rates from suicide and undetermined injury by 17% by 2010 | Reduce substantially the mortality rates from major killers by 2010:  
  - From suicide and undetermined injury by at least 20% | Improve life outcomes of adults and children with mental health problems through year on year improvements in access to crisis and CAMHS services, and reduce the mortality rate from suicide and undetermined injury by at least 20% by 2010 | Substantially reduce mortality rates by 2010:  
  - From suicide and undetermined injury by at least 20% | Reducing the mortality rate by 2010 for suicide and injury of undetermined intent by at least 20% |
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<tr>
<td>Accidental/unintentional injury*</td>
<td>Reduction in accidents involving a hospital visit or a consultation with a family doctor of 20% by 2010</td>
<td>Not featured in this round of PSA targets</td>
<td>Not featured in this round of PSA targets</td>
<td>Not featured in this round of PSA targets</td>
<td>Hospital admissions caused by unintentional and deliberate injuries to children and young people</td>
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<tr>
<td>Teenage pregnancy/sexual health</td>
<td>Not featured in this round of PSA targets</td>
<td>Not featured in this round of PSA targets</td>
<td>Reducing the under-18 conception rate by 50% by 2010</td>
<td>Reducing the under-18 conception rate by 50% by 2010 as part of a broader strategy to improve sexual health</td>
<td>Reducing the under-18 conception rate by 50% by 2010 as part of a broader strategy to improve sexual health</td>
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<tr>
<td>Alcohol</td>
<td>Not featured in this round of PSA targets</td>
<td>Not featured in this round of PSA targets</td>
<td>Not featured in this round of PSA targets</td>
<td>Not featured in this round of PSA targets</td>
<td>Reduce the harm caused by alcohol and drugs:</td>
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<td>• Rate of hospital admissions per 100,000 for alcohol-related harm</td>
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* The term accidental injury was replaced by unintentional injury in this period in line with the World Health Organisation definition. Both terms describe “injury occurring as a result of an unplanned and unexpected event which occurs at a specific time from an external cause”, taken from Ward H and Christie N Strategic review of research: Priorities for accidental injury, report for the Department of Health, University College London, 2000.
The 2007 PSAs, covering 2008/2009 to 2010/2011, are largely in line with the previous focus on improving health and tackling inequalities. However, they take a more integrated approach to national targets, with broad headings that include a number of indicators with responsibility held by one or more departments (for example, PSA 14: “increase the number of children and young people on the path to success”, with the Department for Children, Schools and Families having the lead responsibility, including “under-18 conception rate” as an indicator).

There are changes in some areas, such as the new PSA 25 to reduce the harm caused by alcohol and drugs. Indicator 2 of this PSA will measure the rate of alcohol-related hospital admissions from April 2008. An indicator has been added to PSA 13 (improve children and young people’s safety), to measure hospital admissions caused by unintentional and deliberate injuries to children and young people.

Childhood obesity is an indicator for PSA 12 (improve the health and wellbeing of children and young people). However, the indicator date has changed from 2010 to 2020, and the indicator has changed to “reduce the proportion of overweight and obese children to 2000 levels in the context of tackling obesity across the population”. The earlier target called for a halt in the “year-on-year rise in obesity among children under 11 by 2010”.

PSAs have not been the only means for identifying national priorities. Targets have been identified through a number of other approaches, including national service frameworks or national strategies (such as sexual health and HIV). As table 1 shows, prioritising of targets was not consistent throughout the period. For example, unintentional injury appeared in 1998, but was not included as a PSA indicator again until 2007. Obesity had neither a PSA nor any other specific target until 2004. Although smoking did not have a PSA until 2004, it was highlighted as a priority in the health and social care priorities and planning framework with a three-year target, and this has driven progress. However, the lack of consistency in targets creates confusion about the current status of health improvement issues that are not included as PSAs.

Outcomes for local area agreements
In 2006, the Local Government White Paper set out a new performance framework for outcomes delivered by local authorities, whether acting alone or in partnership. As part of this framework, in 2007 Communities and Local Government published for technical consultation a set of 198 national indicators for local authorities and local area agreements (LAAs) overseen by local strategic partnerships (LSPs). These include 42 indicators for health improvement.

In addition to specific performance monitoring, annual reporting on each of these indicators will be a significant input to the new Comprehensive Area Assessment (CAA) that will be introduced from April 2009. However, these are not ‘must do’s’: each LSP will agree up to 35 targets with central Government, drawn from the 198 national indicators, in their LAA. (There are also 16 statutory targets for education and early years.)

Decisions on priorities will take account of the relevant joint strategic needs assessment (JSNA) – the means by which PCTs and local authorities will describe the future health, care and wellbeing needs of local populations and the strategic direction of service delivery to meet those needs, taking account of information on inequalities. Government
Offices will negotiate LAAs on behalf of central Government. The Department of Health has produced national planning guidance for PCTs to use in their local operational plans (LOPs), with 64 health-related indicators (including those in the national indicator set known as “vital signs”).

**Tackling inequalities in health**

The widening inequalities in health apparent since 1972 across the country meant that policy was needed to address issues of health improvement, as well as service configuration. The Government published *Saving Lives: Our Healthier Nation* (1999) with a focus on tackling inequalities and improving the health of the whole population by increasing the length of people’s lives and years spent free of illness. It called for improvements in the health of the most deprived people. Achieving the targets required partnership working among residents, communities, the health sector and Government. Closely following *Our Healthier Nation*, initiatives such as healthy living centres were developed to support people in staying healthy (for example, through physical activity, healthy eating and stopping smoking).

The targets contained within *Our Healthier Nation* broadly reflected the PSAs in place at the time, but differed in terms of their specific target percentages. The reasons for the differences were not always clear to local organisations working to improve health and tackle inequalities.

**Topic-specific strategies**

Following publication of *Our Healthier Nation*, the Government produced a series of topic-specific strategies and action plans with the explicit aim of improving the health of the population and tackling inequalities. These included: *Smoking Kills: A White Paper on Tobacco* (1998); the national *Teenage Pregnancy Strategy* (1999); *Better prevention, Better services, Better sexual health – The national strategy for sexual health and HIV* (2001) and the *Alcohol Harm Reduction Strategy for England* (2004). Each strategy had different levels of funding, as well as different models for delivery, resulting in uneven implementation as commented on by the leading experts in our fieldwork (see box 7 on page 43).

National service frameworks (NSFs) emerged from *The new NHS*. These made up a rolling programme of policy, procedures and strategies with measurable goals for improving specific areas of care. Many include specific health improvement elements. *The NHS Plan* re-emphasised the role of NSFs as drivers in delivering the modernisation agenda. The NSFs have had a significant impact locally on the delivery of the services they addressed.

**Box 3: Our Healthier Nation targets for 2010**

- **Cancer**: to reduce the death rate in people under 75 by at least a fifth
- **Coronary heart disease and stroke**: to reduce the death rate in people under 75 by at least two-fifths
- **Accidents**: to reduce the death rate by at least a fifth and serious injury by at least a tenth
- **Mental illness**: to reduce the death rate from suicide and undetermined injury by at least a fifth
Box 4: NSFs with health improvement as a component include:

- Diabetes (1999)
- Mental health (1999)
- Cancer (2000)
- Coronary heart disease (2000)
- Older people (2001)
- Children, young people and maternity services (2003)
- Long-term conditions (2005)
- Chronic obstructive pulmonary disease (2008)

A wider approach to tackling inequalities

*Tackling Health Inequalities: A Programme for Action* (2003) set out a cross-government plan to deliver the 2010 national health inequalities target on life expectancy (by geographical area) and infant mortality (by social class), and address the wider causes of inequalities in the years beyond. The key themes were: supporting families, mothers and children; engaging communities and individuals; preventing illness and providing effective treatment and care; and addressing the underlying causes of health.

**Choosing health**

One of the significant policies of the period, because of its profile and ambition, *Choosing health: Making healthier choices easier* in 2004, detailed principles for supporting individuals to make informed health choices.

*Choosing health* built on earlier developments such as healthy living centres to help people improve their own health. Priority areas included smoking, sexual health, obesity, alcohol and mental health. The core principles of *Choosing health* were informed choice, personalisation (with support tailored to individual needs, including NHS health trainers to be in place from 2007 in the areas with greatest need) and working in partnership.

Commentators have noted that informed choice was a challenging value for health improvement activity. Not all people have similar opportunities to make choices. Those who are economically stable and well educated seem to find it easier to navigate their way through complex systems than those who are not. They find themselves supported to identify options and understand the consequences of health-related decisions.

For poorer communities, the converse seems to be true. In addition, there seem to be fewer options available for people living in disadvantaged neighbourhoods, making choice challenging, even when the desire to act differently is evident. Poor people and those with lower educational achievement could be at a disadvantage unless specific measures are taken to avoid this.

An important feature of *Choosing health* was its focus on the leadership role of local councils to bring partners together for concerted and integrated action on health. Pilots were announced for local area agreements (LAAs) between local government and other partners, including PCTs. PCTs were required to develop targets with local partners that met the needs of people living in their area and also contributed to meeting national targets and priorities.

*Choosing health* was followed in 2005 by *Delivering Choosing Health: making healthy choices easier*, an action plan that collated all PSAs and local targets for health improvement.
In 2002, the Chancellor of the Exchequer commissioned Sir Derek Wanless to estimate future costs of the health service, and identify options to prevent excessive expenditure. Wanless advocated a “fully engaged” scenario, where every individual took responsibility, in partnership with the state, to protect their own health and reduce the burden on health services. He estimated health promotion expenditure in England at around £250 million – less than the NHS spends in a day and a half. All three scenarios that Wanless considered projected an increase in health promotion spending, with the fully engaged scenario assuming the largest and most rapid rise, doubling to around £500 million by 2007/2008. However, it is impossible to track trends in public health or health promotion spending since 2002, as no official figures are kept. Given the lack of accurate information, it is impossible to assess whether the fully engaged aspirations for a doubling in public health spending by 2007/2008 have been met.

In 2007, the King’s Fund commissioned Wanless to undertake a review of progress. In Our Future Health Secured? A review of NHS funding and performance, Wanless reported that the Government had struggled to improve the health of population in the 10 years from 1997 to 2007. While noting improvements in areas such as infrastructure, waiting times, access to care and the quality of care, he found that additional funding had not produced the improvements in productivity deemed necessary in the earlier review. He considered that service reorganisations and reconfigurations had taken their toll on the morale of staff, despite improved salaries and increased resources.

Wanless could not assess whether sufficient resources had been spent to achieve the fully engaged scenario by 2008, because the information was not available. The report noted that while the health of the population had improved in broad measures, overall “the evidence suggests that the population is a long way short of the fully engaged scenario and is on a path between slow uptake and solid progress”. Wanless concluded that substantially more spending on healthcare was needed. He called for reform to ensure the effective use of resources.

Population-wide measures have also been undertaken, such as the ban on smoking in public places and restrictions to the legal age for buying tobacco, both in 2007. Early signs are that these interventions have had a positive impact, as discussed in chapter 4 and confirmed by leading experts (see box 7 on page 43).

The health of children and young people has been an important focus of policy. The Department of Health is implementing a

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**Box 5: Wanless explained: Securing our Future Health and Our Future Health Secured?**

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and listed 45 ‘big wins’ – interventions based on expert advice and implementing effective programmes. Topic papers provided further guidance, such as Choosing a Better Diet: a food and health action plan and Choosing Activity: a physical activity action plan (both 2005).

Population-wide measures have also been undertaken, such as the ban on smoking in public places and restrictions to the legal age for buying tobacco, both in 2007. Early signs are that these interventions have had a positive impact, as discussed in chapter 4 and confirmed by leading experts (see box 7 on page 43).

The health of children and young people has been an important focus of policy. The Department of Health is implementing a
number of schemes to help primary and community healthcare providers become better equipped and coordinated to meet the health needs of young people (aged 11 to 19). This includes the You’re Welcome quality criteria (launched in 2005, refreshed in 2007) that are designed to make health services young people friendly, as well as commissioning the Royal College of Paediatrics and Child Health to develop a training scheme in adolescent medicine for all doctors and nurses working with teenagers.

Topic-specific schemes for young people include unintentional injury initiatives, for example the Royal Society for the Prevention of Accidents Accreditation Scheme for Safety Centres, which mainly cater for children, and SmartRisk, which covers adolescents and risk.

System changes to enable delivery

Changing health systems

At the same time that policy focused on specific health improvement topics, a range of policies and guidelines addressed structural, commissioning and service delivery issues. Themes across Government included increased participation and decision-making by communities and individuals, devolution of power and greater focus on performance management.86

The NHS Plan: a plan for investment, a plan for reform in 2000 set out a vision of “a health service designed around the patient”. This signalled broad system reform and promised extra investment for facilities, staff and training, and further devolution of power to local health services. Further policy supported the goals for devolution, recognising the need for a cultural shift in the NHS and for greater cooperation within and across sectors. Radical changes were proposed: increased patient choice, national standards for quality and greater local responsibility, with the centre providing the structure and framework.

The commitment to empower people to take control of improving their own health was reaffirmed. This included enabling patients to choose their service provider. A change of focus was needed – away from the importance and convenience of the system and those running it, to the needs of the patients – in order to bring about a radical change in the ways that local councils and healthcare organisations approached their work.

The new arrangements included mechanisms to support the delivery of health improvement. Each PCT was to have a director of public health (previously a director of public health covered a larger area). This person would drive programmes to improve local health and tackle inequalities.

Organising health improvement work in PCTs – rather than in health authorities, their larger predecessors – meant that the local emphasis of activities was strengthened. However, it also meant that issues that benefited from a wider geographical approach might not be addressed so well.87 This was mitigated by the establishment of public health networks in some geographical areas and for some health topics (such as cancer networks). Guidance on appointments in 2006 emphasised the importance of directors of public health being joint appointments by PCTs and local councils.

