Government response to the House of Commons Select Committee on Health's second report on public health / presented to Parliament by the Secretary of State for Health by Command of Her Majesty, July 2001.

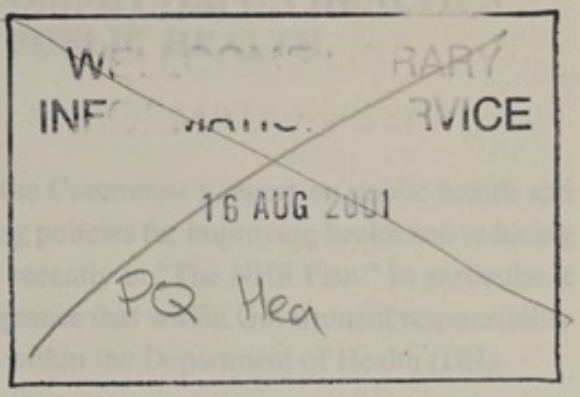
DEPARTMENT OF HEALTH

GOVERNMENT RESPONSE TO THE HOUSE OF COMMONS SELECT COMMITTEE ON HEALTH'S SECOND REPORT ON PUBLIC HEALTH

Presented to Parliament by the Secretary of State for Health
By Command of Her Majesty
July 2001

Cm 5242

£7.30



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GOVERNMENT RESPONSE TO THE HOUSE OF COMMONS SELECT COMMITTEE ON HEALTH'S SECOND REPORT ON PUBLIC HEALTH

SUMMARY

1. The Government welcomes the Committee's report on public health and its overall endorsement of existing policies for improving health and reducing health inequalities, set out most recently in "The NHS Plan." In particular it welcomes the Committee's acceptance that within Government responsibility for public health should remain within the Department of Health (DH).

2. As the Prime Minister said recently, the General Election result has given the Government a strong mandate for reform and an instruction to deliver modernised public services that will make an appreciable difference to the quality of people's lives and life opportunities.

3. At the heart of modernised public services there needs to be a common sense of purpose. Within public health there is a clear consensus about the focus on:

- the protection of the public's health;
- health promotion and disease prevention programmes; and
- reductions in health inequalities.

4. On the last point, the Government has reaffirmed its determination to tackle disadvantage in all its forms. A key element of that commitment will be the delivery of the specific national targets, announced in February, for reducing inequalities in health. The Inequalities and Public Health Task Force established last autumn will be responsible for overseeing implementation of the strategy for reducing health inequalities.

5. As the Committee acknowledged in its report, as part of that programme it is essential to address the underlying determinants – what Acheson calls the "upstream" factors. The Government has already made substantial progress in this area. Furthermore, since the Committee reported – and following the recent General Election – the Government has announced that health inequalities will be the subject of a cross-Government spending review. That will significantly strengthen co-ordination of policies to address the range of "upstream" determinants of poor health.

6. To inform the spending review, and to ensure effective delivery of the health inequality targets at local level, we are launching a nationwide consultation on the measures needed to implement those targets. The Department of Health is publishing a health inequalities consultation paper on spreading best practice and the main measures needed to narrow the health gap. The Department will be consulting key stakeholders, particularly local government, the voluntary sector, other agencies and community groups to

draw up an implementation plan. Particularly important will be establishing the critical role of the new Primary Care Trusts (PCTs) in addressing health inequalities in this area.

7. The roles for PCTs, Strategic Health Authorities (see para 10 below) and regional public health functions set out in this document flow from the Secretary of State for Health's speech on "Shifting The Balance of Power" on 25 April 2001. A discussion document will be published on the emerging views about the implications for the NHS of the Secretary of State's speech. A consultation exercise will be held in the Autumn on the boundaries for Strategic Health Authorities.

8. The public health delivery system will be enhanced additionally as a result of the significant shift in the balance of power within the NHS announced by the Secretary of State for Health in May. More power will be put in the hands of front-line staff and organisations in order to make the health service more patient-centred. Primary Care Trusts are best placed to deliver change at local level. They have the best knowledge and information about local health needs, and they have responsibility for providing services – smoking cessation, healthy diets etc. – essential to the achievement of the targets. For the first time, there will be a public health team in each PCT with a Board level appointment to lead this work.

9. Primary Care Trusts – the organisations closest to the concerns and aspirations of patients and clinicians – will in future be the prime interface between the local community and the NHS, and will lead the latter's contribution to joint working with local Government. In particular they will become the focus for delivery of public health programmes and the wider objectives for social and economic regeneration. Primary Care Trusts will work as part of Local Strategic Partnerships (LSPs) to ensure co-ordination of planning and community engagement, integration of service delivery and input to the wider Government agenda.

10. Around 30 new Strategic Health Authorities will replace the existing 95 Health Authorities (HAs). Each Strategic Health Authority will have its own Director of Public Health (DPH) who will create and develop a public health network and manage the local performance of PCTs and NHS Trusts in delivering public health goals and reducing inequalities.

11. At the same time, the Regional Offices of the Department of Health will be abolished by 2003. Four new Regional Directors of Health and Social Care will oversee the development of local services and provide the link between the NHS and DH. Regional Directors of Public Health (RsDPH) will lead a single, integrated public health function for the region, which will be located in each of the nine Regional Offices of Government (GOs). It will develop multi-sectoral approaches across Government and with other partners to tackling the wider determinants of health, for example through regional work on economic regeneration, education, employment and transport, and through contributing to the over-arching strategic regional sustainable development frameworks.

12. As well as a common sense of purpose, modernised public services also need to have clear delivery systems, and "Shifting the Balance of Power" provides an opportunity to make public health services clearer and more consistent. The Committee itself acknowledged that this had not been sufficiently the case in the past, although the establishment of the Health Development Agency (HDA) and a network of regional Public Health Observatories (PHOs) have helped to strengthen the evidence base and the quality of information that informs public health interventions. The report of the "Chief Medical Officer's Project to Strengthen the Public Health Function," issued on 28 March 2001, has advocated the development of a multi-disciplinary workforce for public health, with improved training and development capacity, and those changes should also improve the quality and consistency of services.

13. The Government is determined to bear down on the big killers and the main determinants of ill-health. The prevention of coronary heart disease and cancer is core to the Government's work on reducing health inequalities. By tackling the major risk factors for these chronic diseases, such as smoking, physical inactivity and poor diet, early deaths can be reduced. Recognising the links between diet and later disease, "The NHS Plan" highlights these as key areas for action. The five-a-day programme aims at increasing access to fruit and vegetables and one of the key elements of this approach is the National School Fruit Scheme. "The NHS Plan" also reinforced the Government's strategy for tackling smoking set out in "Smoking Kills" and set out measures to tackle smoking including setting up world-leading smoking cessation services. "The NHS Cancer Plan" which followed placed increasing emphasis on the need to address inequalities and focus activity on harder to reach smokers. It is recognised that the greatest impact on reducing health inequalities that stem from smoking will be the activities of smoking cessation services, and following an investment of £50m over three years they are now up and running and achieving their targets. Other measures such as our education and media campaigns are designed to help shift attitudes and change behaviour.

14. With these changes the Government believes it has laid the foundations not only for a modernised health service but for a modern public health service too – one which will lay a greater emphasis on the protection and improvement of the population's health, and which will at last start to reduce the widening gap between the best and worst off in society.

THE HEALTH COMMITTEE'S SECOND REPORT ON PUBLIC HEALTH

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

(i) We recommend that health policy should benefit the less well off on a sliding scale rather than targeting only the small group who are the most deprived (paragraph 34).

The Government attaches a high priority to its work to reduce health inequalities, and welcomes the Committee's contributions to the debate on effective interventions to narrow the health gap. Action to tackle health inequalities is part of the wider Government programme directed towards reducing inequalities and promoting opportunity; protecting citizens from threats to health and well-being over which they have little control; and providing modern, efficient public services which make sense to users at the point of delivery.

The Committee's recommendation about the need for health policy to benefit the less well off and not just the most deprived is noted. The health inequalities targets have been set not just in terms of "the small group who are the most deprived". Rather they focus on much broader segments of the population who experience health disadvantage.

For example, we will expect all NHS organisations to tackle the inequalities between more and less deprived areas and communities within their boundaries, not just the fifth of HAs with the lowest life expectancy at birth.

There is a national target to reduce smoking in the whole population, as well as within manual social classes, where "The NHS Cancer Plan" target is a reduction from 32% in 1998 to 26% by 2010.

The average number of fruit and vegetable portions consumed in England is three, which is below the WHO recommendation of five portions per day. Furthermore, the National Food Survey found social class differences in daily consumption of fruit and vegetables and this gap shows no sign of abating. Action is in place to increase access to fruit and vegetables by 2004 and this includes:

- the National School Fruit Scheme;
- working with industry to improve the provision of, and access to, fruit and vegetables; and
- a five-a-day community initiative to improve access to fruit and vegetables, particularly in low income groups.

Whilst teenage parenthood is more common in areas of deprivation and poverty, even the most prosperous areas have higher rates of teenage birth than the average in some comparable European countries. Significant improvements in all areas will be needed to achieve the Government's ambitious national goal of halving conception rates among under 18s by 2010.

That is why we asked *all* Local Authority (LA) areas to produce teenage pregnancy strategies, and to set out the action necessary to achieve agreed local conception rate reduction targets. Even in the areas with the lowest rates, we are seeking a reduction of at least 40% in the under 18 conception rate by 2010.

Action to tackle health inequality will not, therefore, exclusively centre on the most deprived, and the Government expects that the action taken to achieve the targets will bring broader benefits.

A review of the existing weighted capitation formula used to distribute NHS funding is taking place. The Government's objective is that reducing inequalities should be a key criterion for allocating NHS resources to different parts of the country, and as a first step, for 2001/02, an interim health inequalities adjustment has been introduced. £130 million for this adjustment has been shared between 53 HAs.

(ii) We see great potential for health inequality targets to give real bite to the HIMP/Community Plan and to provide a yardstick for Directors of Public Health, Local Authorities and Health Authorities. We welcome their recent publication and were particularly pleased to see a focus on health inequality amongst children. We also recognise that inequalities targets will only make a difference if effective strategies are put into place to achieve them. This should include developing appropriate "baskets" of intermediate targets for each of the headline targets. Intermediate targets may usefully take account of some targets set out in The Health of the Nation, as well as locally-determined targets that are relevant to local conditions (paragraph 35).

The Department of Health is planning to hold a consultation on health inequalities, designed to identify the systems, processes and actions across Government which will support the delivery of the national health inequality targets. It will include the development of a broader basket of indicators on inequality, such as the Committee has suggested. Some of the indicators set out in "The Health of the Nation" strategy documents may be appropriate for the basket, and some may be set in conjunction with local stakeholders and focus on local needs including, for example, race equality and access to services. The Department of Health will consult on the best way to include health inequalities into mainstream planning processes. Under the Government's National Strategy for Neighbourhood Renewal (NSNR), Local Strategic Partnerships (LSPs) have been asked to set local targets, including those for health improvement and to tackle inequality, for their neighbourhood renewal strategies.

The Department of Health has put in train a programme of work to reposition and develop Health Improvement and Modernisation Plans (HIMPs) (formerly Health Improvement Programmes) to ensure that they set the strategic framework for improving health and tackling health inequalities for a local population including setting out for partners in the local health system high level objectives, measurable targets for improvement, and expected outcomes. The HDA is working closely with DH on all of this work.

The Government's infant mortality target, announced in February, is:

Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in infant mortality between manual groups and the population as a whole.

The Government recognises the importance of an effective strategy for meeting that target, including intermediate targets. It is identifying the key interventions that are needed and a basket of indicators by which to measure progress. The Children's Taskforce (CTF), set up to ensure that the proposals in "The NHS Plan" for children's services are implemented successfully, will agree the appropriate interventions and engage with the responsible agencies to make sure they are in place.

The Government has also begun a similar process for childhood morbidity, and again has asked the CTF to sponsor work to define and scope possible targets. The work will relate directly to the development of a Children's National Service Framework (NSF) and link closely with cross-Government work on vulnerable children and families. On teenage pregnancy, local conception reduction targets have been agreed which seek the largest reductions in areas with the highest rates. By 2010, we are seeking a 60% reduction in under 18 conceptions in the worst fifth of wards, thereby reducing the level of inequality between the worst fifth and the average by at least a quarter.

(iii) We recommend that every Government department has a Public Service Agreement to conduct health audits and health inequality audits of relevant policies and to work towards policies which have a positive effect on health. We also think the Government should consider the advantages of the establishment of a Parliamentary Health Audit Committee to assess whether or not departments deliver on this along the lines of the Environmental Audit Committee. Whilst this is a matter for Parliament, not Government, we would welcome the considered views of DH on such a suggestion (paragraph 36).

