A health-promoting NHS
‘Many of the benefits of engaging people in living healthier lives occur in the long term but there are also immediate and short-term benefits when demand for health services can be reduced, especially in those areas where capacity is seriously constrained.’

Derek Wanless

CHAPTER SUMMARY

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

- help local health services to plan and deliver effective action to tackle inequalities and improve health;
- make the most of the millions of encounters that the NHS has with people every week;
- ensure that all NHS staff have training and support to embed health improvement in their day-to-day work with patients;
- address the needs of people at particular risk; and
- ensure that health improvement and prevention services – such as sexual health services, NHS Stop Smoking Services, obesity services and alcohol services – benefit fully from the same drive for modernisation and improvement that exists across the rest of the NHS.

INTRODUCTION

1. One of the founding principles for the NHS in 1948 was that it should improve health and prevent disease. After decades of underfunding, the Government’s programme of historic investment and radical reform focused first on putting NHS treatment services on the road to becoming world class. Now is the time for the NHS to move on to become a true health service and not just a sickness service.

2. We need to invest in helping people to stay healthy. The public believe that the NHS should take a lead role in providing information, advice and support to enable everyone to lead healthier lives and prevent illness.

3. This makes good economic sense too. One of the major choices facing society is how we can best use the £67 billion a year we now spend on the NHS, and make the most effective use of that new investment. Derek Wanless, in his two reports, drew out the financial consequences for a society that does not invest in health. If trends in obesity develop unchecked, or smoking rates stop falling, we will have to spend a growing proportion of NHS funds on coping with chronic conditions like diabetes and heart disease. The NHS will have to run ever faster to stand still. Derek Wanless made

CASE STUDY

‘If England is to secure world-class standards of health, the enormous human, financial and physical resources available to the NHS need to be focused on the prevention of disease and not just its treatment.’

NHS Improvement Plan 2004

a powerful case for a new form of alliance between the NHS and society to halt these trends and become ‘fully engaged’ in promoting health. Action to support good health brings together the interests of individuals, the NHS and tax-paying society.

4. This chapter describes what the NHS will do to deliver on these aims. It describes the next steps to improve health, identify risk and prevent disease, by:

- ensuring that the one and a half million contacts people have with the NHS every day become opportunities for improving and promoting health;
- developing local services designed around the needs of local communities, with a particular focus on those in the most disadvantaged groups and areas; and
- developing the same systematic approaches to health improvement and disease prevention services that are already transforming NHS treatment services.

MEETING DEMAND FOR HEALTH BY PROVIDING CONVENIENT SERVICES

5. Chapter 2 set out how, in a new approach to health policy, the Government will lead a strategy for marketing health and some of the ways in which the Government will respond to raised demand for health. The NHS has a critical role in helping to match a new demand for health,

All patients with learning disabilities, registered at a large primary care centre in Warrington, were offered a health needs assessment and health action plans. A training programme was developed by two public health nurses to help staff deliver adapted mainstream services to people with learning disabilities. A year in to the project, 92% of the population had received an assessment compared with 22% the previous year.

“It was the first time in a long time that someone had asked me how I was feeling and what my worries for the future are. I feel like there is someone there now if I need advice.”

Carer, aged 72
CASE STUDY

“Patients seem to prefer the informality of the walk-in centre which is less intimidating than the hospital environment,” says lead nurse and centre manager at a new, out-of-hours, NHS Walk-In Centre, Southampton.

Green Light Pharmacy near Euston station in Central London not only provides ‘typical’ pharmacy services but has also transformed its basement into a local health education and meeting centre for local black and ethnic minority populations using Neighbourhood Renewal funding and private investment. It provides regular health education sessions to the Bangladeshi community, including specialist smoking cessation services.

The pharmacy also supports the Skilled for Health partnership for Bangladeshi people with diabetes by signposting into the classes and providing translation services. It also operates a training programme for community volunteers who encourage local people to complete a series of ‘health risk assessment’ questions which are analysed by the pharmacy and feedback provided on the patient’s level of risk. The patient may then be asked to attend the pharmacy if they wish to have screening and a further opportunity to discuss healthier lifestyle options.

created by more information and effective national campaigns, with an accessible supply of practical opportunities and support for people to take action. In particular, people in deprived areas need to have good access to primary health care services. We need not just to tell people about what they can do to improve their health but make it convenient for them to follow through and sustain the changes that they want to make.

6. The NHS will play its part by building services around people’s lives, and taking account of the different needs of different groups in the community, so that everyone can benefit. The aim is to put in place a reliable, effective and accessible infrastructure for health improvement and prevention services that matches the infrastructure for high quality treatment services that we all expect.

NATIONAL PLANS TO PUT HEALTH AND PREVENTION AT THE HEART OF EXISTING PROGRAMMES

7. The National Clinical Directors are already working with local clinical networks to drive through the improvements set out in National Service Frameworks (NSFs). These are delivering sustained improvements, building high quality services to treat and prevent conditions such as cancer, diabetes, coronary heart disease and mental ill health, and providing more integrated and effective care for children and older people.
8. In many cases, these already include a focus on prevention, such as several standards in the NSFs for coronary heart disease and diabetes, and the falls standard in the NSF for older people. And these have been backed by action. For example, the Healthy Communities Collaborative engaged older people in pilot areas working with professionals to minimise personal and environmental risk of falls in simple and practical ways. This led to a drop of 32% in the number of falls recorded by ambulance collection data over the one-year pilot.

9. But, as the Government and the NHS engage in a new approach to health policy, with new infrastructure and new action on health, existing health improvement and prevention approaches need to be adapted to maximise their impact and to mainstream a comprehensive approach to health improvement across the NHS from primary care, through hospital care to specialist services.

10. Each National Clinical Director will work with clinical communities and networks to:

- identify where there may be scope to extend primary and secondary prevention in their clinical areas, including geographical variation in preventive action and prescribing rates;
- agree the most important steps to take, in particular to tackle health inequalities; and
- set how progress can be assessed.

The Northern and Yorkshire office of Diabetes UK has successfully worked with local diabetes healthcare teams to organise and run ‘Diabetes for Life’ days in Leeds, Gateshead, South Tyneside and York. These events have each attracted around 150 people with diabetes, providing them with opportunities to better understand their condition, improve their health and get to know the range of local health and voluntary services.

The opportunity to talk to healthcare professionals in the informal setting and environment provided by the voluntary sector was invaluable for people who find it difficult to raise issues in ordinary clinical settings. These events have been led and organised by Diabetes UK but have relied on the full cooperation and participation of the local NHS.
11. As part of this work, the National Clinical Directors with the Deputy Chief Medical Officer will make recommendations by March 2005 on how to build a comprehensive and integrated prevention framework across all the areas covered by the National Service Frameworks. Locally, primary care trusts (PCTs) will need to consider how far current arrangements for delivery of the NSFs meet the new framework.

