The Government's Response to the Health Select Committee Report on Health Inequalities

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1.   The House of Commons Select Committee published its report on health inequalities on Sunday 15 March 2009. This Command Paper sets out the Government's response to the conclusions and recommendations of that report.

2.   The Government welcomes the Committee's support and commendation for taking specific action to tackle health inequalities, and for its support for the national health inequalities target. This action has helped to contribute to major improvements in the health of people in disadvantaged groups and areas. Life expectancy has increased over the last 10 years by almost three years for men living in the most disadvantaged ("spearhead") areas and by almost two years for women in these areas. Infant mortality is at a historic low level, even for disadvantaged groups[1]. This is a significant achievement.

3.   The Government has used the experience of the last 10 years to shape its approach to addressing health inequalities. From the first, it saw that this would not be easy. In particular, the national health inequalities strategy noted that health inequalities are stubborn, persistent and difficult to change[2]. Over this period, the Government has

   •   emphasised – and renewed – its determination to reduce inequalities in health and matched this determination with a comprehensive range of actions across government departments, and at regional and local level

   •   learned from the evidence – a decade ago there was little evidence about what to do and action was random and ineffective. By setting a national target and learning from experience Government has increasingly been able to show what works, and develop evidence-based resources for local planners of public services

   •   recognised that the causes of health inequalities are deep and ingrained and often socially determined – and require action over the long-term

   •   underlined the important of the NHS to this agenda by improving access to primary, reaching out to disadvantaged communities and preventing avoidable early deaths

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[1] Department of Health (2008) *Tackling Health Inequalities: 2005-07 Policy and Data Update for the 2010 National Target*

[2] Department of Health (2003) *Tackling Health Inequalities: A Programme for Action*

- stressed the importance of improvement in local areas – which will save and enhance many lives – while recognising that due to long and complex time-lags, the national target remains challenging

For these reasons, England is widely acknowledged internationally as a leader for its determination and comprehensive approach to reducing health inequalities.

4. Tackling health inequalities requires action across several dimensions. This includes socio-economic differences and the differences between geographical areas as well as those between genders and different ethnic communities. The social determinants of health are crucial to this agenda as are lifestyle factors and the role of the NHS. It requires action based on the best available evidence, and a relentless commitment to action in the long-term.

5. The Government recognises this approach is crucial if there is to be a long-term sustainable reduction in health inequalities. It does not accept the Committee's assertion that it has rushed into this issue with insufficient thought and a lack of clear objectives.

6. There is no single formula or blueprint to tackle health inequalities but a systematic approach has informed Government action in this area. It has drawn on the available evidence, set targets, developed a strategy (the *Programme for Action*) to support the target, and monitored the results against the target and other data. The audit and review of outcomes has improved effectiveness. It also contributes to efforts to improve the health of people in disadvantaged groups and areas, and to narrow the gap. National programmes – such as Sure Start – and many local programmes have evaluated their outcomes. Tackling an issue as complex as health inequalities requires more than one approach. Monitoring, audit and evaluation are key dimensions of an evidence-based approach, and the importance of strengthening these dimensions to improve the effectiveness of subsequent action has been a key lesson from this work..

7. Many of these lessons are set out in *10 Years On – A review of developments*[3]. This document covers the period November 1998 to November 2008, from the publication of the Acheson report to the announcement of the post-2010 strategic review of health inequalities.

8. The Acheson report provided the starting point for the Government's work on health inequalities[4]. This independent report considered the available evidence and identified possible priority areas for future policy development in the light of that evidence.

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[3] Department of Health (2009), *Tackling Health Inequalities: 10 Years On – A Review of Developments*

[4] Independent Inquiry into Inequalities of Health (1998), *Report of the Independent Inquiry into Inequalities of Health*, TSO

9. Many lessons from *10 Years On* are being put into practice, including the need to

    •   build better partnerships across government, and locally with the NHS and local government and other partners

    •   develop more sensitive levers, systems and processes to give priority to health inequalities and promote cross-sectoral working

    •   embed health inequalities in related policy areas so that it becomes part of delivering better services

10. Effective action cross-departmental action is a hallmark of the Government's approach as shown from 2002/03 onwards through the Treasury-led cross cutting review[5] and the Programme for Action. It has also included close working with individual departments particularly the Department for Children, Schools and Families (DCSF). This effective partnership has a strong mutual commitment to the health inequalities agenda, with a clear understanding of the issues vital to this process as shown in the recent joint DCSF/Department of Health child health strategy[6].

11. The learning process is bearing fruit. Ken Judge, a leading academic, has suggested that "Perhaps the best example of a focused strategy with a clear action plan to achieve specified reductions in inequalities can be found in England"[7], a judgement reflecting recent developments with the infant mortality aspect of the programme.

12. Tackling health inequalities needs long-term, sustained action, as the Committee recognises. It requires a coherent, strategic vision backed by effective policy design and implementation. The Government has shown its continuing commitment to action up to, and beyond, 2010 through *Progress and Next Steps*[8] and through the establishment of a post-2010 strategic review of health inequalities chaired by Professor Sir Michael Marmot. This reflects the Government's openness is seeking advice from leading experts and practitioners to turn evidence into practical action that will change for the better the lives of people with the poorest health.

13. Sir Michael also chaired the WHO Commission on the Social Determinants of Health that reported in August 2008. The Commission's findings and its global evidence base will contribute to the strategic review and inform a refreshed post-2010, cross-Government health inequalities strategy.

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[5] HM Treasury/Department of Health (2002), *Tackling Health Inequalities: Summary of the 2002 Cross Cutting Review*

[6] Department for Children, Schools and Families/Department for Health (2009) *Healthy lives, brighter futures – The strategy for children and young people's health*

[7] Judge, K (2008) *Politics and health: policy design and implementation are even more neglected than political values ?*, European Journal of Public Health, vol.18, no. 4, pp 355-6

[8] Department of Health (2008) *Health Inequalities: Progress and Next Steps*

14. This Government response addresses, in turn, the individual conclusions and recommendations of the Committee's report set out in bold below. The response is in normal type. It acknowledges that there is still much to learn and that this learning – including through evidence, audit and evaluation – will continue to inform the development of our approach now and in the future.

Health inequalities – extent, causes and policies to tackle them

Health in the UK is improving, but over the last 10 years health inequalities between the social classes have widened – the gap has increased by 4 per cent amongst men, and 11 per cent among women. Health inequalities are not only apparent between people of different socio-economic groups – they exist between different genders, different ethnic groups, and the elderly and people suffering from mental health problems or learning disabilities also have worst health than the rest of the population. The causes of health inequalities are complex and include lifestyle factors – smoking, nutrition, exercise to name but only a few – and also wider determinants such as poverty, housing and education. Access to healthcare may play a role, but this appears to be less significant than other determinants. (Paragraph 49)

15. The Government recognises the complex nature of health inequalities that the Committee describes and welcomes its acknowledgement that health in England is improving. This improvement has been shared by people in disadvantaged groups and areas. In spearhead group areas, the 70 local authority (LA) areas with the worst health and deprivation indicators, average life expectancy at birth has increased in each period since 1995-97 to 2005-07 – the latest available figures – from 72.7 years to 75.6 years – 2.9 years – for males and from 78.3 years to 80.2 years – 1.9 years – for females[9]. This is a significant achievement.

16. Life expectancy has also improved at a faster rate in some spearhead areas. For example, male life expectancy in Manchester (which had the lowest life expectancy in England in 1995-97) increased by 3.3 years between 1995-97 and 2005-07, reducing the gap with the England average. Male life expectancy in Southwark increased by 4.7 years over the same period and at 77.0 years in 2005-07 was higher than the England average. Both of these are on track to narrow their own life expectancy gap with the England average by 10 per cent by 2010.

17. Cancer death rates (for people aged under 75) in the spearhead group fell by nearly 18 per cent between 1995-97 and 2005-07, and cardiovascular disease (CVD) death rates (for people aged under 75) fell by over 40 per cent over the same period. There have also been reductions in the absolute gap in cancer and CVD death rates between England and the spearhead

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[9] Department of Health (2008) *Tackling Health Inequalities: 2005-07 Policy and Data Update for the 2010 National Target*

group. Over the 1995-97 to 2005-07 period, the reduction is just over 13 per cent for cancer, and the reduction for CVD is nearly 36 per cent.

18. Setting a challenging national target for reducing health inequalities signalled a commitment to tackle these complex and long-standing inequalities through a joined-up and collaborative approach with key delivery partners – both within and outside the NHS. It has also galvanised a wide range of people and organisations into action, and stimulated the development and gathering of new knowledge and evidence.

19. The Government accepts the evidence of a widening of the health inequalities gap and the challenge this poses. It has reported annually on the status of the gap since 2005[10]. The gap reflects the differential improvements in health between disadvantaged groups and areas and the whole of the population. The spearhead areas are the focus of the life expectancy element of the target, not social class as stated by the Committee, and the life expectancy gap between these areas and the whole population has widened over the last 10 years by four per cent for males and 11 per cent for females. The difference between social groups provides the basis of the infant mortality aspect of the target. The infant mortality gap between routine and manual groups and the whole of the population has narrowed slightly in each of the last three years. If the trend continues, this part of the target will be met[11].

20. Addressing the different dimensions – and causes of – health inequalities are at the core of the Government's strategic approach in tackling health inequalities. Specific issues raised by the report are dealt with elsewhere. Measurement and openness have characterised this approach, ensuring that data on health inequalities is available and published both at national and local levels. The recently published *10 Years On*, shows changing patterns of inequalities across these dimensions and over time[12]. Local information is published annually in the *Local Health Profiles for England*.

Designing and evaluating policy effectively

The most damning criticisms of Government policies we have heard in this inquiry have not been of the policies themselves, but rather of the Government's approach to designing and introducing new policies that make meaningful evaluation impossible. As one witness described, "there is a continual procession of area-based initiatives and that in itself is quite disruptive. Nothing is given time to really bed in and function". Even when evaluation is carried out it is usually "soft", amounting to little more than examining processes and asking those involved what they thought about them. All too often Governments rush in with

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[10] Department of Health (2005) *Tackling Health Inequalities: Status Report on the Programme for Action*

[11] Department of Health (2008) *Tackling Health Inequalities: 2005-07 Policy and Data Update for the 2010 National Target*

[12] Department of Health (2009) *Tackling Health Inequalities: 10 Years On – A review of developments*

insufficient thought, do not collect adequate data at the beginning about the health of the population which will be affected by the policies, do not have clear objectives, make numerous changes to policies, and its objectives and do not maintain the policy long enough to know whether it has worked. As a result, in the words of one witness, "we have wasted huge opportunities to learn". (Paragraph 75)

21. The Government disagrees with this description of its approach and rejects the suggestion that it has wasted learning opportunities. Instead, it has sought to build on the evidence and learn from its experience in developing and implementing policies and programmes.

22. From the first, a systematic approach was adopted. Sir Donald Acheson, a former chief medical officer, undertook an independent inquiry into inequalities of health, drawing on the available evidence and the knowledge of leading experts. The results of this inquiry provided the foundation of the health inequalities strategy and informed the development of individual policies. A scientific reference group on health inequalities, made up of senior academics and experts, was established in 2003. This group has advised on scientific aspects of the strategy and overseen its results, including through a series of published status reports. To refresh this systematic approach, a post-2010 strategic review of health inequalities has been established, chaired by Professor Sir Michael Marmot of University College London.

