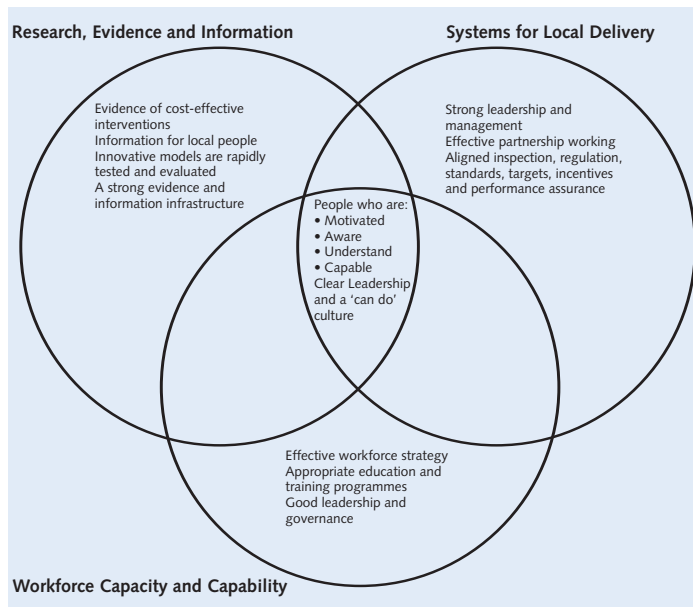


ANNEX B

MAKING IT HAPPEN

1. The key to national health improvement is more people making healthier choices more of the time. Many of the proposals in this White Paper will help make the healthy choice the easy choice for people. Other proposals will develop an environment where people who are disadvantaged in making those healthy choices will increasingly have similar opportunities to others.
2. This annex sets out how we will ensure that there is a strong system to deliver everywhere the commitments we make in this White Paper, and how can we build on the popular support for action to create irreversible momentum for change. To do this we propose actions in three broad areas:
 - Evidence and Information
 - Workforce Capacity and Capability
 - Systems for Local Delivery

3. The diagram below sets out the relationship between these three areas:



4. We will publish a delivery plan in early 2005 which will give more detail on how we will implement each of the commitments we have made in the White Paper. This will build on relevant activity already in hand. So, for example, we will ensure that activities relevant to children and young people are brought together with work underway to improve children's health under the 'be healthy' strand of *Every child matters: delivering change for children*.

EVIDENCE AND INFORMATION FOR ACTION

The challenge

5. In 'Securing Good Health for the Whole Population', Derek Wanless was critical of the dearth of evidence available on what works in health improvement. He called for action to strengthen the evidence base on interventions and their cost-effectiveness, for improved use of information on the population and its health status, and for a sharper focus on using evidence and information to inform practice. He also called for evaluation of new initiatives as a rapid means of filling gaps in the evidence base.

Action to strengthen public health research

6. Action on improving health has been hampered by gaps in the evidence on what works best to support and sustain change in people's behaviour, and how to do this most cost-effectively.

'Although there is often evidence on the scientific justification for action and for some specific interventions, there is generally little evidence about the cost-effectiveness of public health and preventative policies or their practical implication. Research in this area can be technically difficult and there is a lack of depth and expertise in the core disciplines. This, coupled with a lack of funding of public health intervention research and slower acceptance of economic perspectives within public health, all contribute to the dearth of evidence of cost-effectiveness.'

Derek Wanless, February 2004

7. The key challenges we need to address are:
- research funding and effort has not met the needs of front line staff for good evidence on what will improve the public's health;
 - lack of an overarching national strategy for public health has resulted in failure to systematically identify the research gaps and prioritise commissioning of research to fill these;
 - insufficient co-ordination between the different research funders and between the researchers and those charged with front line actions to improve health;
 - lack of funding for research into the interventions that will support and sustain behaviour change, and those which will tackle health inequalities;
 - too long a time lag between conception of a new idea and getting it into practice;
 - a lack of research capacity with the mix of skills and expertise needed, good links between the

NHS and academia and clear career pathways; there are important areas of strength, like epidemiology, but expertise in areas including promoting behaviour change is more limited; and

- there is limited evidence on cost-effectiveness.
8. **We will review the existing R&D strategy for public health to provide a strategy focused on supporting delivery of this White Paper through improved, timely, evidence.**
 9. To meet the challenges this will set, **we will establish a new public health research initiative within the framework of the United Kingdom Clinical Research Collaboration (UKCRC).** This will bring together research funding partners, including the Research Councils and the Wellcome Trust, to agree the long-term research strategy. This co-ordinated approach will make the necessary connections across Government, with the National Institute for Clinical Excellence and with the wider public health information community and consumer interests. It will benefit from working closely with UKCRC workstreams on the research workforce and the regulatory and governance environment.
 10. **Starting in 2005–06, the Government will provide new funding for the public health research initiative, building to £10m by 2007–08.** This is on top of existing plans to increase spend by the Department of Health Policy Research Programme on public health research to £10m per annum by 2006.
 11. **Following the White Paper, we will make an early start by launching two projects to strengthen the evidence base on work to improve health. Early in 2005, we will launch a public health research consortium, bringing together national policy makers and researchers from a wide range of disciplines relevant to public health, to focus effort on strengthening the evidence for effective health interventions to support White Paper delivery.**
 12. **We shall launch a National Prevention Research Initiative, working in collaboration with research funders in the fields of obesity, cancer, coronary heart disease and diabetes, to provide dedicated funding for research aimed at the primary prevention of these diseases.** This will build on existing work between DH and partners through the National Cancer Research Institute. The emphasis will be on studies on the development, evaluation and implementation of interventions to influence behaviour. This includes research aimed at reducing smoking, improving diet and nutrition, preventing obesity and increasing physical activity.
 13. Action to build the public health workforce will include steps to strengthen the academic infrastructure, to build closer links between field practitioners and academic centres, and to strengthen the research and evaluation skills of all public health practitioners.
- Action on evidence of cost effectiveness and best practice**
14. To complement these new developments on research, we shall act to strengthen evidence of cost effectiveness, and to make evidence of what works more readily available to inform and develop frontline practice and to capture evidence of what works from new models of practice in the field.
 15. In July 2004, as part of the Department of Health's wider review of Arms Length Bodies, we announced our plans to transfer the functions of the Health Development Agency (HDA) to the National Institute for Clinical Excellence (NICE), to form a new body with a wider focus on both care and health, and create a Centre for Public Health Excellence. This will build on the complementary experience and skills of the two organisations, with their track records of successful delivery. It will bring to bear the rigour of economic appraisal, which NICE has developed in its work on clinical topics in the NHS, on the wider public health

evidence base already gathered by the HDA, and on future evidence. And it will develop and strengthen the regional presence of the HDA, to ensure that frontline practice is shaped and developed in line with the evidence base.