MEETING DEMAND FOR HEALTH: LOCAL PLANS FOR CONVENIENT SERVICES

12. In order to make a difference, and to enable local health services to provide a strong infrastructure for health locally to meet increased demand for health, we are giving PCTs the means to tackle health inequalities and improve health through:

- funding to give greater priority to areas of high health need. We shall continue and if possible accelerate distribution towards need and promote commissioning for health;
- new investment in primary care facilities for some 50% of the population by 2008 with a focus on the most deprived areas of our communities; and
- development of a tool to assess local health and wellbeing that will help PCTs and local authorities jointly plan services and check on progress in reducing inequalities: a health and wellbeing equity audit.

Taking opportunities for health: the role of NHS staff

Evidence shows that:

- giving up smoking before an operation leads to faster wound healing and a shorter hospital stay;
- intensive individual support to give up smoking following a heart attack or heart surgery increases the likelihood of success;
- screening people who attend A&E in cases where alcohol is a potential cause, and offering brief advice on alcohol misuse, can help reduce re-attendance rates;
- referring older people who have fallen to a falls clinic can help prevent more serious injury at a later date; and
- a healthy diet and stopping smoking can contribute to healthy eyes and provides some protection against age-related macular degeneration.
13. It will be NHS staff who put these plans into action and, to make a real, sustained impact, the whole of the NHS must join in. Across the NHS, there are one million interactions every 36 hours with people who are looking for some kind of help with their health. This offers enormous potential to get the right messages across. Every member of NHS staff has the potential to increase their role in raising people’s awareness of the benefits of healthy living – as part of the wider NHS responsibility to patients to improve health, not just provide healthcare for the sick.

14. We will exploit this potential wherever we spot it. **As part of improving access and availability of tailored help to smokers wanting to quit we will, from 2006, offer NHS Stop Smoking Services on the new ‘choose and book system’**. Choose and book is an electronic appointments service, initially for use by GPs in booking first outpatient appointments. From 2006, smokers will be free to choose available appointment slots for local NHS Stop Smoking Services, and book them through their GP practice. **We are also working towards embedding an offer of stop smoking advice as part of clinical assessment in surgical care pathways from 2006.**

15. NHS staff are among the most respected and valued people in England. People trust them and listen to them. This strategy will begin to provide NHS staff with the support they need to make the most of that opportunity. This strategy marks the start of an important and fundamental cultural change in the way that the NHS relates to patients, with staff providing professional counsel and encouragement to patients on health, as well as high-quality treatment.

16. To support this change, **we will develop a National Health Competency Framework, which will include new programmes to give NHS staff the training and support they need to develop their understanding and skills in promoting health.** Through induction training for all new staff, undergraduate courses and continuing professional development we will equip all frontline staff to recognise the opportunities for health promotion and improvement, and use skills in health psychology to help people change their lifestyles. Elements of this training may also be helpful for workers outside the NHS, including in the voluntary and community sectors.²

**Transforming health and prevention services**

17. Health improvement and preventive services are patchy in quality and variable in coverage across the country. There is a geographical lottery in the support available. For a new approach to health policy in the 21st century, these services need to benefit from the same systematic drive

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² Annex B describes what we are doing to improve the evidence base, develop and disseminate information and best practice and improve training opportunities, learning from international best practice.
for improvement and modernisation that is already transforming access to primary care, surgery and emergency care in the NHS. To meet increasing demand for health in the NHS, England needs fast, effective and universal access to high quality, people-centred health improvement and prevention services which have capacity to deliver.

18. We also need to tackle health inequalities head on, ensuring that the NHS provides people in disadvantaged areas and groups with services designed around their needs so that they want to use them. Developing new, innovative models of care and pursuing opportunities for sustained action as well as quick wins will be particularly important in tackling inequalities. We will need to ensure that service improvements do not increase health inequalities.

19. We will act on the best available evidence or develop new models of care to be evaluated in real time to determine what works ahead of wider roll-out. Health trainers will provide a key part of that infrastructure. Cultural change in the way that the NHS relates to patients, equipping itself to advise on health as well as treatment, will provide another. The rest of this chapter sets out how health and prevention services will be modernised over time, using the new health trainers as the foundation for an NHS where it is increasingly easy to get information and advice or access to services.

The Sheffield CIRC (citywide initiative for reducing cardiovascular disease) Programme aims to reduce inequalities in cardiovascular premature mortality. It delivers high-quality, secondary prevention programmes to an estimated 14,000 individuals with cardiovascular disease in the areas of highest need.

Fifty-one Sheffield GP practices received a tailored programme of support that included: training of nurses and doctors; additional nursing time; IT support; dietetics; physical activity and psychological specialist input. A citywide programme of user support and community engagement with ethnic minority communities also linked into the practice-based activities. Additional funding of £1 million has enabled the programme to be incorporated into the mainstream services of the four Sheffield Primary Care Trusts. By 2003, Sheffield had seen a 23% decline in the under-75 cardiovascular mortality rate in the most deprived fifth of its population since 2000, compared to a 16% decline in the Sheffield population as a whole.
It describes what NHS organisations will do, and how they can work in partnership with local government and the independent sector.

20. In improving these services, we will initially concentrate on:

a. building a new local infrastructure for improving health, within the new arrangements for primary care services;

b. addressing the needs of people who face specific challenges:
   - making particular efforts to improve the health of people who have lifelong illnesses, particularly older people;
   - providing better support for people with mental health problems; and
   - promoting the health of people in prison.

c. tackling the big lifestyle issues:
   - maximising the effectiveness of NHS Stop Smoking Services;
   - improving services to help people who are overweight or obese and prevent overweight gain from an early age;
   - strengthening services to improve sexual health; and
   - delivering better services to prevent and treat alcohol problems.

AN NHS EQUIPPED TO MEET DEMAND FOR HEALTH

21. We will foster and expand a comprehensive range of community health improvement services that includes specialist practitioners who know how to:

- help people develop their understanding and skills to improve their own health;
- strengthen community action for health to tackle inequalities; and
- work with communities, offering training, advice and support to a broad range of health professionals.

22. As part of these changes, new contracting arrangements for primary medical care, pharmacy\(^3\) and dentistry\(^4\) are being introduced, to give more scope for PCTs to work with the health professions to shape services and introduce new providers to meet local need and local demand for health with high quality, professional services to support people in finding a healthy way of life.

23. For general practice, the new primary medical care contracting arrangements offer enormous potential to develop new ways to meet a growing demand for health, with more flexible services; greater choice; increased specialist activity; an improved range and quality of services; and services tailored to local needs.

\(^3\) From early 2005, subject to the conclusion of negotiations.
\(^4\) From October 2005.
CASE STUDY

In South London, the Rushey Green Health Centre has run a ‘Time Bank’ for three years. Doctors write prescriptions for medication but also for a regular hourly visit from a local Time Bank participant. This may be anything from help with the shopping to a friendly voice over the telephone. The Time Bank participants are also patients of the surgery and are happy to offer the care and support needed and earn their own Time Credits with the Bank at the same time. The doctors report that Time Bank participants visit them less.

24. In addition we will put in place measures which make the most of the contribution that pharmacists can make. Working at the heart of the communities that they serve, they have real opportunities to offer health messages and advice on issues such as diet, physical activity, alcohol, stopping smoking and looking after our own ailments ourselves. The strategy for pharmaceutical public health, to be published in 2005, will demonstrate how pharmacists and their staff can contribute to improving health and reduce inequalities and how we can develop new services in the places they work.