Regional directors of public health served as the Department of Health’s presence in the nine regional Government Offices, with a remit to drive local delivery. By 2006, the 28 strategic health authorities that had been set up in 2002 to supervise local health services in
England were reduced to 10, sharing directors of public health with the Government Offices.

The role of public health observatories (set up by the Department of Health to provide comparative information about health outcomes) was also extended to enhance links with intelligence systems across all Government departments and other organisations.

These changes in regional structure created efficiencies but also maintained a period of extended reorganisation, which threatened delivery. Many PSAs required local organisations to work in partnership, which created many opportunities as well as challenges.88, 89

Similarly, the local collaboration needed to contribute to meeting the overall targets entailed a change in organisational cultures. As suggested by the leading experts in our fieldwork (see box 7 on page 43), this was often fraught with difficulties, including a lack of understanding of the interests of partner organisations and the pressures on them to deliver, an inability to communicate effectively, and a resistance to sacrifice areas of work for the good of the partnership.

The separation of the roles of commissioner and provider of health services – which had been in place since 1990 – continued to be critical, with guidance in The NHS Plan for PCTs to become patient-led commissioning organisations working across areas to ensure effectiveness and value for money.

In 2004, practice-based commissioning was established, with GPs taking responsibility for commissioning services to meet their patients’ health needs. Payment by results, a system for funding acute hospital services incorporating a standard tariff for interventions, was introduced in 2004, and local service provision commissioned from a range of providers was endorsed. From April 2008, joint strategic needs assessments have become the foundation for joint commissioning of health and social care services.

A number of agencies were also established to support the implementation of policy. NHS Direct was created in 1998 to reduce pressure on primary care and to provide people with information to enable them to make decisions about their health.

The National Institute for Clinical Excellence was established in 1999. In 2005, it developed into the National Institute for Health and Clinical Excellence (NICE), with a wider remit to review evidence and produce guidance on promoting health and preventing and treating ill health. The NHS Modernisation Agency* was created in 2001 to support the NHS and its partners in modernising services and improving outcomes and experiences for patients. This agency was closed in 2005.

The Health Development Agency was established in 2000† to raise the standards and quality of health improvement provision through the publication of research, guidance and best practice tools. The HDA was dissolved in 2005 and some of its public health functions absorbed by NICE, leaving a gap in the provision of national development support for the frontline staff tasked with implementing Government policy.

* Established April 2001, superseded by Institute for Innovation and Improvement April 2005.
† The Health Education Authority (HEA) was closed and the Health Development Agency (HDA) was set up with a transfer of some functions and staff.
Chapter 3 What Government set out to do

The Department of Health established national support teams in 2006 to support PCTs at risk of not achieving their targets. Among the first areas for support were smoking cessation, teenage pregnancy and 48-hour waiting times for genitourinary medicine services. A national support team for health inequalities was established in 2007.

In line with previous policy, *Our health, our care, our say* (2006) outlined further details for health and social care based on the needs of individuals. Changes were to be achieved by shifting resources to prevention, and more home-based and community care with strong ties to social care.

*Informing Healthier Choices: Information and Intelligence for Healthy Populations* (2007) set out the Department of Health’s vision for information and intelligence to support implementation of *Choosing health*.

**Changing local government**

Over the 10-year period, there have been recurrent themes in relation to local government policy. These have been in line with the themes laid out in *Modern local government: in touch with the people* (1998), with overview and scrutiny committees, children’s directorates and a cabinet structure for councils that allowed designated elected members with responsibility for health.

The Cabinet Office Social Exclusion Unit’s *A New Commitment to Neighbourhood Renewal: National Strategy Action Plan* in 2001 was important to health improvement for its strong commitment to tackling inequalities and underlying determinants of health. Its vision was that “within 10 to 20 years, no-one should be seriously disadvantaged by where they live”. It focused on cross-governmental policies, funding and targets to tackle inequality. Later, local strategic partnerships (LSPs) involving PCTs and councils were established to lead local planning through local area agreements (LAAs), with aligned performance assessment and inspection regimes.

In 2004, the Government published *Every Child Matters: Change for Children*. It aimed for every child, whatever their background or circumstances, to have a range of essentials, including health, safety and economic wellbeing. Children’s trusts were identified as a means to coordinate delivery across local areas, with children’s directorates a radical change to council structures, bringing all services for children into one directorate.

**Box 6: Policy on the NHS**

- *Shifting the Balance of Power within the NHS: Securing Delivery* (2001)
- *Delivering the NHS plan: next steps on investment, next steps on reform* (2002)
- *NHS Improvement Plan: Putting People at the Heart of Public Services* (2004)
- *Creating a Patient-led NHS: Delivering the NHS Improvement Plan and Commissioning a Patient-led NHS* (2005)
- *Our health, our care, our say: a new direction for community services* (2006)
In 2006, Communities and Local Government published *Strong and prosperous communities* to give local communities more power to improve their lives. Its focus was to balance the relationship between central Government, local government and local people.

The Local Government and Public Involvement in Health Act (November 2007) introduced joint strategic needs assessment (which became a duty in April 2008), as well as the role of new local area agreements and community strategies. As part of the support package for joint strategic needs assessment, the Association of Public Health Observatories is developing a core dataset with demographic information (such as ethnicity and disability), which triangulates with the Vital Signs and the National Indicator Set.

**Changing performance assessment and management regimes**

Between 1997 and 2007, greater importance was placed on quality, evidence-based practice and regulation, both in their own right and to support measurement of delivery of the increasing number of targets and respond to devolution of performance management.

In 2000, a new regime for performance assessment and inspection was established, with the Commission for Health Improvement as the lead agency for the regulation of health services. The Health and Social Care (Community Health and Standards) Act 2003 set up the Healthcare Commission in April 2004. *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 to 2007/08 (2004)* including Annex A, *Standards for Better Health*, introduced core and developmental standards for healthcare in the NHS, aiming to move towards standards as the basis for continuous improvements in quality, with fewer national targets and greater scope for addressing local priorities. These standards include health improvement.

Internationally, the Healthcare Commission is the only regulator with a statutory responsibility to assess healthcare organisations in relation to their public health delivery. A recent survey of directors of public health in PCTs, undertaken by the Healthcare Commission, showed that assessment of public health and health improvement performance was considered beneficial for the profile of local health improvement work – a view that was confirmed by leading experts in our fieldwork (see box 7 on page 43).

Experts in our fieldwork made a similar reference to the role of the Comprehensive Performance Assessment (CPA) in stimulating delivery of health improvement programmes and services by local councils in partnership with PCTs and others.

Arrangements are being developed by Government and regulation and inspection bodies to ensure that performance assessment mechanisms are in place to support delivery of local area agreements, and that they continue to meet local need. The Comprehensive Area Assessment (CAA) – the framework for future regulation of public services in a given locality – is being developed by seven inspectorates working together, including the Healthcare Commission and the Audit Commission. Where other performance assessments exist for local authorities’ partners, these will feed into the CAA. Where actions depend on

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* Established in April 2000, CHI was superseded by the Healthcare Commission in April 2004.

† Revised in 2006.
partnership working with local authorities, the indicators and reporting requirements will be identical to those in the local performance framework to avoid duplication of effort or contradictory requirements on councils.

**Building the workforce**

Following *Choosing health*, the Department of Health led a strategy for building both capacity (that is, increasing headcounts) and capability (leadership, knowledge, skills and competence) among public health specialists and practitioners as well as across the wider workforce. Developments have included the establishment in 2006 of nine regional Teaching Public Health Networks, to enhance the knowledge of graduates from all disciplines who can improve the public’s health through their work and create health-promoting universities and colleges.

Through the NHS Core Learning unit, the Department of Health commissioned a public health e-learning module so that all NHS staff, as part of their NHS induction, could understand their health improvement roles. The Public Health Skills and Career Framework was developed with Skills for Health and the Public Health Resource Unit to provide a systematic approach to career development for the public health workforce, and to develop and strengthen the public health competence of the wider workforce.

However, despite the agenda set out in *Choosing health*, there has been a fall in trained public health specialists working in the public health system in the UK, and particularly in England between 2003 and 2007. This contrasts with the rapid rise in clinical professionals and the average increase of 61% of consultant numbers in England between 1996 and 2006. Staffing levels of the consultant workforce remain well below the levels envisaged by Wanless. In England, there is a variation in the self-reported capacity between different parts of the public health function. For example, 44% of PCTs reported adequate or more than adequate capacity compared to 70% of regional government offices.
In the summer of 2007, we held roundtable discussions with over 150 leading experts to reflect critically on the impact of policy on the delivery of health improvement programmes and services, including those that address the priorities of Choosing health. Participants included Government policy makers and representatives from national bodies, local healthcare organisations and councils – a list of participating bodies is shown in appendix D. While the roundtables focused on individual health topics, consistent themes emerged across all health areas.

The detail of each of the roundtable discussions is available on the Healthcare Commission’s and Audit Commission’s websites. A summary of the key themes is set out below.

**Clear, consistent, ambitious and measurable objectives**

- **National policies and targets improved delivery in PCTs and councils; they focused attention and were essential in maintaining focus and momentum.**
  
  As one participant said: “No target, no action”, noting that without targets for particular issues, there would have been no activity. However, programmes and services were not easily sustained in organisations with numerous competing priorities, for example in local councils where hospital closures were members’ priorities, rather than the wider improving of health.

- **The health of the population was not determined by health improvement policy alone.** A range of factors, including fiscal measures such as tackling child poverty, also had an impact. As such, it was difficult to attribute the direct effects of specific health-related initiatives. The actions of individuals had an impact, but the effects of the environments in which people lived were also significant. Health services also played a crucial role.

  - **Choosing health, the most recent policy, had a mixed impact on delivery.** For some issues, such as teenage pregnancy and tobacco control, Choosing health strategically renewed and refreshed efforts. For others, such as alcohol, obesity and mental health, it brought little benefit.

  - **Sometimes policies from other Government departments did not support local efforts.** For example, sex and relationship education within personal, social and health education (PSHE) in schools was not mandatory, despite strong evidence about its effectiveness in reducing teenage conceptions. Policies that promoted choice in schools could result in children attending schools far from home, reducing opportunities for walking to school and being active – contributing to child obesity.

  - **It was not always clear whether new national policies superseded those that went before, as different priorities were put in place.** For example, fuel poverty was a priority in Tackling Health Inequalities, but it was not mentioned in Choosing health. Unintentional injury was a PSA in 1998, but not again until 2007.

**Relevant, reliable and up-to-date information**

- **Good quality, accurate and timely data was crucial, but access to, and use of, data often remained a barrier.** Data can stimulate interest, bring partnerships...
together and describe challenges, particularly when shown in accessible and stimulating ways. Creative approaches to using data were considered useful in capturing the hearts and minds of PCT non-executive directors and elected members, who were crucial in securing progress locally. IT to support collation and analysis of data was not always in place, for example in sexual health services.

- **Current data, particularly the lack of programme budgeting, did not always support effective commissioning of targeted programmes or allow accurate management of performance.** Programme budgeting – a technique for calculating how much is spent on local health services and analysing how spend relates to need – was noted as having the potential to be useful to commissioners, but currently does not allow for sufficient understanding of spend on preventative programmes and services. It was noted that a strong case for investing in health improvement could be established locally if such information existed.

**Consistent focus across the NHS and Government**

- **Effective action demanded leadership at all levels.** Joint posts between PCTs and local councils, including directors of public health, created opportunities to improve health. Secondments into other sectors and agencies built understanding of the pressures and challenges that organisations faced.

- **Local councils were slow to realise fully their potential in improving health and tackling inequalities.** For example, the Single Assessment Process (SAP) for older people, intended to develop coherent care pathways, was not widely used to promote and improve health. However, participants noted that over recent years councils’ willingness to work with PCTs on health improvement initiatives had grown, driven by the Healthy Communities element of CPA.

**Putting the evidence of ‘what works’ into practice**

- **Changes in national organisations had far reaching impacts.** The dissolution of the Health Development Agency and the integration of some of its public health functions into the National Institute for Health and Clinical Excellence (NICE) increased the profile of public health evidence, presenting thorough analysis of ‘what works’ in health improvement. However, a gap remained – there was no longer a body dedicated to support local implementation and develop practice.

**Resources, capability and capacity**

- **Ring-fenced and short-term funding for initiatives brought both advantages and disadvantages.** For some, ring-fencing funding and grants were essential, bringing confidence that resources were available and secure. However, separation from mainstream budgets meant that the work was not always seen as central to delivery, making wider system change difficult. There were concerns that, once ring-fencing for specific issues came to an end, local agencies did not have enough money to resource activities, or were unwilling to provide mainstream funding.
The Quality and Outcomes Framework (QOF), which determines pay for GPs, did not sufficiently address issues of inequality of service use. Financial incentives for GPs would increase performance in primary care in relation to health improvement activities.

Reorganisations in the NHS inhibited equality of service use. The establishment of PCTs incentivises for GPs would increase performance in primary care in relation to health improvement activities. Greater alignment with local councils.

There was a need to develop the skills of health improvement colleagues to work across sectors and organisations. High levels of political literacy were required to work effectively with organisations with differing cultures. Technical public health skills were crucial and needed to be complemented by skills in bringing about change in complex systems.

Commissioning for local need

Local target setting was welcomed but participants feared it could threaten the sustainability of important areas of work. Losing national ‘must do’s’ and the move to non-mandatory indicators from the local authority national indicator set, meant that important activities might cease. Concerns were raised about issues that might be considered too politically sensitive for a local response (such as services for asylum seekers), or where the needs of smaller populations might be overlooked and regional responses might be in order (such as services for homeless people).