23. Over the last 10 years, the evidence base about what works has developed and improved – though gaps remain – and the lessons from earlier work have emerged and informed future thinking. Evaluation is an essential corollary of policy development. Major national programmes addressing health inequalities are subject to evaluation processes increasingly focused on outcomes.

24. For example, a programme of systematic reviews has recently been commissioned aimed at identifying and synthesising the evidence relating to the effectiveness of health service and public health interventions that might contribute to reducing inequalities in the major causes of infant death. Following an initial review of the evidence gaps by the National Perinatal Epidemiology Unit, these reviews – to be published later this year – will focus on the organisation and delivery of antenatal care as a means of targeting the major medical causes of infant mortality. This will include preterm birth in disadvantaged, vulnerable and at risk groups, and interventions aimed at increasing early uptake of antenatal care in these groups.

25. Evaluation plans are part of many programmes introduced to tackle health inequalities, such as Communities for Health and the Improvement Foundation programmes to improve early presentation for cancer and CVD. After the successful pilot phase of the Communities for Health programme,

local activity was evaluated before the programme was rolled out to more areas[13]. Communities for Health, launched in 2005, will run to at least 2010 so allowing time to learn from implementation. Evaluation of the Improvement Foundation programme is underpinned by a baseline of current cancer and CVD data for the areas involved, and a set of clinical and community engagement outcome measures.

26. Monitoring data, measuring progress and managing risk has been an integral part of the national health inequalities strategy. Indicator sets have been developed early to ensure that action was having the desired effect and to inform future policy. The regular data reports, including the status reports have highlighted developments. The decision to establish the review of the target stemmed partly from the findings of the widening gap report in the 2005 report[14]. The review report on the infant mortality aspect of the target focused on improving policy design and delivery to improve local performance and narrow the gap[15].

27. Public health national support teams (NST) have provided tailored support to almost every primary care trust (PCT) in England. The health inequalities NST is looking to fulfil the commitment to offer support to all spearhead areas by summer 2009. A significant body of evidence and learning has been collated, and emerging themes and best practice are now fed back systematically to policy, and shared with local areas and regions[16].

Governments have spent large sums of money on social experiments to reduce health inequalities, but we do not know whether these experiments have worked or whether the money has been well spent. The latest initiative on Healthy Towns has all the failings of previous policies, indicating that the Government has learnt nothing from past mistakes. (Paragraph 76)

28. The Government does not accept that its action to tackle health inequalities and the social determinants of health has not worked. The achievements in this area across a range of indicators are set out in *10 Years On*[17].

29. As emphasised, the Government's approach to tackling health inequalities is systematic and evidence-based, an approach shared by related programmes addressing the social determinants of health. New programmes are developed in this context to maximise effectiveness and ensure value for money. The Government has invested in programmes across departments to improve the health and social circumstances of people living in disadvantaged groups and areas. Assessing the effectiveness of this spending is a core part of programme development and learning. The data

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[13] Department of Health (2007) *Communities for Health: Learning from the pilots*

[14] Department of Health (2005) *Tackling Health Inequalities: Status Report on the Programme for Action*

[15] Department of Health (2007) *Review of Health Inequalities Infant Mortality PSA Target*

[16] Department of Health (2008), *Systematically Addressing Health Inequalities*

[17] Department of Health (2009) *Tackling Health Inequalities: 10 Years On – A Review of Developments*

deployed in successive status reports and in *10 Years On* shows that this investment has been effective, not least in the policies addressing poverty and inequality, including on child poverty, housing, educational attainment, and employment.

30. Learning from previous programmes has informed current activity. For example, emerging evidence suggests that holistic community-based interventions are a valuable tool for tackling obesity, with researchers highlighting the importance of community engagement and partnership working to enhance impact. Drawing on this evidence, the national obesity strategy[18], devised the Healthy Community Challenge Fund (or Healthy Towns programme). Towns were encouraged to suggest innovative approaches, matching local need and providing a sound theoretical basis for their work. Successful candidates must include clear plans for monitoring and local evaluation work to ensure lessons are learnt. This work will be supported by a nationally led evaluation programme that will seek to identify common messages for other areas, and assess the potential for more robust experimental research designs to test key interventions. It will draw upon a wide range of evaluation theory and methodology.

There is an ethical imperative to develop and use evidence-based policy. All the reforms we have discussed are experiments on the public and can be as damaging (in terms of unintended effects and opportunity costs) as unevaluated new drugs or surgical procedures. Such wanton large-scale experimentation is unethical, and needs to be superseded by a more rigorous culture of piloting, evaluating and using the results to inform policy. (Paragraph 77)

31. The Government rejects the Committee's view that its health inequalities policies are damaging experiments that put the public at risk and are, by implication, without a proper evidence base. In fact, policies have been developed systematically in line with the "ethical imperative to develop and use evidence based policy" – from the Acheson inquiry through the Treasury-led cross cutting review to the current post-2010 strategic review on health inequalities.

32. This is illustrated by the experience of the Communities for Health and the Improvement Foundation programmes, both of which were based on the available evidence. Pilot and developmental phases preceded the wider roll out of both programmes.

33. The Government has actively engaged with the international community to develop and share evidence and learning on a wider basis as part of our commitment to an ethical approach. This included work under the banner of the UK Presidency of the EU (2005) where health inequalities was identified as one of two health themes of the presidency[19]. The Department

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[18] HM Government (2008), *Healthy Weight Healthy Lives: A Cross-Government Strategy for England*

[19] Mackenbach, J. *et al* (2006) *Health Inequalities:* Europe in Profile, DH; Judge, K. *et al* (2006) *Health Inequalities:* A Challenge for Europe, DH.

of Health also supported the WHO Commission on the Social Determinants of Health as one of four country partners from across the world to explore key questions around policy, evidence and implementation.

34. The scientific reference group helps ensure the best use of available evidence. The group oversees the monitoring and reporting on developments against the strategy through the status reports. Asking what a model of evidence-based policy might look like, the 2007 report observed "action on inequalities in health in England conforms rather well to evidence-based policy-making"[20].

Simple changes to the design of policies and how they are introduced could make all the difference. We recommend that all future initiatives to tackle health inequalities must, prior to their introduction, demonstrate adherence to the basic set of research guidelines we have detailed in this chapter which include:

- **piloting;**

- **randomisation and pairing of controls;**

- **use of quasi-experimental methods with controls where randomisation would be too costly;**

- **collection of adequate baseline data; and**

- **monitoring and measurement of pre-determined health-related outcomes within a set period of time, and in relation to cost.** (Paragraph 78)

35. The Government welcomes the Committee's practical suggestions to help improve further policy design, and align it more closely to the best available evidence and will refer them to the scientific reference group. Evaluation is recognised as critical by Government in helping to

- learn and disseminate practical lessons from early implementation, as part of a model of evidence-informed change

- improve subsequent policy making

- ensure transparency

36. The Department of Health policy on research and development is outlined in the Research Governance Framework for Health and Social Care[21]. This framework defines the broad principles of good research governance and is key to ensuring that health and social care research is conducted to high scientific and ethical standards.

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[20] Department of Health (2008) *Tackling Health Inequalities: 2007 Status Report on the Programme for Action*, p.5

[21] http://www.dh.gov.uk/en/AdvanceSearchResult/index.htm?searchTerms=research+gover

37. It uses a number of formal mechanisms to monitor and evaluate policy and it has also commissioned a co-ordinated evaluation programme of existing health reforms that is ongoing. It is examining choice, commissioning, provider diversity, competition and the overall impact of reforms, including on inequalities specifically. The Department has recently called for proposals for the second wave of the programme, which is to review and evaluate policy in *High Quality Care for All*, and has identified the impact of policies on health inequalities as a cross-cutting theme to be considered by applicants.

38. The development of research programmes must focus on the question in hand, and on context and feasibility. The guidelines suggested by the Committee will be appropriate in some, but not all, cases as, for example, with the Family Nurse Partnership (FNP) research. In addition, research is resource intensive, and clear priorities need to be identified for application of this model. Applying these guidelines to all policies would be poor value for money.

39. Many of the techniques suggested are employed in policy design in health inequalities and related areas. The FNP programme that supports disadvantaged first time young mothers has developed through systematic piloting and testing, and the results have informed its progress. This good practice contributes to the evidence base to support the programme. As part of this work, a randomised control trial is being conducted to assess robustly the impact for children and families in England, compared with usual services.

40. It is important, however, that a focus on excellence in research methods does not diminish the impact of implementation. The aim of the health inequalities programme is to improve the health of people in disadvantaged groups and areas and narrow the health gap. As the Committee said, there is considerable evidence of what makes people healthy, and the Government has acted upon this. Derek Wanless in his 2004 report said, "the need for change is too pressing for the lack of a comprehensive evidence base to be used as an excuse for inertia"[22]. This is a key lesson from the last 10 years, and it was strongly urged in the national consultation that supported the health inequalities target[23].

Professor Sir Michael Marmot's forthcoming review on health inequalities offers the ideal opportunity for the Government to demonstrate its commitment to rigorous methods for introducing and evaluating new initiatives in this area which are ethically sound and safeguard public funds. (Paragraph 79)

41. The Government welcomes the Committee's support for the post-2010 strategic review of health inequalities chaired by Professor Sir Michael

22 Wanless, D. (2004) *Securing Good Health for the Whole Population*

23 Department of Health (2002) *Tackling Health Inequalities: The results of the consultation exercise*

Marmot. It was announced on 6 November 2008. The review will explore the latest available evidence on health inequalities with reference to the wider social determinants of health, identify possible actions for implementation and consider possible metrics and objectives to support this work. Setting up the review is consistent with the approach of reviewing and refreshing policy over the last 10 years.

42. The Government's efforts in addressing health inequalities – as the Committee noted – are recognised internationally. England is the first country in the world to explore through the review, the implications of the report of the WHO Commission on the Social Determinants of Health at national level. The review will draw on the latest developments in the global evidence from the Commission's report and it mirrors the Government's desire to build policy on a rigorous, systematic approach to the evidence.

43. The review will report its findings at the end of the year.

Funding for health inequalities

Trade offs exist between redistribution of health resources to tackle health inequalities – as happens through the formula which the Department of Health uses to distribute funds to PCTs and the NICE model, which influences PCTs' spending by recommending certain treatments and interventions on the grounds of cost-effectiveness on a population basis. These trade offs have never been explicitly articulated and examined and we recommend that they should be. Professor John Harris said "if rationing is inevitable, let us ration in some fair way… you have to look at the whole range of health care". How far the majority of the population is willing to forgo health care to switch resources to the most needy is a moral question which requires a wide debate. (Paragraph 105)

44. The Government does not agree that there is an obvious trade-off or tension between NHS resource allocation and the National Institute for Health and Clinical Excellence (NICE) technology appraisal. In the Government's view, the two things are different, but not in conflict. Resource allocation to PCTs is designed to ensure equal access for equal need and help to reduce health inequalities. It aims to target resources to where health care need is greatest. NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

45. The potential costs of new technologies being appraised by NICE are identified as part of the spending review process and inform allocations. Once the resources have been allocated, it is for the local NHS to look at what local people need and to manage their resources as effectively as possible in order to meet that demand. One source of evidence to inform these decisions will be NICE guidance.