25. Many of the issues that affect people's general health are important for oral health too. Under the new contractual arrangements for NHS dentistry, from October 2005 dentists will give a new focus to advice on the prevention of disease, lifestyle advice and the discussion of options for care. They could, for example, work in conjunction with the wider primary care public health team to provide advice on smoking, and diet and nutrition – including prescribing sugar-free medicines where appropriate.

Maximising the reach of screening programmes

26. Each year the NHS offers health screening to about ten million people. The offer is of a specific screening test and it is for each individual to decide for themselves whether or not to accept it. Screening programmes\(^5\) do not operate in isolation; they have to be integrated with measures to encourage and promote the primary prevention of disease, and with the treatment services for those people who develop disease.

27. There is evidence of inequalities in take up of screening. As discussed in Chapter 2, the first step in influencing health behaviours in any group is to understand why people make the choices that they do, and the second is to design and deliver any new initiatives in consultation with them. PCTs will need to use health equity audits\(^6\) to build a better understanding of why some people or groups are less likely to use the range of available opportunities for screening, and then act to promote take up.

SUPPORTING PEOPLE IN MAINTAINING THEIR HEALTH

About 60% of adults report some form of long-term or chronic health problem, including diabetes, asthma, arthritis, heart disease, depression, psoriasis and other skin conditions that can be controlled but not cured. Long-term conditions affect older people more than younger people. People in lower socio-economic groups are more likely to be diagnosed with more than one condition.

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5 The screening programmes for individual conditions are grouped into four main programmes: the Antenatal and Newborn Screening Programme; Health for All Children – screening for children after the newborn period is integrated with a wide range of different measures to protect and promote health such as cancer screening; cardiovascular screening and diabetic retinopathy.

6 See Annex B.
28. Health professionals need to consider the long-term benefits of encouraging patients to adopt healthy lifestyles even when advice on giving up smoking, exercising or changing diet is unwelcome and may initially make relationships difficult. For older, frailer people, who are more vulnerable to loss of independence and dignity, the right kind of support can markedly improve their ability to take ownership of planning and following through a healthy lifestyle.

29. The new arrangements in primary care will be important in helping people with long-term conditions or multiple conditions to make the most of their health. Most people with chronic diseases or disabilities are able to manage their condition themselves and to maintain reasonable general health with support from others. With help to develop their skills they can take greater control of their own health and their lives. The right support can often either slow the progression of the disease or reduce the problems of managing severe phases of illness.

The Expert Patient Programme supports people with long-term conditions to increase their confidence and improve their quality of life. Courses are designed to help patients develop skills in communication, managing emotions, managing daily activities, using the healthcare system, planning for the future and also improving their health through exercise, diet and ability to rest. Following the current pilot phase, we will make the course available through all PCTs by 2008.*

* The course will be available in a range of languages and media for people whose first language is not English and for people who may have sensory impairments or disabilities

30. We will ensure that community matrons take the lead in providing personalised care and health advice with support from health trainers. By 2008, there will be 3,000 Community Matrons who will take on responsibility for case-managing patients with complex health problems.

31. Giving health improvement advice can help people with chronic conditions improve their fitness and overall quality of life. Community Matrons will identify vulnerable people who are at risk or who would benefit from health advice to prevent deterioration in their condition, so that their needs can be better met, and the risk of deterioration or hospital admission can be minimised.
32. Using proven best practice and modern information technology, local services will have the ability to provide targeted support. The Department of Health will advertise for independent sector partners to work with the NHS in a number of areas to develop new approaches to supporting health as part of self-care for chronic conditions linked to personal health guides.

IMPROVING HEALTH FOR ADULTS WITH SOCIAL CARE NEEDS

33. The health needs of the adults who access social care will be the subject of further consultation in the preparatory work for the proposed Green Paper on adult social care. This has already identified action in line with the principles of this White Paper to improve adults’ health and wellbeing.

PEOPLE IN PRISON

34. Generally speaking, people in prison have poorer health than the population at large and many of them have unhealthy lifestyles. Many will have had little or no regular contact with health services before coming into prison, and prison populations reveal strong evidence of health inequalities and social exclusion.

- The majority of prisoners are young and male.
- Most prisoners are in custody for periods of weeks or months, rather than years.
- Sixty to seventy per cent of them were using drugs before imprisonment and over 70% suffer from at least two mental disorders.
- It is estimated that at least 80% of prisoners smoke.
- Sixty-six per cent of all injecting drug misusers in the community have been in prison at some time, of whom half had been in prison before they started injecting.
- Male prisoners are much more sexually active in the community than the general population; all age groups having more lifetime sexual partners, and more partners in the year before entry to prison, than would be expected from the general population. They are also six times more likely to have been a young father.

35. Initiatives to improve health of prisoners offer a valuable opportunity to identify and tackle the wider health needs of a vulnerable and socially excluded population. They could, for example, be given information on health services and how to use them as well as information and support aimed at influencing their drug and alcohol and tobacco usage. Even if this did not persuade them to stop it might influence them towards less risky
“Many people with a severe mental illness experience considerable weight gain as a side effect of the anti-psychotic medication they take. They need dietary advice to deal with this. Some also live fairly chaotic lifestyles and need support to ensure that they eat regularly and healthily.”

RETHINK 2003

People in prison are being helped to stop smoking through services specially targeted to their needs, including access to Nicotine Replacement Therapy (NRT). These services are proving very successful. Early indications are that quit rates amongst prisoners, some 80% of whom smoke, are as good as or better than rates for other groups in the community. The initiative for prisoners grew out of a project between the Department of Health and the Prison Service. Learning from the project has been evaluated and disseminated to the field. Longer-term evaluation is taking place with prisons in the North West. Regional seminars have spread the learning widely across the NHS. This resulted in a set of ‘transferable principles’ being identified to reach disadvantaged smokers.

36. Some health promotion work has already been undertaken with prisoners. Results from prison smoking cessation programmes continue to be encouraging, with quit rates as good as, or better than, those in the outside community. The ‘Walking the Way to Health’ initiative, is being

Young people with psychosis who were previously ‘missing’ from mental health services in Plymouth are getting help from Insight, a local youth agency project which won a National Institute for Mental Health in England Positive Practice Award in 2003.

Sixteen to twenty-five year olds had been reluctant to access mental health services but now they wait at the doors at the Insight early intervention project, an integrated part of the Plymouth Youth Enquiry Service (YES). This aims to foster independence and inclusion in mainstream youth activities of those who are experiencing psychosis for the first time in their lives.

YES Deputy Director, Ruth Marriott, said, “Walking into a youth service used for social and leisure activity has a different feel to walking into adult mental health provision. Because the services on offer include sexual health, personal development and accommodation, as well as mental health, no one knows what aspect young people are accessing when they come in. This has helped to reduce the stigma attached to mental health issues.

“The focus is on all the issues that affect young people at this transitional time in their lives, such as housing, education and employment. We support them in making choices which have a positive impact on their mental health.”

piloted in 10 prisons and promoting healthier eating and weight management proved a success in a project in a women’s prison.