Joint strategic needs assessments (JSNAs) will be crucial in securing the importance of local health improvement programmes and services. They will have the potential to keep health improvement on the radar of directors of finance and local strategic partnerships.

Clear accountabilities for commissioning and delivery

Reorganisations in the NHS inhibited progress. The establishment of PCTs brought health improvement activity closer to local people and resulted in greater alignment with local councils. However, it also resulted in the loss of joint activities previously developed with other agencies. In addition, structural reorganisations in the NHS resulted in the dilution of professional expertise.

There was potential for overview and scrutiny committees (OSCs) to drive improvements in local delivery. In some places where health improvement activities were under-funded, OSCs had maintained a critical focus. However, successful relationships relied on health improvement staff taking time to explain local need and describe effective approaches to improving health and tackling inequalities. This often included development programmes for elected members to understand the role that local councils and healthcare organisations could play in improving health and reducing inequalities.

Public sector regulation stimulated improvements. For example, the establishment of the Healthcare Commission meant that NHS performance in relation to health improvement was assessed for the first time, helping directors of public health keep health improvement issues on the agenda. The development of the healthy communities strand in corporate assessments of local councils as part of the CPA also helped.
In conclusion

National policy between 1997 and 2007 has seen a continued and consistent emphasis on health improvement, with increasing focus on tackling health inequalities. However, implementation has been inconsistent in its reach and the progress secured, as suggested by the leading experts in our fieldwork.

NHS system reforms have aimed for informed choice by individuals and communities and greater responsibility in improving their health. This has been matched by arrangements such as local strategic partnerships, which sought to bring together health and local government to ensure that planning addressed wider determinants of health.

As responsibility is increasingly devolved, local determination will become more significant in setting priorities and ensuring appropriate service delivery. We have yet to see whether these changes will cement successes in health improvement, or whether they will slow progress. The future direction of greater devolution and local decision-making will bring new challenges for regulators, not least the Comprehensive Area Assessment process, discussed in Chapter 4.
Chapter 4
Assessing the delivery of health improvement programmes and services
Chapter 4
Assessing the delivery of health improvement programmes and services

In this chapter, we look at how well local councils and healthcare organisations have delivered programmes and services to improve health and tackle inequalities in health. We examine information and data about performance in NHS healthcare organisations and local councils, as well as wider trends in specific health improvement areas such as delivery models for tobacco control, teenage pregnancy, obesity and alcohol. Service reviews and national reports undertaken by the Healthcare Commission and the Audit Commission have also contributed to the analysis (see box 8).

The assessment, inspection and audit regimes undertaken by the Healthcare Commission and the Audit Commission aim to encourage improvements in service delivery, and to provide a source of information to assess performance and progress at local and national levels.

The Healthcare Commission undertakes the annual health check, which assesses and rates NHS performance in relation to the standards in Standards for Better Health and national targets. It also carries out reviews on specific public health topics.

The Audit Commission assesses the overall performance of local councils and the services they provide through Comprehensive Performance Assessment (CPA). The assessment is made up of a number of judgements: a corporate assessment of how well the council engages with and leads its community, in partnership with others; a scored judgement on how each body is managing and

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**Box 8: Recent reviews and reports on health services and health improvement**

**Healthcare Commission**
- Clearing the air: A national study of chronic obstructive pulmonary disease, 2006
- No ifs, no buts: Improving services for tobacco control, 2007
- Improving services for children in hospital, 2007
- Managing diabetes: Improving services for people with diabetes, 2007
- Performing better: A focus on sexual health services in England, 2007
- Pushing the boundaries: Improving services for people with heart failure, 2007

**Audit Commission**
- Improving health and well-being, 2007

**National Audit Office, Healthcare Commission, Audit Commission**
- Tackling Child Obesity – First Steps, 2006

**Healthcare Commission, Audit Commission, Commission for Social Care Inspection**
- Living well in later life: A review of progress against the National Service Framework for Older People, 2006

**Audit Commission, Healthcare Commission**
- Better safe than sorry: Preventing unintentional injury to children, 2007
using its resources; the Best Value Performance Indicators (BVPA); and assessments from other inspectorates. The Auditors Local Evaluation (ALE) assesses how well NHS trusts and PCTs manage and use their financial resources. It forms the ‘use of resources’ part of the rating for non-foundation trust organisations in the Healthcare Commission’s annual health check.

Understanding local delivery
Assessing delivery of Choosing health and health improvement programmes is complex. There are variations in the quality and comprehensiveness of available data, due to problems of local and national data collection and the overall difficulty of measuring the delivery of health improvement. It is difficult to assess the impact of a particular intervention, as there are multiple factors that affect health. For example, it is hard to separate the impact on reducing new cases of lung cancer of interventions such as stop smoking services, national and local awareness campaigns, and the ban on smoking in public places.

There are also challenges in establishing consistent and accurate data collection systems, including the IT infrastructure required to support collection. The Healthcare Commission’s reviews of tobacco control and sexual health, our joint review of unintentional injury and our joint review with the National Audit Office of child obesity all highlighted the lack of consistent and specific data as a block to progress.

For example, in tobacco control there were inconsistencies in the way trusts collected and used data, as well as differing motives for, and methods of, collection. The review also found a lack of consistency in the collection of data on the quit rate by ethnic group and age. There were examples of trusts interpreting guidance on data definitions differently and hence reporting non-comparable figures.

Analysis of sexual health data is difficult, owing to the time lag in availability of data on teenage conceptions, combined with a lack of locally available data due to confidentiality because of the small numbers of cases, and a lack of data on ethnicity and areas of residence.

Partnership working between local bodies, especially PCTs and councils, is essential for the effective delivery of programmes addressing the range of factors that determine poor health. Performance ratings for individual organisations can only provide part of the picture. Obtaining an overall assessment of all organisations working locally is problematic because of the differing functions, aims and geographical boundaries of agencies (although PCT and local council boundaries are now more closely aligned following PCT reconfiguration).

In addition, regulators have used differing methodologies and timeframes for their assessments, making comparisons difficult. The development of Comprehensive Area Assessment, as discussed later in this chapter, is welcomed and should go some way to addressing these issues, although it should be recognised that different regulators rightly have different regimes to meet the relevant regulatory legislation.

Performance ratings for health services and local government

Health services
Assessments of NHS organisations by the Healthcare Commission are based on the standards in Standards for Better Health and indicators derived from national targets.

Since 2003, ratings have shown a steady overall improvement in the performance of the NHS as a whole. The proportion of all NHS trusts (including PCTs) that were rated excellent for their quality of services increased from 4% in 2005/2006 to 16% in 2006/2007. However, the proportion of PCTs that were rated excellent or good for quality of services was lower than for all other trust types (from a total of 152 PCTs, only two achieved a rating of excellent and 38 were rated good; almost three quarters of PCTs were rated fair or weak). This may be due to the organisational changes that were happening in PCTs.

Over the same period, the proportion of trusts with a rating of excellent for use of resources increased from 3% to 14%. PCTs’ performance for use of resources mirrored the overall picture of improvement, with 19% of PCTs achieving a rating of excellent or good in 2006/2007, compared with 8% in 2005/2006.

**Measuring health improvement**

The core standards relating to public health, against which all healthcare organisations assess themselves, are:

- **Core standard C22**: Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:
  a) Cooperating with each other and with local authorities and other organisations.
  b) Ensuring that the local director of public health’s annual report informs their policies and practices.
  c) Making an appropriate and effective contribution to local partnership arrangements, including local strategic partnerships and crime and disorder reduction partnerships.

- **Core standard C23**: Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks and national plans, with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.

- **Core standard C24**: Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.

For provider trusts, C23 includes collecting, analysing and sharing data, health improvement interventions and provision of advice along the patient care pathway and with regard to the health of staff. For PCTs, C23

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* The use of resources score is based on financial audit information provided by the Audit Commission’s Auditors Local Evaluation (ALE). ALE does not directly assess an organisation’s programme of public health delivery.
includes assessing the health needs of the population, commissioning in relation to needs assessment, evidence of effective interventions and responsibility for staff health programmes.

Because of PCTs’ central role in improving the health of their local population, they are assessed in more detail than provider trusts on the public health core standards. In future years, there will be an increased focus on commissioning for PCTs, with public health as a fundamental component of the commissioning process. Although provider trusts focus on the individual rather than the combined health of their population, they have a crucial role in offering health improvement and promotion measures to their patients, staff and, through partnership working, to their local population. The Healthcare Commission is increasingly focusing on health promotion and improvement measures that provider trusts are able to implement along the patient pathway and with their workforce.

In April 2008, 94% of all healthcare organisations declared themselves as compliant with all of the public health core standards that applied to them for 2007/2008*, compared to 91% in 2006/2007. Table 2 shows the percentage of healthcare organisations in 2006/2007 declaring that they did not meet or could not provide sufficient proof of meeting the public health core standards.

To further probe levels of PCTs’ health improvement delivery, for one year – 2006/2007 – the Healthcare Commission assessed performance in relation to the developmental standards within Standards for Better Health. The assessment focused on PCTs’ progress in three areas: how well they know their population in terms of demographic and health profiles; how

<table>
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<tr>
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<tbody>
<tr>
<td>C22a/c</td>
<td>1%</td>
<td>2%</td>
<td>0.3%</td>
</tr>
<tr>
<td>C22b</td>
<td>5%</td>
<td>3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>C23†</td>
<td>7%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>C24</td>
<td>6%</td>
<td>5%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: Healthcare Commission†

* In 2006/2007, all trusts declared in relation to C22b. In 2007/2008, this requirement was removed for all but PCTs.
† Following the programme of visits undertaken by the Healthcare Commission after these declarations, the proportion of trusts deemed “non-compliant” or “insufficient assurance” for C23 increased by 1% in 2005/2006 and 2006/2007.
effectively they commissioned health services for their population; and the effectiveness of their programmes for health improvement and the reduction of health inequalities.

One hundred and forty-three PCTs were eligible to declare with regard to the public health developmental standard, with a further nine considered ineligible because they were not compliant with public health core standards – a total of 152 PCTs. As table 3 shows, a third (33%) declared a “good” or “excellent” level of progress. The largest group (55%) declared “fair” progress in relation to the standard.

This demonstrated the scope for developing methodology for measuring improvement.

<table>
<thead>
<tr>
<th>Number of PCTs</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Limited</th>
<th>Ineligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 (3%)</td>
<td>45 (30%)</td>
<td>83 (55%)</td>
<td>11 (7%)</td>
<td>9 (6%)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Healthcare Commission

![Figure 8: Performance of PCTs in England in relation to key public health targets, 2006/2007](chart)

Source: Healthcare Commission, 2007. See also appendix C.
above a ‘core standard’ level and the range of performance levels to be found within PCTs. Learning from this exercise will be used to inform how the new health and social care regulator will assess commissioning.

**Performance of PCTs in England in relation to key public health targets**

There were eight public health targets in the 2006/2007 annual health check that related most closely to areas highlighted by *Choosing health*: mental health, measurement of body mass index (BMI) by GPs, suicide prevention, smoking, older people, health inequalities, sexual health and long-term conditions. The detailed targets and indicators are set out in appendix C. Performance against these targets varied considerably across PCTs:

- 31% achieved five targets or more
- 42% achieved three or four targets
- 27% achieved two targets or fewer.

PCTs performed best for work on health inequalities and recording BMI by GPs (80% and 63% achievement respectively, see figure 8). In contrast, they performed poorly in achieving the targets for long-term conditions, older people and smoking.

Performance was generally better in spearhead areas (those in the lowest fifth of areas for health and deprivation indicators), with 36% achieving five or more of the eight public health targets, compared with 28% of non-spearhead PCTs. Figure 9 shows that some non-spearhead PCTs achieved no targets, while some spearhead PCTs achieved all eight targets.

Overall, the performance of PCTs in 2006/2007 with regard to most of the public health targets shown in figure 8 was worse than in 2005/2006. Table 4 shows the performance in three of the targets.

The difference in performance between 2005/2006 and 2006/2007 may partly reflect the incremental increase in target thresholds over this period. For some targets, performance in 2006/2007 would have been expected to exceed progress achieved in earlier years. For example, PCTs were expected to have achieved around a 20% reduction in their under-18 conception rate for the 2006/2007 annual health check, compared with an expected reduction of 15% for the 2005/2006 scores.

Organisational change resulting from the reconfiguration of PCT boundaries in 2006 also appears to have affected PCTs’ performance. The impact of organisational change was

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* The 2007/2008 performance in relation to key public health targets will be published in October 2008.
Table 4: Performance with regard to selected public health targets

<table>
<thead>
<tr>
<th></th>
<th>2005/2006 % achieved</th>
<th>2006/2007 % achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI recording</td>
<td>71%</td>
<td>63%</td>
</tr>
<tr>
<td>Sexual health</td>
<td>58%</td>
<td>51%</td>
</tr>
<tr>
<td>Smoking</td>
<td>58%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Source: Healthcare Commission

reflected in the annual health check’s overall quality of service score for PCTs, which gave a rating of “fair” or “weak” to the large majority of PCTs that were reorganised in 2006, compared with only a third of PCTs not experiencing organisational change.

Nevertheless, the difference over 2005/2006 and 2006/2007 in the performance of PCTs against the eight targets most closely related to Choosing health priorities does highlight the challenge many PCTs face in meeting their health improvement targets.

Performance in spearhead areas

There is evidence that current spearhead areas, many of which also benefited in the past from health action zone status and/or neighbourhood renewal funding, perform better with regard to health improvement than non-spearhead areas. Using Healthcare Commission data that assesses performance in relation to 11 key targets, spearhead PCTs are shown to have performed markedly better in eight of these areas and in only one area – sexual health – was performance weaker.