Although it would not generally be appropriate to include health-related targets in each department's Public Service Agreement (PSA) the Government agrees that, where relevant, major new policies should be assessed for their impact on health. The cross-Government spending review on health inequalities will feed into the 2002 PSAs and will be an opportunity to discuss these issues further.

Any parliamentary monitoring of the Government's success in achieving its objective of policies that improve health and reduce health inequalities would be welcome. However, the Government also agrees that this must not degenerate into a paper exercise, should not divert resources from its efforts to place health at the heart of policy-making, nor hinder development of the strategy and methodologies for impact assessment. Once such methodologies have been developed they will be disseminated via, amongst other routes, the web-based electronic repository of best practice in policy-making currently being developed by the Centre for Management and Policy Studies in the Cabinet Office.

(iv) Ironically, the very energy and zeal which the Government brought to bear in the battle against health inequalities has, to some extent, undermined their policy goals. Health Action Zones developed too slowly to spend all the money allocated to them in their first year. Each of the initiatives we have reviewed seems to have its own merits. The difficulties have arisen more from their quantity and lack of integration. We believe that the problems in implementing some of the public health initiatives to date are not necessarily short-term glitches that will be solved over a period of time. Instead, we believe these difficulties reflect more profound systemic and structural problems which relate to the lack of co-ordination between different Government Departments, statutory agencies, elected authorities and the voluntary sector. Below we set out our recommendations for creating greater purpose, direction and integration of services (paragraph 40). *[See also viii, xxxii, xxxv]*

The Government has recognised the need for more effective co-ordination at all levels and is putting in place structures to address this. For example, the review of DH announced by the Permanent Secretary highlights the need for dissolution of unnecessary barriers, for example across Government at national and regional level. The spending review on health inequalities will involve a wide range of Government departments.

The Regional Co-ordination Unit (RCU) (see xxxii) and the Neighbourhood Renewal Unit both have a role to join-up activity across central Government, and the RCU has already begun to play a part in the co-ordination and regulation of area-based initiatives. The Department of Health and other Government departments are supporting this, and there are plans to co-locate regional public health and some other functions with GOs.

The development of LSPs (see xxvii and xxxii) will also enable better local co-ordination between public sector bodies as well as with the private, voluntary and community sectors. Central Government has begun to take action to rationalise existing requirements to set up partnerships and will issue proposals later this year for further rationalisation of partnerships, plans and other local initiatives. For example, the guidance on LSPs outlines the potential for Health Action Zones (HAZs) to become integrated into LSPs to strengthen the links between health and other areas of policy and to enable health to play a key role in the development of LSPs.

Health Action Zones did take more time than expected to set up and become operational, for example due to delays in recruiting staff for the many projects each HAZ was leading on. Bearing in mind these factors, Ministers had given permission early on for HAZs to carry forward underspends on 1999/2000 (their first full year) work programme budgets into 2000/01 to enable them to establish themselves and start to take forward new programmes.

(v) We note that both the Scottish and Welsh NHS Plans accord a higher prominence to the health agenda, an approach that we welcome (paragraph 44).

"The NHS Plan" makes very clear the importance we attach to improving health and reducing health inequality. Improving health is a priority for all Government departments in England.

(vi) We recommend publication of Sir Kenneth Calman's report on the public health function without delay (paragraph 46).

The final report on the "Chief Medical Officer's Project to Strengthen the Public Health Function" was issued on 28th March 2001. Five key themes emerged during the Project as being essential for a successful public health function and they were reflected in the "Saving Lives: Our Healthier Nation" White Paper (SL:OHN). These are:

- a wider understanding of health and well-being;
- better co-ordination and communication within the public health function;
- effective joined-up working;
- sustained community development and public involvement; and
- an increase in capacity and capabilities in the public health function.

The report identified three core workforce categories that contribute to the latter. These are:

- most people, including managers, who have a role in health improvement and reducing inequalities;
- a smaller number of professionals who spend a major part, or all of their time, in public health practice; and
- public health consultants and specialists who work at a strategic or senior management level, or at a senior level of scientific expertise.

Detailed recommendations are contained within the report which can be found on the world wide web at www.doh.gov.uk/cmo/phfunction.htm, and which sets out a programme in support of the public health aspects of "The NHS Plan."

(vii) We accept the Secretary of State's assurance that the NHS Plan is of equal status to Saving Lives. We particularly welcome the fact that the Plan includes a commitment to health inequality targets. But we believe that a great opportunity to give public health a real impetus has been lost by the lack of emphasis on this area in the Plan. The whole notion of a Plan is of a working agenda. So if it is the case that Saving Lives has equal status with the Plan this should have been made explicit in the Plan itself. Taken with the interminable delay in the publication of the Calman report on the development of the public health function we believe it adds credence to the notion that, for all the laudable Government rhetoric about dragging public health from the ghetto, in

the race for resources it runs the risk of trailing well behind fix and mend medical services (paragraph 47).

The Committee is right to accept the Secretary of State for Health's assurance that "The NHS Plan" is of equal status to SL:OHN. The Plan builds upon and strengthens the public health policies set out in SL:OHN, although the latter remains an important document, emphasising as it does the need for cross-Government working to tackle ill health and reduce health inequalities.

The Plan sets out a multi-faceted and comprehensive approach to improving public health. In particular it sets out policies for improving public health by a) strengthening multi-sectoral collaboration nationally, regionally and locally; b) expanding community development; c) tackling major determinants of health e.g. smoking, diet, exercise d) tackling major killers such as heart disease and cancer; and e) by making the NHS as powerful a determinant of health as possible. All this is underpinned by new national inequalities targets, and the inclusion of public health in the mainstream of NHS performance management.

"The NHS Plan" creates many new opportunities for public health professionals and others to have a major beneficial impact on the public's health. But these benefits can only be realised if they are grasped enthusiastically. Resources are not the main limiting step in delivering better public health. Cynicism and a failure to recognise and make the most of the opportunities presented by the Plan are a far greater threat.

(viii) We believe that there is merit in Professor Macintyre's suggestion that area-based interventions should be subject to far more rigorous analysis, although we are not convinced that randomised controlled trials are necessarily practical. We hope that this void can, at least in part, be filled by the work of the Health Development Agency (paragraph 50).

The Department of Health and other Government departments take the evaluation of area-based initiatives very seriously and recognise that they are complex. The Department for Education and Skills (DfES) has consulted widely on the design of the evaluation of Sure Start; the Department for Transport, Local Government and the Regions (DTLR) – formerly DETR – is taking careful advice on the evaluation of the Neighbourhood Renewal programme; the Department of Environment, Food and Rural Affairs (DEFRA) will be involved on questions of local air quality, and the local environment generally, as well as on policies for local access to a diverse range of fresh food within the overall framework for sustainable development at regional and local level; DH is funding an evaluation of HAZs; and RCU is in the lead on assessing the overall impact of area-based initiatives. There will be much valuable learning to be shared from this work.

(ix) We think it is crucial that the voices of those intended to benefit from interventions are acknowledged and that they feel some sense of ownership in the projects. At the moment, the impression is of grandiose

schemes being foisted on to communities. The most effective interventions that we witnessed took their strength from local leadership, responsiveness to local need, and local involvement and participation at every level. Given the evidence we received relating to the general lack of involvement of lay individuals in, for example, the Health Action Zones and Health Improvement Programmes, we believe it is essential that Government takes action and makes it a condition of further funding that there is clear feedback and input from those individuals intended to benefit from public health projects, including children. We are not convinced that any wider sense of "ownership" has yet been established (paragraph 57).

(x) It seems to us particularly regrettable that area-based initiatives have often failed to engage the communities they aim to serve (paragraph 57).

Health Action Zones are demonstrating some very effective practice in engaging local communities on the broad health agenda. The active HAZ Community Involvement Network (facilitated by The Standing Conference for Community Development) has developed a programme of work to promote strategic involvement with local communities which makes coherent sense with other stakeholders, including local Government. Early findings from the HAZ Evaluation show that, whilst involving community members in the design and implementation of programmes takes time and can encounter a range of potential problems, HAZs have made positive progress, particularly through network and forum structures. It is through these that HAZs are tackling problematic issues when trying to involve communities in planning and decision-making processes, and there is much learning to share in this area. This has been reflected well in the most recent wave of applications to the New Opportunities Fund (NOF) for Healthy Living Centres (HLCs) where proposals from HAZs are well represented and where the quality of applications has improved. The need for effective partnership, working is a key criterion for HLC funding from NOF, and the HAZ experience of partnership-working is clearly proving a sound basis for generating effective community development.

Whilst DH has examples of effective local involvement in HIMPs we're still in a learning phase, though doing better, and this area is being addressed as part of the HIMP Development Programme. Aligning HIMPs with Community Strategies (which principal LAs are also under a statutory duty to prepare) will provide local health systems with an opportunity to collaborate with LAs on engagement with their communities. Local Strategic Partnerships will underpin the need for collaboration.

It is not accepted that area-based initiatives have usually failed to engage their communities, and some HAZs have demonstrated innovative and effective ways of involving them. HAZnet, www.haznet.org.uk, contains many examples of good community involvement in areas like Sandwell, Bradford, Tyne & Wear, Manchester, Salford and Trafford, Merseyside and Walsall. The lessons being learned in these areas are being disseminated. Sure Start, a

Government-wide programme to increase opportunities for disadvantaged young children, is another example of an initiative that very closely engages with parents in the community.

(xi) The precise status of Health Promotion England seems to us unclear. The nature of its short-term contract, its relationship to its predecessor body and its means of liaison with the Health Development Agency (HDA) all seem too opaque. We are not convinced that this body has the direction, energy or resources to make a real difference. We would urge the Government to make clear its plans for the future of health education (paragraph 62). *[See also xii]*

The Health Promotion Campaign programme is planned year-on-year by the public health staff in DH and agreed with the Minister for Public Health. The Communications Directorate of DH works closely with Health Promotion England (HPE) and the lead for whole campaigns is shared between the two agencies. Health Promotion England offers an additional capacity in two functional areas: linkages and working with the health promotion community in the NHS, and specialist health promotion publishing and distribution.

The Health Development Agency now has a very different purpose. Its role is to take an independent objective view of the evidence for the effectiveness of such campaigns and has three core functions:

- research and evidence;
- standard setting; and
- developing the capacity and capability of the public health work.

Its remit is, however, much wider than the evidence for the effectiveness of campaigns and health education and there is no expectation that the HDA and the HPE should develop a special or unique relationship by comparison with their working relationships with other agencies and with DH.

(xii) We were impressed by the evidence given by those representing the HDA. We would be disturbed if this new organisation was not properly resourced. We are anxious to ensure that the HDA will have the resources to be able to assess 'bottom up' projects. We also recommend that its funding should be ring-fenced and kept apart from mainstream health funding so that its independence in offering objective advice on 'what works' in health is not compromised. Establishing 'what works' in public health will ultimately yield value for money savings (paragraph 65). *[See also xlviii, lxii]*

The Health Development Agency was established to ensure that "organisations and individual practitioners engaged in public health base their work on the highest standards and over time raise the quality of the public health function in England". It has a remit to work in partnership with key organisations and individuals to improve public health and tackle health inequalities and has three core functions:

- **research and evidence:** to establish and maintain an evidence base of what works in public health practice; dissemination of practical guidance on public health interventions which have been shown to work will be an early priority;

- **standard setting:** to advise on developing and setting standards for public health practice in a similar role to that which the National Institute for Clinical Excellence (NICE) plays in relation to clinical practice; and

- **developing the capacity and capability of the public health work force:** to support the delivery of the public health strategy and to improve the quality of service.

The Health Development Agency will assess what works in public health and establish a clear evidence base so that organisations and individuals will have the latest information to inform their work. A key task for the HDA will be to work with a range of bodies and add value to their efforts by:

- providing access to reliable evidence, and helping them to use it effectively;

- setting up networks so that they can share knowledge and good practice;

- giving support that takes account of local circumstances and need;

- joining together previously unconnected initiatives to increase their impact on health; and

- improving communications between local, regional and national public health services.

Since its creation the HDA has had a discrete budget agreed by the Secretary of State for Health and there are no plans at this stage to merge this budget with mainstream health funding. Decisions on the level of funding are taken annually, and the Secretary of State for Health has to make judgements about the appropriate level of funding for this and other budgets against many competing priorities.

(xiii) We recommend that the national Public Health Workforce Development Plan and Public Health Skills Audit (mentioned in the Department of Health's evidence) assesses whether primary care actually has the capacity to take on public health responsibilities (paragraph 70).