16. The challenge for both bodies is to create a strong, new organisation which will be called the National Institute for Health & Clinical Excellence. This will have a broader and more complex role than either existing body. So we shall take special steps to support its development but ensure that the internationally recognised brand of NICE is retained.
17. **We will provide additional resources to support the National Institute for Health & Clinical Excellence, in its new work on health improvement.** Over and above the efficiency savings we will make from bringing HDA together with NICE, we will provide additional resources from 2006/07 to deliver specific objectives related to the White Paper.
18. **The National Institute for Health & Clinical Excellence will appoint an Executive Director for Health Improvement to provide professional leadership in delivering public health for its work across the NHS and partner organisations in local government, in education, in voluntary and community organisations. Additional Non Executive Board Members will also be appointed to improve its capacity to discharge its significantly extended role across this wider range of sectors including Local Government.**
19. For the first time, the National Institute for Health & Clinical Excellence will integrate upstream (prevention) and downstream (treatment) knowledge and guidance on effective practice and intervention as NICE and the HDA are already doing together on obesity, identifying which actions will have the greatest impact on health. It will become possible to compare evidence for the

cost effectiveness of early ill health prevention programmes with the evidence of the cost effectiveness of treatment later. The NHS and its partner organisations, including local government, will benefit from this stronger evidence base both as to what works within the field of public health, inequalities and ill-health prevention and on the case for investment upstream.

20. Bringing the experience and expertise of these two organisations together will also strengthen our ability to get evidence into practice and evaluate new interventions rapidly. We will retain and build on NICE as a strong brand with the NHS and the HDA's wider networks with other government departments and NHS partner organisations at national and at regional level, to build an internationally recognised organisation promoting excellence in public health.

Action on information

21. Good, relevant, timely information is needed to identify health problems early, to help decide what to do, and how to do it and to track progress. Information is also essential to make the case for change and investment in health.
22. Derek Wanless was surprised to observe that despite 50 years of the National Health Service,

'Little comprehensive information is collected on the health status of the population, the prevalence of important behavioural factors, such as smoking, drinking, diet and exercise, or what the NHS actually spends its money on in relation to public health.'

And he identified the same weaknesses at local level:

'... there is no regular mechanism by which a PCT or local authority can gather reliable information on its own population ...'

23. Some important building blocks are in place, but they do not yet add up to a coherent information system geared to today's needs. *Saving Lives: Our Healthier Nation* established Public Health Observatories in each region to support local bodies by helping them to identify local health problems and track progress in tackling them. We need now to build on their work to establish a modern public health information and intelligence system to understand the present and to model the future.
24. **Following the White Paper, we will establish a Health Information and Intelligence Task Force to lead action to develop and implement a comprehensive public health information and intelligence strategy.** Priorities for this will be to:
- develop real-time public health information leading to action at a local level, across the NHS and in the local community;
 - identify an agreed set of core data, where possible from existing data sources, to support agreed measures of progress to be used nationally and locally;
 - tackle weaknesses within existing data, eg information on ethnicity and use of NHS services;
 - bringing together sources of information on health and wellbeing from routine sources and local studies to give a comprehensive picture of how lifestyle factors affect health;
 - build on the work of Public Health Observatories on regional public health indicators to establish a framework for health surveillance at a regional level which supports a more robust national framework;
 - work with the Health Protection Agency to develop effective systems, eg for sexual health;
 - use new sources, such as marketing information and systems of information to improve the health of the population, including the NHS National Programme for IT, the new contract for General Medical Services and the UK Biobank;
 - give guidance on data sharing, and on disclosure and confidentiality. We need to ensure that recent developments in data protection and other legislation on information are clear, and organisations are aware of what they can and can't do; and
 - build on existing knowledge management systems, including the National Electronic Library for Health, to ensure information is readily available to promote best practice.
25. We will invest £5 million in 2005 and £10 million per annum from 2006 in Public Health Observatories and in developing the national public health information and intelligence strategy. This will ensure that the Public Health Observatories are better placed to support directors of public health and their teams with information and skills to promote local action and monitor its impact on health.
26. Collecting and analysing information is only half the task. Ensuring that the right people know what that information contains and understand how to use it is part of the challenge we face. For local government the Improvement and Development Agency has agreed to support the dissemination of information on approaches that demonstrate successful outcomes. Public health practitioners and NHS staff will be supported in developing skills to assist effective dissemination. Public Health Observatories will support the development of skills for example in equity audits and health impact assessments.
27. The Department will continue to work with the NHS and others on better ways of using information to inform local communities and drive

action. Chapter 4 described the new forms of local reports that Primary Care Trusts will publish to provide accessible information on the health of the local community, clearly communicated in an approachable style. Public Health Observatories will produce the information for these.

28. We are also launching a Health Poverty Index, to provide summary key information on differences in health outcomes between different areas and groups for local decision-makers. In the longer term the Government is working with the Audit Commission, Healthcare Commission and others to build in a strong health component to 'Local Area Profiles'. This will produce profiles of the quality of life and services in a local area by bringing together existing data collections.

Promoting Innovation and Evaluation Fund

29. Our new arrangements to fill gaps in the research and evidence base will take time to deliver results. Derek Wanless commented,

'...the need for action is too pressing for the lack of a comprehensive evidence base to be used as an excuse for inertia'.

He proposed a more systematic approach to the evaluation of current public health policy and practice, and of new initiatives, to identify what works, so that successful approaches can be rolled out rapidly, and those which are unsuccessful discontinued.

30. The NHS Modernisation Agency will develop a 'spread and adoption' strategy aimed to shorten the process and timescales for getting the best ideas widely taken up across local communities and organisations.
31. **We will establish a new Innovations Fund, of £30m in 2006–07 and £40m per annum from 2007–08. This will support and test new models of working and provide real-time evaluation and feedback to enable faster learning so that proven**

models can be put into practice much more rapidly than in the past.