Table 5 shows the absolute and percentage differences in performance between the two groups. Using long-term conditions (which has the largest percentage difference) as an example, the table shows that if there were 100 spearhead and 100 non-spearhead PCTs, 15 more spearhead PCTs would achieve the target. Expressed as a proportion, 88% more spearheads achieved the target than non-spearheads.

Assessment of performance with regard to targets takes into account several indicators. More notable differences in performance can be seen by looking at the numbers of trusts to fall in each scoring category at this more detailed indicator level.*

For example, spearhead trusts performed better than non-spearhead trusts with regard to suicide prevention overall (a challenging target, which only 48% of spearhead PCTs and 29% of non-spearhead PCTs achieved). This target is made up of two indicators – the care programme approach seven-day follow-up and commissioning of early intervention in psychosis services. A higher proportion of spearhead PCTs achieved both of these indicators. The differential in performance in relation to early intervention is considerable: 68% of spearhead PCTs achieved the highest level of the indicator for early intervention, while only 40% of non-spearhead PCTs achieved this level. Forty-six per cent of non-spearheads failed this indicator altogether, while only 13% of spearhead PCTs failed.

Screening Plus

During 2007/2008, we developed a new approach to screening core standards for PCTs. ‘Screening Plus’ is a report produced for each trust three times a year, detailing the data that

* Trusts score “achieved”, “underachieved” or “failed” based on their performance in relation to each target.
the Healthcare Commission has at that point for each of the core standards. We identified three topics within C23 that cover a range of PCTs’ public health activities: basic public health, cardiovascular disease and sexual health. A group of 10 PCTs whose performance across the three topics was significantly poorer than expected were highlighted to our assessors for follow-up engagement. Of these 10, three went on to declare some form of non-compliance for 2007/2008 in their assessment declaration. All had declared full-year compliance with C23 in 2006/2007.

**Local councils**

Comprehensive Performance Assessment (CPA) measures how well councils are delivering services for local people and communities. It looks at performance from a

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<table>
<thead>
<tr>
<th>Target</th>
<th>% of PCTs achieving target</th>
<th>% difference in performance*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spearhead</td>
<td>Non-spearhead</td>
</tr>
<tr>
<td>Long-term conditions</td>
<td>32</td>
<td>17</td>
</tr>
<tr>
<td>Suicide prevention</td>
<td>48</td>
<td>29</td>
</tr>
<tr>
<td>Mortality</td>
<td>52</td>
<td>34</td>
</tr>
<tr>
<td>Older people</td>
<td>37</td>
<td>26</td>
</tr>
<tr>
<td>Drug misuse</td>
<td>68</td>
<td>52</td>
</tr>
<tr>
<td>Mental health</td>
<td>52</td>
<td>41</td>
</tr>
<tr>
<td>Smoking</td>
<td>34</td>
<td>29</td>
</tr>
<tr>
<td>Health inequalities</td>
<td>87</td>
<td>76</td>
</tr>
<tr>
<td>Cancer</td>
<td>84</td>
<td>80</td>
</tr>
<tr>
<td>GP BMI</td>
<td>61</td>
<td>64</td>
</tr>
<tr>
<td>Sexual health</td>
<td>44</td>
<td>57</td>
</tr>
</tbody>
</table>

* Negative values indicate a weaker performance in the spearhead PCTs.
range of perspectives and combines a set of judgements to provide both simply understood scores and a more complex picture of where to focus activity to secure improvement. The Audit Commission has developed tailored frameworks for CPA for single tier and county councils, district councils, and fire and rescue authorities. The frameworks have four common components: corporate assessment, use of resources assessment, service assessment and assessment of direction of travel.

Corporate assessment measures how effectively the council engages with and leads its communities, delivers community priorities in partnership with others and ensures continuous improvement across a range of council activities. Key lines of enquiry (KLOE) provide a framework which covers how well councils understand their local communities and neighbourhoods and provide community leadership; how this understanding of local people and places translates into councils’ ambitions and priorities; their capacity to deliver these; and what, in practice, councils are achieving.

While CPA has a specific section on Healthier Communities (included in corporate assessments), this covers a wide range of initiatives, of which public health is a subset that is not individually rated. Instead, it is assessed along with four other sub-themes – sustainable communities and transport, safer and stronger communities, older people, and children and young people. Achievement examines how well councils are delivering local priorities and outcomes across the sub-themes, reflecting agreed shared priorities.

Since 2005, corporate assessments have been undertaken at the same time as a joint area review (JAR) of children’s services as part of a three-year programme (2005 to 2008) of assessments led by Ofsted. The annual performance assessment and JAR process provides a comprehensive report on the outcomes for children and young people, in line with the aims of the Every Child Matters agenda, in each local area.

**Performance of councils in England in relation to health improvement**

In the most recent CPA, covering 2006/2007, the picture that emerges is mixed, with some councils making greater progress in tackling health inequalities than others.

Many councils, including some of those who have yet to involve other agencies in partnership in their Healthier Community Strategy (HCS), were clear about their role in relation to the health agenda, focusing on prevention and promotion and with an emphasis on tackling inequalities. However, in some places, basic health inequalities, including infant mortality rates, were getting worse. Nevertheless, there is evidence that a growing number of councils are choosing to target their services at the most deprived areas and at groups most at risk.

The local councils that were improving the most had plans that took account of national priorities such as smoking and obesity, as well as focusing on local issues. There was evidence that they targeted activity for children and young people – focusing on exercise, healthy eating, sexual health and enhanced support to parents with children under five years of age. However, infant mortality and low birth weight also remained priority issues in many areas. These improving councils also addressed wider health improvement issues such as employment and access to suitable housing.
Initiatives that transcend the traditional health agenda were rare, but some councils included health objectives within plans for regeneration, housing and tackling crime. Some local councils were also developing initiatives to make the connection between health and community involvement, for example, by training local people to run sports and local exercise classes in their community to positive effect.

There has been some improvement in the reporting of performance in health. Some local councils used a simple traffic light system to record their progress and some had set up processes of robust internal challenge, such as high level strategic partnership boards which sought to improve health and tackle inequalities, and reports to elected members. However, evidence is not yet available to conclude whether overview and scrutiny committees are making a significant difference in securing improved outcomes in health.

Working across administrative boundaries or in partnership is key to achieving improvements in health. Although some local councils had a robust, overarching approach to improving health, there was little evidence of councils demonstrating widespread innovative partnership initiatives. Councils who were best placed to achieve their ambitions were those focusing on a limited number of priorities, agreed jointly with the PCT. In a number of examples, the development of shared facilities enabled health staff and council staff to work collaboratively to achieve common goals and ambitions by delivering coordinated and integrated services.

Health improvement snapshots

The following section looks at four important health improvement areas – stop smoking services, teenage pregnancy, obesity and alcohol. It considers performance to date in relation to the target (where this exists) and the cost of the programme (where this is possible to identify). The section also considers the model for delivery that has been undertaken in each area.

As part of our research for this report, we reviewed a range of models of delivery of health improvement programmes, including the components identified by the Health Development Agency (HDA) for successful health improvement programmes (HimPs); approaches identified by NICE for behaviour change programmes at population, community and local level; and Government reports, including the Foresight report on obesity.

Also, as previously mentioned, the Healthcare Commission and the Audit Commission undertake reviews to deepen understanding of delivery on a wide range of health areas.

From these reviews, we have identified the main components of an effective approach to the delivery of better outcomes in programmes to improve health and tackle health improvement. The snapshots look at the delivery models in relation to these elements:

• **Clear, consistent, ambitious and measurable objectives**: stretching goals that are clearly set out and capable of being measured.

• **Relevant, reliable and up-to-date information**: nationally available and standardised data and information systems in place to prioritise programmes and measure progress.
• **Consistent focus across the NHS and Government:** consistent working across national Government, with policies that complement each other, associated targets and incentives, and joined-up working at a local level.

• **Putting the evidence of ‘what works’ into practice:** effective – and cost effective – methods used by service providers, including through support for commissioners and providers to deliver effectively.

• **Resources, capability and capacity:** adequate financial resources and appropriately skilled staff are available to deliver programmes.

• **Commissioning for local need:** commissioning effective and efficient services that are based on local need.

• **Clear accountabilities for commissioning and delivery:** performance management together with inspection, performance assessment and audit can be important levers to drive improvement and ensure delivery.
Policy into practice snapshot 1:
Tobacco control

Introduction
Smoking is the UK’s single greatest cause of preventable illness and early death from a wide range of illnesses, including cancer, respiratory disease and heart disease.100 People from lower socioeconomic groups are more likely to smoke than others. In 2005, around 81,900 deaths in England (17% of all deaths of adults aged 35 and over) were estimated to be caused by smoking, with a larger proportion of men (23%) than women (13%) dying from smoking-related diseases.

Twenty-four per cent of adults in England were smokers (25% of men and 22% of women)101, a decrease from 1974 when 45% of adults smoked (51% of men and 41% of women).102 The proportion of those in manual groups who smoked went down from 33% in 1998 to 29% in 2005.

Performance
Although the national target for 800,000 four-week quitters* was exceeded by March 2006†, there has been significant variation across PCTs in recent years, with performance ranging from under 50% achievement of planned quitters to over 200% in 2005/2006, and from under 40% to over 300% in 2006/2007.

The available data suggests that services to help people stop smoking are more effective in the most disadvantaged PCTs, where smoking rates are highest, and where people can find it more difficult to stop smoking. In 2005/2006, the planned quit targets set by PCTs and the actual four-week quit rates achieved, were higher in PCTs where there were higher estimated levels of smoking. In addition, PCTs in more deprived areas accounted for a higher proportion of successful quitters in 2005/2006: 26% of all successful quitters living in the most deprived 20% of PCT catchment areas, compared with 16% of all quitters in the least deprived 20%, a positive development in relation to health inequalities.

The evidence that services in disadvantaged areas are attracting more smokers is supported by the Healthcare Commission’s 2005/2006 tobacco control improvement review No ifs, no buts, which gave 11% of PCTs a score of “fair”, 56% a score of “good” and 33% a score of “excellent”. No PCTs were given a score of “weak”, showing that all trusts were getting the basics right. PCTs in deprived areas and spearhead PCTs performed better than the national average. Several evaluations of smoking treatment services and a study of stop smoking services in the North East have also concluded that these services were targeting more deprived areas.103

Costs
Treatment of diseases caused by smoking costs the NHS approximately £1.5 billion a year. This includes the costs of hospital admissions, GP consultations and prescriptions. The Government also pays for sickness and invalidity benefits, widows’ pensions and other social security benefits for dependants.

An analysis of the cost benefits of achieving Government targets to reduce smoking has shown that £524 million could be saved as a

* A four-week quitter is a user of NHS stop smoking services who has set a quit date and is still not smoking four weeks after this date.
† A target was set in the Priorities and Planning Framework (2003-2006) for the NHS to achieve 800,000 smokers from all groups successfully quitting at the four-week stage by 2006. At the end of the three-year period, almost 833,000 four-week quitters were recorded.
result of the subsequent reduction in the number of heart attacks and strokes.

NHS stop smoking services (formerly smoking cessation services) were launched in health action zones in 1999/2000 and rolled out to other areas in 2000/2001. Approximately £51 million was spent on stop smoking services in 2006/2007, at a cost of about £4 per smoker or £160 per quitter (22% lower than the cost per quitter in 2001/2002). Funding for these services was weighted towards spearhead PCTs and a specific target set to achieve 800,000 four-week quitters over the period 2003 to 2006.

An indicator for four-week smoking quitters has been measured by the Department of Health since 2001/2001 and has been included in the Healthcare Commission’s performance scores since 2003/2004. This was measured by comparing the number of planned quitters, as set out in a PCT’s local delivery plan, against the actual number of quitters. Fifty three per cent of people setting a quit date with NHS stop smoking services successfully quit over the 2006/2007 period.

**Commentary**

Work on tobacco control has involved a number of the components that contribute to successful programmes. The national tobacco control strategy, *Smoking Kills* (1999), set out the case for having a national campaign to reduce smoking. Clear targets were established, with ring-fenced funding allocated, initially through health action zones and then rolled out across the country. Responsibility for implementation was taken up by numerous national organisations, such as the royal colleges, the Health and Safety Executive and the Chartered Institute of Environmental Health, as well as the local health improvement community within PCTs.

Local smoking cessation coordinators were appointed to expand services and improve performance in relation to four-week quitters, monitored by strategic health authorities. In some areas, tobacco control officers are being employed with a wider remit than smoking cessation, and overview and scrutiny committees are beginning to take a keen interest. In addition, the ban on smoking in public places was a bold and significant step in the long-term campaign to reduce smoking and improve health.

Overall, the Government’s approaches to controlling tobacco and reducing smoking have been successful, but it is important that the pressure is not reduced. Although it is encouraging that NHS stop smoking services are targeting those areas with higher need, the deterioration in performance seen in 2006/2007 suggests that the target as well as funding and infrastructure was important to delivery. It is crucial that funding for effective programmes and services continues to build on the success to date, and ensure that those people who find it hardest to quit are adequately supported.
Policy into practice snapshot 2: Teenage pregnancy

**Introduction**
Teenage parenthood is associated with poorer health and economic outcomes for both teenage parents and their children. Rates of teenage pregnancy are far higher among deprived communities, which means that the negative consequences of teenage pregnancy are disproportionately concentrated among those who are already disadvantaged.

The *Teenage Pregnancy Strategy* aims to halve England’s under-18 conception rate by 2010, from the 1998 baseline, through a coordinated strategy to address the causes and consequences of teenage pregnancy. The national strategy is underpinned by local targets, shared between local councils and PCTs, ranging between a 40% and 60% reduction in under-18 conceptions by 2010.