SUPPORT FOR MENTAL HEALTH AND WELLBEING

37. Transforming the NHS from a sickness to a health service is not just a matter of promoting physical health. Understanding how everyone in the NHS can promote mental wellbeing is equally important – and is as much of a cultural shift.

38. A coherent approach to promoting mental health needs to work at three levels:

- **Strengthening individuals:** increasing emotional resilience through acting to promote self-esteem, and develop life skills such as communicating, negotiating, relationship and parenting skills.
- **Strengthening communities:** increasing social support, inclusion and participation helps to protect mental wellbeing. Tackling the stigma and discrimination associated with mental health will be critical to promoting this increased participation.
- **Reducing structural barriers** to good mental health: increasing access to opportunities like employment that protect mental wellbeing.

39. Other chapters discuss action to support families and children, and set out how strong communities and healthy workplaces can promote mental wellbeing. The NHS’s distinctive contribution centres on the close contact that so many staff have with people at times when they may be vulnerable and in special need of support – new mothers, people coping with serious family illness or bereavement, people experiencing domestic violence, or people facing the loss of a job and the loss of self-esteem that can accompany that. We will ensure that standard one of the NSF for Mental Health, which deals with mental health promotion, is fully implemented.

40. The Department of Health will work through the National Institute for Mental Health in England (NIMHE) to ensure that day services for people with severe mental health problems develop to provide support for employment, occupation and mainstream social contact beyond the mental health system. This should include:

- access to supported employment opportunities where appropriate;
- person-centred provision that caters appropriately for the needs of all individuals, including those with the most severe mental health problems;
developing strong links and referral arrangements with community services and local partners;

- providing befriending, advocacy or support to enable people to access local services (including childcare services);
- involving people with mental health problems in service design and operation; and
- a focus on social exclusion and employment outcomes.

Progress in service redesign will be monitored through the annual review of mental health services (the ‘Autumn Assessment’) by Local Implementation Teams. NIMHE will publish guidance for commissioners in early 2005.

41. As part of this work, we will ensure that the new training offered to NHS staff helps them recognise times when patients may be particularly vulnerable and strengthens skills and confidence to offer initial support and provide information on the sources of help that are available.

42. People with poor mental health tend to experience worse physical health than the rest of the population. Yet there is evidence that a healthier lifestyle will help improve not just physical health, but also mental health, mood and wellbeing. For example, regular physical activity reduces the risk of depression and has positive benefits for mental health including reduced anxiety, enhanced mood and self-esteem. We need to do more to promote a more joined-up approach to NHS support for people with poor mental health. One early priority for NIMHE’s anti stigma and discrimination programme is to address the physical health inequalities experienced by people with mental health problems.

People with severe mental illness (SMI) are 1.5 times more likely to die prematurely than those without; partly due to suicide, but also to death from respiratory and other diseases. Depression is consistently been linked to mortality following a myocardial infarction; it increases the risk of heart disease fourfold, even when other risk factors like smoking are controlled for. People with severe mental illnesses also tend to have a poor diet; they are more likely to be obese; to smoke more; to access routine health checks less frequently, and get less health promotion input than the general population.

43. We will use the lessons from a new approach being piloted in eight centres in England to extend the new models of physical healthcare for people with mental health problems across all PCTs. Further development of this model will be linked into plans for providing NHS health trainers, outlined in Chapter 5, as health trainers may

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7 New approaches to the management of physical ill-health among people with mental illness are being piloted by Lilly Pharmaceuticals.
8 Specialist teams, working in partnership with primary and social care providers, help support people with severe mental illness who are vulnerable to physical ill-health. The teams offer health checks and blood tests, guidance on diet, smoking and exercise, information for the patient and their GP, and the care worker, as well as ongoing support and follow-up. This approach can identify the early signs of disease, such as diabetes or coronary heart disease.
chose to focus development of their skills in mental health or other specific areas.

44. We know that people who suffer from mental illness want more information about mental health and illness to help them manage their own care. We will develop new approaches to helping people with mental illness manage their own care and make available information for them on all aspects of health, both mental and physical wellbeing.

45. For example, the report of the Social Exclusion Unit on Mental Health and Social Exclusion published in June 2004 sets out the action that central and local government will take, working together with different agencies, to strengthen support for people with mental health problems to access employment, as well as the education and leisure facilities that should be available for everyone. There are longstanding concerns about the quality of care and support provided to people from black and minority ethnic groups who have mental health problems. The Department of Health is developing a programme of work to take forward the recommendations in Delivering Race Equality: A Framework for Action, which outlined a whole system approach to tackle the inequalities experienced by people from black and minority ethnic communities in the mental health system of care.

‘Regular smokers who die of a smoking-related disease lose on average 16 years of life expectancy compared to non-smokers.’

Support for smokers

46. Helping people to give up smoking remains one of the most important ways of preventing avoidable illness and death and reducing health inequalities. Studies have shown that smoking remains the most important cause of ill health in the most deprived areas. We have already set out our plans for action on information campaigns, for restrictions on smoking in enclosed workplaces and public places and for action on sales to underage young people. These actions will boost our wider, comprehensive tobacco control strategy, including the ban on tobacco advertising already implemented and new picture warnings on tobacco packets. The NHS has a special responsibility to back up all these measures with professional support to people who are trying to give up smoking, and to listen to what they want to help them quit.

47. Seventy per cent of smokers say they would like to be able to stop. Every year nearly three million smokers try to quit, although most find it very difficult because tobacco is so addictive. On average, ex-smokers have taken five attempts to quit for good. Achieving the national target to reduce smoking prevalence to 21% or lower by 2010 will not only depend on fewer people taking up smoking but also on large numbers of current smokers successfully quitting. If we hit our new

9 Evidence suggests that this can include electronic self-help options.
**Variation in NHS Stop Smoking Services across PCTs in 2003–04**

<table>
<thead>
<tr>
<th>Quitting method adopted</th>
<th>Number of smokers trying this method in each year</th>
<th>Success rate one year on</th>
<th>Number of smokers quitting through this route long-term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willpower: no pharmaceutical or formal professional support</td>
<td>1 million</td>
<td>3–4%</td>
<td>30,000–40,000</td>
</tr>
<tr>
<td>NRT from shop or pharmacy</td>
<td>900,000</td>
<td>8%</td>
<td>72,000</td>
</tr>
<tr>
<td>NHS or other professional advice with NRT or bupropion (Zyban) through NHS (e.g. on prescription from GP)</td>
<td>600,000</td>
<td>8%</td>
<td>48,000</td>
</tr>
<tr>
<td>NHS Stop Smoking Services (with NRT or Zyban)</td>
<td>300,000</td>
<td>15%</td>
<td>54,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2.8 million</strong></td>
<td><strong>214,000</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Professor Robert West, Cancer Research UK

2010 target this would mean about 2 million fewer smokers in England as a whole, but with relatively higher numbers quitting in routine and manual groups where the target is to reduce prevalence from 31% in 2002 to 26% or less by 2010. We aim to increase the number of smokers who try to quit, and to support them to maximise their chances of sustaining success when they do.

48. Smokers choose a range of routes to try to quit. Most rely on willpower. Others also try without outside support but with the help of Nicotine Replacement Therapy (NRT) purchased from a shop or pharmacy. Many get NHS help in the form of advice from a health professional, backed by NRT or bupropion (Zyban) (another stop smoking product) supplied under the NHS.