46. As well as the appraisal of new technologies, NICE also manages an extensive programme of clinical guideline development, which provides advice on the care and treatment of people with particular health problems, as well as publishing a growing suite of guidance on public health programmes and interventions. These guidance programmes provide valuable advice on how best use can be made of the resources that are already invested in care, as well as identifying areas in which any new investment might usefully be deployed. They provide a sound evidence-base for local work to address the health priorities that individual PCTs identify.

As we have stated in previous reports, more needs to be known about the relative cost effectiveness of treatments and services that are displaced to fund the new treatments recommended by NICE. A first step in this process would be to research the cost of implementing NICE guidance in each PCT in England – which we recommend the Government should fund immediately. (Paragraph.106)

47. The Government recognises that NICE has a key role in providing the NHS with guidance on the clinical and cost effectiveness of treatments and services. It does not believe it is necessary for NICE to fund research into the costs of implementing its guidance since it already carries out work to estimate the costs of implementing its guidance in the NHS. When NICE publishes final guidance, it publishes costing reports and templates that estimate the cost to implement its guidance and to enable individual PCTs to estimate the costs, and any potential cost-savings, of implementing its guidance locally.

The resource allocation model used by the Government seeks to equalise the funding available to PCTs in relation to proxies for need. It has had a major effect on the funding PCTs receive; the neediest PCTs receive almost 70 per cent more money per head than the least needy. However, many PCTs have not yet received their full needs-based allocations. The Government must move more quickly to ensure PCTs receive their real target allocations. (Paragraph 107)

48. The Government shares the Committee's aim and is committed to moving all PCTs towards their target allocations as quickly as possible. However, this aim must be balanced with the need to ensure that all PCTs have sufficient, stable funding that both supports existing commitments and allows long-term planning, as well as recognising the unavoidable cost pressures that all PCTs face. Moving PCTs towards their target allocation too quickly would result in painful cuts to services in some PCTs.

49. The target revenue allocations for PCTs are made based on a fair funding formula, recommended by the independent Advisory Committee on Resource Allocation (ACRA), which directs funding towards areas of greatest need. Whenever the funding formula or the data it uses are updated or changed, PCTs' distance from target allocations change.

50. The allocations for 2009/10 and 2010/11 achieve this by ensuring that:

  - average PCT growth is 5.5 per cent each year;

  - minimum growth is 5.2 per cent in 2009-10 and 5.1 per cent in 2010-11;

  - no PCT will be more than 6.2 per cent under target by the end of 2010-11; and

  - no PCT will move further under target because of above average population growth in 2010-11

51. Further, the most under-target PCTs will benefit from the highest increases in funding. At the start of 2009-10, the most under target PCT will be 10.6 per cent below its target allocation. Over the next two years, that PCT's allocation will grow by more than 17 per cent and it will end 2010-11 only 6.2 per cent below target. This is a significant achievement by historic standards, given that at the start of 2003-04 the most under target PCT was 22 per cent below target.

Furthermore, money that was intended to be spent on preventive health promotion programmes which may have reduced health inequalities has instead been spent by PCTs on the acute sector in times of financial difficulty. (Paragraph 108)

52. The Government has made monies available to improve health and tackle health inequalities, local PCTs make the decisions about local spending against national priorities.

53. Funding in the 2006-07 and 2007-08 revenue allocations to PCTs to support implementation of the *Choosing Health* White Paper was targeted on the most deprived areas, including the PCTs in Spearhead areas. While the *Choosing Health* delivery plan set out in more detail expectations of how this funding should be utilised, it was PCTs responsibility to decide how to use these funds.

Suggestions for protecting the NHS public health budget included a return to ring fencing, or relocation of public health budgets in local authorities rather than PCTs. We also heard that PCTs' current funding constraints, including one-year financial cycles and inability to retain and invest surpluses, should be removed in the interests of enabling more long-term investment in health inequalities. We did not receive enough evidence on these specific points to be able to recommend them. (Paragraph 109)

54. The Government – like the Committee – does not believe there is any single answer to protecting the public health budget. Public health spending has been a priority over recent years. A recent survey has shown that public health spending has doubled over the last seven years as a share of total

health spending. It has increased to £4.7 billion (including pharmaceuticals but excluding secondary prevention) and £3.4 billion (excluding pharmaceuticals and secondary prevention), and the share of total health expenditure spent on public health and prevention in England had doubled over seven years to 3.6 per cent for 2006-07. The average share of public health spending for OECD countries as measured by the survey was 2.9 per cent[24]. £550 million was identified in 2006-07/2007-08 to support implementation of *Choosing Health*.

55. In order to meet its objective to reduce avoidable health inequalities, the independent ACRA developed a separate health inequalities formula within the weighted capitation formula used to inform the 2009-10 and 2010-11 PCT revenue allocations. ACRA, whose membership comprises GPs, academics and NHS managers, found it was not possible to determine technically the proportion of the overall funding that should be allocated the basis of health inequalities formula and the weighting of the health inequalities formula was left for ministers to decide. However, ACRA has recently commissioned further work on the issue of health inequalities as part of the research programme for revenue allocations post- 2010-11.

The Government has not made even basic calculations about how much has been spent on tackling health inequalities. We recommend that the Department of Health finds out both how far PCTs spend the funds they received under the resource allocation formula on tackling health inequalities and what funds specifically allocated on health inequalities are spent on, and the outcomes achieved. As a first step, the Department should commission an in-depth study of health inequalities funding in a small sample of PCTs. (Paragraph 110)

56. The Government will examine the Committee's recommendation for an in-depth study of health inequalities funding in a small sample of PCTs, recognising the limitations of this approach would make it difficult to extrapolate findings across the NHS.

57. The Government spending on health inequalities follows the principle of mainstreaming, that is embedding spending and resource considerations into policy and service delivery across the NHS and other services. It believes this approach is likely to lead to better results than a ring-fenced programme budget located in one department, given the complexity and far-reaching nature of the determinants of health inequalities. Any calculation about overall spending is unlikely to be either reliable or meaningful.

58. In terms of individual programme spending, *Progress and Next Steps* identified specific, evidence-based health inequalities initiatives for 2008-09

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[24] Health England (2009) *Prevention and Preventative Spending*; total public health and prevention spend for 2006-07 including secondary prevention was £5.1 bn. Department of Health (2008) *Public Expenditure on Health and Personal Social Services 2008*

of £34 million to boost existing work to deliver the target. This included £19 million to support local communities in disadvantaged areas and £15 million focused on those with the greatest need including children, those living and working with disadvantaged communities and those living with mental health issues.

59.	In the NHS and local government, priority and performance management systems are used to promote specific health initiatives and a wider health inequalities approach in other policy areas.

60.	The complexity of health inequalities means that to be effective, policies to tackle health inequalities must fit with the aims and priorities of other government programmes. This is necessary because the scale of change to deliver the target and achieve a long-term sustainable reduction in health inequalities will only happen if mainstream services become more responsive to the needs of disadvantaged populations, and funds are leveraged, as necessary, to support this work as part of a broader pattern of spending objectives.

PCTs do not have adequate knowledge about money should be spent to best tackle health inequalities, and we recommend investment in the systematic evaluation of policy initiatives with a focus on relative cost effectiveness, following the principles set out in chapter three, to inform these difficult choices. (Paragraph 111)

61.	The Government welcomes the Committee's support for a stronger focus on cost-effectiveness for health inequalities policies and it will continue to strengthen this aspect of its work. The importance of cost effectiveness for PCTs and the wider NHS was made clear by Derek Wanless, former chief NatWest executive and Treasury adviser on health investment. In his 2002 report, he noted the impact of action on health inequalities and public health on the future costs and viability of the NHS[25]. The ability to demonstrate cost-effectiveness helps PCTs and other local organisations to take up and implement health inequalities programmes.

62.	The Department of Health has developed tools for use at local level designed to promote an evidence-based approach and to sharpen local delivery. For example, the health inequalities intervention tool, jointly developed with the Association of Public Health Observatories, was launched in 2007 to help spearhead areas with their local service planning and commissioning to achieve the public service agreement (PSA) target for life expectancy. In 2008, an additional tool, based on the same methodology, was made available to all LAs and PCTs, including the spearhead areas.

63.	The interventions identified by the tool include CVD control using statins and antihypertensives in those with existing CVD. The cost effectiveness of

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[25]	Wanless, D (2002) *Securing our future health: taking the long-term view*

these therapies in primary prevention in the targeted group was calculated carefully, based on data from a health technology assessment report on statins and data made available by the authors of the Royal College of Physicians guideline on antihypertensives.

64. The Department of Health has commissioned work on local priority setting for public health interventions taking account of the effectiveness and cost-effectiveness, many of which bear on health inequalities[26]. This will help inform local practice.

Specific health inequalities initiatives

During the course of this inquiry, we heard widespread praise and support, both in this country and abroad, for the explicit commitment this Government has made to tackling health inequalities. This commitment has involved a framework of specific policies, underpinned by a challenging and ambitious target. We would like to emphasise our support and commendation for the Government for taking specific actions to tackle health inequalities, although, as we have written, we are critical of aspects of planning and evaluation. (Paragraph 113)

65. The Government welcomes the support of the Committee for the action it has taken in tackling health inequalities, notwithstanding its specific comments on planning and evaluation. Health inequalities blight the lives of too many groups and communities in our society. The Government recognises and accepts the moral imperative to act on these issues and this has underpinned our efforts since 1997.

66. Professor Sir Michael Marmot also noted that his work when chair of the WHO Commission on the Social Determinants of Health, underlined the importance and relevance of the work undertaken in England on the international stage. He said "this country has shown leadership through its pioneering approach of reviewing the evidence, setting targets, developing a comprehensive strategy across government, and monitoring progress"[27]

Health Action Zones were an ambitious initiative that could not achieve the extremely challenging targets that were set for them in the short time they were in existence. We have heard that they were a victim of many of the problems with policy design and implementation documented previously – they were both under funded in relation to their objectives, and ill-thought through. (Paragraph 119)

67. The Government acknowledges that Health Action Zones (HAZs) were an ambitious initiative and notes that it yielded useful lessons. The Government

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[26] Department of Health (2008) *Prioritising investments in public health*

[27] Department of Health (2008) *Tackling Health Inequalities: 2007 Status Report on the Programme for Action*

has sought to learn and apply the lessons from the HAZ experience to current and future programmes.

68. There were several obstacles to tackling health inequalities in the 1990s, not least its complexity and a lack of frankness in acknowledging the nature and extent of the issue. This made it harder for people to develop an adequate local response. A flurry of uncoordinated, small-scale and short-term initiatives resulted in some innovative thinking from a range of local bodies, but the impact of this work was often unclear and it was hard to replicate. This small scale, project-based approach reflected the lack of secure funding and organisation at the beginning of this period. The HAZ programme was an early attempt to try to bring local programmes together, and share learning more widely.

69. It was launched in 1997 to improve health outcomes in disadvantaged areas, reduce health inequalities and act as trailblazers for new ways of working[28]. This was before publication of the national health inequalities strategy and the related developments that strengthened policy design and delivery.

70. The evaluation of health action zones showed that while their activities pushed health inequalities as a priority up the local agenda, they did not have last long enough to impact on conventional indicators of population health or health inequalities[29]. Instead, they enabled development of local capacity and demonstrated possibilities for change. A key lesson from the HAZ experience was that there is no single blueprint for addressing complex causes of health inequalities at local level. HAZs also showed themselves to be capable of making many significant and lasting contributions to the development of Local Strategic Partnerships (LSPs). Lessons have been learned from the HAZ evaluation and the policy process has moved on.