**Performance**
An assessment of progress towards these local targets has formed part of PCT performance scores since 2003. Before 1998, there was no consistent pattern in teenage conception rates. Between 1998 and 2006, England’s under-18 conception rate fell from 46.6 per 1,000 females aged 15 to 17 to 40.4 per 1,000 – the lowest in over 20 years and an overall reduction of 13.3% since 1998 (see figure 11). The average rate for the most disadvantaged areas also fell. Although this reduction is encouraging, progress needs to accelerate rapidly if the 2010 target is to be achieved (figure 12). Also, as recent statistics show, abortion rates for this age group remain too high.

Between 1998 and 2006, more than four in five local authorities (89%) had experienced an overall reduction in their under-18 conception rate. Progress towards local targets varied markedly, with some areas experiencing rate increases of over 15% and others reductions of over 30%. Eleven per cent of areas show increases over that period.

Results from the 2006/2007 annual health check showed that 51% of PCTs were assessed as being on track to reach their local 2010 reduction target. The remaining 49% were either significantly off-course, or showing an overall increase in their under-18 conception rate since 1998. In terms of reducing inequalities between areas, the greatest absolute reductions in under-18 conception rates have been in the most deprived 20% of local councils, where rates have fallen on average by 7.5 per 1,000 from 1998 to 2006, compared with the average of 3.8 per 1,000 in the least deprived councils.

**Costs**
Funding for teenage pregnancy services is approximately £28 million a year and is delivered via local councils and PCTs. The Local Implementation Grant was allocated on a formula taking into account both rates and numbers of conceptions. A report published by the former Department for Education and

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**Figure 11: England’s under-18 conception rate, 1974-2006**

Source: Teenage Pregnancy Unit, 2008
Skills in 2006 gave an evaluation of the first four years of the teenage pregnancy strategy, showing that the rate of decline in teenage pregnancy was steeper in areas that received more funding. This report was based on 2003 data. Data for 2005 also indicate that there are examples of high performance in the areas with high rates of teenage conceptions that received higher levels of funding. However, this is not universal, suggesting that funding is not the only factor in success.

**Commentary**

Teenage conception rates in England are among the worst in Western Europe. Teenage pregnancy is a complex social issue and one that can be met with local resistance and argument as to whether it is an appropriate issue for local councils and healthcare organisations to tackle. Ethnicity, local culture, educational achievement, deprivation and class all combine with sexuality in young people to make this a difficult issue to address. Results for the 2006/2007 annual health check show that just 44% of spearhead PCTs, which have the most challenging 2010 reduction targets, were on track to meet their 2010 target, compared with 57% of non-spearhead PCTs.

Nevertheless, after eight years of the Teenage Pregnancy Strategy, conception rates in England are lower than they have been for over 20 years, when – before the strategy – rates were increasing.

The national programme has deployed a range of approaches to tackle this issue, including: ongoing PSA targets and locally-set targets for each area; collection and use of data down to ward level to develop targeted programmes; development of an evidence base of what works; staffing and infrastructure at national, regional and local level; ring-fenced resources; and clear accountability to both PCTs and local councils for delivery, with local areas called to account by national Government. In-depth research informed the initial programme of work, and ongoing, pragmatic research has identified what works. There has been considerable joined-up working, with partnership boards and teenage pregnancy coordinators often reporting to both health and local government. The Department of Health’s National Support Team for Teenage Pregnancy provides specific and tailored support for those areas facing the greatest challenge in reaching their teenage pregnancy reduction target.

While it is difficult to conclusively attribute the change to any single factor, this model of delivery appears to have been central to a steady downward trend in teenage conception rates – a complex social issue. It will be important to continue to build on the success of this programme to ensure that progress is maintained across all local areas, with the greatest reductions in the most deprived areas with high under-18 conception rates.
Introduction
Obesity has been highlighted by the Department of Health’s Choosing health, a range of national reports – including our joint review with the National Audit Office, Tackling Child Obesity: First Steps – and the media as the most important health issue facing Britain today. Obesity is related to a number of conditions, including coronary heart disease, stroke and diabetes.

One in four adults is now obese – the highest prevalence in Western Europe. In 2006, 38% of adults were overweight and 24% were obese. A greater proportion of men than women were overweight (43% compared with 32%), but there was no significant difference between the proportion of men and women who were obese. Although the prevalence of morbid obesity remains relatively low, women were more likely to be morbidly obese than men (3% for women and 1% for men).

Childhood obesity is also increasing sharply. In 2006, 16% of children aged two to 15 were classed as obese, an increase from 11% in 1995. Despite this increase, the proportion of girls who were obese decreased between 2005 and 2006, from 18% to 15%. There was no significant decrease among boys over that period. The Foresight report predicts that on current trends, by 2050, 60% of men, 50% of women and 26% of children and young people will be obese. Incidence of type 2 diabetes is set to rise by 70%; stroke by 30%; and coronary heart disease by 20% as a result of obesity. Obesity-related disease will cost the nation an extra £50 billion a year.

There is some evidence that eating habits are beginning to change. The 2006 DEFRA Family Food Survey (February 2008) shows that the population in England now eats more fruit and vegetables. This is important for the health of the whole population, but the data also shows that the greatest increase has been among deprived communities. Between April 2003 and December 2006, the amount of fresh and processed fruit bought has risen by 10%, including an increase of 14% in fruit juices. The amount of vegetables bought (other than potatoes) has risen by 5.8%.

Performance
Measuring progress at a local level towards the Government target – to reduce the proportion of overweight and obese children to 2000 levels by 2020 – has proved challenging due to lack of accurate and complete data collection. The National Child Measurement Programme (NCMP) measures the height and weight of primary school children in reception year (aged four to five) and year 6 (aged 10 to 11). Data was first collected in 2005/2006, but with only 48% of all eligible pupils measured, concerns over data quality and completeness seriously limited the reliability of results.

Although an improved rate of around 80% was achieved in 2006/2007, there are pockets where data quality is very poor, particularly for year 6. Analysis from the NCMP shows that

![Figure 13: Obesity in adults, by gender, 1993-2006](image-url)

Data from 2003 are weighted

Source: The Information Centre
the prevalence of obese and overweight children in year 6 may be slightly underestimated (with children opting out of the measurement programme somewhat more likely to be those with higher body mass indices), but that results for children in reception are likely to be more robust. This variability in year 6 reporting may make assessing performance over time problematic.

Programme costs
As the Foresight report highlights, increasing rates of diabetes, strokes and heart disease – caused by rises in the number of those who are overweight and obese – are set to cost the NHS £10 billion a year by 2050.113 Wider costs to business and society are estimated to reach £50 billion a year (at today’s prices).114 A previous assessment of a £7 billion annual cost was noted by the House of Commons Health Select Committee in 2004.115

In addition to resources identified in Tackling Child Obesity: First Steps (2006) – including School Meals, the School Sports Strategy, and Big Lottery Funds supporting play – in 2007, further investment was committed by the Prime Minister and the Secretary of State for Health to contribute to the prevention of overweight children and obesity through education in schools. This includes £100 million to be spent on improving school food and providing cooking lessons within the national curriculum116 and a further £100 million to ensure that every child has access to five hours of sport a week.117

There have been numerous resourcing commitments from central Government in relation to childhood obesity, focusing on improving diet and increasing physical activity.


In addition, the Department of Health and DFES allocated £5.7 million annually (2002-2005), £9.3 million (2005-2006), £2.3 million (2006-2007), £13.2 million (2007-2008) and £16.2 million (2008-2009) for the Healthy Schools programme. This programme seeks to improve the health of children and young people across a range of physical and mental health areas, of which tackling obesity is a key element. Significant progress has been made with this programme and 61% of schools have achieved Healthy School status.

Commentary
Relatively few of the components of a coordinated, effective approach to the delivery of better outcomes have been in place in relation to obesity. The Health of the Nation118 – health policy under the Conservative Government – included a target for obesity.* A National Audit Office report in 1996 noted that this target was unlikely to be achieved.119

Following Choosing health, the publication of Choosing a Better Diet (2005) led to a range of programmes, including School Fruit and the ‘5 a Day’ campaign.

Choosing Activity, a physical activity action plan (2005) brought together the physical activity commitments from Choosing health across government, with detail on action at national, regional and local levels.

* To reduce the percentage of men and women aged 16 to 64 who are obese by at least 25% for men and at least 33% for women by 2005 (from 8% for men and 12% for women in 1986/1987 to no more than 6% and 8%, respectively).
regional and local levels. By April 2007, the majority of the commitments had been achieved, including the establishment of 49 County Sports Partnerships by Sport England and a Department for Communities and Local Government planning policy statement that town centres in planning should give priority to pedestrians and cyclists and improve the pedestrian environment. This represented the first cross-government plan to coordinate action aimed at increasing levels of physical activity across the whole population.

However, although a number of healthy eating and physical activity programmes have been in place through the period 1997 to 2007, childhood obesity was not included among PSA targets until 2004 (see chapter 3 for details). Tackling Child Obesity – First Steps (2006), which looked at the delivery chains to deliver the PSA target*, called for a number of elements to be in place to achieve the obesity target, including: a national strategy and action plan; improved working across Government; the need for good data to measure progress in programmes to reduce obesity; stronger performance management; support and capacity building for frontline staff; and involving and influencing parents and children.120

The Foresight report provided evidence of the magnitude of the obesity problem, which informed the national strategy Healthy Weight, Healthy Lives: A Cross-Government Strategy for England, published in 2008. This is designed to be the first step in a sustained programme to support people to maintain a healthy weight.

Future reports will analyse trends and evidence and make recommendations for further action. BMI collection by GPs is being dropped as an indicator, which has the potential to reduce the focus on obesity in adults in primary care, although indicators for prevalence in children under 10 will be available in 2008/2009.

* Delivery chains are the structures, processes and organisations from national to local level that must be in place to deliver programmes.
Policy into practice snapshot 4: Alcohol misuse

**Introduction**
Over 90% of the adult population in England drink alcohol. For the majority of people, alcohol consumption – in line with the sensible drinking guidelines – causes no problems. However, drinking above the sensible guideline limits is linked to more than 60 different medical conditions, increasing the risk of premature death.\(^{121, 122}\)

The negative impact of alcohol misuse can be seen throughout the population, affecting individuals, their family and friends, the wider community and the local economy and infrastructure. It is estimated that excessive drinking accounts for a substantial number of years lost through disability or death in England, surpassed only by tobacco and high blood pressure (to which alcohol can be a contributing factor).\(^{123}\)

Alcohol use is broken down into different categories as shown in box 9.

The relationship between alcohol misuse and related harm in different socioeconomic groups is complex and needs further exploration. Despite people from higher income households consuming more alcohol, people from lower socioeconomic groups are more vulnerable to the negative effects of alcohol (see figures 14 and 15). Health inequalities as a result of alcohol misuse are also evident in other vulnerable groups such as ex-prisoners, homeless people, children of alcohol users, young drinkers and those with multiple needs such as mental health problems and substance misuse issues.\(^{125}\)

A national strategy to tackle alcohol misuse and related harm was published in 2004.\(^{126}\)

<table>
<thead>
<tr>
<th>Box 9: Types of drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sensible drinking</strong> is drinking in a way that is unlikely to cause significant risk of harm to yourself or others.</td>
</tr>
<tr>
<td><strong>Harmful drinking</strong> is drinking at levels that lead to significant harm to physical and mental health and at levels that may be causing substantial harm to others. Examples include liver damage or cirrhosis, dependence on alcohol and substantial stress or aggression in the family.</td>
</tr>
<tr>
<td><strong>Binge drinking</strong> is essentially drinking too much alcohol over a short period of time, for example over the course of an evening, and it is typically drinking that leads to drunkenness. It has immediate and short-term risks to the drinker and to those around them.</td>
</tr>
</tbody>
</table>

Source: HM Government, *Safe, Sensible, Social. The next steps in the National Alcohol Strategy, 2007* \(^{124}\)

While the strategy set out a useful focus on health and crime as the main areas of alcohol-related harm, and proposed to reduce this harm through:

- Improved and better-targeted education and communication
- Better identification and treatment of alcohol problems
- Better coordination and enforcement of the current framework to tackle crime and antisocial behaviour
- Encouraging the alcohol drinks industry to promote more responsible drinking and take a role in reducing alcohol-related harms.
tackling alcohol misuse and related harm, it was not accompanied by national targets or dedicated funding. Therefore, improvement at a local level has been inconsistent across the country.

However, the review of this national strategy in 2007 – Safe. Sensible. Social – set a long-term goal: to minimise the harm to health, violence and antisocial behaviour associated with alcohol, while ensuring that people are able to enjoy alcohol safely and responsibly. It introduced a range of outcomes, including one to reduce alcohol-related hospital admissions. It also made it a requirement for all local crime and disorder reduction partnerships to have a local strategy in place by April 2008. The new alcohol and drugs PSA is jointly held by the Department of Health and the Home Office, and strengthens the cross-government focus on the harm to health caused by alcohol.

**Performance**

Following the strategy, a national needs assessment was carried out and found that alcohol-related service use varied considerably between different regions. Hazardous and harmful drinking varied from 18% in the Eastern region to 29% in the North West and alcohol dependency varied from 1.6% in the East Midlands to around 5% in the North East, Yorkshire and Humber, and London.127

It was also found that the identification of alcohol problems by GPs and onward referral to specialist services was low, and on average only 5.6% of people who would benefit from treatment were actually accessing specialist treatment services (again this figure varied by region).128

Data collection and monitoring for alcohol misuse and related harm at a local level are poor as there is no national requirement to do so. For example, there is little robust information on alcohol-related A&E attendances, ambulance calls, and crime and antisocial behaviour.