The Public Health Workforce Development Plan, announced in SL:OHN, is currently being prepared. It will identify the staff needed, the skills required, and the education and training necessary for the future delivery of the public health function recognising the important responsibility that primary care will have in this area. The Development Plan will outline the workforce implications for the next 5 years and will take account of the new NHS organisational structures announced by the Secretary of State for Health in his speech on 25 April 2001.

A review of the primary care workforce is currently underway which explores the implications for primary care in delivering modernised, improved services, and also examines the roles and staff groups involved in taking this forward. This work takes account of the demands which public health places on primary care. While we want to deliver convenient, integrated and high quality services, we fully recognise that resources are needed to support this. The report of the primary care workforce review will make recommendations for increasing, developing and re-focusing the primary care workforce so that the vision can become a reality.

A strategic programme to develop the nursing, midwifery and health visiting contribution to public health has been developed which includes primary care practitioners. The Health Visitor/School Nurse (HV/SN) Development Programme is part of this and was developed 'to make significant, demonstrable progress over the next three years (to April 2002) towards a family-centred public health role for health visitors and a child-centred public health role for school nurses'. Several projects within this Programme are specifically designed to assess and increase the public health capacity of health visitors and school nurses in primary care both in terms of capacity and capability. The Public Health Skills Audit has also examined the role of health visitors and school nurses with the aim of identifying any skill gaps. These staff groups form an important part of the public health capacity of PCTs, and will contribute to strengthening their capability to fulfil their new and fuller role in the local delivery of better population health and well-being.

(xiv) If GPs are to be more involved in wider public health work, particularly of a community development kind, the Government must find some way of creating a career and pay structure which enables them to do this and allows them sufficient time and provides sufficient incentives to facilitate their involvement (paragraph 71).

General Practitioners (GPs) increasingly are aware of the public health elements of what they do, such as immunisation and screening programmes. They are generalists, their role is continually evolving, and within the generalist role many have taken on some degree of specialisation, such as providing extra care of people with diabetes, additional health promotion etc. At one level, this sort of specialisation is just what is needed to help support the new public health development functions within a local health community.

Whilst not so explicit, GPs clearly understand that implementation of the NSFs is partly a public health aspect of individual care. The Department of Health is already intending to roll out the 1000 GP specialists as in "The NHS Plan", and some of these doctors might well have extra training in aspects of public health.

Many public health doctors in post now have spent some time in general practice – and some continue to combine both roles. This sort of opportunity has always been open to GPs.

The General Medical Services (GMS) Regulations require them to provide the following services to patients: opportunistic health promotion giving advice, where appropriate, on general health and in particular about the significance of diet, exercise, the use of tobacco, the consumption of alcohol and the misuse of drugs or solvents; offer a registration health check to new patients within 28 days; provide three yearly health checks to patients aged 16-75 who have not been seen in the last three years; and offer annual health checks to the over 75s. Personal Medical Services (PMS) GPs, who work to locally agreed contracts, are expected to provide a service which is at least similar to this.

General Medical Services GPs are paid separately for childhood immunisation and cervical cytology through a target payment scheme, and are paid allowances for providing Chronic Disease Management Programmes in asthma and diabetes.

General Practitioners working in PMS pilots follow national core contractual guidance which includes the public health targets in childhood immunisation and cervical cytology.

Primary Care Trusts offer an opportunity (probably for the first time) for one organisation to be able to provide a comprehensive range of services across primary and community care. They will have responsibility for assessing need, ensuring services are delivered to meet that need, and providing advice that will prevent people developing illness. This puts PCTs at the heart of a preventative health improvement agenda, which is, after all, one of their three key aims. Underpinning this will be the new public health team in each PCT, with a Board level appointment to lead the work on improving health and reducing inequalities in local neighbourhoods by integrating public health into primary and secondary care, and by working in partnership with LAs, other agencies and other parts of the NHS.

Health improvement for a PCT will involve a number of different strands, namely a public health role delivered through true community development; service planning, health promotion securing and providing appropriate health care, occupational health and performance management.

The successful PCT will be one that works with all interested stakeholders to develop the local HIMP, and it will have clearly identifiable plans for delivering its commitments within it. The Primary Care Trust will also need to be fully engaged in the developing LSP approach to health improvement.

As a result, the PCT is in a unique position of being a statutory organisation responsible for a joint primary and community care approach to the delivery of public health programmes.

(xv) Evidence exists from the USA and Canada to show that the benefits derived from a programme of home visits to women who are expecting a baby and then in the first two years of the life of the baby, are "uncontroversial", according to Sir Donald Acheson. This evidence should be capitalised upon to back a government focus on developing the

health visiting workforce and other professions working with children (paragraph 74).

The Department of Health recognises the importance of home and community-based support to families during pregnancy and the early years. The national health inequalities target for infant mortality – starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between manual groups and the population as a whole – begins to address this issue. So does the Government's target to eradicate child poverty within a generation and halve it by 2010. To achieve this will need concerted action by all those professionals working with children and their families.

In developing the new, family-centred, public health role of health visitors account has been taken of this evidence. The Health Visitor/School Nurse Development Programme (see xiii) has funded a range of projects (training and services) to improve family support in the early years. A strengthened public health approach aims to ensure that those families in need of support are identified and their needs met at an individual and community level. However, LAs, other agencies and the local community also have an important role in supporting parents in pregnancy and the early years.

The Sure Start Programme, with its integrated approach to the health, social, emotional and educational aspects of children's well-being is delivering a range of support (including some which is home-based) to the most deprived communities. Within "The NHS Plan" midwives also have a key public health role in providing support during pregnancy and in promoting family well-being.

The NSF for Children will look further at support in pregnancy and early years.

(xvi) We believe health visitors should work with the elderly or other needy groups, so as to broaden their skills base to encompass other activities. We would also like to see a role for health visitors as the key public health resource for all community health care professionals. We are concerned that health visitors are not sufficiently empowered in terms of resources and capacity to carry out wider public health functions beyond their statutory duties. We also think that there is scope for greater integration and co-ordination between health visitors, school and community nurses. We recommend that the role of the health visitor is reviewed and clarified. We would like to see it developed as a holistic, public health function (paragraph 76).

The new role of the health visitor emphasises the importance of assessing health needs and working with local communities to address these. "Saving Lives: Our Healthier Nation" identified this new role for both health visitors and school nurses, and "Making a Difference" and "The NHS Plan" also highlight the important contribution that nurses and health visitors can make to improving the health of the population and addressing health inequalities. The Department of Health's HV/SN Development Programme is funding a

wide range of projects, posts and materials aimed at raising awareness and clarifying what their new roles mean in practice, though we recognise that further work still needs to be done to address the barriers that prevent health visitors from maximising their public health role. Further guidance will be considered to clarify this within PCTs, and the latter provide opportunities for greater empowerment of health visitors to fulfil their public health function.

Additionally, NSFs provide opportunities for health visitors and school nurses to take a leading role in promoting an active healthy life into older age, reducing heart disease in the population, and promoting mental health for all.

An additional 100 commissions have been provided for health visitor training for this year (from 1999-2000 budget rollover) and a significant number of new posts are being created through Sure Start and other partnership initiatives. Work is taking place within both primary care and public health to develop more integrated nursing services. Guidance has been issued to the NHS on integrated nursing teams ("Making a Difference – Update") and the HV/SN Development Programme takes an integrated approach to their public health roles.

(xvii) We recommend that the Government take steps to create incentives for community pharmacists to play a more active role in public health. We welcome the idea that a pharmacy could act as a more general health resource centre, thus better utilising the very considerable expertise of pharmacists (paragraph 81).

In September 2000, the Government published its programme for pharmacy in the NHS, "Pharmacy in the Future – Implementing the NHS Plan." The programme contains a variety of measures intended to make fuller use of the skills and expertise of pharmacists. The large majority of community pharmacies qualify for a professional allowance from the NHS, one condition of which is that they display up to eight health promotion leaflets. Through the Pharmacy Healthcare Scheme, DH funds the provision of health promotion materials specifically for use by and in community pharmacies. In addition, there are many examples of HAs involving pharmacies locally in initiatives such as smoking cessation, the provision of emergency contraception and other health promotion activities.

The Government intends to build on this both nationally and locally. It has made the development of medicines management services a priority, and by 2004 there will be schemes in all parts of the country to give patients more help from pharmacists in using medicines. The introduction of Local Pharmaceutical Services pilot schemes will also encourage the development of a wider role for pharmacies by allowing HAs and pharmacy owners to experiment with innovative local approaches to designing and contracting for community pharmacy services. In addition, the Government will be reviewing the national contractual framework in order to promote and reward quality of service, not simply volume of prescriptions.

(xviii) If the information resources of primary care are to be exploited, a properly resourced information management and technology structure will have to be implemented (paragraph 83).

(xix) The Government must performance-manage public health responsibilities to ensure that PCG/Ts do take up their new responsibilities meaningfully. It must also ensure that the relevant training and support is provided to all PCG/Ts to enable them to do this (paragraph 85).

(xx) We recommend that PCG/Ts should be required to have an additional designated officer from the local authority with a broader remit for public health. If PCG/Ts are significantly to influence health, they must have access to those local government services which affect the social determinants of health. PCG/Ts also need to be given more information about how local government works, so that they can begin to use it more effectively (para. 89).

(xxi) We believe health authorities will have to work hard to improve their communications with primary care, perhaps through secondments or work-shadowing, to improve mutual understanding of the different ways of working (paragraph 92).

(xxiii) A better solution to the problem of supplying public health advice to PCTs, which will certainly be needed, might be in the form of managed public health networks, with which PCTs and indeed Local Authorities could contract for public health support. It may be that, with PCTs becoming the predominant purchasers, health authorities could focus on public health almost exclusively and house such centres of expertise on a hub and spoke model. It may well be that no one national solution will cater for the different local situations of different areas, but guidance and an exploration of this area is vital. We recommend that the Government conduct a review of the best way of providing public health support to the variety of local agencies which require or will require it (paragraph 94).

(xxiv) There are a number of ways in which primary care could contribute more to the wider public health vision. The primary care team could become a fulcrum for interagency work, physically providing a base for various combinations of 'one-stop shop' or healthy living centre or at least creating an information link to other statutory services. Formalised links and defined referral pathways to local government departments such as housing, leisure (such as through the exercise on prescription scheme) and schools, to name a few, would link the medical health care team more effectively to the social determinants of health and the statutory powers who may affect such determinants. On a wider canvas, health visitors and nurses could lead primary care involvement with community interventions and development. The establishment of PCTs should allow Primary Care to take a broader population perspective. Given that PCGs and PCTs have as one of their three key

functions "to improve the health and address inequalities of their community" a way must be found to make public health a viable reality for primary care (paragraph 95).

Primary Care Trusts will be responsible for improving health and ensuring the delivery of health services to meet the needs of their local community, will work with a range of partners including LAs, and will be accountable to the Secretary of State for Health via the new Strategic Health Authorities. Their functions will include community development, service planning and delivery, securing the provision of a range of services, health promotion, health education commissioning, occupational health and performance management. They will undertake population needs assessment, the development of health improvement and modernisation programmes and will work as partners in LSPs (see below).

Primary Care Trusts are in many respects best placed to deliver change at local level because: they will have the best knowledge and information about local health needs; they have responsibility for providing services – smoking cessation, healthy diets, services – essential to the achievement of the targets; they are the link with LSPs and neighbourhood renewal action teams; and because they are best placed to act as advocates, from the health perspective, with other local agencies, for example to promote improvements in housing standards for the most deprived, or local transport strategies which counter locational disadvantage and reduce the risk of accidental injury.

The Department of Health recognises, therefore, the importance of ensuring public health responsibilities are part of mainstream PCT business. Performance management of primary care organisations will be the responsibility of Strategic Health Authorities, and the Department of Health is working to develop PCTs' capacity/ability to deliver on real health improvement by providing relevant training and support. This will include a set of Performance Indicators (PIs) for Primary Care Groups/Trusts (PCGs/Ts), reflecting these aims and balanced across the six Performance Assessment Framework (PAF) domains. Development work is already in hand, and a first PI set is expected to be ready in 2002 with the introduction of a traffic light performance measurement system for primary care organisations during 2002/03.

The Department of Health also recognises that relationships between LAs and health services are critical to the ability of both to contribute to service development. Aligning HIMPs with Community Strategies will provide PCG/Ts with the incentive and opportunities to influence local Government service delivery and visa versa. The PCT will need to continue to ensure that, wherever it is possible and practical to do so, it will be co-terminous with a LA boundary.