The early years period was emphasised throughout our inquiry as a crucial focus for efforts to tackle health inequalities, and we commend the Government for taking positive steps to place early years at the heart of the health inequalities agenda through Sure Start. Many witnesses were very positive about the benefits of Sure Start. National evaluations shows that it has enjoyed some success, but it has yet to demonstrate significant improvements in health outcomes for either children or parents, achieving positive evaluation in only 5 out of 14 measures that were studied. (Paragraph 137)

71. The Government welcomes the Committee's recognition of the importance and focus given to early years in its efforts to tackle health inequalities. The results of the Sure Start evaluations show the growing impact of the work in this area.

[28] Health Development Agency (HDA) (2004) *Lessons from health action zones* (HDA Briefing number 9)

[29] Barnes M, Bauld L, Benzeval M, Judge K, Mackenzie M, Sullivan H (2005) *Health Action Zones – Partnerships for health equity*. Routledge.

72. The importance of early years for tackling health inequalities cannot be underestimated. The Acheson report gave priority to mothers and children, a priority echoed in the *Programme for Action* and the evidence to – and the conclusions of – the WHO Commission report[30]. Early childhood experience is critical to the entire life-course. Many challenges in adult society have their roots in the early years of life and it is better to provide a positive start early rather than resorting to remedial action later. Brain development is highly sensitive to external influences in early childhood, starting in utero, with lifelong effects. Supporting mothers and families with young children will not only help to tackle health inequalities where they occur now, but can also help to break the intergenerational cycle to prevent socio-economic disadvantage being passed on to future generations.

73. Sure Start Children's Centres have a key role to play in delivering the Healthy Child Programme and health related services provide a clear opportunity to make sure children get the best possible start in life. Children's Centres aim to increase access to health services by engaging with families who, traditionally, have been unwilling or unable to take up services, delivering them in a way that better meets their needs.

74. Sure Start was put in place to tackle the legacy of multiple disadvantage. The independently produced National Evaluation of Sure Start (NESS)[31] shows clear benefits for children and their families living in Sure Start areas – and rapid change is not always possible in tackling such issues. Information available, for example from Head Start in the USA, reveals that these type of interventions often take time to bed in and do not usually have immediate, measurable, beneficial effects. Research into similar interventions does, however, show benefits in the medium to long-term and this emphasises the commitment to on-going evaluation.

75. Early evidence from the NESS shows that there has been a reduction, greater reduction than in England, in emergency hospitalisations for 0-3 year olds for severe injury or respiratory infection, as well as increases in health screening. The most recent research[32] supports these early observations. It identifies children living in Sure Start Local Programme (SSLP) areas, as compared with children in other areas, as being more likely to have received the recommended immunisations and less likely to have had an accident based injury in the year preceding assessment. However, caution is warranted in interpreting these results, as they may be due to a general improvement over time.

76. Health visitors and midwives are extremely important to these programmes, particularly in terms of making initial contact with families. Home visiting,

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[30] WHO (2008) *Closing the gap – the report of the WHO Commission on the Social Determinants of Health*

[31] Barnes, J. *et al* (2007) *Changes in the Characteristics of Sure Start Local Programme Areas in rounds 1-4 between 2000-01 and 2004-05*, NESS Research Report 21, DCSF.

[32] Melhuish, E. Belsky, J. Leyland, A. *et al.* (2008) *The Impact of Sure Start Local Programmes on Child Development and Family Functioning*, NESS Research Report 27, DCSF

antenatal services, access to specialists and services for children and parents with special needs are regarded as the most important health services.

77. Programmes have improved access to maternity provision by delivering them in new places, and in new ways. They have also created special services to meet the needs of particular groups of people. The extra investment Sure Start has made in maternity services enabled staff to spend more time and develop relationships with women, especially those who needed the most support. Good team working between midwives and health visitors assists the smooth handover of women between the antenatal and postnatal periods.

78. The most widespread health-related intervention offered by these programmes is breastfeeding advice and support. From the small amount of information available, there is an indication that the rate of breastfeeding has risen significantly within some programme areas. Smoking cessation and healthy eating advice are highly important aspects of almost every programme. The majority of programmes studied also provided home safety equipment.

79. The evaluation recognises that health is the service that most often provides a gateway to other facilities and a way of contacting families with complex needs. Many women benefited from gaining related training and by acting as peer supporters, with some using this as a springboard to further training

Moreover there is concern that extending this policy, via Children's Centres, to all areas of the country, risks distracting from the original focus of deprived families who are most in need of support. We did not receive detailed evidence about the evolution of Sure Start programmes into Children's Centres, but again this is a policy change that has not been properly piloted or evaluated prior to its introduction. It is absolutely essential that early years interventions remain focused on those children living in the most deprived circumstances, and Children's Centres must be rigorously monitored on an ongoing basis. (Paragraph 138)

80. The Government remains committed to providing early years interventions for disadvantaged children and their families. A universal children's centre model – with a Children's Centre for every community by 2010 – will mean that many more disadvantaged children and their families benefit from integrated early childhood services, helping to end child poverty and improve community cohesion. Additional resource is already enabling local authorities to fund additional outreach workers. The Government continues to monitor rigorously the development of Children's Centres.

81. The decision to move to a universal children's centre model was taken following the Interdepartmental Review of Childcare in 2002, and a report produced jointly by HMT and the then Department for Education and Skills, Department of Work and Pensions (DWP), the then Department for Trade

and Industry, and the Department of Health . It was taken in order to make best use of the learning from the approach used by SSLPs in working with communities made up of some of the most disadvantaged families. The earlier programme was area-based, reaching around 400,000 children under-five within strict geographical boundaries to enable the monitoring and evaluation of this "experimental" stage. SSLPs served a proportion only of the poorest children in the country – moving to a universal children's centre model will mean there is a centre in every community by 2010.

82. Sure Start Children's Centres, wherever they are, share the same objectives – to deliver integrated early childhood services that will improve outcomes for all young children and, in particular, will reduce the inequalities between disadvantaged children and the rest, and helping to end child poverty. Guidance makes clear that local authorities, whose responsibility it is to use the Sure Start Early Years and Childcare Grant effectively to deliver on these objectives, must direct the greatest resource to communities with the highest levels of need. There is clear emphasis on the most disadvantaged families to ensure that they are encouraged to take up the services they need.

83. All Children's Centres are required to reach out to families, particularly those who may not come forward of their own volition, and to increase the engagement they have with families in the most vulnerable groups. For example, this will include teenage parents, workless households including lone parents, families from black and minority ethnic groups, families where children or parents have disabilities that mean they have special needs. From 2008-09 onwards, additional resources have been allocated to enable LAs to fund two additional outreach workers to work with families in the most disadvantaged communities.

84. The evaluation of the earlier SSLP is continuing. The NESS report, published in March 2008, contains much that is positive. It suggests cautious optimism about improvements since the 2005 report with "greater attention to the hard to reach". The report ascertained that the positive effects did not vary significantly across population sub-groups – nor were there any significant statistical negative findings. It also found that in SSLP areas compared with non-SSLP areas:

- parents of three-year-old children showed more positive parenting skills, while providing a better home learning environment

- three-year-olds showed better social development, and higher levels of positive behaviour and independence

- families took more advantage of the range of support services available than in areas without Sure Start

85. Sure Start Children's Centres will be evaluated. DCSF is in the process of considering tenders for the evaluation. In addition, most local authorities

use the performance management framework suggested by DCSF in 2007 to manage the performance of their centres. This is an annual cycle which encourages local authorities and centres to "plan, do, and review" in order to support well-informed forward planning which focuses on outcomes. The framework consists of a range of performance indicators, linked to the National Indicator Set and the PSA targets, and a self-evaluation process for centres.

86. Legislation in the current session includes a duty for the Office for Standards in Education, Children's Services and Skills to inspect Sure Start Children's Centres. Pilots, being conducted this year, will inform the final design of the inspection regime, which is likely to be introduced next year, once the legislation is in place.

It is likely that the Government's health inequalities target will be missed. This is unsurprising since it is the toughest target adopted anywhere in the world. Despite this likelihood, we agree with the HCC that aspirational targets such as this can prove a useful catalyst to improvement. We commend the Government for its adoption of this target and we recommend that the commitment be reiterated for the next 10 years. (Paragraph 159)

87. The Government welcomes the Committee's recognition of the target's role as a catalyst for action. It has helped focus NHS, local government and other partners on health inequalities in a way that has not happened previously and made health inequalities part of the mainstream business of commissioners. The 2010 target is ambitious but the Government does not agree that the target will be missed. The target remains challenging but achievable.

88. The *Programme for Action* noted the time lag between interventions and the achievement of results and it is difficult to assess the short-term contribution of individual programmes towards the target. It was clear that the impact of programmes is likely to be most visible in the second half of the decade. Current data (for 2005-07) is half way to target date (for 2009-11). While the life expectancy gap has widened – albeit against a background of significant improvements in the health of people in disadvantaged groups and areas – the infant mortality aspect of the target is showing signs that it will be met if recent trends continue.

89. Professor Sir Michael Marmot has been asked to consider possible future metrics and objectives – including possible targets – for the post-2010 period.

Health inequalities have many facets – health is unequal according not only to social class, but to gender, ethnicity, age, disability and mental health status, to name only a few. It is crucial that the Government's focus on socio-economic inequalities alone does not lead to other aspects of health inequalities going unnoticed and ignored. We were pleased

to see that some local areas already focus on health inequalities related to ethnicity as appropriate to their local populations; however, there is little to suggest that health inequalities relating to either gender, age or mental health status are even being adequately measured let alone addressed. A wider range of inequalities should be measured. Such measurements should include not just unequal outcomes in terms of length and quality of life, but should also examine unequal access which would lead to unequal outcomes. We have also heard that there are statistical problems with the infant mortality target because there are so few infant deaths in each area. We recommend that this target be reconsidered. We recommend that the best ways to measure and target health inequalities be investigated by Sir Michael Marmot's forthcoming review. (Paragraph.160)

90. The Government welcomes the Committee's recommendation for Sir Michael's review to consider the best ways to measure and target health inequalities, including looking at a wider range of measures reflecting the different facets of health inequalities. This is part of the remit of the review which will consider a wide range of options around metrics and objectives, and possible future targets for the post-2010 period, including the current target on infant mortality and life expectancy at birth.

91. Notwithstanding issues around the formulation of the infant mortality aspect of the target, action in this area is a crucial part of any effort to achieve a sustainable reduction in health inequalities. There are 3,000 infant deaths a year with wide variations in the numbers and rates of infant mortality by area and ethnicity. For example, there are major differences in infant mortality depending on the mother's country of birth, especially Pakistan and the Carribean where infant mortality rates are almost twice the national average[33]. A recent review identified 43 local authority areas with high numbers of infant deaths in the routine and manual (R&M) target group as a focus for tackling the infant mortality gap[34]. It showed that, by concentrating efforts on this group of areas where R&M infant deaths are highest, significant progress could be made towards meeting the national target.

92. The Government recognises the importance of all dimensions of health inequalities, including age, gender, ethnicity as well as socio-economic differences. Each of these dimensions was explored separately in the Acheson report. They feature in the *Programme for Action* and in the work on delivering the target. For example, ethnicity and age are key risk factors for the infant mortality aspect of the target. 44 per cent of the black and minority ethnic population of England live in spearhead areas, and the life expectancy inequalities target is measured separately for men and women. The Department of Health will also publish later this year, a single equality scheme for 2008-11 that sets out what is being done to meet our statutory duties under race, disability and gender legislation.