The Comprehensive Spending Review 2007 for the first time included a public service agreement (PSA 25) to “reduce the harm caused by alcohol and drugs”. All local councils will be monitored on locally decided indicators in their local area agreement, which may include alcohol-related indicators such as alcohol-harm related hospital admission rates and perceptions of drunk or rowdy behaviour as a problem.129

**Programme costs**

The impact of alcohol harm on the economy of England was estimated in 2004 at around £20 billion a year, with the cost to the health service at between £1.4 billion and £1.7 billion.
a year. However, this figure has recently been estimated by the National Social Marketing Centre to be £55.1 billion (2007), of which £43 billion is made up of the human cost (in terms of disability-adjusted life years) and the cost to individuals and families/households as a result of care costs and loss of income. At the same time, alcohol in the UK was 69% more affordable than in 1980.

PCTs are responsible for planning local health responses to alcohol-related harm, dependent on local need. £15 million was allocated to PCTs in England for specific alcohol interventions. The average amount spent on alcohol treatment by a PCT in 2006 was £273,495. However, this money is not ring-fenced and is therefore at risk of being allocated to other priority areas by commissioners. In addition, it is estimated that the annual spend on specialist treatment services in 2002/2003 was £217 million.

Alcohol treatment has been shown to be cost effective. A recent review calculated that for every £1 spent on treatment, savings of £5 are made elsewhere, for example in reduced alcohol-related ambulance calls, hospital admissions and treatment and social care for those with alcohol-related morbidity.

**Commentary**

Alcohol misuse and related harm remain a substantial problem in the UK. However, local authorities have a crucial role to play as licensers of services, and with the ability to act to prevent alcohol-related disorder and misuse – for example, the recent ban on alcohol consumption on public transport in London. Since 2004, there has been a national strategy, updated in 2007 by *Safe. Sensible. Social*. From 2008, all Crime and Disorder Reduction Partnerships (CDRPs), which include the police, local authorities, fire and rescue authorities and PCTs, will be legally required to have a strategy to tackle crime, disorder and substance misuse in their area. In more serious circumstances, the Violent Crime Reduction Act 2006 gives local authorities the power to designate, with the consent of the police, a locality as an alcohol disorder zone.

However, the other components we have identified as contributing to successful programmes are not yet in place. There was no PSA target until 2007. Alcohol is not included in the Quality Outcomes Framework for GPs and a lack of standardised data collection has made local performance management challenging, without clear local data on need. Uneven levels of investment have meant that service delivery at a local level is inconsistent across the country and dependent upon local capacity and commitment.

CDRP strategic assessments and the future duty of PCTs to share data, as well as joint strategic needs assessments locally, will help...
to improve data collection and monitoring around alcohol misuse and related harm. Following the publication of the national strategy\textsuperscript{136}, several key documents were produced including the Alcohol Needs Assessment Research Project \textit{Guidance on Developing a Local Programme of Improvement}\textsuperscript{137} and the \textit{Review of the Effectiveness of Treatment for Alcohol Problems}\textsuperscript{138} providing relevant information and guidance to improve practice at a local level.
Chapter 5
Conclusions
In this chapter, we summarise our conclusions about the impact policy has had on the delivery of improved public health. In doing this, we have used the themes relating to delivery models that we set out earlier. These components each contribute – either positively or negatively – to the success of programmes and services for improving people’s health and tackling inequalities in health. None of these elements, however, can improve health or reduce inequalities on their own.

Broadly, the Government is to be commended for setting an ambitious programme to improve health and tackle inequalities – often through joint responsibility across two or more Government departments. This approach – set early in the 10-year period – has continued to be a focus of national policy, covering a range of health improvement issues.

In line with our analysis of the components contributing to the success of programmes, we have found that a number of initiatives and services tackling health topics that have shown improvement over the 10-year period – such as tobacco control, access to genitourinary medicine services, and teenage conceptions – have taken account of these components. Other important health areas – including obesity, alcohol, unintentional injury, and mental health promotion – have not had consistent approaches in line with these components over the 10-year period.

Clear, consistent, ambitious and measurable objectives
Our study looked at a range of policy drivers put in place to improve health and tackle inequalities. One key focus of policy over the past 10 years has been targets. Our analysis shows that national targets, set by Government, have clearly driven progress when combined with a good model of delivery. It is difficult to assess whether progress would have been made in relation to specific health issues, if the targets had not been in place. However, prior to the setting of a target for a number of health topics, incidence was increasing or there was little evidence of improvement. For example, teenage conceptions have been an intractable social issue, one that was steadily increasing before the target was put in place. Now rates are at the lowest in more than 20 years. Before the introduction of the target for 48-hour access to genitourinary services, access was poor, with waits of five to six weeks not uncommon. This target has been achieved by the vast majority of PCTs.

The strong view of our roundtable experts was that targets were effective in driving action – despite some problems associated with them, such as the risk that they take focus and resources away from other important areas. In addition, our experts felt strongly that where there had been no targets – for example, contraceptive services and unintentional injury – there had been relatively little progress.

However, targets have been successful only as part of a model of delivery that includes a number of components. Areas that have shown greater progress – such as four-week stop smoking rates, teenage pregnancy, the 48-hour access target for genitourinary medicine clinics and establishing screening for chlamydia – have so far been characterised by: strong central targets; detailed guidance on actions required; investment in programmes and dedicated staff at national, regional and local level, including training and development; research on effectiveness; better data; and strong management of performance.

Other areas where prevalence has been
increasing – for example, obesity – did not have a target until 2004 or a strategy until 2008, although it is difficult to attribute a rise in the prevalence of obesity to a lack of a target, as increases in obesity are part of an international trend.

Over the period covered by our review, clear, consistent and measurable objectives have not always been in place to ensure that objectivity and public accountability were achieved. As the Government moves to a more devolved system of decision-making and delivery, it is not yet clear whether a balance will be reached between objectives determined nationally and those that are locally derived, with monitoring in place to show the impact of this system change.

Priority health improvement areas within *Choosing health*, such as alcohol misuse, did not receive full strategic focus and resources, and as a result delivery has been inconsistent. Contraceptive services did not benefit from the targets and support that other areas of sexual health received, although an allocation of £28.6 million new funding was made by the Department of Health in 2008. Other areas have seen renewed focus and attention. For example, unintentional injury in the home was not included in *Choosing health* (although it was a target in *Our Healthier Nation* in 1998) – a point highlighted in our joint report *Better safe than sorry*, published in early 2007. It now features in the children’s PSA, published in summer 2007, and in early 2008 the Department of Health asked NICE to provide guidance on this issue in relation to people under the age of 15.

Initiatives such as Health Action Zones, Healthy Living Centres, New Deal for Communities and Sure Start, which were implemented in the areas of the country of greatest need, seem to have stimulated new ways of working between partner agencies, from which good practice and learning was shared. Our analysis shows that spearhead areas performed significantly better than non-spearhead areas in relation to key public health targets.

Although there has been a consistent focus on targets for improving health and tackling inequalities in health throughout the 10-year period, there was not always clarity about the status of those targets, for example whether an earlier version of a similar target had been superseded, or whether targets that did not reappear in updated PSAs were still in effect.

**Relevant, reliable and up-to-date information**

Of critical importance has been the slow progress due to the lack of data that enables effectively targeted programmes and management of performance. This has been the case in a number of areas, particularly obesity, alcohol and sexual health. Ethnic monitoring and information about disability have not been consistent across the country.

Also, targeting pockets of deprivation is not always possible, as spearhead areas are large and do not allow identification of particular neighbourhoods in need of support. While PCTs and local councils are responsible for identifying and targeting these neighbourhoods – and there is often good data at ward level – there are few incentives to drive such an approach. It is often easier to work in neighbourhoods that have problems that are relatively simple to fix, than focus effort in the poorest neighbourhoods where progress is slow and improvements take much longer. In addition, the lack of IT in some service areas (such as sexual health) adds to difficulties in collating and analysing data.

There was a lack of financial information – particularly programme budgeting, which was noted as being potentially useful to
commissioners in understanding the spend on preventative programmes and services.

For healthcare organisations, Informing Healthier Choices: Information and Intelligence for Healthy Populations in 2007 set out the Department of Health’s vision for information and intelligence to support implementation of Choosing health. However, to have an impact information will need to be generated over a number of years.

**Consistent focus across the NHS and Government**

Despite a number of targets with joint responsibility across two or more Government departments, there were tensions in the policy-making process during the period, with policies that were not fully aligned. For example, the development of local economies through expansion of leisure opportunities, including bars, fast food outlets and restaurants, was sometimes at odds with efforts to reduce alcohol consumption and tackle obesity. The lack of full alignment across Department of Health and wider Government policy sometimes made systematic and coherent implementation difficult. Routine assessment of the impact on health and inequalities of all Government policies could help to alleviate these difficulties.

Local strategic partnerships have the potential – through planning based on joint strategic needs assessments – to make sure that local area agreements reflect local need. There is increased potential for both councils and healthcare organisations to play a coordinated role in improving health and tackling inequalities, through their roles as employers and commissioners and providers of services.

**Putting the evidence of ‘what works’ into practice**

There were disparities in how readily evidence and advice about delivering effective services were available and taken up across the country. The role of the National Institute for Health and Clinical Excellence (NICE) – appraising, synthesising and making available information about what works in improving health and tackling inequalities – was a significant development.

However, while NICE produces guidance on effectiveness and the Department of Health’s national support teams provide support to organisations most at risk of not delivering, it would be timely to clarify who offers support at a national level for healthcare organisations to commission and deliver services effectively.

The new world class commissioning programme, led by the Department of Health, may offer support through the strategic health authorities in the future.

**Resources, capability and capacity**

Resourcing of health improvement programmes and services has been a key issue. Ring-fenced and one-off arrangements brought a number of advantages and disadvantages. Ring-fenced monies ensured activity and resulted in marked successes, but tended to limit the ability to access additional mainstream resources.

Short-term funding enabled developmental and innovative activities, but made sustained action challenging. In recent years, ring-fencing has not often been applied to funding. For example, money allocated to PCTs at the time of publication of Choosing health was not ring-fenced, and PCTs were not required to spend the money specifically in the topic areas. This coincided with a time of considerable financial crisis elsewhere in the system and concern was expressed that funding that was not explicitly dedicated was sometimes used
to address deficits. Wanless noted that “tackling recent financial difficulties in the NHS by raiding public health budgets has not been in the long-term interests of the public health of the nation”.[140] As a result, progress in the delivery of local health improvement programmes and services was reduced.

More generally, resource allocation over many years has rightly sought to match funds to needs and has, therefore, favoured more deprived areas. In 2007/2008, PCTs were allocated £70.4bn of which £17.5bn (25%) was channelled to fund extra access to health services and to improve the health of deprived populations. Access rates to services are broadly in line with the extra funding, the funds substantially matching extra service use by more deprived populations compared to those less deprived. However, the extra funds have failed to improve the health of deprived populations, compared to those less deprived. Such data suggests that improving access to health services alone will not improve health and reduce inequalities, but that progress is made when prevention programmes are in place in conjunction with efforts to improve access.

Initially there were difficulties in identifying enough senior public health staff with sufficient expertise to provide leadership. This meant that even where there were resources earmarked for delivery, progress was slow.

Workforce development issues were also important. Choosing health emphasises the development of workforce capacity and competence. A number of initiatives have been put in place and there have been welcome changes to the ways in which public health specialists were accredited, widening the field to entrants with more diverse – and less medically oriented – skills. However, concerns remain that there are few immediate or long-term plans to train a workforce to deliver across agencies, work with communities and deliver health promotion.

Policies that sought to reform delivery systems, such as those resulting in structural reorganisations and changes in resourcing, actually slowed progress in improving health and tackling inequalities in health. Changes in geographic boundaries and governance relationships resulted in confusion about how organisations related to each other and partnerships were sometimes destabilised. Continuous reorganisation created uncertainty for managers, staff and partner organisations. In addition, critical functions such as health promotion were lost in reorganisations and the redesign of local healthcare organisations.

Commissioning for local need
The lack of timely, accurate and available data – for example, for sexual health or obesity – prevented effective commissioning, as there were limited standardised measures of local need in some health areas. This made developing, commissioning and performance managing of targeted programmes a challenge. In addition, commissioners were not always confident in knowing how to use existing data to inform planning and procurement. Joint strategic needs assessment has the potential to enable systematic communication about local needs between agencies and residents. Programme budgeting is crucial in developing cost effective plans, but it needs further development in terms of health improvement.

Clear accountabilities for commissioning and delivery
The establishment of local strategic partnerships with local area agreements based on need has given a structure for
delivery across agencies. According to the Healthcare Commission’s survey of directors of public health, performance assessment of healthcare organisations by the Healthcare Commission and the Audit Commission appear to have contributed to improvements in the commissioning and delivery of health improvement programmes and services.

However, it is unclear that this progress will be maintained, given the uncertainties about the future of public health regulation in health services by the Care Quality Commission. However, the new Comprehensive Area Assessment is expected to be beneficial in driving forward local health improvement priorities.

Devolution of planning is welcomed for its contribution to local ownership and responsiveness of targets to local need. However, it was universally agreed by participants in our roundtable events that ‘must do’ health improvement PSA targets helped to keep health improvement and health inequality issues as central priorities and there was concern if these were to disappear.

The high number of competing local demands and limited resources has the potential to result in a reduced number of health indicators from the 42 health-related national indicators included as part of the local set of 35 (plus 16 education indicators) to form local area agreements. However, early analysis suggests that local area agreements are focusing on health issues, although it might be prudent to keep a watchful eye on future developments.