Summary

32. This concerted drive to improve the base of information and intelligence will ensure we can meet Derek Wanless' challenge to build local and national understanding of the factors that impact on people's health at present and in future.
33. The changes set out above will mean that:
- there is a growing body of research evidence on cost-effective interventions to improve health and this informs commissioning and the practice of front line staff
 - local communities see regular information about their health, trends over time, comparisons with other areas to promote local action
 - innovative models of practice are tested and evaluated rapidly so that if they are successful they can be adopted as mainstream practice
 - the drive for health improvement is supported by a strong infrastructure with the evidence and information systems to sustain progress.

CAPACITY AND CAPABILITY: BUILDING THE WORKFORCE

The challenge

34. The changes set out in the White Paper will only occur if the right people, with the right skills, are in place to deliver them and if barriers to change and old style professional boundaries are broken down. This means people with the right skills at all levels:
- across the wider workforce;
 - as public health practitioners;
 - as public health specialists; and
 - in the leadership of organisations

working in a multidisciplinary workforce to respond to current problems, identify future health threats, provide expert advice and co-ordination in the delivery of high quality health improvement services and evaluate the impact of their efforts, particularly on reducing health inequalities.

The strategy

35. The NHS has already developed capacity plans to support faster access to treatment. Every national service framework – for example to improve services for people with heart disease or with mental health problems – has been supported by action to ensure the right workforce, with the right skills, is in place. This same systematic and determined approach to workforce planning and development must now be extended to health improvement. Plans will need to be aligned with mainstream NHS programmes including Agenda for Change and Modernising Medical Careers. These plans must cover not just the NHS, but also the needs of local government, voluntary organisations, academic research, and others with roles in health improvement.
36. Our overall strategy is to develop and build capacity for health improvement at all levels of the system, with the backing of a national competency framework for health to support the development of the necessary education and skills. We will identify and tackle capacity and capability gaps. Priorities will be to
- engage people from local communities in a new role as NHS health trainers, and assist them to acquire the skills to change behaviours;
 - use the health trainer's development programme to accredit existing community workers or volunteers as health trainers, thereby promoting the development of skills within communities;
 - better equip the wider workforce to deliver improved health by ensuring basic skills and knowledge for more people including all those working in the NHS, by increasing understanding of key messages and how to communicate them to support behaviour change;
 - ensure public health practitioners have the correct skills for their work in improving health and are used effectively;
 - address critical shortfalls in specific staff groups;
 - support the development of effective specialist public health practice and leadership;
 - develop models for managing health improvement programmes; and
 - ensure strong leadership for health improvement across organisations.
37. All staff need to be supported to understand and value their own health, and to understand and communicate the key health messages, the evidence that lies behind them and, most importantly, the most effective methods of supporting people to adopt healthy behaviours. The NHS should become as professional in its approach to delivering consistent, high quality advice and support for health as it has been traditionally in delivering high quality treatment and care. The Government are working with Skills for Health and other key stakeholders to ensure that Occupational Standards and the NHS Knowledge and Skills Framework properly reflect health improvement and the science of behaviour change.
38. **The new induction programme for all NHS staff will include basic information. In addition the curricula for pre-registration training, post-graduate education and continuous professional development will be reviewed. Staff from other local partners, particularly local authorities, including environmental health officers may also benefit from access to similar training and development. Flexible modular approaches, consistent with the NHS skills escalator will be**

developed, to create opportunities for multisectoral and lifelong learning.

Skills in the community

39. Chapter 5 describes a new role for NHS health trainers. These will be people drawn from local communities (broadly equivalent to the existing health care assistant role) who receive accredited training in health improvement, communication skills and promoting behaviour change. They will be equipped to work with people who want personal support to improve their health. **We will commission work on the core competencies for this role, as a basis for commissioning and accrediting training.** In the NHS, this will offer a first entry point to the 'skills escalator', as a potential start to a career, either in health improvement or in other areas of NHS work.
40. **We will work with the Improvement and Development Agency, the NHS Employers Organisation and other Government Departments, to establish the best way of offering elements of this training to other frontline staff – for example, housing officers, home care staff, non-teaching assistants, and staff working in leisure centres. We will explore with the relevant educational awarding bodies the possibility of developing a core curriculum for a new national Health Trainer Certificate.**
41. Since there are a number of existing models for community engagement in health improvement we propose to work initially with the 20% of PCTs with the worst health and deprivation indicators and their partners to evaluate the best ways to maximise the potential of this approach and to roll these out across the country.
42. Development of these skills and competencies will be part of the national competency framework for health. As part of this at a local level we will ensure the development of capacity and skills to deliver local initiatives, including Healthy Start,

home visiting, and sexual health information services for young people. We will ensure that capacity is developed to engage with our initiatives such as Communities for Health and to deliver the specialist competencies around obesity prevention and treatment, with particular awareness of the needs of ethnic minorities and vulnerable groups

43. We will ensure that the increased capacity needs of the services we propose, for example sexual health and occupational health, are assessed through SHAs working with their PCTs and local hospital trusts and other local partners.

Skills development for public health practitioners

44. Staff who have specific roles and skills in health improvement will have additional needs for training and skills development. These will include staff who work within a health improvement service like smoking cessation or nutrition advice; public health practitioners – including health visitors, midwives and school nurses; community pharmacists; community dentists; members of the primary care teams including GPs and other practitioners with a special interest. Others may work in the local authority workforce, such as environmental health officers and trading standards officers. Local public sector employers will need to review the numbers of people and the types of skills they need to meet the health challenges they now face and to plan for the development of these groups. Expansion of school nursing to meet the challenges set out in Chapter 3 will be a particular priority, as will health trainers.
45. There are other important groups of staff who are particularly well placed to contribute to health improvement as part of their everyday clinical practice. For example, the Pharmaceutical Public Health Strategy to be published in 2005 will discuss how best to equip pharmacists to make the most of this role.