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[33] Department of Health (2008) *Tackling Health Inequalities: 2007 Status Report on the Programme for Action*
[34] Department of Health (2007) *Review of Health Inequalities Infant Mortality 2010 PSA Target*

93. As part of the work to promote equality and human rights in healthcare, there are several short-term funded programmes aimed at working with the NHS. For example, the Pacesetters programme, currently based in six strategic health authority (SHA) regions, and working with 34 trusts, aims to reduce inequalities for patients and staff subject to discrimination and disadvantage. The programme works across all equality strands, including age, disability. Each SHA and its trusts will work on a range of local and core issues. Each participating trust will take on three local issues, all with a patient-focus, and taking account of local views and evidence. The "core" elements, suggested by DH, will cover both workforce and patient care issues, and comprise:

- promoting dignity and respect, including tackling bullying, in the workplace

- developing flexible working options, particularly for staff from communities that experience inequalities

- improving and using "equality" data collections for both patients/service users and the workforce

- improving the health status of gypsies and travellers.

94. In early 2007, an equality monitoring group was established to take stock of the equality data collected by the Department of Health and the NHS, with a view to refining collection methods and improving the use of data collected on patients, service users and staff. The group provides leadership on the equality monitoring agenda, to improve the level and range of equality data collected, inform better policy-making and meet obligations under equalities legislation. Currently, the group is leading work on disaggregating the Vital Signs to better understand health outcomes across the equality strands. It is also leading on the design of an Equality Information Strategy to facilitate a coherent and strategic overview of the collection and use of equality data. This work will provide more insight and disaggregated information on health outcomes on which to act.

95. In terms of measurement, some key health data, such as mortality information, are routinely available by age and gender. Much work has been done to improve the availability of information on the health of particular groups. For example:

- the Health Survey for England provides information on the public's health and factors affecting health. Selected health surveys focus on particular groups – older people in 2000 and 2005, children and young people in 1997 and 2002 and ethnic minorities in 1999 and 2004.

- the Office for National Statistics has recently published data on infant mortality by ethnic group for the first time (data for babies born in 2005 were published in June 2008)[35].

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35 ONS (2008) *Infant mortality by ethnic group, England and Wales*

In 2003, the Treasury's Cross Cutting review set out a seemingly ambitious plan of action across government departments to tackle health inequalities; however, we were told that this was simply an attempt to "map existing policies" on to the target, with little thought given to what would actually work. Five years on, the measures listed in the Cross-Cutting review have not delivered what they promised – although almost all the indicators have been achieved, we are still as far as ever from actually reducing health inequalities. (Paragraph 161)

96. The Government published its national health inequalities strategy (the *Programme for Action*) in 2003, the most ambitious plan for action in this area ever seen in this country. Its aim was to start the process of meeting the 2010 target and to lay the foundation for a long-term sustainable reduction in health inequalities. It was not a paper exercise but set out clear roles and responsibilities for action across government and a performance framework to monitor and assess developments to help achieve these goals. It included 82 departmental commitments to contribute to this effort.

97. These commitments were based on the earlier Treasury cross cutting review which looked at – and tested – the available evidence, identified and mapped policies across government with reference to what works. A summary of the review was published in 2002[36].

98. While 75 out of 82 commitments were wholly, or substantially, achieved, the link between the delivery of these commitments and health inequalities outcomes is tenuous. These commitments sought to improve the health and life experience of people in disadvantaged groups and areas and this has been achieved[37]. Reducing the gap is more complicated and since the publication of the *Programme for Action*, more sophisticated modelling techniques have been developed to help clarify the link between interventions and impact[38].

99. Effective cross-government action is crucial for delivering this agenda. The Cabinet sub-committee Domestic Affairs (Health and Wellbeing -DA(HW)) oversees health inequalities for Government. PSA Board 18 monitors developments against the target. An official cross cross-government programme board on health inequalities is being established to strengthen this work and oversee the development of the post-2010 health inequalities strategy.

Despite much hype and considerable expenditure we have not seen the evidence to convince us that any of the specific support given to deprived areas to tackle health inequalities has yielded positive results. Spearhead status on its own has done little to galvanise areas to tackle health

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[36] HM Treasury/Department of Health (2002) *Tackling Health Inequalities: Summary of the Cross Cutting Review*

[37] Department of Health (2009) *10 Years On: A Review of Developments*

[38] Department of Health (2008) *Tackling Health Inequalities: 2007 Status Report on the Programme for Action*, see also London Health Observatory, Health Inequalities Intervention Tool website www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx

inequalities. Support is now being offered by the National Support Team, but although PCTs have welcomed this, there is little evidence to suggest it is or will be an effective intervention. We are also concerned that this was only introduced six years after the target was announced, and we consider that it would have been more logical and effective to have offered central support to PCTs to achieve this critical target right from the beginning. (Paragraph 170)

100. The Government rejects the Committee's view that action to tackle health inequalities in the spearhead areas has not yielded positive results. On the contrary, spearhead status for local areas is embedded in the life expectancy element of the target. The latest data (2005-07) show that 47 per cent of spearhead areas are on track to narrow their own life expectancy with England by 10 per cent, by 2010, compared to 1995-97 baseline for either males or females or both[39]. This is an improvement on 2004-06 where data showed that 41 per cent were on track.

101. This view is supported by the joint Audit Commission/ Healthcare Commission report[40]. It shows evidence that spearhead areas, many of which also benefited in the past from HAZ status and/or neighbourhood renewal funding, perform better with regard to health improvement than non-spearhead areas. Using Healthcare Commission data that assesses performance in relation to 11 key targets, spearhead PCTs are shown to have performed markedly better in eight of these areas and in only one area – sexual health – was performance weaker.

102. It is backed by the work of the national support teams (NSTs). The NST model is based on evidence from successful tailored, clinical support to local NHS organisations on orthopaedic waiting times and A&E. The model was adapted for public health outcomes and rolled out incrementally whilst evaluating impact. The first public health NST, on sexual health, demonstrated a 58 per cent improvement in GUM access in areas supported by the NST, compared to an average improvement of 42 per cent for all PCTs over the same period[41].

103. The health inequalities NST employs an evidence-based diagnostic approach derived from successful work in Sheffield. This work showed a reduction in heart disease mortality at a faster rate in more deprived areas than in the city as a whole. When extended to the whole city, this approach contributed to Sheffield heart disease mortality falling to below the national average, as well as narrowing the gap between the targeted groups and the rest of the population[42].

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[39] Department of Health (2008) *Tackling Health Inequalities: 2005-07 Policy and Data Update for the 2010 National Target*

[40] Audit Commission/Healthcare Commission (2008) *Are we choosing health?* page 54

[41] Department of Health figures using monthly data comparing percentage of GUM appointments offered in PCTs supported by the sexual health NST versus PCTs that did not receive sexual health NST support between February 2006 and March 2008

[42] Department of Health (2005) *Status Report on the Programme for Action* page 62

104. This approach has been used in 40 spearhead areas across England. It emphasises the need to apply key interventions on an 'industrial scale' to narrow the gap, accumulated many good practice examples and shared the lessons with other local areas[43]. The majority of areas visited have shown significant change to their structure and process – as evidenced at the health inequalities NST's six weeks and six months reviews. For example:

- East Lancashire – where an action plan has been produced following recommendations made by health inequalities NST. So far, 10 recommendations have been met, and a further 13 are ongoing. Progress against the plan is on target. The *Save A Million Years Of Life* programme aims to save a million years of life through increases in life expectancy between 2006 and 2011 across a population of 380,000. In the first year of the programme, 300,000 life years were saved – significantly exceeding the projected first year target.

- Hartlepool – where a CVD local enhanced service for GP practices was developed as a result of the HINST visit. All Teesside is following this model, and going 'big scale'. They plan to screen over 90 per cent of 40 to75 year olds over 3 years.

105. An early, initial, analysis of QOF performance between 2006-07 & 2007-08 shows that non-clinical QOF scores in PCTs visited by the health inequalities NST from February 2007 to October 2007 saw improvements above the gains seen among other spearhead areas, and across non-spearhead areas.

106. For example, at the time of the health inequalities visit to Bolton in 2007, assessment of the chronic disease registers showed major shortfalls between the numbers registered and the estimated numbers that would be expected. These "missing" patients were not receiving therapies known to prevent death and disability in people with these conditions. Following the health inequalities NST's visit, Bolton PCT re-appraised their strategies. The resulting initiative, the *Big Bolton Health Check*, incentivised, supported and performance managed GPs to assess all adult patients for existing CVD, diabetes and chronic kidney disease, as well as screening for high risk. The resulting activity produced dramatic change – an estimated 83 per cent-85 per cent of all patients will have been assessed by the end of March 2009, and practices in the more deprived neighbourhoods have been supported to achieve the best results.

107. While it is always better to deploy effective methods earlier, this is to misunderstand the nature of tackling health inequalities. The development of NSTs illustrates both the relative weakness of the evidence base and the dynamic nature of policy delivery in this area. Lessons have been learned from others – in this case clinical practice – and test out the emerging lessons for public health, modifying practice in the light of that experience – an approach similar to that recommended by the Committee.

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[43] Department of Health (2008) *Systematically Reducing Health Inequalities*

The role of the NHS in tackling health inequalities

Treatment, screening and interventions to change health behaviours are the key tools available to the NHS for tackling health inequalities. Preventive prescribing of antihypertensive and cholesterol-reducing drugs have already been identified and promoted by the Government as an effective approach to tackling health inequalities and the Government has already announced that a large-scale vascular screening programme will be introduced. However, whilst some evidence exists to support the clinical effectiveness of some of these interventions, less is known about their cost effectiveness, and in particular about how to ensure they are targeted towards those in the lowest socio-economic groups so that they actually have an impact on health inequalities. We urge the Government to plan the introduction of vascular checks with great care, and according to the steps outlined in Chapter 3, so that it does not waste another crucial opportunity to rigorously evaluate the effectiveness and cost effectiveness of this screening programme. (Paragraph 200)

108. The Government agrees with the Committee that the NHS has a key role in tackling health inequalities. It needs to be effective in delivering key services and the importance of evidence and evaluation for delivering health inequalities and related programmes has already been emphasised in this response.

109. There is good evidence for the effectiveness of a range of interventions in preventing vascular diseases, including coronary heart disease. The interventions promoted through the vascular risk assessment and management programme (NHS Health Check) are based on NICE recommendations[44, 45]. Although there has been no direct evidence of the impact in reducing health inequalities, it is known that vascular conditions (mainly coronary heart disease, stroke, diabetes and chronic kidney disease) are the largest contributor to the gaps in health between different ethnic groups and between spearhead areas and the England average.

110. Preventing these conditions through a universally available approach, tailored locally to encourage participation from disadvantaged groups, carries significant potential to reduce these gaps. This is the approach adopted by the NHS Health Check programme to prevent vascular disease, which PCTs will begin to implement from 2009-10.