The increased focus on performance management and assessment are welcomed. In the period of transition to a more devolved model of planning and delivery, it will be important that incentives and levers that maintain the profile of health issues nationally and encourage local action are in place to ensure delivery of health outcomes.

Despite their great potential to act as a local community voice in performance management and assessment, overview and scrutiny committees have been inconsistent across the country in their ability and willingness to hold local healthcare organisations to account for their delivery of health improvement programmes and services. On occasion, members appear to be ill-equipped to ask pertinent questions about population-wide issues – such as local variations in health – rather than queries about individual services. However, there are instances where members showed leadership in health improvement issues, for example where they have championed the tobacco control agenda. In addition, joint strategic needs assessments will offer additional opportunities for local people to influence priority setting.

**What worked in a selection of health topics**

In appendix A, we set out a selection of health issues and show the relative difference between them in relation to resources and staffing, clear and consistent objectives, and consistent focus across the 10-year period.

For each, we show the movement of incidence and inequalities. This information comes from a range of sources, including the Department of Health’s *Departmental Report 2007* and data sources as noted in the text. We include expert views that came from the roundtable discussions that formed part of the research for this report. The conclusion sums up the analysis across individual topic lines in terms of the extent to which the programme to address each health improvement topic has been successful.
Chapter 6
Recommendations
Chapter 6
Recommendations

Over the last decade, good progress has been made in improving life expectancy and health outcomes in a number of priority areas. However, further progress in achieving a healthier nation – and more equal health outcomes for all – requires a renewed drive and focus from Government, local councils and healthcare organisations, wider society and from individuals taking more responsibility for their own health.

It will be important both to continue to build on successes to date – for example, in relation to cancer and circulatory diseases, smoking cessation, access to genitourinary medicine services, and teenage conceptions – and to ensure areas that have had less focus to date – such as obesity, alcohol misuse, mental health promotion and unintentional injury – are tackled through programmes that take into account all the components identified as contributing to better outcomes.

Local strategic partnerships will play a critical role in improving health and tackling health inequalities, with roles for local councils, healthcare organisations and their statutory partners in relation to health and the wider factors impacting on health.

Our national recommendations for improving the development and delivery of health improvement programmes and services are set out below. We also make recommendations that apply at a regional and local level, and these are shown in appendix B alongside the national recommendations.

Clear, consistent, ambitious and measurable objectives
Organisations and partnerships at all levels, led by central Government policy, should ensure that they have clear, consistent, ambitious and measurable objectives for all policies for improving people’s health. In particular:

- National objectives should be more ambitious in terms of the contribution that organisations can make to health and the broader aspects of health improvement. For example, this would include mental health services helping people to lead more independent lives and get back into work, or alcohol services helping to cut antisocial behaviour and crime.

- Objectives at all levels must be backed up by effective delivery plans. These plans need to be developed with local partners and communities, based on evidence of effectiveness, with identified resources and investment in building capacity and capability. They must have clear accountabilities for delivery and appropriate information systems to track and report on progress.

Relevant, reliable and up-to-date information
The Department of Health should continue to work with the Information Centre, public health observatories and others to provide information systems that enable local public services to prioritise health improvement programmes and enhance delivery. In particular:

- The Department of Health should build on the work of Informing Healthier Choices to support the capacity of local organisations to improve local data collection. Data collection should include information such as ethnicity and disability in line with the public health observatory core data set, and include more information at a neighbourhood level. Local organisations should collect and share data in line with national guidelines and the public health observatory core data set, and use it to target programmes to address inequalities.
• The Department of Health should further develop systems for healthcare organisations that allow clear identification of expenditure on health improvement programmes. The existing work on ‘programme budgeting’ provides a good foundation for this, and should be developed to cover specific health improvement areas. Local commissioners should use programme budgeting information alongside outcome data to prioritise spending, track progress and evaluate the impact and value of health improvement programmes.

Consistent focus across the NHS and Government
Across Government, all policies should be analysed at an early stage to ensure that negative health impacts are minimised and positive impacts maximised in relation to health and health inequalities, that policies are aligned, and that roles are identified and maximised across statutory, private and third sectors. For example, sex and relationship education should be mandatory to support achievement of the under-18 conception target. Local area agreements should maximise the potential for all partners in local strategic partnerships to improve health and reduce health inequalities.

Putting the evidence of ‘what works’ into practice
The Department of Health should continue to support the identification of evidence of what works and increase focus on identifying value for money. The Department should ensure that information and support are available to healthcare organisations on how best to deliver programmes that improve health and tackle inequalities in health. Support should be aligned with that given to local councils and should complement the work of NICE and the national support teams. Approaches can be learned from the Care Services Improvement Partnership (CSIP) and the Improvement and Development Agency for local government (IDeA). Of particular importance will be support for effective action to prevent alcohol misuse and obesity.

Resources, capability and capacity
The Department of Health should provide sufficient economic and other incentives to support the delivery of health improvement programmes and services, with a particular concentration on issues that have had least focus, such as obesity, alcohol, mental health promotion and unintentional injury. Local strategic partnerships and PCTs should explicitly identify health improvement expenditure in their plans, and demonstrate a substantial level of commitment to improving health and tackling inequalities.

When considering the use of the GP payment system known as the quality and outcomes framework (QOF) as an incentive, the Department of Health should ensure that health promotion is taken into account.

Commissioning for local need
Through the world class commissioning programme, the Department of Health should strengthen the capability of PCTs and local councils as commissioners, and ensure a strong focus on health improvement that addresses local health needs. At local level, this will include the use of joint strategic needs assessment. It will be important to develop and use programme budgeting and specific data to commission services that meet the needs of disadvantaged groups (including black and minority ethnic communities, disabled people and older people) and deprived neighbourhoods.
Clear accountabilities for commissioning and delivery

Independent assessment by an arm’s length body of the performance of PCTs and local councils as commissioners is an important component in improving local public accountability. The Health and Social Care Bill gives the new health and adult social care regulator this function in relation to PCTs and social services. Comprehensive Area Assessment, the framework for the future assessment of public services working together in a given locality, should emphasise the potential for improving people’s health.

- In-depth reviews undertaken of both commissioners and providers should include health improvement and tackling inequalities in health.

- Commissioning: The new health and adult social care regulator’s assessment should include the performance of healthcare organisations in relation to commissioning of services. This should cover improving health and tackling health inequalities and issues such as access to services for people from different ethnic groups, disabled people and older people, and those living in deprived areas. All appropriate aspects of assessments should contribute to the wider Comprehensive Area Assessments.

- Providers: The Department of Health should ensure that requirements in the registration system for health and social care providers include responsibilities for improving health and tackling inequalities in health. Improvement standards should be set to drive up the level and breadth of performance (including, for example, effectiveness of services and programmes, the integration of health improvement along the care pathway, partnership working and the health of staff).
Appendices
### Appendix A: Health topics: policy and performance in selected health policy areas

<table>
<thead>
<tr>
<th>Policy area</th>
<th>Financial resources</th>
<th>Staffing resources</th>
<th>Clear and consistent objective</th>
<th>Consistent focus</th>
<th>Level of incidence</th>
<th>Level of inequalities</th>
<th>Participant view</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tobacco control</strong></td>
<td>✓ R</td>
<td>⬤</td>
<td>⬤</td>
<td>⬤</td>
<td>❌</td>
<td>❌</td>
<td>Education and reduction in smoking have been a priority over the last 10 years. Smoke-free legislation was welcomed, but must not be considered a panacea for tobacco control, as it could pose a risk to the momentum of smoking cessation. The four-week quitter rate seems to have driven PCT performance, although this has worsened in 2006/2007.</td>
<td>Progress has been solid. Momentum must be maintained.</td>
</tr>
<tr>
<td><strong>Teenage pregnancy</strong></td>
<td>✓ R</td>
<td>⬤</td>
<td>✓</td>
<td>⬤</td>
<td>❌</td>
<td>No change</td>
<td>At the beginning of the period under review, teenage pregnancy rates were rising. They are now the lowest in 20 years and have declined across both the most and least deprived areas. There are still areas that are at risk of not achieving the 2010 target through both lack of progress and increases in rates. A pragmatic and creative approach to developing models of best practice, resources at national, regional and local level and a strong national focus were seen as critical elements for this success.</td>
<td>Although there are a significant number of areas at risk of not achieving the target, the innovative, pragmatic, evidence-based approach, and resources and strong performance management and assessment make this a model for other health areas. Momentum should be maintained.</td>
</tr>
<tr>
<td>Policy area</td>
<td>Financial resources</td>
<td>Staffing resources</td>
<td>Clear and consistent objective</td>
<td>Consistent focus</td>
<td>Level of incidence</td>
<td>Level of inequalities</td>
<td>Participant view</td>
<td>Conclusion</td>
</tr>
<tr>
<td>------------------------------------------------</td>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Sexual health (48-hour access to GUM services)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>↑</td>
<td>No change</td>
<td>The 48-hour target has successfully reduced waiting times for access to GUM services. STI rates have continued to rise, including chlamydia and HIV. Concern was expressed that resources allocated to sexual health did not reach services. There was also concern about reduced focus on, and resources for, contraceptive services, which suffered as a result. The lack of data hampered targeted programming and performance management.</td>
<td>While the 48-hour access target and access to chlamydia screening have been positive developments, further attention is needed to ensure delivery of a range of contraceptive methods and that resources reach contraceptive services.</td>
</tr>
<tr>
<td>Obesity</td>
<td>X</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>↑</td>
<td>Not yet known</td>
<td>Obesity rates are increasing rapidly. Despite there being a PSA since 2004, obesity has not yet had sufficient resources for a focused programme of work. Recently there has been increased policy focus, with a national strategy launched in 2008. Progress has been made in relation to data sets.</td>
<td>This is an ambitious target – and one that has not been achieved anywhere in the world. However, there has been a lack of strategic focus, resources and joined-up working. Sustained focus and resources will be required.</td>
</tr>
</tbody>
</table>

Appendices
<table>
<thead>
<tr>
<th>Policy area</th>
<th>Financial resources</th>
<th>Staffing resources</th>
<th>Clear and consistent objective</th>
<th>Consistent focus</th>
<th>Level of incidence</th>
<th>Level of inequalities</th>
<th>Participant view</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unintentional injury</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>Childhood unintentional injury continues to have the steepest social class gradient. The PSA has only recently been set. There are limited national drivers.</td>
<td>There is an urgent need for Government action in relation to tackling inequalities.</td>
</tr>
<tr>
<td>(in the home)</td>
<td>X</td>
<td>X</td>
<td>⬇️</td>
<td>⬆️</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol misuse</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>⬆️*</td>
<td>Not known</td>
<td>There has not been a strong policy steer in relation to alcohol and no hard targets to drive improvement, with the result that the alcohol agenda is relatively new and underdeveloped. Evidence in relation to achieving sensible drinking is variable. The widespread acceptability of alcohol is a key issue. However, there was optimism that the time for making real progress had arrived, not least because a PSA has been set.</td>
<td>Despite increasing incidence of alcohol-related disease, there has been little progress over the past 10 years. It will be essential to focus strategy and resources in this area.</td>
</tr>
</tbody>
</table>

**Note:** Cancer (death rates from cancer among people under 75) and coronary heart disease (death rate from heart disease, stroke and related illness among people under 75) have shown a reduction in incidence.

**Key:**
- **Financial resources:** ✓ = financial resources allocated to the area; ✓R = ring-fenced funding; X = no substantial resources
- **Staffing resources:** (capacity at national, regional, local and frontline): ✓✓✓ = dedicated staff at national, regional and local level; ✓✓ = dedicated teams at national and regional level; ✓ = some dedicated staff; X = no substantial teams
- **Clear, consistent objective** [PSA in place]: ✓✓✓ = PSA in place throughout 10 years; ✓✓ = PSA in place for 4-7 years; ✓ = PSA in place for 3 years or under; X = no target
- **Consistent focus** [wider policy focus, including development of good practice guidelines, focus of reviews etc]: ✓✓✓✓ = significant policy focus throughout 10 years; ✓ = some policy focus over period; X = no focus

* The increase in incidence here is in alcohol-related diseases, such as cirrhosis of the liver.
## Appendix B: Recommendations: national, regional and local action

### National action

<table>
<thead>
<tr>
<th>Clear, consistent, ambitious and measurable objectives</th>
<th>Regional action</th>
<th>Local action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisations and partnerships at all levels, led by central Government policy, should ensure that they have clear, consistent, ambitious and measurable objectives for all policies for improving people’s health. In particular:</td>
<td>Strategic health authorities and regional government offices should encourage local healthcare organisations and councils to feature population health issues in their development of local area agreements.</td>
<td>Local healthcare organisations and councils should feature population health issues in their development of local area agreements and local operational plans, on such areas as obesity, alcohol and unintentional injury. These plans need to be developed with local partners and communities, based on evidence of effectiveness, with identified resources and investment in building capacity and capability. They must have clear accountabilities for delivery and appropriate information systems to track and report on progress.</td>
</tr>
<tr>
<td>• National objectives should be more ambitious in terms of the contribution that organisations can make to health and the broader aspects of health improvement. For example, this would include mental health services helping people to lead more independent lives and get back into work, or alcohol services helping to cut antisocial behaviour and crime.</td>
<td></td>
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</tr>
<tr>
<td>• Objectives at all levels must be backed up by effective delivery plans.</td>
<td></td>
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</tbody>
</table>

### Relevant, reliable and up-to-date information

<table>
<thead>
<tr>
<th>The Department of Health should continue to work with the Information Centre, public health observatories and others to provide information systems that enable local public services to prioritise health improvement programmes and enhance delivery. In particular:</th>
<th>Public health observatories should continue to play a key role in assembling, analysing, interpreting and communicating information on the health of the population.</th>
<th>Local organisations should collect and share data in line with national guidelines and the public health observatory core data set, and use it to target programmes to address inequalities. Local commissioners should use programme budgeting information alongside outcome data to prioritise spending, track progress and evaluate the impact and value of health improvement programmes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The Department of Health should build on the work of <em>Informing Healthier Choices</em> to support the capacity of local organisations to improve local data collection. Data collection should include information such as ethnicity and disability in line with the public health observatory core data set, and include more information at a neighbourhood level.</td>
<td></td>
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</tr>
<tr>
<td>National action</td>
<td>Regional action</td>
<td>Local action</td>
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<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• The Department of Health should further develop systems for healthcare organisations that allow clear identification of expenditure on health improvement programmes. The existing work on ‘programme budgeting’ provides a good foundation for this, and should be developed to cover specific health improvement areas.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Consistent focus across the NHS and Government**

Across Government, all policies should be analysed at an early stage to ensure that negative health impacts are minimised and positive impacts maximised in relation to health and health inequalities, that policies are aligned, and that roles are identified and maximised across statutory, private and third sectors. For example, sex and relationship education should be mandatory to support achievement of the under-18 conception target.