The Department of Health is currently working with the Nuffield Institute for Health and the King's Fund to run a programme for developing the mutual understanding of lay members of PCTs and the role of elected members of LAs. Guidance issued in April 2000 to appoint public health members to the

Executive Committee of PCTs is clear that the public health professional should have an ability to work across boundaries, and implicit in this is the need to develop close links with LA players.

Primary Care Trusts will also be able to contribute to the wider public health vision through their association with LSPs. In particular the work with HIMP/Community Plan activity and partnerships will be taken forward to improve health through neighbourhood renewal strategies in the most deprived areas.

Primary Care Trusts offer an opportunity (probably for the first time) for one organisation to be able to provide a comprehensive range of services across primary and community care. We know that many primary care teams are already developing effective referral schemes to LA housing departments for housing and maintenance, such as "care and repair". For example, some PCTs work with local Citizens Advice Bureaux and welfare rights groups to improve uptake of welfare benefits. We need to identify and share good practice like this.

Over time PCG/Ts will forge powerful partnerships with such local bodies – schools, employers, housing departments etc – to deliver shared health goals, and they also work closely with Social Services and other agencies in planning and delivery of services. Over half of PCGs have already introduced smoking cessation initiatives.

The planned introduction of Care Trusts will help develop these links further by allowing for the even closer integration of health and social care services. They will, for the first time, allow governance arrangements to be changed so that council member representatives can become full members of the Boards overseeing these bodies. In addition Chairs and Non-Executives of PCTs, although not appointed as LA members, may often have roles/experience within LAs and with the voluntary sector and community groups. Scrutiny committees have been set up in a positive way to develop mutual indicators of population health needs and to ensure that these will be addressed. Such committees are a vital component of the local health partnership and where they are effective they will be able to hold the NHS to account in a systematic and public fashion which it is hoped will create greater public confidence and at the same time highlight real achievements.

Where appropriate, and where partners agree, some aspects of housing and education can be included in those functions being delegated to Care Trusts, creating a single organisation with responsibility for cross-boundary services and opportunities to develop whole-systems working, with single assessment processes, one-stop-shopping and holistic care provision.

The work taking place to look at how we discharge the public health function effectively at different population sizes will consider the best way public health advice can result in changes on the ground. The move to Strategic Health Authorities and the accompanying changes in roles and functions of

these and PCTs also provides an opportunity to ensure organisational change is managed in such a way as to promote the very best of partnership working across local health systems. Many PCTs, and the primary care teams within them, will have staff who have traditionally worked without any problems across HA, NHS Trust, and primary care boundaries. These include the various professionals who will be operating out of one organisation to deliver public health messages such as GPs, health visitors, district nurses, school nurses, and health promotion specialists. Many entrants to specialist training in public health have also worked in primary care. However, we do need to ensure that both public health and NHS management trainees gain experience in PCTs, and in many places secondment/shared working between HA Public Health Departments and PCTs is already well established.

Primary Care Trusts are taking advantage of the valuable source of public health expertise and knowledge provided by specialists who are HA employees. The Public Health Skills Audit and Workforce Development Plan will identify how and where the workforce needs to be developed to ensure a strong and effective public health function. Strategic local workforce planning and individual staff development will complement this national activity and help to inform communications between HAs and other sections of the NHS community, including primary care.

The new family-centred public health role of health visitors gives them also a key role in working with communities and leading multi-disciplinary teams to address local health needs. The 30 leadership posts funded by the HV/SN Development Programme, and the nurse consultant posts in public health, are establishing ways of linking community development and primary health care. Such posts have demonstrated how health visitors can lead on community development with a wide-range of groups and health priorities.

The Government is also aware that a properly resourced Information Technology (IT) structure will be required for primary care. The updated NHS Information Management and Technology (IM&T) Strategy, "Building the Information Core: Implementing the NHS Plan," contains targets to improve the IT infrastructure in GP practices. These targets are to ensure that all GP practices are computerised, with NHSnet connections and that those with Local Area Networks (LANs) have access to desktop applications by March 2002. Project Connect is working and on target to deliver these improvements to GP practice IT infrastructure. As at 15th May 2001, 8278 (94%) of practices had an NHSnet line installed, and 6555 (75%) of practices had a LAN installed & connected to NHSnet. A detailed breakdown of progress is available on the NHS Information Authority website at www.gpnet.nhsia.nhs.uk

(xxii) The Government needs to clarify exactly what the respective public health roles of the different tiers of the health system will be (paragraph 93).

Work is already in hand with the field to consider the implications of the changes in the national business agenda set out in "The NHS Plan," and in the

Secretary of State for Health's recent speech to launch the Modernisation Agency. This includes how the public health functions can be effectively discharged for different population sizes:

- **at national level:** DH has already established an Inequalities and Public Health Taskforce to lead the implementation of "The NHS Plan" commitments; the recent announcement of a cross-Government spending review on health inequalities will require the establishment of a Ministerial steering committee chaired by Yvette Cooper, the Minister for Public Health, to oversee the analysis and development of action across Government on this; structures to support more effective cross-Government working will also be set in place;

- **at regional level:** "the Plan" made a commitment to harmonise the public health resource at NHS regional level with the GOs; strong public health groups, headed by an RDPH, within each GO will be able to contribute effectively to each regional sustainable development framework and develop an integrated, cross-sector, approach to tackling the wider determinants of health; for example, they will play an important part in taking forward the NSNR, will be responsible for the health dimension of regional work on economic regeneration, education, employment, environment and transport, and have an overview of the health contribution to LSPs in their regions;

- **at local level:** local action should be supported and facilitated through the PAF for the NHS and the delivery systems for provision of other local services; in particular, LSPs will have a crucial role to play in setting and delivering on local targets; Strategic Health Authorities and PCTs will need to take the action described in the previous section.

(xxv) We agree with the Secretary of State that health authorities are not solely responsible for improving health, however we consider that the strategic lead for public health must be clarified. The "plethora of partnerships" make it vital that there is clear strategic leadership of public health at a local level. Whatever arrangements are made, leadership should be strong, explicit and should have clear lines of accountability (paragraph 102). *[See also lxii]*

The Department of Health is currently looking at the delivery of the public health function at all levels (see recommendation (xxii)) and a major consideration in taking forward this work is the need for strategic leadership to promote effective public health practice in the local health system. The Department acknowledges that there is a plethora of partnerships, but the opportunities now created for public health to influence a number of levels need to be taken. Locating the public health function in the GOs will take advantage of their capacity for strategic thinking and for the planning of other services with an impact on health, such as neighbourhood renewal. The new

Integrated Public Health Groups will also have a vital leadership role to play by ensuring a commonality of approach to public health issues.

Primary Care Trusts as the main drivers for improving health can enable a new focus on neighbourhoods and communities through programmes to promote regeneration and tackle deprivation. For instance, this can be through the public health role of primary care staff in NSNR, and through PCTs in active participation in LSPs. The recently published Government guidance on the latter sets out the key role that HAs should play in the development of such partnerships. This includes ensuring that health input to LSPs from all key stakeholders in the local health community is co-ordinated, though there needs to be a clear lead at all levels. The introduction of Care Trusts will also provide an opportunity for strategic re-thinking of partnership arrangements and how services are delivered in local health economies. In future, Strategic Health Authorities will ensure that local health systems, including PCTs, play their full part in partnership working at all levels.

(xxvi) We recommend that the Government, if it is serious in its commitment to public health, ensures that NHS organisations and local authorities have the proper resources, including staff, to enable them to take forward their public health responsibilities (paragraph 104).

The Government has recently set out its agenda for moving investment to the frontline of the NHS through a programme of reform that will give PCTs much greater control over the use of resources and, with it, greater freedom to innovate. We envisage the NHS working with all stakeholders in health improvement (eg. the private sector, voluntary organisations, LAs etc.) to improve health and reduce inequalities in deprived areas, within the increased provision the Government has already provided in this area.

A programme of work is underway to ensure that HIMPs are a key means of implementing "The NHS Plan" and of underpinning LSPs. This will assist NHS organisations in taking forward their public health responsibilities, and PHOs are another key local public health resource strengthening the availability and use of information at local level to improve health surveillance.

The Department of Health is working with the HDA to produce a Public Health Workforce Development Plan (para xiii), and funding has been made available from the Public Health Development Fund. The Workforce Plan will take account of the Government's modernisation agenda for the NHS, and make recommendations for the entire public health workforce in England, not just those working in the health sector.

Examples of specific initiatives that are relevant here include:

- in 2001–02, a total of £30m from across Government is being invested nationally to tackle teenage pregnancy; this includes £11.5m for local implementation through a network of local and regional teenage pregancy co-ordinators, and £4.5m to improve co-ordination arrangements between key agencies including HAs and LAs and the voluntary sector;

- a review of the existing weighted capitation formula used to distribute NHS funding is taking place, and the Government's objective is that reducing inequalities should be a key criterion for allocating NHS resources to different parts of the country; as a first step, for 2001/02, an interim health inequalities adjustment has been introduced; £130 million for this adjustment has been shared between 53 HAs;

- some £53m is being invested in smoking cessation services over three years, plus much more through the unified allocations for bupropion and Nicotine Replacement Therapy; and

- the Government has made a commitment to introduce a National School Fruit Scheme to improve the diet of children; the scheme will entitle every child aged 4 to 6 years in infant schools to a free piece of fruit each school day by 2004 and is already covering over 80,000 children in more than 500 schools across England; we plan to give schools a real opportunity to play a key role in the delivery of important public health messages, which the Government is also encouraging through the National Healthy Schools Standard (NHSS) and the recently announced £2.2m Food in Schools initiative with the DfES.

(xxvii) We consider that local authorities have a vital role to play in improving the health of their communities and have influence over a greater number of factors affecting health than the local NHS. We strongly support their new power to promote wellbeing and recommend that this leads to public health being placed at the core of their initiatives and strategies. We welcome the attempt to do this by some local authorities. We discuss the location of public health locally at paragraph 126 (paragraph 109).

Central Government has recognised this potential for forming partnerships with local Government on a policy level, and there have already been round-table discussions involving DTLR, the Local Government Association (LGA) and the Improvement and Development Agency (IDeA) to explore health and well-being activity. Particular issues included linkages between HIMPs, Community Strategies and the use of the well-being power, and how the partners involved can help support development and activity on implementation in a joined-up way. The local development of the Healthy Schools Programme reflects the vital health role of LAs, and the pre-requisite for each local partnership has been jointly-agreed plans between each Local Education Authority (LEA) and HA (over half of LEAs are already accredited under the NHSS). The new power to promote well-being will enable closer joint working between LAs, HAs and other bodies to target health issues, and it will be for LAs, working collectively with their partners, to pursue this.

In February 2001 the Government awarded beacon status to five councils for their local health strategies. Local PSAs have been concluded this year with 20 LAs and will be extended to other county councils, London boroughs,

unitary authorities and metropolitan districts, on a voluntary basis, over the next two years. Local Authorities can include targets to narrow health inequalities, such as reducing teenage pregnancies or the incidence of tuberculosis. There will also be health benefits from their actions in other target areas, such as reducing unemployment and tackling drug misuse.

The Local Strategic Partnerships the Government is seeking to establish across England (iv & xxxii) will provide opportunities for LAs to work in effective partnership with the NHS, other public sector organisations and the private, voluntary and community sectors to tackle the problems in their areas. Under the Government's NSNR, LSPs will develop neighbourhood renewal strategies to tackle deprivation and inequality. A core goal is to improve health in deprived areas and LSPs will be setting targets, including those for health and well-being, to support the delivery of their strategies.

The cross-Government spending review on health inequalities will need to look at this further.

(xxviii) We recommend that health should be a key element of the local authority community plan (paragraph 110). *[See also:xxxiii]*

It is recognised that health and well-being is, and should be, a key element of the Community Strategy. Work is underway as part of a development programme looking at, amongst other things, how we might align activities for HIMPs with Local Authorities' Community Planning processes.

(xxix) We recommend that the NHS Executive gives urgent consideration to developing a pro-active role for the NHS in area-based regeneration and neighbourhood renewal. In particular, we recommend that the substantial resources of the NHS at all levels are used, as far as is practicable, to improve health through direct and indirect employment and through its procurement and planning functions (paragraph 125). *[See also xxxiv]*

The NHS will play a full part in the Government's NSNR, and will help to develop the LSPs that will be key to implementing the Strategy. It has a key role in this through the delivery of health services and health improvement interventions, and also through supporting economic regeneration of deprived areas.