111. Through work in spearhead areas, the NHS is also targeting statin and antihypertensives use in groups of the population with existing CVD or those at high risk of coronary heart disease, based on extensive evidence of effectiveness and cost-effectiveness as noted by NICE. To maximise the impact on health inequalities, the NHS Health Check programme

44 Ward. S et al. (2005) *Statins for the Prevention of Coronary Events*

45 *Hypertension. Management in adults in primary care: pharmalogical update*. The National Collaborating Centre for Chronic Conditions, 2004 www.nice.org.uk/CG018

has been designed so that the basic risk assessment and management components of the vascular check are suitable to be undertaken in a variety of settings, including pharmacies, community centres and other sites such as supermarkets and football grounds, as well as GP practices. People who are not in touch regularly with formal health care, particularly GP services, will be encouraged to access the checks at convenient locations and times. The economic modelling included the costs incurred if a proportion of the checks are undertaken outside GP practices and the programme was found to be highly cost effective. The extent to which the NHS Health Check programme realises its potential to have an impact on health inequalities will depend on the success of implementation of the programme, including effective targeting of disadvantaged groups.

112. Evaluation of the NHS Health Check programme will be an important part of the implementation and ongoing phases. The Department of Health is planning to commission an independent evaluation in the summer.

113. The Cancer Reform Strategy set out a commitment to establish a National Awareness and Early Diagnosis Initiative[46]. The overarching goal of this initiative is to promote earlier presentation and diagnosis of cancer. This will help improve survival rates and reduce morbidity and mortality earlier, potentially reducing the cost of expensive or longer treatments and enabling surviving patients to continue to contribute to society.

114. The Government recognises that evaluation of this work is crucial. Evaluation tools, including the cancer awareness measure, will be used to measure the impact and effectiveness of both local and national cancer awareness work and inform local NHS action.

115. Breast, bowel and cervical screening all meet the internationally agreed criteria on the clinical and cost-effectiveness of screening used by the UK National Screening Committee.

Changing health behaviour is widely acknowledged to be difficult, and evidence suggests that traditional public information campaigns are less successful with lower socio-economic or other hard-to-reach groups – in fact we were told that these interventions can actually widen health inequalities because richer groups respond to them so well . Social marketing is heralded as an approach that allows messages to be communicated in more tailored and evidence based ways. We have not seen firm evidence to support this claim, and we recommend that social marketing interventions are evaluated to ascertain their success. A sound evidence base does exist to support brief, opportunistic interventions in primary and secondary care, followed by referral to more specialist health promotion services. However, it seems that further steps are needed to ensure that the most heavily addicted smokers, who are often those from the lowest socio-economic groups, benefit fully from these interventions.

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[46] Department of Health (2007) *Cancer Reform Strategy*

This will have implications for the training of NHS staff and others.
(Paragraph 201)

116. The Government welcomes the recommendation for the evaluation of social marketing interventions to assess its success. Evaluation is a key part of the social marketing programme and this work is in hand.

117. The *Choosing Health* White Paper (2004) set out the challenge for improving health and changing health behaviour. It acknowledged that encouraging positive health behaviour requires sustained and coordinated action, and highlighted social marketing as an approach that could make a significant contribution both nationally and local.

118. By applying lessons from the commercial sector to the social and health sectors, social marketing puts a detailed knowledge of consumer behaviours at the heart of developing behaviour change interventions, campaigns and programmes to improve health and reduce inequalities, and is reflected in programmes such as Change4Life.

119. Change4Life is a three year marketing programme to combat obesity, in support of the Government's target to reduce the proportion of overweight and obese children to 2000 levels by 2020. The aim of the programme is to use marketing as a catalyst for a societal shift in lifestyles in England, resulting in fundamental changes to those behaviours that lead to people becoming overweight and obese. Change4Life has been informed by a comprehensive programme of research to provide insights into the attitudes and behaviours of families in relation to diet and activity and what activities, communications and support might help families change those attitudes and behaviours. The impact of the programme will be measured on awareness, attitudes, understanding of key messages, intent to change and self-reported behaviour change, as the campaign progresses. This will be complemented by further monitoring and evaluation.

120. The social marketing strategic framework, *Ambitions for Health* (2008), sets out how social marketing principles will be embedded into health improvement programmes and help build social marketing competencies and capacity in England, drawing on good practice around the country.

121. The Government recognises that evaluation is crucial in demonstrating the effectiveness of social marketing. Ten PCT and LA-based learning demonstration sites were established by the National Social Marketing Centre (NSMC) in March 2007. Their aim is to help local areas apply and integrate social marketing into their programmes and strategies, whilst developing a robust evidence base for social marketing. These sites are located across England and address a range of health behaviour issues, from breast-feeding and healthy eating to smoking cessation and anti-social drinking.

122. The outcomes from individual sites are being evaluated by the London School of Hygiene and Tropical Medicine, and the results are expected to be published in March 2010.

123. In addition, the ShowCase database, hosted by the NSMC and accessed through their website, gives details of fully researched health-related case studies from a range of counties, including the UK, that demonstrate the effectiveness of social marketing in achieving and sustaining positive changes in people's behaviour.

124. In terms of reaching smokers from the lowest socio-economic group, the communications and marketing strategy for tobacco control has been designed for maximum impact on smokers from routine and manual groups and benefits from research insights into the smoking behaviour, attitudes and quitting activity of smokers from routine and manual communities. This includes improving treatment effectiveness, performance management and access to effective treatment through NHS support services and help lines, as well as improving the evidence base for smoking cessation work and intelligence on the efficacy of interventions.

125. The Department of Health launched a new very brief advice resource called "3As" in January 2009 to assist GPs in helping their patients to quit smoking[47]. This resource is the first stage of a drive throughout the year to help support primary care in triggering more quit attempts among routine and manual smokers. This new guidance stresses the vital role that primary care has to play in fighting Britain's biggest killer, by offering very brief advice and referring smokers to their local NHS Stop Smoking Service. Smokers are up to four times more likely to quit smoking successfully with support from their local NHS Stop Smoking Services[48].

126. The very brief intervention approach – backed by clinical evidence – recognises the lack of consultation time that many clinicians in primary care and other settings have to raise the issue of smoking. It sets out three short steps (Ask, Advise, Act) which they can follow in just 30 seconds, to increase the chances of their patients quitting successfully. A similar approach has been developed for alcohol[49].

127. The Department of Health is also funding an NST to help areas improve the effectiveness of tobacco control interventions at a local level through partnerships. Related work is also planned with LAs and the Improvement and Development Agency (IDeA) to identify ways of reducing smoking prevalence in routine and manual groups through wider tobacco control in community settings.

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[47] www.smokefree.nhs.uk/resources/resources/

[48] Department of Health (2009) *NHS Stop Smoking Services: service and monitoring guidance*; see also: www.smokinginengland.info

[49] Department of Health (2005) *Alcohol Misuse Interventions: Guidance on developing a local programme of improvements*

PCTs and SHAs should play a central role in informing and co-ordinating efforts to tackle health inequalities. However, our evidence has not suggested that they are currently providing the leadership that might be expected of them. We have been told that numbers of senior public health specialists working in these organisations are falling; while public health specialists clearly have not demonstrated progress in tackling health inequalities to date, and we have not seen evidence specifically supporting their effectiveness in this role, it is concerning that the section of the NHS workforce, probably most able to provide good leadership for tackling health inequalities is in decline, and we recommend that the government monitor this trend closely. Nor did we see any evidence to suggest that the drive towards , 'World Class Commissioning' is likely to have a measurable impact on health inequalities in the near future.
(Paragraph 218)

128. The Government agrees with the Committee that local health organisations have a key role in informing and co-ordinating efforts to tackle health inequalities. This is relevant in workforce planning where local workforce planners are best placed to assess the healthcare needs of their local population. However, the Department of Health will continue to ensure that the frameworks are in place to enable effective local workforce planning and monitor the number of senior public health specialists.

129. The Department is currently involved in a range of initiatives to ensure that SHAs play a key role at regional level, fostering investment and collaboration to ensure that the right conditions are in place across their regions for improving talent and leadership development. SHAs will also add value at a regional level through the commissioning and provision of development programmes for senior leaders. National guidance for NHS talent and leadership planning and will support SHAs in assessing current leadership capacity, using collaborative methods to meet gaps between demand and supply, and developing the most efficient investment strategies[50].

130. However, achieving the shared ambition for putting quality at the heart of this approach will require a renewed focus on leadership at all levels of the NHS. Leadership is also a responsibility at all levels, across all parts, of the NHS system

131. The NHS operating framework requires PCTs, providers and local government to work together in partnership. The national guidance on health commissioning emphasises the importance of keeping people healthy and independent, and of partnership working to achieve this. PCTs are required to focus on the interventions that evidence shows can have the biggest impact on reducing health inequalities. Whilst some action is taken nationally, the main contribution is made locally. LAs and PCTs know that they must act together if they are to address this issue and use their resources effectively. In many areas, joint plans to address health

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[50] Department of Health (2009) *Inspiring Leaders: leadership for quality*

inequalities, underpinned by joint strategic needs assessments, form part of the Local Area Agreements (LAA). LA and PCT work in a number of areas is supported by a joint director of public health, along with other joint appointments.

132. World Class Commissioning (WCC) is a vehicle for the delivery of wider health reforms and a mechanism to minimise health inequalities and increase NHS access. To promote this role, all PCTs will be assessed annually through metrics to measure progress on tackling inequalities. Minimising health inequalities is part of the core business of all commissioners, and world-class commissioners as local leaders of the NHS will take forward this responsibility.

133. All PCTs have produced strategic plans setting out the priorities for their local populations over the next five years. Within these plans, they have prioritised the top 10 outcomes that matter most to their population, which includes a focus on health inequalities.

Access to high quality health care is an important responsibility of PCTs and SHAs, and the Government has advertised its drive to improve access to GP services as part of its policy to tackle health inequalities. The extra GPs that are to be introduced into deprived areas which are under-doctored, are welcomed, unless they are being relocated from other deprived areas, which would simply move rather than solve the problem. However, most of our evidence suggests that while access to healthcare is important, it is not high on the list of priorities for tackling health inequalities; indeed research has said that England compares well to other countries in this regard. We are also concerned that the central edict for all PCTs to introduce a GP-led health centre has not involved due consideration of either need or inequalities, and that in fact centralising GP services may make access more difficult for lower socio-economic groups. We recommend that Sir Michael Marmot's review should examine the issue of access to healthcare closely, paying particular attention to claims of 'institutional ageism' and that access is worse for those suffering from mental health problems and learning disabilities. (Paragraph 219)

134. The Government – like the Committee – places a high priority to developing GP services and improving access to primary care for people in disadvantaged groups and areas.

135. Traditionally, in areas with the greatest health needs, general practice has often been less well developed both in the terms of the numbers of GPs and other primary care clinicians as well as in the quality of provision, despite efforts by successive Governments over the years. The Government is determined to tackle historic and persistent problems with inequity of access to GP services, especially in more disadvantaged or deprived areas, and it

has identified tackling health inequalities as a key priority in successive NHS Operating Frameworks.

136. There is also clear evidence that increasing the number of primary care clinicians in areas with the greatest health need is one of the most effective ways of improving the health of the population[51]. The Department of Health has provided additional funding for our most poorly served and disadvantaged areas to commission 112 extra GP practices which are additional and complement existing GP provision[52]. This will help the NHS to plug gaps in local provision by introducing new capacity to deliver additional services to meet local needs, thereby reducing pressure on existing practices, whilst prompting local providers to be more responsive in meeting their patients' needs.

137. The Department has also invested additional resources for every PCT across the country to develop a GP-led health centre that will increase capacity and provide extra access to GP services and extra choice for patients to get the care they want. That is what patients across the country want to see. National surveys of patients demonstrate that there are no PCTs that would not benefit from this additional capacity to improve access and better meet local expectations.