49. Willpower on its own is the least successful approach. There is good evidence that those who receive some formal support are more likely to succeed in quitting. We need to make it easier for people to access forms of help that we know are effective.
Increasing numbers of people are using NHS Stop Smoking Services, which provide more structured help for smokers who need or want it. These services use trained advisers to support smokers through the crucial first few weeks of a quit attempt (for example, with practical advice on how to cope with cravings) and help them to access and use NRT or Zyban to the best effect, along with the choice of one-to-one or group support. Since 1999, NHS Stop Smoking Services have helped over half a million smokers to give up for at least four weeks. However, there is currently an unacceptable tenfold variation between PCTs in the numbers of smokers successfully quitting per 100,000 population. These variations are in the numbers of smokers attracted to use the service, not in success rates once people enter a service. Some of the best services are in the most deprived areas. The most successful services:

- provide easy access through informal locations (community and leisure centres, pubs and clubs) at convenient times (eg outside working hours);
- encourage primary care contractors, and other NHS, community and workplace contacts to refer people to the service;
- identify and respond to special local needs, eg running mobile clinics in rural/isolated communities, providing services specifically for particular cultural groups; and

In early 2002, Hartlepool’s first smoking cessation Drop-in Clinic was established at Greatham, a small village on the outskirts of the town. The success of this initiative led to the subsequent expansion of these community-based clinics across Hartlepool. Drop-in Clinics, staffed by Smoking Cessation Advisers working alongside Nurse Prescribers, offer clients an informal environment with easy access. They provide a holistic package of assessment, advice, information and a prescription of NRT with follow-up support and reviews.

Drop-in Clinics are run across Hartlepool. Perhaps one of the most unusual venues is the Fens Pub, where support is available on a weekly basis between 6pm and 8pm. The Fens Pub is within short walking distance of an area of the town which not only has a disproportionately high number of smokers (70% of adults in some pockets), but also some relatively profound levels of deprivation and health inequality (IMD national rank 25 in Owton ward). Up to 43 smokers wishing to stop have attended this clinic in a two-hour session.

The Drop-in Clinics create an atmosphere of understanding and non-judgmental support, which encourages those who fail to quit to ultimately return and try again. The target set by the DH for Hartlepool was to achieve 1,680 four-week quitters over a three-year period. The three-year target has almost been met within two years. Over 60% of those setting a quit date are smoke free at four weeks.
Paragraph 153 of the Health Select Committee report

‘We believe that an integrated and wide ranging programme of solutions must be adopted as a matter of urgency, and that the Government must show itself prepared to invest in the health of future generations by supporting measures which do not promise overnight results but which constitute a consistent, effective and defined strategy.’

make good use of the media, linking to national campaigns like No Smoking Day, and adding targeted marketing for their local services.

51. We will now mainstream and resource this approach, and learn from what works best, driving improved performance through the system, and measuring for sustained success. We also need to gear up services to provide support to people who work in organisations which become smoke-free. New initiatives will need to be specifically targeted at routine and manual groups where the problems are greatest, and services tailored to reflect the needs of these groups. PCTs have a clear target to achieve in diminishing the prevalence of smoking and reducing inequalities and they will be performance managed against it; health trainers will provide extra capacity for stop smoking advice. To help them meet their target:

- In 2005–06, the Healthcare Commission will examine what PCTs are doing to reduce smoking prevalence among the local population, including their own staff, through tobacco control campaigns, championing smoke-free environments and provision of NHS Stop Smoking Services. Ongoing progress will be assessed against national standards and indicators.

- We will establish a national taskforce to help increase the effectiveness and efficiency of the NHS Stop Smoking Services and provide practical guidance for local implementation, in particular how to make services more people-centred.

- We will identify and disseminate good practice on what works through Regional Tobacco Control Managers and the NHS.

- We will develop pilots on using the electronic booking system to trigger advice for smokers on stopping, with a view to national roll-out.

52. Although the formal NHS Stop Smoking Services may maximise smokers’ chances of successfully quitting, not all smokers want to use them. We will expand the choice of help available and provide more support through alternative routes to meet smokers’ needs.

53. We have piloted a new programme, Together, which offers ongoing help and support to smokers who want to quit. We will develop the Together programme of support for smokers to quit and roll it out across England from Spring 2005 as part of the range of services that will be linked to Health Direct.

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11 This includes work with local authorities, all local NHS Trusts and community groups to identify opportunities for referrals to NHS Stop Smoking Services and the role of local clinical networks in prevention and championing Stop Smoking Services by increasing local referrals.
CASE STUDY

‘Obese people, and the severely obese in particular, are more likely to suffer from a number of psychological problems, including binge-eating, low self-image and confidence, and a sense of isolation and humiliation arising from practical problems.’

Appendix Five, Paragraph 11, National Audit Office Report

The Together programme will offer smokers support through phone, e-mail and text in quit attempts. The pilot showed an increase in quit rates for those in the programme and very substantial increases among some groups.

54. We want also to widen the use and availability of NRT, which the National Institute for Clinical Excellence (NICE) as identified as among the most cost-effective of health interventions. However, NRT is not as readily available as we would like and both health professionals and smokers need to be more aware of how effective it is.

55. We have a well-established partnership with the manufacturers of NRT, who have an important role in public health and in the promotion of therapies. In 2003 we agreed an innovative deal with the companies involved, under which they provide free NRT patches to PCTs in recognition of the increased investment the NHS is making in stop smoking products. This arrangement will increase the resources available to the NHS to help even more smokers quit.

The Dorset ‘Shape Your Life’ programme was devised in 2002. Clients with a body mass index of over 30 with coronary heart disease risk factors and/or diabetes were identified from GPs’ registers. If clients were sufficiently motivated, they joined a six-month weight reduction programme, with the aim of losing at least five kilograms. A wide range of options was offered, which included practice-based weight management groups, walking groups, commercial slimming organisations and Weight To Go at local leisure centres. Clients visited their practice nurse on a monthly basis to record weight and blood pressure and complete an evaluation form.

One hundred and forty clients have completed the programme across Dorset: 79% have lost weight, of whom 30% have lost five kilograms or more. Body mass index and blood pressure also reduced in the majority of clients.
‘It is difficult to separate cause from effect in the relationship between obesity and psychological disorders. Whilst mental wellbeing may suffer as a result of the pressures associated with being obese, psychological problems may equally contribute to the type of behaviours, such as emotional and binge-eating, that can result in the onset of obesity.’

Appendix Five, Paragraph 13, National Audit Office Report

56. The companies have publicly committed to look at new and innovative ways of making NRT more widely available. They are currently discussing with the Medicines and Healthcare products Regulatory Agency (MHRA) the licensing restrictions around NRT, and are looking at wider access issues and other ways to promote the use of NRT, including:

- raising awareness among healthcare and related professions by committing resource to that work;
- new media campaigns;
- developing new and innovative therapies;
- promotion of therapies through a wider choice of outlets; and
- encouraging retailers to allocate more space for stop smoking therapy products and space alongside cigarettes.