The NHS is a main employer, trainer and purchaser in many deprived areas and the NHS economy thus needs to be engaged as part of neighbourhood renewal strategies. The Department of Health is currently seeking to facilitate this role and will seek to link constructively with the King's Fund team also looking at this. Improvements are being sought in particular on working closer with other Government departments and the way information and advice is provided to NHS organisations.

The Secretary of State for Health and the Permanent Secretary/Chief Executive for DH have written to local health communities to encourage their participation in neighbourhood renewal as part of a programme to develop

knowledge and understanding of the Government's strategy and the role of the NHS.

This is one of the issues that DH will consult on as part of the plan for delivering the health inequality targets.

(xxx) We are persuaded by the argument put to us that major structural upheaval in the location of the local public health function is not the answer however attractive it may appear. There can be no return to the past. Rather, we believe ways must be found of providing incentives to ensure that the public health function delivers across the entire health system regardless of where it happens to be positioned (paragraph 132). *[See also xlvii, lxii]*

Opportunities for developing robust incentives will emerge through alignment of HIMPs to Community Strategies, the move to Strategic Health Authorities and through the enhanced role of PCTs. Other mechanisms include developing PMS schemes to reward public health.

(xxxi) We note, too, that there is considerable experimentation taking place at local level in the organisation of the public health function with innovative joint arrangements between health and local authorities being put in place. These include joint appointments of DsPH and others working in public health, and joint health units of the type being established in Manchester. We believe that there should be a presumption in favour of joint appointments. We recommend that these arrangements be monitored and supported where they appear to work. They should be urgently evaluated in order to establish their impact and effectiveness. If they work then their uptake should be actively encouraged elsewhere. We believe that the way ahead lies in local solutions in preference to central prescription. But Government must also ensure that best practice from these local developments is rapidly mainstreamed so as to avoid a gap opening up between the leaders and laggards (paragraph 135). *[See also xxxiv]*

The Government fully supports the establishment of innovative joint-working arrangements between HAs and LAs, but the recent announcement of changes to the configuration of HAs will have implications for this which will work through over time into the new structures in the NHS. For example, the Modernisation Agency will work with LAs to ensure that the sharing of innovation and best practice is maximised for the benefit of local people. Similarly the Health Development Agency, the IDeA and the LGA have been working together to share information and practice and to explore opportunities for joint evaluation. The Department of Health has also commissioned the Office of Public Management to evaluate existing joint appointments and will be able to learn lessons from the healthy community collaborative that will be launched shortly.

Many Consultants in Communicable Disease Control (CCDCs) already hold joint appointments, and this is seen to be an effective way of spanning the respective responsibilities of HAs and LAs.

(xxxii) In its evidence to us, the HDA argued that :"The inter-relationship of several major strands of government policy needs to be made much clearer. For example, there are the neighbourhood renewal strategy, Sure Start, the various zone-based initiatives, as well as planning mechanisms such as HImPs, community plans and regional development strategies. Each has its own goals and targets and measures of success. People need to be able to understand the relationships among them (and the links between goals to do with economic success, social regeneration, eliminating child poverty, sustainable development, quality of life, well-being and health)." We endorse this view and recommend that the Government clarifies how the various strands of policy are connected to provide a more coherent policy framework. Otherwise there is the risk of serious failure in partnership working. Paradoxically, the danger of so many partnerships in existence is that a new order of fragmentation will occur (paragraph 140). *[See also iv]*

The Government accepts its responsibility to provide a coherent policy framework. A number of steps to achieve coherence are in hand.

For example, the Permanent Secretary/Chief Executive's review of DH aims to ensure that the Department has more coherent policy development, and themes that are already emerging from the review include the need for a change in "culture" such as dissolution of unnecessary barriers both internally and externally. Mechanisms to facilitate this include the Inequalities and Public Health Task Force, and better co-ordination across Government at national level (e.g. through working groups), at regional level (e.g. through the new Integrated Public Health Groups) and at local level (e.g. through incentives for joint working between LAs, Strategic Health Authorities, and primary care organisations).

The Regional Co-ordination Unit (see iv) challenges all departments proposing new or extended area-based initiatives to consider their health implications and to make contact with relevant officials in DH. This will be reflected in amended guidance to be published in the Summer, and in addition the RCU is to undertake a review of existing area-based initiatives.

Most regional sustainable development frameworks are now in place, providing a context for the work of Regional Development Agencies (RDAs) to co-operate with other regional stakeholders. Guidance on RDA strategies is currently being reviewed to ensure that it includes advice on new areas of cross-Government policy and that RDAs are aware of Government initiatives that impact at regional, sub-regional and local levels. Following the Spending Review that was announced in 2000 to cover the financial year 2003-2004 (SR2000), Ministers announced that the Single Regeneration Budget, as well as the other programmes that RDAs operate, will be merged into a single programme from April 2002.

The Government is also seeking to establish LSPs (see iv and xxvii) across England to, inter-alia, co-ordinate and rationalise the activities of other local partnerships in order to improve the delivery of services and cut down the

number of separate local partnerships. The Department for Transport, Local Government and the Regions (DTLR) (in consultation with Her Majesty's Treasury and other Government departments) is carrying out a comprehensive review of the current planning requirements for existing and proposed service and policy plans, and will issue further proposals later this year.

The issue of plan rationalisation was also raised and discussed as part of the local PSA process. Several departments have committed themselves to working with the pilot authorities on plan rationalisation in this context, and the Government has also asked the Children and Young People's Unit to examine further the potential for substantial rationalisation of planning for children's services at the local level. The Unit's aim is to remove the burdens, confusion and duplication among local agencies and focus instead on overall outcomes expected for the well-being of children.

The cross-Government spending review on children at risk should also help to clarify and strengthen partnership working.

(xxxiii) We were persuaded by the evidence from Sandwell and Hillingdon Health Authorities where progress had been made in integrating the HImP and Community Plan. We recommend that other localities should follow suit and that the Government issues guidance accordingly. Such guidelines will require collaboration between all the Government departments involved (paragraph 144). *[See also xxviii]*

The Government accepts that closer integration of HIMPs and Community Strategies would be advantageous. Work is in hand by the HDA to examine how best to achieve this.

(xxxiv) We urge that health objectives are at the heart of neighbourhood renewal strategies (paragraph 149). *[See also xxix]*

Improving the health of people in deprived areas remains one of the key outcomes set by the Prime Minister for the Government's NSNR, and one initiative already linked to achieving this is that on teenage pregnancy. Local Strategic Partnerships are required to address these key outcomes and to set targets for change over time in their neighbourhood renewal strategies. Department of Health PSA health targets were also included in the "New Commitment to Neighbourhood Renewal: National Strategy Action Plan" to focus efforts on the problems of deprived neighbourhoods.

(xxxv) We understand there is now a respectable body of research identifying the success criteria to ensure effective partnerships. We urge the Government to apply these to its own proposals to establish new partnerships in the form of Local Strategic Partnerships as well as to its 'joined up' policy agenda across government departments. In particular, we recommend that the lessons from the HAZs emerging from the national evaluation are taken on board in the development of LSPs (paragraph 151). *[See also iv]*

The Government agrees.

Lessons from the first phase of HAZ development have been assessed by the National HAZ Evaluation Team, and the team's initial findings will be made available across Government in connection with the development of LSPs. The Evaluation of HAZs shows that they have important lessons to share on partnership-working and the integration of communities in this process. A report focussed on the community involvement aspect of the Evaluation will provide further details later this year.

Government guidance on LSPs also contains advice on good practice in partnership-working and gives examples of partnership structures.

The Department for Transport, Local Government and the Regions also intends to carry out a series of research projects on partnership-working and LSPs, which will include the lessons from the National Evaluation of the HAZs. This will involve assessing the progress made by LAs and their partners as well as identifying the lessons learnt and examples of innovative practice. The Department for Transport, Local Government and the Regions/Regional Co-ordination Unit research on "Collaboration and Co-ordination in Area-Based Initiatives" (final report due Summer 2001) looks at models of successful integration across a range of initiatives including HAZs.

(xxxvi) Our strong impression is that the current role of the Director of Public Health is too vague and the influence the DPH can bring to bear too little. We were not struck by any real sense that the DsPH were acting in the entrepreneurial way the BMA suggest. The DsPH do not seem to us generally to be providing the necessary leadership in the public health field (paragraph 157).

(xxxvii) The lack of priority accorded to population health at the annual health authority review meeting, and the fact that over half of the DsPH surveyed failed even to attend the meeting, suggests to us that DsPH do not, on the whole, carry real weight within the health service. We recommend that guidance is immediately circulated to require DsPH to be present at the annual review of the health authority and to require population health to be an agenda item, a requirement made even more pressing by the recent publication of the national health inequalities targets (paragraph 160).

(xxxviii) We note that the Government is currently reviewing the impact of the annual report of the DPH. We believe that the annual report of the DPH should adopt a consistent format to ensure compatibility of data. It should clearly distinguish between past trends in epidemiology and key present agenda concerns. We feel that the Health Development Agency should have an early input into producing guidance to ensure a far greater degree of standardisation across the DPH report whilst still allowing sufficient flexibility to achieve sensitivity to local conditions and needs. Guidance should be issued on the range of bodies that should be consulted in drawing up the annual report. For example, Dr Rosemary

Geller, DPH for Shropshire, told us she used the need to draw up an annual report as an opportunity to visit all relevant organisations and stakeholders once a year so as to get their input. We believe that, in drawing up the annual report, the DPH should record the contributions not only of the statutory sector but also of local, voluntary organisations. The annual report of the DPH ought to be a critical document in the formulation of the joint HImP and Community Plan (paragraph 161).

After the recent speech on "Shifting the Balance of Power" by the Secretary of State for Health, the role of the HA DPH is bound to change and the concerns of the Committee will be taken into account in defining this new role as it develops between now and 2004. Nevertheless, there will be a public health team in each PCT with a Board level appointment to lead this work. Every Strategic Health Authority will have a DPH with responsibility for managing the performance of the local public health team, and for developing clinical networks and public health networks which ensure sound clinical performance and the safety of patients and the public. There will also be a strong regional public health group, co-located in the nine GOs and led by an RDPH, which will concentrate on the development of an integrated, multi-sectoral approach to tackling the wider determinants of health and on informing regional work on economic regeneration, education, employment and transport. It will also ensure the quality of the public health function, including the protection of health across the region, and emergency and disaster planning and management.

At present the essence of the DPH's responsibilities is being able to make use of the full gamut of opportunities to intervene to protect and promote the public's health. Its strength lies precisely in it being generalist. The leadership skills it requires are also needed by a wide range of public health specialists and practitioners, and the importance of strengthening leadership skills for the public health field was recognised with the establishment of pilot Public Health Leadership programmes in West Midlands and London in 1998 funded by DH. There is now a national programme, integrated with the NHS Leadership Centre, which has built upon these pilots and successful experience in the USA.

The DsPH must be able to discharge their responsibilities in a way that gains the confidence of a range of different local groups and organisations. The breadth of public health issues, for which the DsPH need to maintain an overview, is part of the challenge and opportunity of the role. Currently it is expected to encompass the following:

- strategic leadership, working with all agencies that can affect public health, to implement local health and health protection strategies;
- leading and managing a multidisciplinary Public Health Department, including responsibility for surveillance, monitoring and control of communicable disease and health protection;

- advising LAs;
- advising on the appropriateness and effectiveness of both clinical and non-clinical interventions;
- developing public health capacity and capability in the NHS and LA workforce;
- developing and sustaining relationships between the health authority and clinicians (including GPs), LAs and the local community; and
- providing the focus for all local public health advice including ensuring that providers of primary, hospital and community care, including the voluntary and private sector, have access to adequate and appropriate public health advice.

Annual Reviews of HAs are currently part of the performance management process undertaken by NHS Regional Offices. The current performance agreements are drawn up annually and would be expected to cover key health and health care issues. However, the formal Annual Reviews are conducted differently (depending on local circumstances) in different regions and, therefore, the variation found by the Committee in the attendance of DsPH at the Reviews will reflect that. Health Authority Chairs are required to be present at the Review and would be expected to be briefed on, and be aware of, the key public health issues in their districts. Most DsPH would be able to contribute to these and the wider issues covered in the Review, but the annual meeting is only one (albeit important) part of the process. Their influence can be exercised in many other ways.

The performance management process will be changing to take account of the recently announced changes in Regional Offices and in HAs, and the new systems will need to give due weight to health improvement and reductions in inequalities in performance managing all NHS organisations. Specifically the role of the Strategic Health Authorities in managing and enabling the performance of local health systems, and particularly PCTs in respect of their public health responsibilities, will put the DPH firmly centre-stage.