138. The 152 new GP-led health centres are in addition to the existing 8,300 GP practices, and represent additional investment for additional services – more GPs and nurses, more appointments, and longer and more convenient opening hours – to promote better health, better access and provide more convenient care for patients who wish to use these services.

139. The Government has never set a requirement to centralise existing local GP provision, nor are the new health centres in any way intended to replace existing GP services. Patients can choose to register with health centres if they wish, or stay registered with their existing GP practice and use the health centre as well (when they are away from home or when their GP practice is not open).

140. Access to healthcare should not create inequities for particular groups in society. National reports last year, by Professor David Colin-Thome[53] and Professor Mayur Lakhani[54], recommended clear actions for practices and PCTs that will improve access and responsiveness to communities with the poorest experience. A programme bas been established that will support practices and PCTs to deliver the best practice that already exists elsewhere in the NHS.

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[51] WHO (2008) *Report into Primary Health Care*, Geneva

[52] Department of Health (2007) *Our NHS, Our Future: NHS Next Stage Review: Interim Report*

[53] Department of Health (2008) *Report of the National Improvement Team for Primary Care Access & Responsiveness*

[54] Department of Health (2008) *No patient left behind: how can we ensure world class primary care for black and ethnic minority people?*

141. The majority of PCTs are seeking to develop additional services beyond the core requirements that have a strong focus on promoting health, particularly for hard-to-reach groups, and on reducing health inequalities, including for vulnerable groups. Where such services are being developed to meet local needs, PCTs have the support of national frameworks such as the one for older people's mental health. This framework includes the national dementia and learning disabilities strategies[55] and it affirms that access to high quality healthcare for people with learning disabilities is a right, and essential for enabling people to lead healthy, active and fulfilling lives.

142. The Government cannot accept the Committee's recommendation on extending the remit of Sir Michael's review. It has already been agreed that the review will focus on the wider, social determinants of health. The Government will consider healthcare issues as part of its overall commitment to develop a post-2010 national health inequalities strategy.

We also recommend that wherever local primary care services are lost because of the introduction of GP-led health centres, the impact of this on the most needy and vulnerable groups should be carefully monitored by PCTs and steps taken, if necessary, to revert to traditional, more local patterns of service delivery. (Paragraph 220)

143. The Government's aim is to increase local primary care capacity by additional investment in primary care services. However, that does not mean that existing GP provision will remain as it is. There has been a long-term trend, led by GPs, away from single-handed or small practices towards more GPs working together in teams.

144. There are 5,300 more GPs working in the NHS now than in 1997, but there has continued to be an overall reduction in the number of GP practices. Over a quarter of existing practices now have six or more GPs working together in a single team providing a wider and more comprehensive service to local patients. 500 practices have nine or more GPs working in partnership together.

145. The introduction of the extra capacity represented by the new GP-led health centres and additional GP practices will not affect those continuing decisions by the profession to choose how they best configure themselves to deliver care to patients. However, PCTs are expected to work together with local government to review regularly the services they commission to ensure they address the health and care needs of their local population.

General Practice is at the frontline of tackling health inequalities; evidence from QOF data suggests that those practices in deprived areas are performing well in difficult circumstances. QOF has made a start in tackling inequalities, covering most of its major causes but with modest

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55 Department of Health (2009) *Living well with dementia – the National Dementia Strategy; Valuing People Now – the learning disabilities strategy*

targets. However, we were told that the fact that the performance of the GPs in deprived areas had caught up with that of GPs in more affluent areas was a fortuitous 'side effect' of QOF, and that the QOF had not been designed to address health inequalities. We received many suggestions for additions to the QOF points system. It is clear that QOF needs radical revision to fully take greater account of health inequalities and to improve its general focus on the product of patient health. We therefore recommend that tackling health inequalities should be an explicit objective during annual QOF negotiations and that this objective should have measurable characteristics that can be evaluated over time. The QOF should be adjusted so that less weight is placed on identifying smokers and more weight placed on incentives to stop smoking.
(Paragraph 235)

146. The Government welcomes the Committee's recognition of the potential value of the quality and outcomes framework (QOF) to tackling health inequalities. The evidence the Committee received showed there is more to do, given that QOF scores between affluent and deprived areas are small and of relatively little significance.

147. The Department of Health announced the further development of the QOF strategy as part of the NHS Next Stage Review[56] to focus resource on new or enhanced indicators to promote health and greater clinical quality. As part of implementing this strategy, NICE has been asked to oversee a new independent and transparent process for prioritising, developing and reviewing QOF clinical and health improvement indicators from 1 April 2009 as part of their role in providing guidance for the NHS based on evidence of clinical effectiveness and cost effectiveness. A consultation document was published in October 2008 to consult widely with patients, carers, NHS professionals and commissioners on how the new process should work. Over 200 responses were received to the consultation and the response was published on 19 March 2009[57].

148. The phased introduction of a full prevalence adjustment will have a significant impact in incentivising better case-finding and further strengthening the impact of QOF in reducing health inequalities.

149. The Government remains committed to ensuring that existing and new indicators continue to reduce inequalities. NICE's independent QOF advisory Committee will need to consider a number of criteria for prioritising relevant indicators, of which cost effectiveness will be one.

150. It will also consider further whether improvements in exception reporting arrangements could contribute to improving care for more disadvantaged communities.

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[56] Department of Health (2008) *NHS Next Stage Review, Our vision for primary and community care*

[57] Department of Health (2009) *Developing the quality and outcomes framework: proposals for a new independent process; consultation response and analysis*

151. In terms of smoking, the evidence shows that GPs are giving high levels of in-house advice on smoking cessation, and this will help encourage more effective interventions to help smokers quit before they go on to develop disease. NICE will be leading an independent and transparent process for setting priorities for QOF indicators from 1 April 2009.

Primary care is the chief target of most efforts to tackle health inequalities through improving NHS services; however, in solely focusing on this, there is a very real risk that inequalities in other NHS services will persist and that the great opportunities that exist throughout the rest of the NHS to tackle health inequalities will be missed. We heard evidence that the physical health needs of mental health patients are almost entirely ignored by specialist mental health services, leading to shocking health differences between mental health patients and the rest of the population. We find it scandalous that hospital patients – even those hospitalised for smoking-related illnesses – are not being referred to smoking cessation services – this was offered to only one third of smokers in one trust surveyed by ASH. In our view, these examples are likely to represent only the tip of the iceberg in terms of missed opportunities to tackle health inequalities away from primary care. We recommend that the role of secondary care in tackling health inequalities should be specifically considered by Professor Sir Michael Marmot's forthcoming review, and this should include consideration of including tackling health inequalities as part of the Payment by Results framework and/or the Standards for Better Health. (Paragraph 245)

152. The Government agrees with the Committee's view that primary care is crucial in tackling health inequalities but other services – including secondary care services – also have a contribution to make in tackling health inequalities. Sir Michael Marmot's review started work at the beginning of the year. Its remit is around the wider, social determinants of health and their impact on health inequalities. Issues around secondary healthcare will be considered separately as part of the commitment to develop a post-2010 national health inequalities strategy.

153. *Progress and Next Steps* explicitly addresses the links between inequalities in mental and physical health, as do the conclusions of the Next Stage Review. One of the key commitments given in the Next Stage Review final report is that every PCT will commission comprehensive wellbeing services that tackle mental health alongside obesity, smoking, sexual health and drug and alcohol misuse[58]. The guidance for PCTs on vascular checks (and the impact assessment of that guidance) which followed in the wake of the Next Stage Review drew attention to the greater risk of vascular disease for people with a mental illness, and the need to remove the barriers to screening that mental health services users can face.

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[58] Department of Health (2008) *High Quality Care For All*

154. Every opportunity has been taken to concentrate NHS attention, systems and procedures onto the issue. *Progress and Next Steps* and the Next Stage Review final report provide two of the most significant statements of vision and direction. Other examples include:

- guidance accompanying the standard contracts, which stresses the importance of individualised assessments of needs that address service users' physical health, and recommends local arrangements with primary care services to ensure health checks and inclusion in screening and health promotion activity for mental health service users; and

- revised guidance on the Care Programme Approach for people with complex mental health needs, again published last year, which describes a holistic approach covering quality of life, health checks, the physical effects of mental illness and psychiatric treatment, the effect of physical symptoms on mental well-being, smoking and obesity.

155. The Government is committed to increasing the quality and quantity of stop smoking support available in secondary care and to increasing referrals to intensive support from this setting. Guidance with key recommendations for service development in the acute sector has recently been updated[59].

156. NICE is currently developing a tool to help NHS Stop Smoking Services demonstrate the financial and clinical impact of pre-operative stop smoking support services in acute settings to both acute and primary care commissioners. Publication of this tool is expected later in 2009.

157. In terms of stop smoking interventions for smokers with mental health problems, it became a legal requirement for all mental health facilities to be smoke free from 1 July 2008. This presents a particular challenge since smoking prevalence among people with mental health problems is far greater than that of the general population: 44 per cent of the total cigarettes smoked in a nationally representative sample were by those with a mental illness.

158. Although existing evidence on effective interventions for smokers with mental health problems is weak, steps are being taken to develop the evidence and this topic will come under the remit of the NHS Centre for Smoking Cessation and Training. Recommendations for the development of stop smoking support for those with mental health problems have been included in the updated guidance.

159. Payment by Results (PbR) is a way of paying secondary care providers for services commissioned on behalf of NHS patients and the Department of Health has already consulted widely on the future of PbR[60].

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[59] Department of Health (2009) *Service and Monitoring Guidance for NHS Stop Smoking Services 2009/10*

[60] Department of Health (2007) *Options for the future of PbR: 2008-09 to 2010-11*

160. *High Quality Care For All*, signals some important elements for the future development of PbR. New "best practice" tariffs will be introduced in 2010-11 to encourage best practice care, rather than simply reflect current practice. In addition, from 2009-10, providers have the opportunity to secure additional income from PCTs through Commissioning for Quality and Innovation (CQUIN) schemes. CQUIN provides an opportunity for PCTs and secondary care providers to focus on delivering higher quality of care for their populations including by reducing health inequalities. Examples of this work include collecting data

   • to improve the percentage of smokers undergoing elective surgery and young mothers who agree to be contacted by stop smoking services, in order to reduce health inequalities, mortality and morbidity

   • to identify and target the percentage of mothers who are exclusively breast-feeding on discharge from midwifery services broken down by postcode, allowing social class differences to be seen

We have been told repeatedly that the early years offer a crucial opportunity to 'nip in the bud' health inequalities that will otherwise become entrenched and last a lifetime. While there is little evidence about the cost-effectiveness of current early years services, it seems odd that the number of health visitors and midwives, currently the main providers of early years services, are falling, and members of both those professions report finding themselves increasingly unable to provide the health promotion services needed by the poorest families at the same time as the Government reiterates its commitment to early years services. The Department of Health must undertake research to find out the consequences of decline in numbers of health visitors and midwives and to consider whether some aspects of the health promotion role played by midwives and health visitors could effectively be done by other types of staff to bolster early years health services. (Paragraph 258)

161. The Government has already discussed in this response the vital importance of action in the early years to address the long-term consequences of health inequalities. Effective early year's services are crucial, whether delivered through NHS organisations and LAs – such as Sure Start Children's Centres, the provision of childcare and nursery education – or in partnership together. Existing services have been expanded over the last 10 years and important new services have been developed.