46. There is also scope to increase engagement of staff through the new contractual arrangements as well as increasing practitioners with a special interest among GPs, nurses, midwives, health visitors and allied health professionals. **We will commission guidelines to help PCTs develop roles for practitioners with a special interest to promote health improvement.**

Increasing capacity and developing skills in public health specialists

47. Action to expand specialist capacity in public health includes:
- expanding the number of public health specialist training posts;
 - increasing the number of healthcare graduates with experience of public health by strengthening public health input to the undergraduate curriculum;
 - offering new career pathways, for example for doctors in training through the work of Modernising Medical Careers and the Postgraduate Medical Education Training Board, and for nurses by utilising Agenda for Change;
 - improving retention of specialists in public health by creating greater flexibility in care pathways including opportunities to move between defined areas of specialist and generalist practice;
 - work with other national agencies, such as the HPA, to develop workforce capacity;
 - assess the need to develop new areas of specialist practice, such as public health genetics;
 - recruiting managers to support delivery of health improvement services;
 - exploring international recruitment and fellowships as means to developing additional specialist capacity;
- recruiting managers to support delivery of health improvement; and
 - supporting the development of academic public health, including joint appointments with the NHS to reflect local population and delivery needs.
48. Public health specialists, including those charged with leading and delivering key health improvement services, will need to be competent to work with communities and tackle health inequalities. In addition to skills in the use of research, evaluation and information they will need skills in communications and marketing. These specialists will have an important role in training and developing other staff, to raise the skills and knowledge base of the whole workforce and ensure effective front-line delivery of services to people. Specialist training is now available for a diverse workforce from a wide range of backgrounds, all of whom need to achieve common recognised and validated standards of professional practice. **We will work with key stakeholders to ensure that training, continuing professional development and professional regulation promote the generic skills that all public health specialists will need. We will also work with stakeholders to address critical shortfalls in staff numbers.**

Leadership for health

49. Local authorities lead action on community well being. All NHS organisations will also need to provide leadership for health if the NHS is to live out the commitments to health improvement which form part of its founding purpose. Strategic leadership for health within the NHS and across partner organisations is essential. This is a matter for organisations, their Chief Executives, and their expert public health leadership.
50. **We will work with the Improvement & Development Agency, Modernisation Agency and**

the NHS Leadership Centre and the National College for School Leadership to identify the core skills and competencies that are needed for the new style of leadership that is required at different levels. This work will also recognise the development needs of managers and non-executives in PCTs and other health trusts, and will develop programmes that can be used to bring key players in local government and health together to plan action at a local level.

51. The creation of Primary Care Trusts created an important new focus for **public health** leadership, but has also stretched capacity. PCT Public Health Directors and their teams have a core role. Expert capacity is stretched and public health networks provide a way of sharing scarce resources as long as they are managed and supported. So SHAs should review the need to strengthen and develop networks to deliver the commitments in this White Paper.
52. SHA DsPH will oversee work with SHA workforce directorates, Regional Directors of Public Health, training directors and Deaneries to develop a robust local health improvement workforce plan to meet local needs. We will invest £5 million in 2005/06, and £30 million per annum from 2006/07 to support this work at a national and local level. This work will be assisted by the development of models to support local capacity and capability planning which encompass the whole workforce from health trainers to specialist practitioners. We will expect regional public health groups to play a key role in working with regional and local government to ensure adequate capacity to achieve local health improvement targets.

Summary

53. This adds up to a complex programme, with many contributors, locally, regionally and nationally.
54. Locally, the immediate focus will be the capacity planning that the NHS needs to begin with its

partners, to support Local Delivery Plans for 2005–06 to 2007–08. These will be followed by a National Workforce Strategy in spring 2005, which will have health improvement as an important component.

55. **We shall establish a Health Improvement Workforce Steering Group to develop a strategy and coordinate the action needed, within this framework, to ensure delivery of this White Paper.**
56. These actions will ensure that the drive for health improvement is integral to the NHS and supported by a strong infrastructure with the capacity and capability to deliver high quality health improvement services in partnership with other sectors.

SYSTEMS FOR LOCAL DELIVERY

The challenge

57. Along with the policies and goals we have described to improve health, we need to know what works and how to make this a reality across England. This section of the Annex describes and clarifies our concept of the system for these specific policies on health, concentrating on the NHS and local authority contributions. As part of our delivery plan we will ensure that everyone is clearer about who will do what, which organisations have the lead and our expectations of effective partnerships.

Introduction

58. In line with the Prime Minister's public sector reform principles, the overall direction, standards and values that guide the public sector elements of the system for improving health will be established nationally by agreement across Government. Devolution and delegation to the front line will give local leaders responsibility for delivery and the opportunity to design and develop services around the needs of local people.

59. This will be achieved by: aligning investment, performance assurance mechanisms, planning guidance, inspection and regulation processes to deliver increased flexibility; by reducing red tape; providing greater incentives and rewards for good performance; encouraging innovation; and enabling strong leadership and management at a local level.

Different organisations working together

60. Public sector contributions to delivering health at local level are not only through health structures, but also through local government. Alongside, and central to effective local delivery, are the contributions of independent businesses, voluntary organisations and the community sector, as well as individuals. This section of the Annex does not outline the contributions of sectors other than the NHS and local government. This will be addressed as part of the delivery plan.
61. The roles and responsibilities for individual NHS organisations originally outlined in the NHS Plan and *Shifting the Balance of Power: Securing Delivery* need to be fully adopted and consolidated throughout the NHS. Opportunities to support the health improvement agenda include joint appointments of Director of Public Health posts, utilisation of Health Act flexibilities, pooled budgets, integrated service teams and managed public health networks between PCTs and local authorities. The potential of these has not been fully realised. We will encourage PCTs to explore these and Strategic Health Authorities will be expected to empower and enable their NHS organisations to do so.
62. The NHS Improvement Plan signalled the need for major cultural change to address a shift from sickness to health. Cultural change is needed at all levels – both individual and corporate.
63. We need to be clear about the roles, responsibilities and accountabilities for organisations, partnerships and individuals.
- We will establish coherence between planning processes, targets, incentives, performance measurement and inspection systems. As part of this process we will clarify the roles and responsibilities of public health specialists in the different parts of the system. Within the NHS we have already started to align these in ways that promote health through the recently issued NHS Improvement Plan and its supporting implementation programme, *Improving the System*. Where we have identified gaps, e.g. in the role of NHS Trusts and Foundation Trusts, we will issue additional guidance as part of the delivery plan for this White Paper.
64. Clinicians within the NHS will also need to address this cultural shift and view their individual roles and specialties within the context of improving health. All clinicians should enable patients to make healthier, more informed choices and ensure they are offered opportunities that will address prevention as well as treatment and care. We look to the professional bodies collectively to consider how they might ensure that this wider dimension to health care is addressed within the educational, training, development and regulatory frameworks for all clinical professionals.
65. We want to see an effective system for health delivered through close alignment between local community partners.
66. Supported by the existing and developing structural and organisational frameworks for NHS bodies, local authorities, networks and partnerships, this change will be sustained and reinforced throughout by alignment of:
- investment and resources;
 - planning guidance and performance improvement regimes, including the balance between fewer nationally and more locally determined targets; and
 - inspection, regulation and audit.