In most HAs, the Public Health Department provides data and interpretation to inform the HIMP, and the DPH's Annual Report is used to inform the latter (there is currently debate and discussion about this). The DPH can also advise how national guidance can best meet local needs, and how performance management of the HIMP can be effectively undertaken. As an Executive Director of the HA the DPH will participate in annual objective setting and appraisal processes with the Chief Executive, and performance and effectiveness would be assessed through this process.

The "Saving Lives: Our Healthier Nation" White Paper also gave a commitment to ensure that the Annual Reports of DsPH are used more systematically to formulate health improvement programmes and to meet common standards. The Department of Health is currently developing revised guidance on the production of DsPH Annual Reports which will be circulated

for consultation among key stakeholders and opinion leaders (including the HDA). When published later this year, it will help to ensure better, more helpful and more consistent DsPH reports on the health of the local population. Annual DsPH reports are key vehicles for taking forward and implementing "The NHS Plan", are central to supporting the development of HIMPs and the Community Planning process, and increasingly underpin LSPs. They, therefore, support the modernisation of both health and local Government services as well as the reduction of health inequalities. Whilst acknowledging the independence of the DPH Annual Report, the new guidance will ensure that the core content reflects national as well as local priorities and enables local groups to track progress year-on-year.

(xxxix) Support for joint health authority/ local authority appointments was voiced by many of our witnesses and we would regard this as a positive measure. We are not convinced that the DoH has been sufficiently proactive in helping this come about. We acknowledge that joint appointments are much more straightforward in areas where there is co-terminosity, though even here they are the exception rather than the rule. We would argue, as the Cabinet Office report Reaching Out suggested, that greater moves towards co-terminosity need to be made. But even where there is not co-terminosity we feel that all stakeholders in local and health authorities ought to be able to agree a strategy to have a Director of Public Health in post whom they regard as partly their responsibility. However, we do not necessarily believe that joint appointments will bring an end at a stroke to turf wars between local and health authorities. In this regard we would especially like to endorse the suggestion of Ken Jarrold that, as well as having structures to bring about joint appointments of DsPH, other structures had to be effected to make them jointly accountable to each authority. We also maintain a line of argument from several of our previous inquiries that the DPH should have ready access to those in local government, placing population health in the immediate context of many of the factors – housing, the environment, transport – which most impact upon it (paragraph 164). *[See also xxxiv]*

Co-terminosity is clearly a key driver for joint working and partnerships and that is why the Department of Health wants to ensure that the new Strategic Health Authority boundaries do not cut across LA boundaries. Where co-terminosity does exist some jointly appointed DPH posts have already been established and the experience gained from these early appointments and from PCTs working across boundaries will be disseminated.

The study currently being undertaken, on behalf of DH, by the Office for Public Management will also support the development of joint appointments by providing a number of effective models for use by HAs and LAs. Even where a DPH is not jointly appointed, the LA normally has a representative on the appointments panel and when appointed, one of the roles of the DPH is to act as a formal adviser to the LA.

The Department of Health is currently also seeking to improve the role of the NHS as an employer in deprived areas and will seek to link constructively with the King's Fund team who are also looking at this work. Improvements are being sought in particular on close working with other Government departments and the way that information and advice is provided to NHS organisations.

One example of a specific action already taken is that every Social Services authority area in England now has a teenage pregnancy co-ordinator, jointly appointed by HAs and LAs.

(xl) We recommend that the Government adopts population-based funding and clear policies for its application and then leaves it up to local agencies, as part of the HImP, to get on and deliver on these policies with the appropriate training in place to equip managers and others with the requisite skills. At the very least the bidding process needs to be reformed. We recommend that the Government conducts a review of the bidding process in the context of public health funding, with a view to formulating a more equitable system for the allocation of money, particularly in regard to voluntary or charitable organisations (paragraph 174).

The Government agrees with the need to carry out a review of the bidding process in the context of public health funding and there is already work in progress across departments to simplify the grant application processes for voluntary bodies. This includes making information about schemes more easily accessible to applicants, facilitating the sharing of information amongst departments to avoid repeated requests for the same information, and the (longer-term) possibility of providing a common portal for applications on the Internet.

Currently the Department of Health allocates the bulk of NHS funding to HAs on the basis of the relative needs of their populations. A weighted capitation formula is used to determine each HA's target fair share of available resources to enable them to commission similar levels of health services for populations in similar need. The formula includes a wide range of health and socio-economic variables to reflect the increased health needs of deprived populations. Within the next two years the Government's intention is to no longer allocate funding for local health services to HAs. With the move to Strategic Health Authorities, PCTs will in future commission services for their populations and funding will be allocated direct to them. The review of the existing weighted capitation formula will take this into account.

(xli) We recommend the Government does more to research and involve the views of children in initiatives aimed at improving their health (paragraph 184).

Children and young people's participation is a key, and very successful, theme of the "Quality Protects" programme which is focussed on improving social services for children and families. The Children's Task Force will be

taking that experience, developing it and applying it more broadly to health settings, especially through the development of the Children's NSF. A key theme of the NSF will be how best to involve children and parents in choices about care and the Department of Health is also seeking out children's views as it considers what the NSF's scope and extent should be.

The Healthy Schools Programme and the NHSS are underpinned by a "whole school" approach which seeks to involve all those with an interest in the work of the school: parents, governors, teachers, school nurses and pupils. Specific guidance on pupil involvement has been produced for schools to assist them in this area and explicitly stresses the importance of taking account of the views of pupils in signing up to the Standard. The participation of young people in the development of local programmes is a key criterion for accreditation under the latter. Similarly, on teenage pregnancy, a programme of research has recently been issued for tender and requires that both the proposals and the research seek the views and involvement of young people.

(xlii) We recommend that the employment structures of school nurses be rationalised so as to allow effective joint working and partnerships (paragraph 186).

The Department of Health recognises the need to ensure that school nurses should not become professionally isolated nor the service fragmented as a result of any changes in employment structure.

To engage effectively school nurses have to work with schools, communities and primary care to establish close links with a wide range of organisations and professional groups (for example, where measures to prevent accidents fall outside the curriculum, the school nurse should be well-placed to promote safety). Primary Care Trusts with their responsibilities for health improvement and developing primary and community health services will provide an opportunity for greater links between school nursing and other services.

(xliii) We recommend that the Government should support and consult the professional bodies to develop the school nursing service as a vital public health role. We also think it would be beneficial if this service could be integrated with other public health workers in the community (paragraph 188).

A range of initiatives undertaken by professional bodies have been supported by DH, for example, the HV/SN award scheme for innovation in the new public health role. The Department of Health has been pleased to support and consult with professional organisations such as the English National Board, the Royal College of Nursing, the Association of Nurses in Substance Abuse, the Community Practitioners and Health Visitors Association, UNISON and the Queens National Institute on developing the school nursing service, and will continue to involve a wide range of professional organisations. The Department has worked closely with such bodies in both developing and implementing its policies on the child-centred public health role of school

nurses and school nursing within the NHSS. Primary Care Trusts provide opportunities for school nurses to be integrated with other public health workers in the community. Guidance has been issued to the NHS on integrated nursing teams ("Making a Difference – Update") and the HV/SN Development Programme takes an integrated approach to their public health roles.

The Children's NSF will be looking at health needs throughout childhood.

(xliv) We note how in countries such as Cuba and Australia the sporting agenda is seen as part of a much wider health and regeneration agenda. We believe that better liaison is essential between all Government departments-notably DCMS, DfEE, DETR and DH – if this is to be achieved. Accordingly we recommend that the Government appoints advisers specifically to co-ordinate the work of all Government departments to deliver the sport and health agenda as a matter of urgency (paragraph 198). *[See also lx]*

Better liaison between Government departments is needed, and there are already some good examples where departments work closely together. As identified by the National Audit Office in their report "Tackling Obesity in England," there is already a substantial amount of cross-departmental work in the areas that are central to addressing the rising prevalence of obesity, such as education, physical activity and diet. Examples include the Healthy Schools Programme which is a joint initiative between DH and DfES to encourage healthy lifestyles and attitudes through school culture, and the Inter-Ministerial Group to Improve Children's Diets and Physical Activity which was set up last year. In addition, there is regular contact between officials through fora such as the Inter-Departmental Group on Physical Activity and the School Travel Advisory Group. The Government agrees that it needs to build on this established cross-cutting work and is looking at ways to improve further the co-ordination and organisation of joint-working.

With regard to the issue of joint advisers, the Department of Culture, Media and Sport(DCMS)/Department for Education and Skills adviser, Sue Campbell, has been very effective in ensuring close liaison between the two Departments. Building upon this success DCMS and DH are now looking into proposals for a similar joint adviser.

The Department of Culture, Media and Sport's PSA target of increasing year-on-year levels of activity among 6-16 year olds will contribute to improved health, as will specific DCMS play and sport policies designed to increase levels of activity across the population. Many of these are practical and proactive examples of joint-working, for example Sport England's "Active Mark Programme" disseminates British Heart Foundation learning packs to primary schools. Measures of impact on health are included in current DCMS research on play provision and in the School Sport Co-ordinator Monitoring and Evaluation Framework.

(xlv) We are not convinced that DCMS is the appropriate ministry to have responsibility for sport. We think it perpetuates the notion of sport

as a matter for spectators rather than participants. We were impressed by the example of Cuba, where sport is treated as intimately bound up with the public health agenda. We think that sport, like public health, needs greatly to strengthen its profile across Government. We would also point out that the Minister's justification of leaving sport where it is (that it attracts more attention in a small department) completely contradicts the Public Health Minister's argument for retaining public health in the DH (that it carries more weight as part of a big department-see below, paragraph 235). However, we accept that immediate reorganisation may be unwelcome, and would urge the Government to keep under review the location of sport in Government, with a view to creating much closer links with public health. As an interim measure we recommend that the Minister for Sport should become a full member of the key Cabinet Committee on health policy, the Ministerial Committee on Home and Social Affairs (Health Strategy) (paragraph 200). *[See also lx]*

The Prime Minister keeps the structure of Government, including responsibility for sport, under regular review and he has no immediate plans to make any changes. The Government agrees that sport has significant benefits for public health, especially when there is an emphasis on increasing the level of public participation. There are, however, wider implications than the links to health that justify leaving the responsibility for sport within DCMS:

i. effective delivery of the Government's objectives for sport requires strong policy and operational links with the key responsibilities of a number of departments – on health, education, planning, and a range of social policy issues; DCMS has successfully developed and maintained these, and linking sport exclusively with health (or education, or crime) would risk dominance of a single issue.

ii. sport has prospered as part of DCMS; the Department's record with regard to its stewardship of sports policy speaks for itself, with increased funding for sport, a higher profile in Government, greater prominence given to sport and physical education in schools and more medals at international competition.

Furthermore, the Domestic Affairs Committee, which has replaced the key Cabinet Committee on health policy, the Ministerial Committee on Home and Social Affairs (Health Strategy), includes the Secretary of State for DCMS so this particular concern of the Health Committee has been addressed.

The Government agrees, nevertheless, that closer links are needed between DH and DCMS and positive steps have been already been made. For example, DH has been working closely with DCMS on the development of the Government's Plan for Sport. Closer links are also being forged between School Sports co-ordinators and Healthy Schools co-ordinators and it has been agreed that DH should be a member of the School Sport Alliance alongside DfES and DCMS.

The Government's strategy, "A Sporting Future for All," gives a clear indication of its aspirations for sport. We wish to see more people of all ages and social groups take part in sport, and more success for our top competitors and teams in international competition. This demonstrates that participants are the predominant focus of policy, rather than spectators.

(xlvi) The NAO concluded that there may be benefits if more GP practices were more active in educating their patients on obesity, and we would endorse their conclusion. We believe that the rapid growth in the extent of obesity poses a major public health hazard and that all health authorities should regard it as a first order priority. We hope that the publication of the National Service Framework will encourage health authorities to take prompt action and recommend that the Department should monitor health authorities' activity levels and strategies in this area as a matter of urgency (paragraph 203).

The National Service Framework for Coronary Heart Disease is a ten-year strategy to overhaul and improve every aspect of prevention, treatment and rehabilitation services for the condition. By April 2001, all NHS bodies working closely with LAs were required to have agreed, and be contributing to, the delivery of local programmes of effective policies on a) reducing smoking, b) promoting healthy eating, c) increasing physical activity, and d) reducing overweight and obesity.

The Department of Health will closely monitor local activity levels and strategies and the NSF requires every local health community to have quantitative data about the implementation of these policies by April 2002.