57. As part of the strategy outlined in Chapter 2, we will extend our awareness-raising campaigns to promote the use of NRT for people quitting on their own or as part of an NHS-supported attempt.

Better services to tackle obesity

In 2002, almost six out of ten women and seven out of ten men were overweight or obese. Balancing our calorie intake with calories we spend through physical activity is critical. Even eating an extra 10kcals a day can lead to gaining an extra pound in weight per year and gradually over the years this can become a significant problem.

‘Overall, it appears that, over the past 20 to 30 years, there has been a decrease in physical activity as part of daily routines in England but a small increase in the proportion of people taking physical activity for leisure. Total miles travelled per year on foot fell by 26% and miles travelled by bicycle also fell by 26% (1975/6–99/01 National Travel Survey). This produced a difference of 66 miles walked per year between 1975–6 and 1999–2001. Twenty-five years ago we walked nearly three marathons a year more than we do now. For a person weighing 65kg this represents an annual reduction in energy expenditure equivalent to almost 1kg of fat.’

At least five a week: Evidence on the impact of physical activity and its relationship to health.

A report of the Chief Medical Officer.
Department of Health.
58. Trends in diet and lifestyle over the last three decades have combined to bring an epidemic in obesity. More sedentary lifestyles, ready access to ‘energy dense’ food, an increased use of convenience foods, snacking and eating out, have all played their part.

59. In addition to the health risks – diabetes, heart disease and cancer – obesity can have far-reaching psychological and social implications for both adults and children, including reduced self-esteem, increased risk of depression, social isolation and lack of employment.

60. Action on obesity is not just a matter for the NHS: other chapters discuss the role of the food industry, food promotion to children, creating more opportunities for people to be physically active, and opportunities within schools. But a comprehensive response to the threats that obesity poses to individuals and society must include concerted NHS action. The aim must be as systematic and determined an approach to the prevention and treatment of obesity as to other signs/symptoms that signal high risk of disease, for example, high blood pressure.

‘The obesogenic environment needs to be tackled at the highest levels. It is not adequate to focus on the individual, especially the child, and expect them to exercise self-control against a stream of socially endorsed stimuli designed to encourage the consumption of excess food calories.’

Paragraph 176, Health Select Committee Report

Dr Foster survey of obesity services in the UK

The Dr Foster report concludes that:

- There is significant variation between areas in the UK in terms of primary clinical response to obesity and service provision.
- Action is focused on obesity as a risk factor for other chronic diseases rather than an illness in its own right.
- National initiatives to promote healthier behaviours – such as 5 A DAY and exercise on prescription – have been widely adopted and are now almost universal.
- There is more consistency around second line treatments (surgery and drugs) than first line.
- There is variation between areas in terms of services available and the communication of services to the public, the way in which the services are organised, and primary responsibility.
- There is scope for improved information for the public about schemes to tackle obesity – around 10% of areas said they did not provide any form of written information about services available.

Dr Foster website (www.drfoster.com)
61. Recent studies\(^{12}\) have found clinical services for obesity wanting, with significant variation across England. Although there are examples of good practice, preventive action is often taken only when obesity coexists with other chronic diseases, rather than as a clinical problem in its own right. Research\(^{13}\) has found that there is a reticence among health professionals about raising the issue of obesity with patients, a lack of necessary skills to deal with obese patients, and a lack of clear referral mechanisms and services. Around 10% of areas did not have any written information about services available. There is a need for much improved information for health professionals and the public on how to prevent weight gain.

62. Children are particularly at risk and need a healthy start in life, but about 17% are now obese. We have introduced a national target to halt the year-on-year increase in obesity in under-11 year olds in the context of a broader strategy to tackle obesity in the population as a whole by 2010. The NSF on Children, Young People and Maternity Services includes action on obesity.\(^{14}\) Chapter 3 outlines what schools and others will do to encourage healthy lifestyles in children and enable early identification and personalised help for those at risk of becoming overweight or obese.

<table>
<thead>
<tr>
<th>Body mass index</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formula:</td>
<td></td>
</tr>
<tr>
<td>[ BMI = \frac{\text{weight (kg)}}{\text{height (m)} \times \text{height (m)}} ]</td>
<td></td>
</tr>
<tr>
<td>Classifications</td>
<td></td>
</tr>
<tr>
<td>(kg/m(^2))</td>
<td></td>
</tr>
<tr>
<td>Less than 20</td>
<td>Underweight</td>
</tr>
<tr>
<td>20 to 25</td>
<td>Desirable or healthy range</td>
</tr>
<tr>
<td>25 to 30</td>
<td>Overweight</td>
</tr>
<tr>
<td>30 to 35</td>
<td>Obese (Class I)</td>
</tr>
<tr>
<td>35 to 40</td>
<td>Obese (Class II)</td>
</tr>
<tr>
<td>Over 40</td>
<td>Morbidly or severely obese (Class III)</td>
</tr>
</tbody>
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63. The basic messages about how to maintain a healthy weight by balancing energy in and energy out through diet and activity are clear. But there is currently less evidence about effective ways to help people who are obese or overweight to lose weight. Although we need better evidence, the urgency of the problem means developing, rapidly evaluating and implementing new approaches to managing obesity alongside research on what works.

64. We shall build on the good foundations already in place to implement the NSFs for coronary heart disease and diabetes. Guidance for PCTs on priorities and planning includes the need to give advice on diet and activity. The next challenge will be to act

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12 Recent studies include those by the Health Select Committee and Dr Foster.
14 National Service Framework for Children, Young People and Maternity Services: Key Issues for Primary Care (September 2004) pages 11 and 12
www.dh.gov.uk/PublicationsAndStatistics/Publications/
on obesity as an issue in its own right using levers such as the new primary medical care contracting arrangements, including enhanced services and through negotiated changes which may be possible in the Quality and Outcomes Framework.

65. We have put action in hand to strengthen the evidence base on effective interventions. NICE has already carried out appraisals and published guidance on the use of drugs and surgery to treat obesity. The DH has also commissioned NICE to prepare definitive guidance on prevention, identification, management and treatment of obesity and this is due to be available in 2007.

CADISAP is a pilot scheme which is seeking to establish if culturally sensitive cardiac treatment and rehabilitation, designed around the needs of South Asian patients and their families living in the Waltham Forest area, can improve this population’s health and quality of life. For the first time, it brings together teams from primary and secondary care to comprehensively manage treatment, support and education along the care pathway in a way which seeks to overcome some of the barriers which may prevent the South Asian population from benefiting from cardiac prevention and rehabilitation services.

Education about cardiac risk factors is provided along with psychological support, nutrition and weight management advice, support on taking lipid-lowering medication, increasing physical activity and blood pressure control. A gradual increase in periods of physical activity to at least 30 minutes most days of the week is encouraged, with practical support given, such as walking up the stairs rather than taking a lift, and walking to the shops rather than driving or taking a bus. Translation services are also available for those who need them.