67. Structural and organisational arrangements have never delivered perfect alignment of resources and functions for the public sector. Wanless and the NHS Plan have confirmed that there is a sustainable institutional framework for the NHS, through which an effective system for health can be delivered that is closely aligned with local community partners.
68. In the NHS, Primary Care Trusts are population-based organisations which have a local focus, clear unequivocal responsibility for improving health. They have close contact with local leaders from other sectors, voluntary, business and local government, to deliver an integrated approach for their community.
69. Local authorities have responsibilities for social, economic and environmental wellbeing for their population as well as the duty of partnership with the NHS. Their contribution towards leadership of many local partnerships, and responsibility for health scrutiny place them alongside PCTs as the public sector leaders for addressing health inequalities, protecting the health of their local communities and promoting health to their populations.
70. The health improvement agenda for NHS Trusts, including Foundation Trusts, Care Trusts, etc is broadening. The national focus on health inequalities and health protection recognises the important role that NHS service providers have to play.
71. All types of NHS organisations, and particularly NHS Trusts and Foundation Trusts, must work with PCTs and other partners to contribute to health improvement in the local community, recognising their contribution to employment and economic development locally. They are expected to deliver these functions through the empowerment of clinical teams and patients, working across organisational and sectoral

boundaries. They will encourage innovation and creativity in reaching out and providing services as close to local communities as possible, to maximise the benefit of NHS resources across the local community.

Major contributions of Public Health professionals within NHS Trusts and other acute service providers are in relation to:

- evidence-based clinical policy;
- development of clinical governance;
- high-quality information systems;
- appraisal of health technology;
- reduction of infection and health protection;
- disease prevention;
- pharmaco-epidemiology;
- research;
- green hospitals and the 'greening' of hospitals; and
- the NHS as a corporate citizen.

72. The majority of NHS Arms Length Bodies contribute towards the system for public health and some have key responsibilities in the delivery of health improvement. Major examples are obviously the Healthcare Commission, which is described elsewhere in this Annex, but also the Health Protection Agency, NICE and the HDA. Other government agencies with key health improvement roles include the Environment Agency and the Food Standards Agency.
73. Health protection is a core component of an effective public health delivery system. Key national challenges such as influenza and SARs, uptake of immunisation, tuberculosis, sexual health including HIV/AIDS and chlamydia, infection control including MRSA and emergency preparedness are all important current challenges. The general public health infrastructure must be able to support delivery on these at a local level including the capacity for surge response in

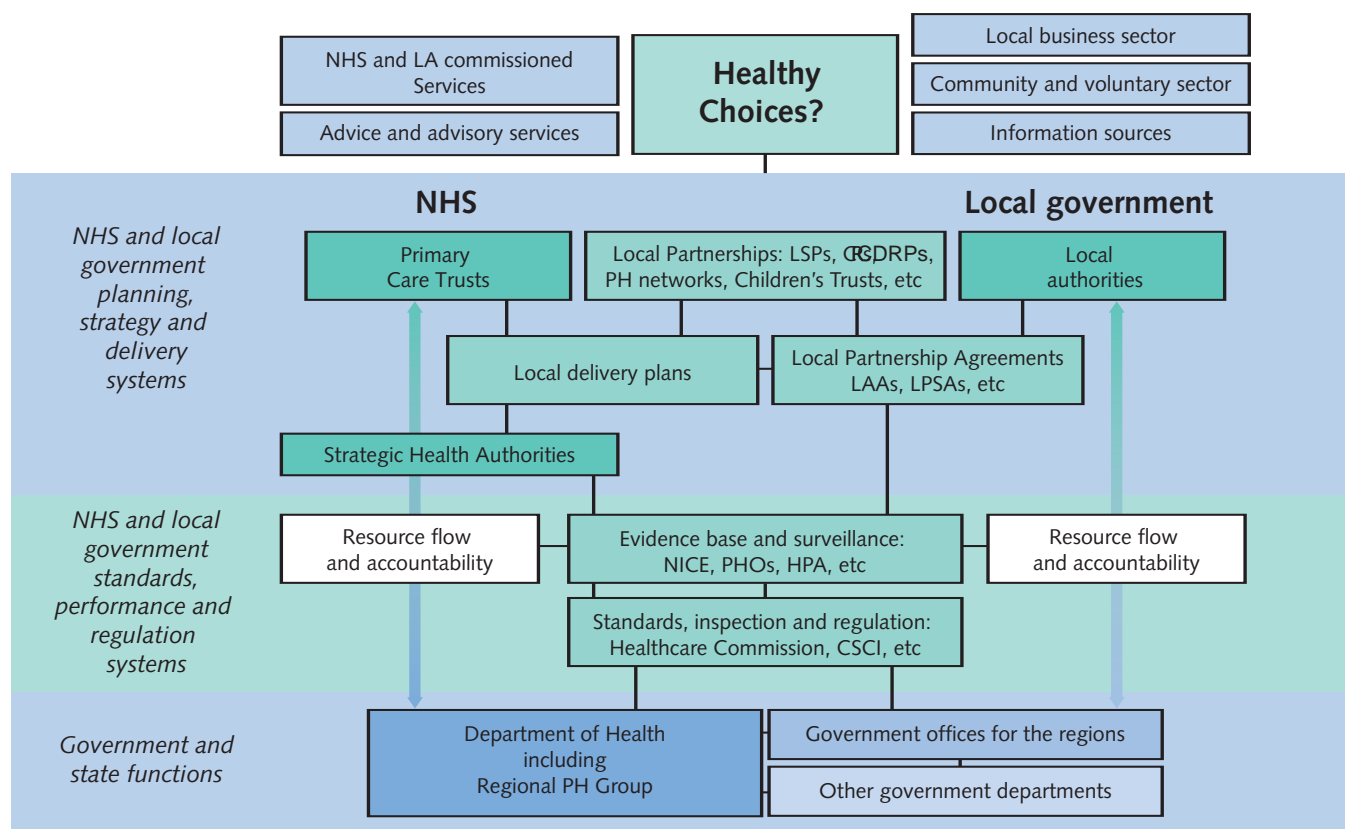
emergencies. This requires robust relationships between the Health Protection Agency and the NHS with clarity around roles and responsibilities.

- 74.** From April 2005 the Children Act 2004 places a duty on Strategic Health Authorities, Primary Care Trusts and others to cooperate with the local authority and its partners in making arrangements to improve the wellbeing of children. Wellbeing is defined in terms of the five outcomes of the Every Child Matters: Change for Children Programme: being healthy; staying safe; making a positive contribution; enjoying and achieving economic wellbeing.