(xlvii) We consider that NHS resources, time and effort are being directed towards healthcare services issues, to the detriment of the wider improvement of the public's health. We recommend that new high-level performance indicators are developed around public health (paragraph 206). *[See also xxx, lxi]*

The NHS Performance Assessment Framework (PAF) seeks to move away from the former emphasis on cost and activity, and to present a balanced view of the Service across six performance areas. The Health Improvement area is already populated with a range of public health indicators at HA level.

The Indicator Set to support the PAF approach is under continuous development, and a wide ranging consultation on the next and subsequent sets is currently underway. The next set is expected to include both new public health indicators and indicators of health inequalities across a wide range of PAF areas. The Department of Health aims to publish such indicators at PCT level by 2002.

The Department will also consult widely on indicators to monitor progress on the new health inequalities targets (para lxii). Some of these may be included as high-level PAF indicators or as supporting benchmarking databases for local use. In addition new public health indicators are being developed to monitor the impact of the implementation of the NSFs and "The NHS Cancer Plan."

(xlviii) Professor Parish of the HDA told us that they "have been working with the Improvement and Development Agency for Local Government to see how we can bring a public health perspective to their best value reviews so that when they undertake these reviews of local government, we bring public health to bear". We strongly support this approach. Local PSAs are also being piloted and we urge that some of these are also based on public health (paragraph 207). *[See also x, xi, xii]*

Professor Parish's comments to the Committee about the Health Development Agency's work with the IDeA are a good illustration of the scope of the HDA's remit across Government. (See also x and xi.)

(xlix) The Government has stressed the need for joined-up policy; we believe it should also have joined-up objectives and a common methodology. We recommend that the DETR and DH develop a shared Public Service Agreement based on the need to narrow the health gap between socio-economic groups and between the most deprived areas and the rest of the country (paragraph 210).

As the Committee notes, the Government is keen to join-up both policy making and policy delivery. Improving the health of people in deprived areas is one of the key outcomes set by the Prime Minister for the Government's work to tackle social exclusion and deprivation. Government departments including DH, DTLR and DEFRA are already working together to reduce health inequalities, and regeneration programmes, such as the New Deal for Communities, have improving health as a core goal.

The cross-Government spending review on health inequalities will help to inform PSA targets, and the spending review of interventions in deprived areas bound DH, DTLR, DEFRA and other key departments to working together to tackle the causes and effects of deprivation including health and other inequalities. This commitment is described in the Government's "A New Commitment to Neighbourhood Renewal: National Strategy Action Plan" that includes DH PSA health targets on narrowing the gap between socio-economic groups and between the most deprived areas and the rest of the country. The Neighbourhood Renewal Unit (NRU) has been set up to ensure that the Government delivers on its commitments and to join-up policy, and "A New Commitment to Neighbourhood Renewal – National Strategy Action Plan" sets out the key PSA targets for deprived areas with the teams/agencies with responsibility for delivering them.

(l) We recommend that the Government assesses the capacity of the communicable disease control service, and in particular that of the PHLS, and takes the necessary steps to ensure 'surge capacity' is in place. We hope that these issues will be addressed by the Government in its forthcoming Communicable Disease Strategy. We would urge the Government to issue its new strategy as quickly as possible (paragraph 218).

The Chief Medical Officer (CMO) aims to publish his Communicable Disease Strategy later this year. It will address the issues raised and provision

of adequate surge capacity is already recognised to be one of Public Health Laboratory Service's core responsibilities.

A Public Health Workforce Development Plan is currently being prepared (see recommendation xiii) which will also take account of the capacity needed to ensure a robust and effective communicable disease function and address development needs for the entire public health workforce, including those associated with health protection.

Furthermore, the Health Development Agency was asked by the CMO in late October 1999 to undertake a programme of activities to audit skills needed for the new public health agenda, as outlined in the SL:OHN White Paper. The Skills Audit is building on work already undertaken within the "Chief Medical Officer's Project to Strengthen the Public Health Function" and by Regional Offices to analyse public health capacity and capability. It will help to identify where the knowledge and skills of the public health workforce need to be enhanced and where there are gaps in capacity and capability. The Audit will, in turn, help inform the Public Health Workforce Development Plan.

(li) We recommend that the DH issues guidance to health and local authorities clarifying the roles of the DPH and the CCDC. This is another manifestation of the lack of clear leadership within public health (paragraph 219).

The Department of Health issued guidance to HAs and LAs about the role of the DPH and of the CCDC in Health Service Guidance (HSG) (93) 56. However, the need for further guidance will be considered in the context of the CMO's Communicable Disease Strategy and changes in NHS structures following the Secretary of State for Health's speech to the Modernisation Agency on 25 April.

(lii) We recommend the Government revisits data protection legislation and takes action to ensure that proper health surveillance at a population level is not jeopardised (paragraph 220).

The Government appreciates the need for information about patients for a wide range of uses, but believes that use can be made of it without violating the law.

Data Protection legislation provides an effective framework for ensuring that personal data is processed fairly and lawfully, and does not prevent properly conducted health surveillance at a population level. However, it is not clear that all such activity satisfies requirements arising from common law obligations of confidentiality.

Transitional powers have been provided through Section 60 of the Health and Social Care Act 2001 to set aside these obligations whilst the potential of IM&T is harnessed to effectively support surveillance and other essential work without breaching confidence or undermining patient privacy.

The Department of Health is seeking to comply with the law as well as

meeting essential requirements. Taking patients' views into account when using information that identifies them is very much in line with the emphasis in "The NHS Plan" on putting them first.

(liii) We believe, however, that the NHS Executive Regional Offices could take a greater strategic lead in public health (paragraph 221).

(liv) There is the welcome move put forward in the NHS Plan to develop joint accountability for public health at a regional level by making the Regional DsPH jointly accountable to the regional director of the NHS regional office and the director of the government office. We support this move and urge the Government to monitor it closely in order to assess its effects on the regional health agenda (paragraph 223).

(lv) We would also urge that there should always be co-terminosity between the RDAs and DoH regions to ensure the most effective delivery of services and to demonstrate joined up Government (paragraph 224).

(lvi) We support the Cabinet Office view that the regional tier has more to contribute to joining-up policy and providing coherence in respect of a raft of initiatives and schemes (paragraph 225).

(lvii) We recommend that the Government clarifies the NHS structural arrangements at regional level as soon as possible in order not to divert attention from the public health function at this level for longer than is absolutely necessary (paragraph 226).

Close working between the existing Regional Offices and other organisations at regional level is already taking place. Much of this involves ensuring that the public health dimensions of policies being implemented through, for example, the GOs are reflected in the approaches to targeting effort and monitoring progress.

By 2002, and in the light of implementing the "Shifting the Balance of Power" speech by the Secretary of State for Health, a strong regional public health group will be co-located in the nine GOs. It will be led by an RDPH and concentrate on the development of an integrated, multi-sectoral, approach to tackling the wider determinants of health; informing regional work on economic regeneration, education, employment and transport; maintaining an overview to ensure that there is proper health contribution to LSPs; accountability for health protection (communicable diseases and hazards) across the region; ensuring the quality of the performance management of the public health function; and emergency and disaster planning and management. By 2003, the four new Regional Directors of Health and Social Care will maintain the key links to Strategic Health Authorities, LAs and GOs.

In addition, "Saving Lives: Our Healthier Nation" heralded the creation of a network of PHOs. The newly created regional public health groups should also be well positioned to play a key role in health intelligence as they are available to all those with an interest in public health within a region.

Locating the public health function in GOs will take advantage of their capacity for strategic thinking and for planning other services with an impact on health, such as neighbourhood renewal. The establishment of Regional Task Forces on Inequalities and Public Health is another important mark of strategic leadership.

(lviii) We accept the Secretary of State's view that the role of Minister for Public Health has not been downgraded. We think that the fact that so many outside bodies have been quick to argue that the alteration in title equates to an actual diminution in the status of the job is worrying. It strikes us as petty and superficial, and distracts from the much more important debate on how the Minister for Public Health can actually influence the health of the public (paragraph 229).

The Government endorses this view.

(lix) We conclude that the present arrangements do not adequately promote cross-Government working. Given the undesirability of change for its own sake, we recommend that the public health function remains with the Department of Health for the present. We would, however, like to see far greater evidence that it has assumed priority within that Department. If that is not forthcoming, we think the case for relocation would be much stronger (paragraph 237). *[See also xlvii]*

In the evidence that he gave to the Committee, the Secretary of State for Health made clear that the SL:OHN White Paper and "The NHS Plan" have equal status and are complementary. The Department of Health will be publishing a document entitled "From Vision to Reality" which will summarise progress on the inititiatives in SL:OHN, and the way in which they contribute to the implementation of the public health aspects of the Plan and vice versa. It is precisely because it considers public health to be so vital that the Plan aims to bring it within the mainstream of NHS activity (e.g. through measures on smoking cessation), and the recent appointment of a joint Permanent Secretary of DH/Chief Executive of the NHS was also intended to ensure that public health issues are at the forefront of DH policies.

His review of DH has identified the need for dissolution of unnecessary barriers, both internally and externally, by operating more effectively across Government at national and regional level, and by working across boundaries to support better joint planning and working by local health and social care organisations.

Furthermore, the Plan acknowledges that to reduce health inequalities, in particular, the NHS needs to work in partnership with other sectors across and outside Government. It announced, for example, an extension of the Expert Patients Programme that will be based on the recommendations of a Task Force to which many different organisations (e.g. those from the voluntary sector) have contributed, and the Department of Health chairs a Forum of Non-Governmental Organisations with an interest in Public Health. All these measures are intended to reflect the Government's commitment to inter-sectoral action to improve health and well-being.

(lx) We accept the point that several of our witnesses made that the exact location of the Minister was not the key issue: what is more crucial is that the structures are in place to co-ordinate the very wide public health agenda across Government and the different countries of the United Kingdom. We are not convinced that this is yet happening, as the lack of co-ordination between the sports agenda and the health agenda, for example, made clear (paragraph 239). *[See also xliv, xlv]*

The review that the Permanent Secretary/Chief Executive of DH has initiated includes a strand on cross-Government working, and DH is already working with the Cabinet Office to help ensure that other departments consider the possible impact of their policies on health. The sport and health agendas are being brought more closely together, and the Government is beginning to put in place procedures to co-ordinate action. It has made clear its intention to improve co-ordination of the public health agenda across departments by setting up a cross-cutting spending review on health inequalities to be led by the Minister for Public Health.

As an illustration of cross-departmental working, the Inter-Ministerial Group to Improve Children's Diet and Physical Activity was set up last year to examine the findings of the National Diet and Nutrition Survey; to review current Government activity and policies which influence the diets and physical activity levels of children; and to consider further opportunities for action to improve the diets and activity patterns of children and young people to improve their short and long-term health. This work will also be taken forward as part of the work on the Children's NSF.

On co-ordination of policy with the Devolved Administrations (DAs), there is regular contact between senior policy members and other professional officers as well as at Ministerial level. The Department of Health and the DAs keep these arrangements constantly under review with the aim of revising and improving them when necessary.

(lxi) We recommend that all cross-departmental initiatives design in appropriate targets, performance management and progress indicators for all partners involved at all levels. We further recommend that departments co-ordinate initiatives better to avoid unhelpful duplication of effort (paragraph 240). *[See also xlvii]*

The Department of Health intends to consult on the action across Government and across sectors needed to deliver the national health inequalities targets. This will allow for a greater coherence in inter-departmental working and will include the development of a cross-Government basket of indicators. This should support joined-up policy making and ensure that all contributions from Government departments add value and do not duplicate effort. In addition, the NRU, based at DTLR, will be setting up a high level cross-Government group to monitor the delivery of the Action Plan for the NSNR, which also includes health targets.

(lxii) A number of the key themes emerged throughout the inquiry:

- **the need to achieve balance in health policy between health and health care, upstream and downstream.**

We found that the present health policy agenda is heavily dominated by "The NHS Plan" with its overwhelming concentration on acute care, hospitals and beds, and numbers of doctors and nurses. We accept these are issues of vital importance to the NHS but we think the case for re-balancing health policy is strong. *[See also xxv]*

"The NHS Plan" is about investment and reform. Whilst investment equates to expansion, reform concentrates on a much wider policy agenda. The Plan is not simply about increasing the numbers of staff, building new hospitals and buying new equipment. It represents a fundamental shift in the way in which services are delivered, and sets out a whole new approach, not just in terms of the physical environment, but in developing smarter ways of working and a partnership approach. The policy implications of the Plan cover almost every aspect of healthcare delivery and tackling inequalities and improving public health are integral to it.