Regional strategies (such as regional economic and spatial strategies) should be aligned to ensure that they maximise the opportunity to improve health and tackle inequalities in health.

Local area agreements should maximise the potential for all partners in local strategic partnerships to impact on health and health inequalities.

Local strategies (such as the operational plans of local healthcare organisations and councils) should be aligned to ensure that they maximise the opportunity to improve health and tackle inequalities in health. This could include:

• Extending the role and capacity of school nurses and health visitors to work with children and young people in community settings.

• Using the Single Assessment Process for older people to include opportunities for health and wellbeing.
### National action

<table>
<thead>
<tr>
<th>Putting the evidence of ‘what works’ into practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Department of Health should continue to support the identification of evidence of what works and increase focus on identifying value for money. The Department should ensure that information and support are available to healthcare organisations on how best to deliver programmes that improve health and tackle inequalities in health. Support should be aligned with that given to local councils and should complement the work of NICE and the national support teams. Approaches can be learned from the Care Services Improvement Partnership (CSIP) and the Improvement and Development Agency for local government (IDeA). Of particular importance will be support for effective action to prevent alcohol misuse and obesity.</td>
</tr>
</tbody>
</table>

### Regional action

<table>
<thead>
<tr>
<th>Resources, capability and capacity</th>
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</thead>
<tbody>
<tr>
<td>The Department of Health should provide sufficient economic and other incentives to support the delivery of health improvement programmes and services, with a particular concentration on issues that have had least focus, such as obesity, alcohol, mental health promotion and unintentional injury. When considering the use of the GP payment system known as the quality and outcomes framework (QOF) as an incentive, the Department of Health should ensure that health promotion is taken into account.</td>
</tr>
<tr>
<td>There should be a strong presence at regional level to support development of local skills and capacity necessary for improving health and tackling health inequalities.</td>
</tr>
<tr>
<td>Strategic health authorities and Government Offices should ensure that incentives are taken up by local organisations and that good practice is shared with other regions.</td>
</tr>
<tr>
<td>Local strategic partnerships and PCTs should explicitly identify health improvement expenditure in their plans, and demonstrate a substantial level of commitment to improving health and tackling inequalities.</td>
</tr>
</tbody>
</table>

### Local action
### Commissioning for local need

<table>
<thead>
<tr>
<th>National action</th>
<th>Regional action</th>
<th>Local action</th>
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</thead>
<tbody>
<tr>
<td>Through the world class commissioning programme, the Department of Health should strengthen the capability of PCTs and local councils as commissioners, and ensure a strong focus on health improvement that addresses local health needs.</td>
<td>Strategic health authorities and Government Offices should:</td>
<td>At local level, this should include the use of joint strategic needs assessment, programme budgeting and specific data to commission services that meet the needs of disadvantaged groups (including black and minority ethnic communities, disabled people and older people) and deprived neighbourhoods.</td>
</tr>
<tr>
<td></td>
<td>• Support programme budgeting through performance management.</td>
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<tr>
<td></td>
<td>• Identify mechanisms for regional commissioning of services where there is need that has not reached critical mass in a single local council area (e.g. district-wide media campaigns for HIV services, or services for refugees and asylum seekers).</td>
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</tr>
<tr>
<td>National action</td>
<td>Regional action</td>
<td>Local action</td>
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<tr>
<td>-------------------------------------------------------------------------------</td>
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<tr>
<td><strong>Clear accountabilities for commissioning and delivery</strong></td>
<td></td>
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<tr>
<td>Independent assessment by an arm’s length body of the performance of PCTs and</td>
<td>Performance managers should come together to look at health indicators within</td>
<td>Local authorities should strengthen overview and scrutiny committees to hold</td>
</tr>
<tr>
<td>local councils as commissioners is an important component in improving local public</td>
<td>LSPs’ local area agreements – including indicators not prioritised in LAAs – to</td>
<td>PCTs and councils to account for the delivery of health improvement programmes</td>
</tr>
<tr>
<td>accountability. The Health and Social Care Bill gives the new health and adult</td>
<td>ensure plans are meeting local health need.</td>
<td>and services.</td>
</tr>
<tr>
<td>social care regulator this function in relation to PCTs and social services.</td>
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<tr>
<td>Comprehensive Area Assessment, the framework for the future assessment of</td>
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<tr>
<td>public services working together in a given locality, should emphasise the</td>
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<tr>
<td>potential for improving people’s health.</td>
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<tr>
<td>• In-depth reviews undertaken of both commissioners and providers should</td>
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<td></td>
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<tr>
<td>include health improvement and tackling health inequalities.</td>
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<td></td>
</tr>
<tr>
<td>• Commissioning: The new health and adult social care regulator’s assessment</td>
<td></td>
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<tr>
<td>should include the performance of healthcare organisations in relation to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>commissioning of services. This should cover improving health and tackling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>health inequalities and issues such as access to services for people from</td>
<td></td>
<td></td>
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<tr>
<td>different ethnic groups, disabled people and older people, and those living in</td>
<td></td>
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<tr>
<td>deprived areas. All appropriate aspects of assessments should contribute to</td>
<td></td>
<td></td>
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<tr>
<td>the wider Comprehensive Area Assessments.</td>
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<tr>
<td>• Providers: The Department of Health should ensure that requirements in the</td>
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<tr>
<td>registration system for health and social care providers include responsibilities</td>
<td></td>
<td></td>
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<tr>
<td>for improving health and tackling inequalities in health. Improvement standards</td>
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<tr>
<td>should be set to drive up the level and breadth of performance (including, for</td>
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<tr>
<td>example, effectiveness of services and programmes, the integration of health</td>
<td></td>
<td></td>
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<tr>
<td>improvement along the care pathway, partnership working and the health of staff)</td>
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</tbody>
</table>
### Appendix C: Key national performance targets for public health 2006/2007

<table>
<thead>
<tr>
<th>Area</th>
<th>National targets</th>
<th>Indicators*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>Improve life outcomes of adults and children with mental health problems by ensuring that all patients who need them have access to (crisis services by 2005, and) a comprehensive child and adolescent mental health service by 2006.</td>
<td>• Commissioning a comprehensive child and adolescent mental health service&lt;br&gt;• Commissioning of crisis resolution/home treatment services</td>
</tr>
<tr>
<td>GP recording of body mass index</td>
<td>Tackle the underlying determinants of ill health and health inequalities by halting the year-on-year rise in obesity among children under 11 by 2010 (from the 2002-2004 baseline) in the context of a broader strategy to tackle obesity in the population as whole.</td>
<td>• GP recording of body mass index status</td>
</tr>
<tr>
<td>Suicide prevention</td>
<td>Substantially reduce mortality rates by 2010 from suicide and undetermined injury by at least 20% (from the Our Healthier Nation baseline, 1995-1997).</td>
<td>• Care programme approach seven-day follow up&lt;br&gt;• Commissioning of early intervention in psychosis services</td>
</tr>
<tr>
<td>Smoking</td>
<td>Reducing adult smoking rates (from 26% in 2002) to 21% or less by 2010, with a reduction in prevalence among routine and manual groups (from 31% in 2002) to 26% or less.</td>
<td>• Smoking status among the population aged 15 to 75&lt;br&gt;• Progress of four-week smoking quitters</td>
</tr>
<tr>
<td>Older people</td>
<td>Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible: increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008, and increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.</td>
<td>• Community equipment&lt;br&gt;• Older people’s mental health: assessment of needs and services</td>
</tr>
</tbody>
</table>

* These are indicators agreed between the Healthcare Commission and the Department of Health to measure the national targets.
<table>
<thead>
<tr>
<th>Area</th>
<th>National targets</th>
<th>Indicators*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health inequalities</td>
<td>By 2010, to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.</td>
<td>• Infant health and inequalities: smoking during pregnancy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Infant health and inequalities: breastfeeding initiation rates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Data quality on ethnic group</td>
</tr>
<tr>
<td>Sexual health</td>
<td>Reducing the under 18-conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health.</td>
<td>• Teenage conception rates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Access to genitourinary medicine clinics</td>
</tr>
<tr>
<td>Long-term conditions</td>
<td>To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people at most risk, and to reduce the number of emergency bed days by 5% by 2008 (from the expected 2003/2004 baseline) through improved care in primary care and community settings.</td>
<td>• Emergency bed days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Community matrons and additional case managers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Number of very high intensity users</td>
</tr>
</tbody>
</table>

* These are indicators agreed between the Healthcare Commission and the Department of Health to measure the national targets.
Appendix D: Organisations participating in roundtable discussions, summer 2007

Addaction
Alcohol Concern
Ashton, Leigh & Wigan PCT
Association of Greater Manchester PCTs
Barking & Dagenham PCT
British Association for Sexual Health and HIV
Bury Drugs and Alcohol Action Team
Bury PCT
Camden PCT
Cancer Research
Child Accident Prevention Trust
Civil Service Pensioners Alliance
Commission for Social Care Inspection
Department for Children, Schools and Families
Department of Health
Derby City PCT
Faculty of Public Health
Family Planning Association
Food Standards Agency
Gateshead Council
Government Office for Yorkshire and The Humber
Hammersmith & Fulham PCT
Harrow PCT
Improvement and Development Agency
Islington PCT
Kent County Council
Lambeth PCT
London Health Commission
London Health Observatory
Manchester PCT & Faculty of Public Health
Medical Foundation for AIDS & Sexual Health
Mind
National Audit Office
National Children’s Bureau
National Institute for Health and Clinical Excellence (NICE)
National Obesity Forum/Child Growth Foundation
National Obesity Task Force
National Treatment Agency
Natural England
Newcastle PCT
Newham PCT
North East Public Health Observatory
North West Strategic Health Authority
Nottingham City Council
Ofsted
Oldham Drugs and Alcohol Action Team
Redbridge PCT
Royal College of Nursing
Royal College of Paediatrics and Child Health
Royal College of Physicians
Royal Pharmaceutical Society of Great Britain
Sainsbury Centre for Mental Health
Salford Drugs and Alcohol Action Team
Salford PCT

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Appendices

South London & Maudsley NHS Foundation Trust
Specialist Pharmacy Services
Tameside Metropolitan Borough Council
Terrence Higgins Trust
Turning Point
UK Public Health Association
West Midlands Public Health Observatory
West Midlands Strategic Health Authority
Westminster City Council
Yorkshire and Humber Public Health Observatory
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13. Department of Health, Addressing inequalities – reaching the hard to reach groups, 2002

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28. The Information Centre, June 2007
34. Department of Health, Alcohol Needs Assessment Research Project and ONS
42. Office for National Statistics. Age-standardised rates for the three categories of cause of death (per million population), registrations, 1995-2005

43. London Public Health Observatory, *Indication of Public Health in English Regions, Ethnicity and Health*, 2005


49. Harris EC and Barraclough B, 1998


56. Hospital Episode Statistics 2005


64. HM Treasury, *Securing Our Future Health: Taking a Long-Term View*, 2002


68. Relevant reports can be found on the Local Government Information Unit website: www.lgiu.gov.uk/ and www.dhn.org.uk/dhn

69. Examples include:


70. www.archive.official-documents.co.uk/document/cm41/4181/psa-04.htm

71. www.hm-treasury.gov.uk/spending_review/spending_review_2000/psa/pss_psa_doh.cfm

72. www.hm-treasury.gov.uk/Spending_Review/spend_sr02/psa/spend_sr02_psahealth.cfm

73. www.hm-treasury.gov.uk/media/8/7/sr04_psa_ch3.pdf

74. www.hm-treasury.gov.uk/pbr_csr/psa/pbr_csr07_psaindex.cfm


76. www.hm-treasury.gov.uk/media/8/7/sr04_psa_ch3.pdf


82. See, for example, Healthcare Commission, Audit Commission, Commission for Social Care Inspection, *Living well in later life: A review of progress against the National Service Framework for Older People*, 2006

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84. HM Treasury, Securing Our Future Health: Taking a Long-Term View, 2002
88. See for example, National Audit Office, Healthcare Commission, Audit Commission, Tackling Child Obesity – First Steps, 2006
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112. DEFRA, *Survey Family Food 2006 (UK Purchases and Expenditure on Food and Drink and derived Energy and Nutrient Intakes)*, 2008


115. Select Committee on Health, Third Report, 10 May 2004

116. Speech by Rt Hon Alan Johnson MP, Secretary of State for Health, 19 October 2007

117. Department for Culture Media and Sport press release, “Five hours of sport a week for every child”, 13 July 2007


139. Department of Health, *The Quarter: quarter 4, 2007-08*

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