The scheme, which is supported by the British Heart Foundation and the Department of Health, and partly funded by the Neighbourhood Renewal Fund, has already resulted in a high quit rate among current smokers, improved exercise capacity and changed dietary practices. A formalised, randomised controlled trial is now under way in the second phase of the scheme.
66. We will develop a comprehensive ‘care pathway’ for obesity, providing a model for prevention and treatment. A typical care pathway for a patient would involve:

- Raise awareness and provide information
- Raise the issue opportunistically and provide advice
- Referral as appropriate to specialist service – to consider type of support required eg diet/physical activity; drugs; surgery
- Review and maintenance of progress

67. More specifically the prevention and treatment of obesity will ensure that:

- we have coordinated activity on obesity prevention and management in each PCT for both adults and children with a range of appropriately trained staff – to include health trainers, school nurses, health visitors, community nurses, practice nurses, dieticians and exercise specialists. Services may also be drawn from the voluntary and independent sector;
- there are clear referral mechanisms to specialist obesity services which will be staffed by multidisciplinary teams with specialist knowledge and training in obesity management (see paragraph 66); and
- in addition to specialist services there will also be trained staff who can work in different settings such as schools, leisure services and the community, working alongside obesity prevention and management experts within the overall whole system approach to obesity within a PCT.

68. We will also commission production of a ‘weight loss’ guide, to set out what is known about regimes for losing weight and help people select the approaches that are healthy and are most likely to help them to lose weight and then maintain a more healthy weight.

69. We will commission further studies to support development of new approaches where there are gaps in the evidence base within the new framework for research discussed in Annex B. This will include production of specific guidelines for children’s exercise referral.15

70. We will support the setting up of a ‘national partnership for obesity’. The partnership will act to promote practical action on the prevention and management of obesity and as a source of

information on obesity (for both diet and physical activity) and evidence of effectiveness.

71. The NHS will need to act on existing guidance and prepare to be ready to implement NICE guidance. The additional funding that will go to PCTs from 2006 will help them strengthen primary care capacity to prevent weight gain and tackle obesity, and to develop services to respond to patient needs across the whole care pathway.

**Treatment programmes, including:**
- regular weight checks for patients and advice on diet, nutrition and physical activity and weight loss by health trainers and other healthcare professionals;
- early identification of those at risk, eg opportunistic measuring of patients’ BMI, followed by advice;
- local partnerships between the NHS, local authorities, schools and workplaces to deliver joined up action on nutrition and exercise;
- local initiatives on healthy eating—eg ‘5 A DAY’ community pilots; and
- local interventions to promote activity across the population run by PCT, local authority and voluntary sector.

72. The number of people who are overweight and obese means that each PCT area will need a specialist obesity service with access to a dietician and relevant advice on behavioural change. PCTs do not need to commission all these elements from NHS providers, but should develop innovative clinical models that will help support evaluation of different approaches to delivery of obesity services at local level eg quality assured, commercial diet providers and leisure centres. Local partnerships with the voluntary and community sectors, local authorities, the leisure industry and other alternative service providers will be able to enhance capacity and the new primary care contracting arrangements support this. The **independent sector may have a key role in providing effective**
CASE STUDY

www.healthm8.net has been created by the Northamptonshire Healthy Schools Development Team, which works on behalf of Daventry and South Northants PCT, Northamptonshire Heartlands PCT, Northampton PCT and Northamptonshire County Council Schools Service. The website was designed in response to research which established that young people want an information source that is up to date, speaks their language, and is relevant and interactive. Young people and local partners have been involved in its development.

The site can be accessed anywhere that young people have the opportunity to use the internet, whether at school, at home, or in a cyber cafe, and they remain anonymous. It deals with subjects topic by topic. The sex and relationships section deals with building a relationship without feeling pressured to have sex; contraception; STIs; HIV and AIDS; confidentiality and where to go for help. The drugs section provides information about all categories of drugs, including prescribed and legal drugs and the law. It also deals with the consequences of taking drugs including their impact on health, travel, future opportunities and sport. Alcohol and smoking sections are also live. Healthm8 has an online agony aunt to answer any sensitive questions that young people may have.

Young people say that, “It’s just what we wanted, it actually talks about sex!” and “It made us laugh, but got us talking”. Teachers talk about the fact that, “It takes the pressure off of them having to introduce an embarrassing subject.” Health professionals have welcomed the introduction of online confidential support for young people.
behaviour change programmes in ways that are more acceptable than traditional NHS care to some groups of patients. We will test this as part of a procurement for a ‘year of care’ for diabetic patients.

73. Another model we will test is to use the Healthy Communities Collaborative (HCC) principles in the prevention and management of obesity. This will build on existing HCC work on diet and nutrition, and accidents (see chapter 4).

74. As part of the National Health Competency Framework we will allocate new funding for training, management, provision of evidence-based obesity prevention and treatment, based on National Occupational Standards for obesity. A priority will be to ensure that staff get the training they need.

75. We also need to help healthcare professionals develop more effective interventions. We will develop a patient activity questionnaire, which will be available by the end of 2005 to support NHS staff and others to understand their patients’ levels of physical activity and assess the need for interventions, such as exercise referral.

TRANSFORMING SEXUAL HEALTH SERVICES

HIV prevalence increased by 20% in 2002 compared with 2001

As many as one in ten sexually active young women under the age of 25 may be infected with chlamydia. If untreated, this can lead to pelvic inflammatory disease, ectopic pregnancy and infertility.

If a condom was used for every act of unprotected sex with a risk of an unplanned pregnancy or transfer of a sexually transmitted infection (STI), there would be a massive and immediate impact on the rise in STIs and HIV, significantly fewer unplanned teenage and other pregnancies and a reduced number of abortions.

76. Chapter 2 set out our plans for a major new campaign on sexual health. But information alone will not be enough. We are committing new capital and revenue funding to tackle the high rate of STIs in England. This will support modernisation of the whole range of NHS sexual health services, to communicate better with people about the risk, offer more accessible services to provide faster and better prevention and treatment, and deliver these services in a different way. This will need action to break down the boundaries between primary and specialist services, and new staff roles and skills. It is why

16 The Government is funding SkillsActive and Skills for Health – the sector skills councils for leisure and healthcare – to work together to produce common core modules of training on physical activity, diet and obesity which can form part of workforce training across all sectors. This work will be linked with the development of the new competency framework for health trainers discussed in chapter 5.

17 We are also consulting on making sport and exercise medicine a medical discipline.

18 Better and more timely information is needed to monitor trends and test the impact of action in all age groups. We will develop the Health Survey for England to monitor body mass index, and utilise data from primary care and schools, and the next round of National Diet and Nutrition Survey to achieve this.
Females  Males
0
188
157
54
50
66
100
150
200

Rates of diagnoses of uncomplicated genital chlamydial infection by sex, GUM clinics, England* 1995–2003

Diagnosis rate per 100,000 population

Source: KC60 statutory returns and ISD(D)5 data.

National Standards, Local Action: Health and Social Care Standards and Planning Framework (2005–06/2007–08) includes improving sexual health within the national targets for the NHS and why sexual health will be included in the forthcoming round of Local Delivery Plans.