An Inequalities and Public Health Taskforce was established in October 2000 to oversee the implementation of this vital agenda and the Secretary of State for Health announced two national health inequalities targets in February this year: on reducing inequalities in infant mortality and premature adult deaths. These targets will help shape the new ways of working in the service and beyond, and a consultation document on their implementation is due to be published shortly. Work is also continuing on programmes to reduce smoking, tackle obesity and improve the physical well-being of the population by promoting healthy eating and encouraging physical activity. Furthermore, there are close links between these programmes and the delivery of "The NHS Cancer Plan" and the NSFs for Coronary Heart Disease, Mental Health and Children. Working in partnership with others – both within and outside the NHS – is crucial in developing this wider agenda.

- **strengthening public health leadership at all levels.**

We have described the confusion surrounding the leadership of public health at every level. We call for the Minister for Public Health to be empowered to demonstrate more positive and public leadership for improving health and reducing health inequalities. Stronger leadership at the centre must be matched by stronger leadership at regional, intermediate and local levels.

The National Public Health Leadership programme is addressing the development of stronger leadership at local level. This programme began in February 1999 as two pilots in West Midlands and London, and following the success of these it was opened up to applicants from across the country. The programme is now part of the NHS Leadership Centre and will develop a cadre of public health leaders with enhanced skills to lead change and to bring about local health improvement through effective partnership-working.

Similarly, many health visitors and school nurses are taking part in the National Leadership Programme for Nurses, and the National Nursing Leadership Project (part of the National Leadership Centre) is beginning to look at ways of strengthening public health leadership within nursing. As part of this the North West are leading a piece of work taking Sure Start as a model for strengthening public health leadership within nursing, midwifery, health visiting and other professional groups. The leadership programme for health visitors and community nurses was identified in "The NHS Plan" and this work is being overseen by the Inequalities and Public Health Task Force.

- **establishing strong partnerships at all levels for a broad-based approach to public health.**

We have endorsed the need for partnerships in delivering the public health function. We support a more pro-active role for the NHS in regeneration initiatives, the introduction of joint posts in public health, and a single Community Plan in each locality incorporating the HImP.

The "Saving Lives: Our Healthier Nation" White Paper stressed the importance of partnerships at national, local and individual levels. For example, DH, along with nine other Government departments and agencies, has joined in partnership with the Health and Safety Executive to take forward "Securing Health Together" – a long term occupational health strategy, with challenging targets to reduce the incidence of work related ill-health. The "Securing Health Together" best practice database holds a number of projects that demonstrate occupational health initiatives which are held as an information source on the website, www.obstrategy.net, for access by all interested stakeholders.

Tackling disadvantage in all its forms is key to tackling the worst health problems in our country. The Government's "New Commitment to Neighbourhood Renewal: National Strategy Action Plan" sets out for the first time a joined-up approach to tackling the socio-economic determinants of health such as poor educational attainment, crime, unemployment and poor housing.

"The NHS Plan" affirms DH's commitment to play a full part in implementing the New Commitment to Neighbourhood Renewal, and in particular, to helping to develop the LSPs that will be central to the implementation of the Action Plan. Local health communities must play an effective role in LSPs to ensure that health and well-being are central to local renewal strategies.

The New Commitment to Neighbourhood Renewal and "The NHS Plan" will thus operate as complementary strategies, alongside other programmes such as "Quality Protects" and the NSFs. The Plan shares some of the key themes of the New Commitment to Neighbourhood Renewal, in particular the need to improve services, the commitment to set national health inequalities targets, and the reduction of such inequalities as a key criterion for the allocation of NHS resources.

Local Strategic Partnerships will allow the NHS to participate with others in tackling some really long-standing issues. It has a great deal to bring to the table in neighbourhood renewal as often the NHS is the largest employer, investor and trainer in poor neighbourhoods. The need is to make sure this power is used to best effect. By increasing employment of local people the NHS helps to address staffing problems, while contributing to the neighbourhood and ensuring that local needs are co-ordinated and developed systematically.

The role of the NHS in supporting the NSNR more generally is being developed, initially through a programme of regional events to follow on from letters from the Secretary of State for Health. The Permanent Secretary/Chief Executive's review of DH is considering how to support the new emphasis on this role, and the HDA and the King's Fund are engaged to support this work.

The Government fully supports the establishment of innovative joint working arrangements between HAs and LAs. The recently established Modernisation Agency will actively work with LA colleagues to ensure that the sharing of innovation and best practice is maximised for the benefit of local people.

There are already examples of alignment of HIMPs and Community Strategies. In addition DH is exploring how we progress this further with the HIMP Development Group, as part of the HIMP Development Programme. The Group consists of various policy leads as well as members from the NHS, the LGA and the HDA.

- **placing the emphasis on public health practice and implementation rather than on knowledge acquisition for its own sake.**

We consider that insufficient attention has been given to the application of knowledge and practice in public health. For too long the public health function has been dominated by a culture, mind set and training scheme which stresses the epidemiology and science of public health, rather than its practice in bringing about change. We hope our recommendations on developing capacity within public health will encourage the development of practitioners at all levels who can implement the theory.

The Department of Health recognises the important relationship between policy development and policy implementation and this is an issue which at a central level will be addressed as part of the review initiated by its Permanent Secretary/Chief Executive. The recently established Modernisation Agency will be actively working to ensure that best practice is shared to maximise the benefits for local people. We will also be able to learn lessons from the healthy community collaborative that will be launched shortly.

The Department of Health has also funded Healthwork UK to develop draft standards for Specialist Public Health Practice and the development of a standards framework is a major step towards multidisciplinary public health.

The standards will be used in a number of ways: to support implementation of the new specialist in public health post in the NHS; to develop public health education and training programmes; and to audit skills in organisations and to accredit specialist practitioners. In the field of accidental injury prevention, for example, we are already looking for the most effective interventions that are known to work, rather than relying too heavily on theory, and in general we are committed to building up the evidence base.

The Health Visitor/School Nurse Development Programme is supporting the development of public health practice at the level of the community and primary care. An education and training sub-project is aiming to strengthen the public health training of health visitors/school nurses. Within "The NHS Plan", midwives are identified as having a key public health role in providing support during pregnancy and in promoting family well-being.

A key role of the HDA is in developing the capacity and capability of the public health work force to support the delivery of the public health strategy and to improve the quality of service. They will provide access to reliable evidence, and help public health professionals to use it effectively. They will do this through setting up networks so that they can share knowledge and good practice and giving support taking account of local circumstances and need. Joining together previously unconnected initiatives will help to increase their impact on health.

- **avoiding distracting and probably counterproductive reorganisation of structures imposed from the centre while allowing local initiatives to flourish.**

We have found a recognition amongst stakeholders that progress in public health must not rely on structures but on processes and incentives, coupled with effective and appropriate performance management arrangements. *[See also xxx]*

The Performance Fund for the NHS will provide resources for policy development and design incentive schemes tailored to the particular needs of each area and aimed at supporting implementation of "The NHS Plan." This will include locally designed health inequalities and public health schemes.

The Department of Health will consult across Government and across all sectors on the most effective way to deliver the new health inequalities targets, which will be subject to mainstream performance management. We will be consulting on a basket of indicators to monitor progress against the targets, and the NHS components of the indicator set will populate the PAF domains, which are an important part of the performance improvement agenda.

- **creating incentives for health improvement activity.**

We have found an over-emphasis on top-down targets and performance agreements. Stronger incentives to give health improvement priority for action are essential. *[See also xxx]*

The changing structures within the NHS will gradually roll out between now and 2004, but in the meantime every health organisation will undertake a Local Modernisation Review (LMR). The aim of each LMR will be to engage staff, service users and the NHS' partners in local Government and the private and voluntary sector in reviewing what needs to be done to deliver "The NHS Plan" locally and how this is to be achieved in local health communities. The findings from the Review will be used to create robust plans for the delivery of the Plan, including its health inequalities aspects, and the link to repositioned HIMPs. The process will be bottom-up (it will be for health communities to assess their fitness to deliver) and will be driven by the local health system and all its partners. A central part of the LMR process will be the development of plans for engaging staff and service users in developing measures to assess local progress towards providing a more user-responsive service that reduces inequalities and provides access to consistently high standards of care.

The NHS Performance Fund provides resources for locally developed and designed incentive schemes tailored to the particular needs of each area. The Fund provides incentives for staff delivering care in NHS Trusts, PCTs and GP practices to develop service delivery in ways that lead to real and sustained improvements in performance. It is for managers at local level, working with regions where appropriate, to decide where to target the Fund to achieve this, and which areas of performance need to improve most given local circumstances as reflected in LMRs. The Fund provides the means to recognise and reward those who go further by making outstanding efforts to innovate and improve how care is delivered.

The Performance Assessment Framework gives a rounded view of performance, and health inequality indicators will populate a range of its domains in addition to the health improvement area. Performance against the Framework will become increasingly important as traffic light status, the amount of earned autonomy and the use of the Performance Fund by NHS organisations will be dependent on performance across its domains. This will give health improvement a greater prominence.

- **building the evidence base in public health.**

Knowing what works, why and how, remains a key challenge in ensuring effective implementation of public health policy. *[See also xii, xlviii]*

The Government has put considerable effort into building partnerships to ensure that there is a very good and improving evidence base for public health work:

- an information strategy;
- Public Health Observatories;
- the Health Development Agengy established and supported;
- a Public Health R&D Strategy developed across a wide range of funders; and

- new investment in R&D on inequalities and public health aspects of "The NHS Plan."

The key aim in establishing the HDA was so that it could provide practitioners with clear guidelines on what really works to prevent ill-health and help reduce health inequalities. The Government charged the HDA with identifying gaps in the evidence which will need to be filled with new research, and disseminating to the field practical guidance on public health interventions which have been shown to work. Earlier this year the Minister for Public Health launched the HDA Evidence Base that will play a key role in this. It contains electronically-available systematic reviews of effectiveness, literature reviews, expert group reports, and other information about what works to improve public health and reduce health inequalities. The database contains summaries of documents elsewhere on the Internet in areas such as smoking and nutrition, as well as cancer, coronary heart disease and injury prevention. It will also act as a gateway to key sites containing public health reviews and research. The Government expects public health managers to look at the Evidence Base, to identify what has worked in areas around the country and to replicate that work locally. The Evidence Base is an innovative and exciting programme that will help the Government to raise standards in public health practice and tackle health inequalities.

Many other funders also have a large role to play in helping to provide the evidence base in public health. The research programmes of several Government departments, and of most Research Councils, make a major contribution, and together they have developed a Public Health R&D Strategy that can be found on www.doh.gov.uk/research

- **learning the lessons from past failures or partial successes in putting health before health care.**

We believe it is imperative that the Government learns the lessons of previous policy, particularly with regard to political leadership and commitment, making health improvement a central priority, and ensuring that local government and other partners recognise the importance of their public health role (paragraph 242).

Development work is underway to ensure that HIMPs lead the planning round, and are the local health system's strategy for improving health and healthcare, reducing health inequalities, and addressing the health needs of the local population.

(lxiii) We would welcome a clear statement of principle by the Government on the desirability of a Tobacco Regulatory Authority. We feel that our report was one of the most comprehensive analyses of the tobacco industry ever undertaken in the UK, had access to documentation that had hitherto been concealed, and got very much to the heart of the behaviour of the tobacco companies. We would like the Government unequivocally to support our recommendation and – when parliamentary time permits – introduce appropriate legislation to support it (paragraph 248).

The Government agrees that there is a need for tighter regulation of tobacco products, and more information about the additives used in them and their effect upon health.

It also agrees that there is a need for greater control of the contents of tobacco products and more information about the effects on health of the various ingredients. However, the Government is not convinced that all existing legislative powers have been fully applied and is considering how these might be used to regulate tobacco products more effectively. Wide-ranging powers exist under the Consumer Protection Act 1987 to ensure the safety of consumer goods, and the Government will not hesitate to use these, if necessary, to ensure that changes are made to tobacco products so as to reduce the harm these cause. That said, it is not in principle opposed to the idea of a Tobacco Regulatory Authority, should existing mechanisms prove inadequate, and will keep this whole area under review.

The Government continues to believe that work in this area will be most effective at a European level and good progress is being made. The Directive of the European Parliament and Council on the manufacture, presentation and sale of tobacco products (2001/37/EC) came into force on 18 July 2001. This Directive will require Member States to collect thorough details of the contents of tobacco products on the market and to submit these to the European Commission which in turn will be required to draw up a report on its application. The Directive requires that the Commission will be assisted by the necessary scientific and technical expertise.

The Government's disapproval of the Common Agricultural Policy's tobacco regime is well known. However it does not accept that this prevents the Commission taking forward work on the health effects of tobacco products.

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