Ways of working across boundaries: partnerships and networks

- 75.** Partnership working has been referred to extensively and is key if local people are to get joined up and complementary services. An area-based (population) focus, rather than an organisation-based approach assists this.
- 76.** At local level, the foundations of the public health system depend upon PCTs working closely with local authorities. Both work through key partnership mechanisms to develop and implement strategies, policies and plans to integrate, co-ordinate and develop services across both sectors.
- 77.** Since 2001, Local Strategic Partnerships (LSPs) have provided some of the most important fora for partnership working on health. The best LSPs have been very effective in bringing about real improvement in the health of their community by facilitating joined-up planning and delivery.¹
- 78.** Alongside senior local government representation, leadership by Executive Officers of the NHS (eg Chief Executive) of both the PCT and engagement of senior representatives of other NHS organisations (eg Trusts) is often key to success.
- 79.** Managed Public Health Networks provide a key mechanism to support the work of partnerships and organisations by providing highly specialised and essential public health skills, eg statistical analysis, health economics. PCTs, in partnership with their local NHS organisations and local authorities, should proactively manage specialist public health services and functions across the whole health community. Lessons should be learned from developing clinical networks, eg cancer, where investing in infrastructure, management, information, research and governance, as well as clinical leadership, has led to a step change in delivery.
- 80.** Public Health Observatories (PHOs) are a key contributor towards partnerships and networks. An expanded role for public health observatories providing information to PCTs to inform locally commissioned services and providing local analysis and information to Local Government will build on the expertise of PHOs in the provision and assessment of regional data. PHOs will not replace the need for PCTs and local government to have their own information services, but will augment and complement this intelligence and knowledge network. PCTs will need to invest in PHOs to support this development.
- 81.** In future, children's trusts will provide the focus for partnership working between health bodies, local authorities and other partners to improve the health of children and young people. This will encompass integrated strategy to develop a joint planning and commissioning strategy; integrated processes to involve health practitioners in utilising the common assessment framework and information sharing; and integrated front-line service delivery through multi-disciplinary teams and increasing co-location of health and other services.

¹ Examples of best practice of local strategic partnerships working on health can be found in 'planning with a purpose' (http://www.hda.nhs.uk/Documents/planning_with_a_purpose.pdf) and 'pooling resources across sectors' (<http://www.hda.nhs.uk/documents/poolingresources.pdf>) and 'planning across LSPs' (http://www.hda-online.org.uk/downloads/pdfs/127805_NHS_TEXT.pdf)



Strategic NHS and regional cross government oversight

- 82.** Strategic Health Authorities are the headquarters for the local health economies of the NHS and are required to have specialist skills in public health. The responsibilities of SHAs are to ensure, through monitoring, improvement and management mechanisms, that the NHS is effectively delivering and contributing to improvements in health and reductions in inequalities in health. They also have a role with other NHS organisations to ensure effective delivery of health improvement, health protection and other public health functions (such as screening) to support delivery of this White Paper agenda.
- 83.** The key role of the SHA will be to ensure that all organisations work together to improve health and reduce health inequalities. They will manage the performance of NHS programmes and networks that span organisational boundaries.

- 84.** SHAs will support and develop PCTs and NHS Trusts to maximise their contribution to achieving the wider government agenda to improve health and wellbeing through local strategic partnerships. SHAs are expected to facilitate and empower, helping their NHS Trusts and PCTs to maximise their autonomy and develop a culture of health improvement and citizen involvement.
- 85.** Government Offices were created in 1994, to bring together the activities and interests of different Government Departments in delivering Government policies in the English regions. In 2002/2003, Government Offices in the Regions (GORs) were responsible for around £9bn of Government expenditure. Their sponsor Departments are ODPM, Dept of Transport, DEFRA, DfES, DTI and the Home Office. They also act as host to co-located personnel from DCMS and DH.

Department of Health representatives located in the regions will:

- lead the work with regional and local government and the NHS to ensure that regional partner policies and activities take account of their health impact, eg housing, transport, planning, employment, education and skills, environment, rural affairs, crime and community safety;
- work in partnership with Strategic Health Authorities to ensure that the NHS contributes effectively to local partnerships such as LSPs and Crime and Disorder Reduction Partnerships and partnership agreements such as LAAs;
- lead the work with regional partners, including SHAs to bring together key performance processes to ensure there is cross-cutting analysis of delivery on health inequalities and joints support and drive processes;
- support SHAs to secure the NHS role in health improvement, particularly for NHS Trusts and Foundation trusts, in sustainable development frameworks across the regions and as an exemplar of social responsibility;
- lead the development and implementation of regional frameworks for health through work in partnership with regional assemblies, Government Offices and Regional Development Agencies;
- work with and through other relevant organisations, including the NHS and local authorities to implement national public health programmes within the region;
- contribute to the development and implementation of government policy; and
- ensure an effective regional intelligence and information function through the Public Health Observatories that supports the availability of regional and local information on health, for local people, the NHS, regional and local partners. This will include reports on health where requested by regional bodies.

86. The Department of Health has a well-established presence at regional level, under the leadership of the Regional Directors of Public Health (RDsPH). They provide leadership for the cross-government work on implementing policy on wider determinants of health in their regions and will oversee the performance of DH's cross government programmes and networks supporting wider determinants of health and reduction of inequalities.
87. Regional Directors of Public Health will have new responsibilities for ensuring that performance improvement information on cross-government agendas for wider determinants of health nationally, in Government Offices and other local and regional bodies, is communicated to and acted upon by Strategic Health Authorities and nationally.
88. A guide for the NHS on the roles and functions of regional partners in relation to health will be produced in 2005, highlighting how these individual partners contribute towards the overall delivery of an integrated cross-government approach to policy implementation for health and inequalities. Amongst others, this will address the role of the Regional Development Agencies, Regional Assemblies and their inter-relationships with the NHS.

Building leadership

89. All NHS organisations will need to lead for health if the NHS is to live out the commitments to health improvement, which form part of its founding purpose. So it is critical that there is adequate strategic leadership within the NHS and across partner organisations.
90. Other parts of the White Paper have already addressed issues relating to the general and specialist workforce for improving health, including public health professionals, and highlighted the need for leadership and leadership

development. This section of the annex looks specifically at supporting the corporate leadership culture across the NHS and local government to ensure a strengthened understanding of the corporate responsibility for improving health in all organisations.