77. In future, sexual health services will be delivered through a flexible multidisciplinary workforce, in a range of settings, including:

- multidisciplinary teams headed by nurses linking between contraception, sexual health specialists (including genito-urinary medicine (GUM) consultants) and community, youth services and sexual health liaison workers working with primary care providers as part of a comprehensive range of services;
- extension of the roles of nurses, youth workers, community workers and pharmacists to include elements of sexual health;
- peer educators/youth workers trained to use the latest communications technology;
- mainstream primary care health programmes delivered by school nurses, health trainers, health visitors, community psychiatric nurses, midwives, and practice nurses;
- ‘enhanced services’ in the new primary medical care contracts; and
- more ‘primary care practitioners with a special interest’ working alongside sexual health experts in contraceptive, HIV and sexual health treatment services.

78. Services like testing and screening for STIs will increasingly be delivered in the community particularly targeting young people, vulnerable people and those who are hard to reach or at significant risk, such as black and minority ethnic groups. There are already excellent examples of good practice, but these are in small pockets and need to be expanded. The following models could form the building blocks for this expansion:

- one-stop shops combining treatment and prevention services;
- delivery of testing and screening in settings such as sports centres, supermarkets, shopping malls, workplaces, universities and community centres, at times and places which fit with people’s lives;
- health buses, outreach workers, community pharmacies; or
- provision by the voluntary and commercial sectors.

79. We will have at the cornerstone of the drive for better sexual health a systematic campaign to reduce the incidence of chlamydia. Chlamydia can cause profound distress later in life through infertility or pelvic inflammatory disease.
High-volume testing for chlamydia is essential if we are to see an impact on rates of infection and the knock-on effect of ill health.

80. We will accelerate implementation of a national screening programme for chlamydia, to cover the whole of England by March 2007. The 1.2 million women who attend contraception services each year – the vast majority under 25 years old – will be the main focus for offering chlamydia screening as well as wider health advice. We believe that the independent sector could contribute to providing efficient and convenient screening services. As part of the national programme we will take steps to introduce and evaluate the effectiveness of chlamydia screening in retail pharmacies starting in London.

81. Prevention services also need to be developed and modernised. Contraception services have a key role to play in protecting against both unplanned pregnancies and STIs. To support this, the NHS will also strengthen the infrastructure for sexual health and contraception services in primary care. Currently contraceptive services are patchy and in some areas virtually non-existent. We will therefore carry out an audit of contraceptive service provision in early 2005 and invest centrally to meet gaps in local services in particular to ensure that the full range of contraceptive services is available, good practice is spread and services modernised.

82. Modernising the whole sexual health service will also involve transforming access to specialist treatment services. There is little point in screening people for STIs if they cannot also access specialist treatment quickly and easily. Current GUM services are struggling with the demands placed on them and primary care services need strengthening. We are carrying out a national review of treatment services to provide advice and support on service modernisation for both commissioners and service providers and will follow this up with investment in both services and infrastructure.

83. Delay in the detection and treatment of STIs promotes onward transmission, the development of expensive complications and the spread of HIV.

84. We intend that the NHS should offer the same fast access to high quality GUM services that patients expect of other NHS treatment. The goal is that by 2008 everyone referred to a GUM clinic should be able to have an appointment within 48 hours – a target that is currently only met for 38% of attendances.
A team at the Accident and Emergency Department of St Mary’s Hospital, London have developed and validated the ‘one-minute Paddington Alcohol Test’ (PAT), a short screening questionnaire that detects those drinking excessive alcohol.

By auditing the use of PAT and selectively screening those who present with the 10 conditions most often associated with alcohol misuse, the department was able to increase the rate of detection of alcohol misuse four-fold.

People found to be consuming excessive alcohol are then offered an appointment with an alcohol health worker. Two-thirds of those offered an appointment accept the offer. If the appointment is on the same day that the person attends the A&E, 65% attend. In a randomised controlled trial examining the effects of referral, it was shown that those offered an appointment drank less alcohol during the following year than those who were not. People offered an appointment were also less likely to re-attend the department: for every two patients who accepted an offer of brief advice, there was one less re-attendance to the department during the following year.

Screening and referral for brief intervention for alcohol misuse in A&E provides an opportunity to help patients develop insight into the consequences of their drinking and promote improved health, thereby making best use of ‘the teachable moment’, i.e. the desire not to make themselves vulnerable again (reference – Crawford et al, The Lancet, 2004: 364: 1334–9).
Up to 35% of all accident and emergency attendances and ambulance costs are estimated to be alcohol-related. Alcohol misuse costs the NHS in England up to £1.7 billion each year.

While prevention interventions will provide the best means of tackling many alcohol-related problems, there is a small but significant number of people, particularly men aged over 30, who develop much more serious alcohol-related dependence or health problems. Left untreated these can lead to long-term ill health, including stroke and cancer, and premature death as well as placing a heavy burden on the families of those involved.

Alcohol treatment is currently provided by GPs and specialist addiction services but most of the 500 alcohol treatment services in England are located within the voluntary sector. These are usually funded by PCTs or local authorities and receive referrals from GPs or other NHS specialists.

The cross-government Alcohol Harm Reduction Strategy for England recognised that the provision of alcohol treatment in England was patchy and that some areas were unable to provide access to the full range of support needed.

By April 2005:

- the DH will publish national and local audits of the demand for and provision of alcohol treatment.

By May 2005:

- the National Treatment Agency (NTA) will publish ‘Models of Care’ guidance on the organisation of alcohol treatment and a road map detailing how to put this into practice.

These will lay the foundation for the future development of alcohol treatment within England. However, it is already clear that in order to provide high-quality, local services suited to the needs of service users, their families and carers, many areas will need long-term improvements in their current provision. To support this we will build on the commitments within the Alcohol Harm Reduction Strategy for England through:

- guidance and training to ensure all health professionals are able to identify alcohol problems early;
- piloting approaches to targeted screening and brief intervention in both primary care and hospital settings, including A&E departments;
- similar initiatives in criminal justice settings with the aim of reducing repeat offending, by ensuring that alcohol treatment needs are met alongside drug misuse treatment needs;
• developing a programme for improvement for alcohol treatment services, based on the findings of an audit of demand for and provision of alcohol treatment in England and the Models of Care Framework for alcohol treatment.

These initiatives will be supported, from April 2006, through additional funding provided through the Pooled Treatment Budget for Substance Misuse.

CONCLUSION

89. The commitments in this chapter set out a starting point for ensuring that the NHS is as well placed to meet demand for health as it is for meeting demand for treatment. It puts in place the foundations for:

• national and local NHS service planning and commissioning arrangements which recognise the needs of all parts of the population and develop services to focus improvement in areas with the worst health outcomes;
• a comprehensive, accessible and high-quality set of health improvement services available in all communities;
• new models of contracting for primary care will mean easier access to health improvement advice especially for those who find it hardest to obtain this now;
• all NHS staff being able to give appropriate advice on basic health and lifestyle issues, promoting physical and mental wellbeing;
• linking health improvement advice to routine clinical practice;
• access to high-quality NHS Stop Smoking Services in all areas;
• the NHS offering real practical support on healthy eating, exercise, weight gain, clinical treatment for obesity, and a strong focus – with partner organisations – on prevention;
• accessible sexual health services delivered in both community and hospital settings;
• chlamydia screening available across England by March 2007;
• 48-hour access to a GUM clinic by 2008; and
• NHS health professionals able to identify problems with alcohol and provide brief interventions in A&E settings.