91. We will target development for Chairs and Non-Executives in the NHS and Leaders and members in local government, together with their Chief Executives, Directors of Public Health, others at Board and Executive Director level, including those with professional leadership responsibilities.
92. These Corporate posts have important roles in:
 - providing focus and direction at local level;
 - giving visible and committed leadership;
 - demonstrating effective management for health;
 - demonstrating understanding of the principles affecting inequalities;
 - working in partnership; and
 - working to empower and inform local people and communities.
93. IDeA have pledged to contribute to the creation of a national workforce development strategy for improving health, including exploring the potential of bringing together NHS and local government leaders and managers for joint development opportunities. They will work with their counterparts within the NHS, the NHS Modernisation Agency leadership centre to secure these opportunities.
94. Critical to successful delivery of their responsibilities will be the influence and leadership of the local Director of Public Health. They will be expected to lead the PCTs' efforts to establish and maintain effective and close working relationships with local government, local partnerships and local

networks. We wish to underline our continuing commitment to the description of the local Director of Public Health contained in *Shifting the Balance of Power: Securing Delivery*. We also reinforce the need for significantly increased investment in capacity to support the delivery of the public health responsibilities supporting commissioning, service delivery and development and partnership working.

Ensuring local delivery

95. In the past, the NHS has been criticised for focusing too narrowly on its own immediate goals. The national cross Government Public Service Agreements and their targets and priorities can only be delivered through effective partnership working. It is important that standards, targets, incentives, support for change, planning, performance and inspection systems are aligned to encourage this. As a priority, this is essential between the NHS and local government, rather than focusing on individual organisations in isolation. Only by adopting this approach can we ensure coherence of delivery systems for health policies.

National standards

96. Recent guidance on standards, priorities and planning were brought together in the publication *National Standards, Local Action*, the Health & Social Care Standards & Planning Framework for 2005–06 to 2007–08. Improving health is identified as one of the four national priorities, with national targets to be met. Performance against standards are to be the main driver for continuous improvements in quality and will be assessed by the independent Healthcare Commission.
97. The standards refer to the need for systematic and managed disease prevention and health promotion programmes and has set action on health and inequalities firmly on the core agenda

for the NHS and its partners. Developing the NHS into a health service rather than one that focuses primarily on sickness is explicitly identified as a focus for the next stage of NHS reform.

- 98.** Following publication of *National Standards, Local Action* the Department of Health issued a technical note to the NHS on Local Delivery Plans to support the delivery of these national targets. We will issue a supplementary technical note to the NHS, reinforcing the priorities of this White Paper and outlining the requirement to plan services to deliver reductions in health inequalities and improvements in obesity status, including among children, and on sexual health.
- 99.** The LDP technical note already emphasises the need for plans to reduce inequalities, address cancer and coronary heart disease, reduce levels of smoking, improve infant mortality, reduce teenage conceptions and suicide mortality. The NHS is directed to develop plans for these national targets and priorities alongside the other national targets for access to services, MRSA, supporting people with long-term conditions and patient/user experience.

Aligning targets

- 100.** The stretching national Public Service Agreements recently agreed with individual Departments have signalled the importance this Government attaches to improving health. The only national targets are those associated with the PSA, leaving greater flexibility for local organisations to determine how they should contribute to the delivery of national priorities.
- 101.** PCTs have more headroom to set local targets in response to local needs and priorities. In developing targets in local plans, PCTs will be required to ensure that they are in line with population needs, address local service gaps, delivery equity, are evidence based, offer value for money and are developed in partnership with local authorities. Partnership with local communities, service providers, patients and service users and particularly with local authorities is highlighted as vital to ensuring that targets and commissioning plans are broadly based and not limited by individual organisational boundaries.
- 102.** Recent changes in the relationships between central government and local delivery agencies within the public sector are already proving a spur to new initiatives and improvements in performance. In local government, the introduction of Local Public Service Agreements (LPSAs) add momentum to local partnerships. LPSAs are agreed between central government and local authorities and their partners, normally through the Local Strategic Partnership. Local partners select priorities for improvement locally and are paid a grant if they achieve targets agreed with central government (equal to around 2.5% of one year's expenditure, paid out in instalments over three years). The LPSA system offers a performance reward grant for achievement that motivates and focuses energy on the desired outcomes.
- 103.** It is up to local partners to decide on the priorities. PCTs are expected to play an active part in helping define and support delivery of local action that benefits health – either directly or by addressing wider factors such as community safety or economic, environmental and social regeneration. So far, 36 upper-tier local authorities have set LPSA targets on health inequalities in the 'second generation' of negotiations, with many more on other areas of health. SHAs should work with regional public health groups to ensure that these are reflected in local target setting by PCTs.
- 104.** The development of the Shared Priority between central and local government recognises the importance of healthy communities. This has led to CPA, the Pathfinder Programme, Beacon

Council scheme and Innovation Forum projects. The picture is larger than just agreeing Local PSAs.

- 105.** For example, improvements in community safety, the educational performance of children, the skills of the workforce, the strength of the local economy and the cohesiveness and capacity of local communities all contribute to the well being and hence to the health of local people. These are not simply local authority priorities. From today they become priorities that the NHS shares. In the same way that the health service must address the wider determinants of health, local government must give a more explicit priority to health improvement, and must work to narrow health inequalities.
- 106.** The more recent extension of this thinking has led to the government's proposals for pilot Local Area Agreements (LAAs). The level of response to the invitation to seek pilot status demonstrated the high level of support for this approach. A significant motivating factor behind LAAs is the promise that separate local funding streams will be merged to give greater flexibility to local authorities and their partners. The themes within LAAs have significant relevance to health.

Incentives

- 107.** Funding is available to support increased investment in the NHS. By 2007–08, total investment in the NHS will rise to £90 billion. Primary Care Trusts will control over 80% of this. They are able to direct an increasing proportion towards local priorities for action and to improve the health of their communities. Nationally, Government will support their efforts through increased investment in campaigns, in research and evaluation, and in information systems.
- 108.** We need the right incentives – for individuals, clinicians, other employees and organisations – to put health first. The coherent system of national and local targets, assessment arrangements and

inspections spanning the NHS and local Government now creates a strong overall framework for this and is described in more detail next. More is needed to redress the NHS's traditional focus and to rebalance investment in favour of sustainable health and healthcare systems.

Support for change

- 109.** The Government recognises that the strength of public interest in the Choosing Health? consultation reflects a strong expectation that there will be changes in our traditional approaches to service planning and delivery. The challenge to the public sector is not just to do new things, but to do them in new ways which engage with individuals, communities and other organisations and businesses to deliver sustainable improvements in the health of the whole population, and a narrowing of the health gap that exists between different groups and communities. In short, we need a culture change programme across large parts of the public sector.
- 110.** For the NHS, supporting the implementation phase of the Public Health White Paper will be a priority task for the NHS Modernisation Agency (MA) and for the national body that will replace the Modernisation Agency from April 2005. It will work alongside PCTs, SHAs and DH to achieve this by focusing on how change can be achieved and embedded across local communities and the health and government system.
- 111.** Implementation rests with local organisations, their communities and individuals. The MA will contribute leading edge improvement expertise, best practice tools, techniques and strategies for change so that the potential for effective and lasting change is enhanced.
- 112.** Innovation processes will be built into implementation and creative ideas can be generated. It will help to test the applicability

There is a nationally agreed general medical services (GMS) contract, used by 60% of general practice. Practices are obliged to provide *essential* services for those who are ill or believe themselves to be ill, and chronic disease management and appropriate health promotion. Nearly every practice offers *additional* services, such as flu jabs, cervical smears and maternity medical services. Many practices also offer *enhanced* services, often provided by a practitioner with a special interest, such as drug abuse services, specialised sexual health services or diagnostics.

- **Personal medical services (PMS)** are a more locally sensitive model, where a contract is agreed with the PCT. PMS contractors may also provide quite specialised services in primary care settings.
- Where it is agreed locally to be necessary, the PCT itself can directly provide services. For example, it might directly employ a GP or a care manager to support the care of those people with many health problems.

- Finally, through **alternative provider medical services**, a PCT can contract for provision of any necessary care for its population, with the private, voluntary or charitable sectors, alone or in partnership with each other or other NHS providers.
- All contracting routes will offer well-organised care that can be monitored through the Quality and Outcomes Framework and over 95% of practices do so. This is an incentivised scheme where there are a number of standards of quality care, other indicators of the way care can be well-organised, access standards and patient experience questionnaires.
- The proposed new pharmacy contract will reflect the public health role of pharmacists both within the essential services component of the contract, which all pharmacists will normally provide, and the locally commissioned enhanced services, which PCTs will commission *essential services* and *enhanced services* to meet local need.

of proven healthcare improvement methods in a wider health context. It will support the identification of best practice changes that have the highest impact, assessing the potential benefits of these changes and the gains that local communities and organisations can make as a result.

- 113.** The ambitious goals of the Public Health White Paper require fresh and innovative perspectives on how to create large-scale change across an entire county. Planned and programmed approaches to change need to be combined with actions to ignite energy and passion around the cause of health, rather than illness, and in doing so, create a locally led, grass roots movement. We will help to support the continued development of the movement for health and well being.

- 114.** The Improvement and Development Agency has pledged to contribute towards the delivery of the national objectives within the White Paper. IDeA and the Local Government Association both endorse recognition the key role of local government in improving health and promoting well being of local communities and have pledged to help drive this agenda forward through their work. To support this, they will pay particular attention to developing greater awareness of health inequalities and the potential contribution of local government to their reduction. Local Councillors will be supported to develop their roles as community leaders for changes that will increase the opportunity for local people to adopt healthier lifestyles and provide environments that protect their communities.

115. We, together with the NHS Modernisation Agency, have recruited ten Regional Change Advisers. They will focus on supporting the change programme which local authorities, Primary Care Trusts and other local partners will be developing in pursuit of their new duty in the Children Bill to make arrangements for local cooperation. This will involve support in moving towards children's trusts to deliver better outcomes for children and young people and in implementing the National Service Framework for Children, Young People and Maternity Services. As part of this agenda, the Regional Change Advisers will support Primary Care Trusts and Strategic Health Authorities in taking forward the actions in this White Paper.

Inspection and performance assessment

116. From 2005 there will be a new performance framework for the NHS and social care, described in *Standards for Better Health*. This set out the level of quality all organisations providing NHS care will be expected to meet or aspire to across the NHS in England. One of the seven domains in *Standards for Better Health* is public health.

117. The independent Healthcare Commission is responsible for developing assessment criteria to be used to determine whether core standards have been met, and judging progress against developmental standards. The annual performance ratings will be based on annual reviews of NHS organisations and those providing services to the NHS and will draw on thematic reviews of particular functions and services, including those for health improvement and public health.

118. In parallel the Audit Commission uses the Comprehensive Performance Assessment (CPA) methodology to assess local authority performance, focusing particularly on continuous improvement, outcomes for service users, proportionality to performance and risk, and partnership. The CPA methodology is being

revised for 2005, with development work underway. Assessment of Councils' performance in promoting healthy communities and narrowing health inequalities will be a key part of the new Comprehensive Performance Assessment framework from 2005.

119. The Healthcare Commission and Audit Commission have agreed to work together on the way in which these new systems assess health improvement. In their combined response to the Choosing Health? Consultation they proposed a several stranded approach to joint work on assessing health improvement and public health on the basis that 'regulation has its part to play in improving (public) health and the regulators must also work in partnership to be effective' The specific proposals include:

'The Healthcare Commission and Audit Commission will seek to align their approaches to assessment of local government and healthcare organisations to produce a common locality based view of progress and performance in improving population health and reducing health inequalities. These will also need to take account the context set by the relevant regional and sub regional bodies.

'The Healthcare Commission and the Audit Commission will develop a framework for thematic reviews of public health issues to inform national and local delivery. Other inspectorates will be involved wherever appropriate.'

120. From 2005, there will also be a single overall inspection framework for children, to underpin all relevant inspections carried out by the Healthcare Commission, the Commission for Social Care Inspection, Ofsted, the Audit Commission and others. This will focus on how services contribute to the overall wellbeing of children and young people, including their physical and mental health. Joint area reviews will look at how children's services are working together to this end.

Summary

121. The systematic approach for delivering improvements in health at a local level will depend on:

- Strong leadership and management
- Commitment to working effectively in partnership
- Aligned inspection and regulation, standards, targets, incentives and performance assurance mechanisms

Making a difference

122. This time we have to build and sustain public health action across Government and at all other levels. A robust delivery system will integrate and develop this systematic approach to deliver the new public health agenda. The White Paper spells out the key challenges for Government, establishing health as a way of life for individuals and communities. This requires us to build effective partnerships and invest to ensure future health and take effective action to reduce inequalities. Health is inextricably linked to the way in which people live their lives, so only if we consider health as an integral part of policy development and implementation at national and local level will we achieve our aim to improve England's health.