162. In terms of the staff numbers of key professionals, the latest data show that the number of midwives increased by 778 whole-time equivalents (wte) or 4.1 per cent between 2006 and 2008[61]. A package of measures was announced in February 2008 to recruit an additional 1,000 midwives by 2009, rising to around 4,000 by 2012, dependent on the birth rate continuing to rise. This increase in the number of births reflects the extra pressures on maternity services in some areas. The Department of Health

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[61] The Information Centre for Health and Social Care *2008 Workforce Census*

will continue to work with SHAs, Trusts and other stakeholders to ensure that sufficient numbers of midwives are in place locally to deliver high quality care in maternity services.

163. The use of appropriately trained and supervised maternity support workers/ maternity care assistants is an integral part of the maternity care team will reduce the time spent by midwives on non-clinical tasks, and may be able to provide general support to the woman, her partner and the midwife to improve their well-being. The key principle in incorporating support workers within the workforce skill mix is to complement not to substitute for midwives.

164. The number of health visitors for 2008 was 8,764 wte, a fall of 292 (3.2 per cent) since 2007. Although health visitor numbers may have fallen, there are more people working in children's services in the community. The total number of qualified nursing and midwifery staff working in community services has increased by 1,909 (3.2 per cent) from 58,835 to 60,744 between September 2007 and September 2008[62]. The way services are organised now means that health visitors are more likely to be working in teams in which support for families is available in more innovative ways, such as in children's centres. Examples of these new ways of working are included in the infant mortality implementation plan[63].

165. The joint DCSF/Department of Health child health strategy, *Healthy lives, brighter futures* highlights the need to increase the health visitor workforce over the next few years[64]. Work is being undertaken as part of the strategy with SHAs, professional bodies and other stakeholders to ensure that appropriate measures are taken to further increase health visitor numbers. This includes a health visitor action programme and the promotion of health visiting as a rewarding career.

Tackling health inequalities across sectors

If, as the Secretary of State told us, the joined up working between the Department of Health and the DCSF is the best in Whitehall, this must mean that elsewhere it is very poor. In our view the DCSF did not display a high level of knowledge about or insight into this area, and it seemed that few attempts had been made at evaluation of the health impacts of DCSF policies to date, suggesting to us that health inequalities are not a particularly high priority on this Department's agenda. (Paragraph 268)

166. The Government challenges the Committee's assertions about joined-up working and the lack of knowledge and insight in DCSF. Tackling

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[62] ibid.

[63] Department of Health (2007) *Implementation Plan for Reducing Health Inequalities in Infant Mortality – A Good Practice Guide*

[64] Department for Children, Schools and Families/Department of Health (2009) *Healthy lives, brighter futures: The strategy for children and young people's health*

inequalities, including health inequalities, is at the heart of the DCSF agenda and the joint working between DCSF and DH. The *Children's Plan* (2007), states the Government's ambition of making this country the best in the world for children and young people to grow up in. It sets out how DCSF and its delivery partners, including health, will tackle the barriers to learning, health and happiness for every child. The *Children's Plan One Year On* (2008), sets out progress made and reaffirms, with priorities for 2009, the need take steps to tackle inequalities in order to achieve this ambition.

167. *Healthy lives, brighter futures* (2009) sets out the vision for supporting young people and their families on health issues. Its four overarching objectives are to secure world-class health outcomes for children and young people, to drive up the quality of services and ensure improvements are reflected in the experiences of services for children, young people and families, and to do more for the most vulnerable to reduce persistent inequalities in health and wellbeing.

168. DCSF will continue to work closely with DH, in the light of Sir Michael Marmot's strategic review of health inequalities, both in terms of how DCSF can tackle health inequalities and, conversely, how health inequalities impact in tackling other areas of inequality such as child poverty – where DCSF, DWP and HMT are jointly responsible.

169. Evidence shows that better educated people enjoy better health, so DCSF's focus on improving educational outcomes will indirectly have a positive impact on health inequalities. Educational standards have been transformed in England over the past decade, attainment levels have risen in every LA – and the most deprived areas have made the biggest gains.

170. DCSF also makes a direct contribution to tackling health inequalities. The Department's Strategic Objective 1 is to "secure the health and wellbeing of children and young people", and DCSF has lead responsibility for delivery of PSA12, "improving the health and wellbeing of children and young people". There is close working with DH at national and regional level in the delivery of this PSA target, including oversight by a jointly chaired DCSF/DH programme board, and on a range of shared policies under other PSAs: 13 (safeguarding), 14 (youth) and 18 (Better Health for All).

171. Specific examples of DCSF's contribution to addressing health inequalities are set out elsewhere in this response, including expansion of the successful Family Nurse Partnership (paragraph 38), Children's Centres and Sure Start (paragraphs 71-86), improving nutritional content and take up of healthy school meals (paragraphs 187-191), improved cooking skills (paragraphs 192-193), as well as introducing statutory PSHE lessons (paragraphs 201-204).

172. In addition to this, DCSF:

- has made a £265 million subsidy available, as part of our funding for extended schools services for 2008-11, to ensure that economically disadvantaged children can benefit from a comprehensive range of exciting, high quality extended services;

- works with the Department for Culture, Media and Sport to deliver the Government's commitment to offering, by 2011, all 5-16 years olds five hours of sport a week. 16-19 year olds will be offered three hours through the PE and sport strategy;

- is improving opportunities for active outdoor play as part of a happy, healthy and enjoyable childhood. The Department has recently overseen the opening of over 500 new or refurbished play areas across England. The 500 play sites are the first part of the first roll out of the £235m play investment announced in the Children's Plan and by 2011 the Government's investment will have created 3,500 new or renewed play areas for children in the areas of greatest need.

- has provided £340m over the three years from 2008-09 to improve outcomes for disabled children through the Aiming High for Disabled Children programme for children's services. *Healthy Lives, brighter futures* set out details of an additional £340m in NHS allocations over the same three year period.

173. The DSCF programme of targeted youth support for young people, focussing on early intervention and prevention of those most at risk, with local agencies working together to help young people realise their full potential. The programme directly contributes towards the delivery of PSA 14, including indicators that have a direct relation to health inequalities (reducing teenage pregnancy and substance misuse) as well as those that have an indirect impact such as reducing numbers not in education, employment or training.

174. DCSF will work closely with DH to implement the recommendations in Lord Laming's review, *The Protection of Children in England: A Progress Report*, to tackle instances of abuse and neglect and to minimise child deaths.

Many measures are now in place to align the objectives of PCTs and LAs towards tackling health inequalities and to promote joined up working. The introduction in some areas of jointly appointed Directors of Public Health is to be welcomed. However, the evidence we received suggested that there is a great deal of work is still needed to translate these objectives into a reality of effective joined-up working between every PCT and its LA, and currently there are no incentives to share data and pool budgets. (Paragraph. 274)

175. The Government shares the Committee's view about the importance of promoting joined-up PCT and LA working and this is being done. Such joint working between NHS organisations and LAs has been at the heart of our approach in tackling health inequalities. This includes engaging

with the available levers and processes to promote joint working, such as LAAs, JSNAs and the first comprehensive area assessments (CAAs) due in November 2009. It also includes working together through joint structures (such as through jointly appointed directors of public health (DPHs) and local strategic partnerships (LSPs), as well as providing support through specific programmes such as the DCLG-sponsored New Deal for Communities.

176. CAA builds on the comprehensive performance assessment that, for the first time from 2005, assessed the performance of LAs in improving the health of their communities and reducing health inequalities. This was instrumental in encouraging LAs to work with PCTs and other partners on health issues.

177. Since 2006, the IDeA has been commissioned to work with LAs and their partners to develop capacity for tackling health inequalities and support local partnership working.

178. The large number of health and well-being priorities selected by LSPs in their LAAs for 2008-11, is a strong indication of partners' commitment to tackling health inequalities and public health issues. In all, 86 LSPs (57 per cent of LSPs) chose to focus on all age all cause mortality, 122 (81 per cent of LSPs) on childhood obesity, 89 (59 per cent of LSPs) on smoking, and 106 on under-18 conception rate (71 per cent of LSPs). All these indicators are in the 12 most popular priorities chosen by LSPs..

179. These measures, together with joint appointments, in particular joint DPHs, have contributed to an increasingly close relationship between health and LAs over the past five years, and are a sound basis for improved partnership working. The greater focus on social care transformation has also led to a strengthening of relationships with directors of adult social care in LAs. The power to pool budgets has been taken up by many partnerships, with LAs receiving £1.1 billion in income from the NHS in 2007/08 as part of pooled arrangements.

180. A long-term evaluation of LAAs and LSPs is being undertaken by a consortia led by Warwick Business School which aims to clarify the effectiveness of current policies.

181. The effective integration of health and social care services is being encouraged, including by the pooling of budgets. Current joint initiatives such as the partnerships for older people projects (POPPs) and the common assessment framework (CAF) encourage joint working, information sharing and better use of shared resources across health and local government. There is also a programme of integrated care pilots, testing and evaluating a range of models of integrated care[65]. This evaluation aims to provide a robust contribution to the evidence base for integrated care, looking at the impact on health outcomes, improved quality of care, service user satisfaction, and effective relationships and systems.

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[65] Department of Health (2008). *The Primary and Community Care Strategy*

Jamie Oliver argued that this country is suffering from 'a new kind of poverty', because many people are now unable to give nutritious meals to our families. We were disappointed that the Secretary of State's response to this – advocating simple health promotion messages – underestimated the challenges of removing the barriers to healthy eating, particularly for more disadvantaged groups. In reality, those people need cheap and convenient access to healthy food, rather than a multiplicity of takeaways on their high street; they need easily comprehensible nutrition labels on the food they buy; and they need the skills to cook healthy meals. Children need a guarantee of at least one healthy meal a day. (Paragraph 293)

182. The Government recognises the importance of this issue and has made promoting good nutrition and tackling obesity a key priority – a central theme of the national obesity strategy is to the promotion of healthier food choices[66].

183. The Department of Health is working with the Association of Convenience Stores to help promote the availability of fruit and vegetables in deprived areas, and situate these products in prominent positions in stores to help encourage people to make healthier choices and achieve their 5-A-DAY. The initial results of a pilot scheme are encouraging, showing an increase in sales of fruit and vegetables and a positive change in consumer attitudes. The plan is for 120 stores to be involved across the North East by May 2009, followed by a national rollout over the next two years.

184. The number of fast food takeaways on the high street is a cause for concern. Local planning authorities are able to influence these outlets through policies in their development plans provided they are supported by a strong evidence base, and the Use Classes Order[67]. An amendment to this order in 2005[68] tightened planning control in relation to such outlets. Waltham Forest is an example where local action to restrict such outlets is taking place. In addition, as part of the preparation of local development frameworks, PCTs should be discussing with local planning authorities, ways to reflect the wider issues of obesity and overall health in their planning policies.

185. The Government understands the importance of cooking skills in enabling children and families to adopt a healthier diet, and this work has focused on giving schoolchildren practical opportunities to learn to prepare and cook a healthy meal.

186. In terms of health in schools and nutrition labelling, these issues are discussed below in response to the Committee's specific recommendations.

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[66] HM Government (2008) *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England*

[67] The Town and Country Planning (Use Classes) Order 1987 (as amended)

[68] The Town and Country Planning (Use Classes) (Amendment) (England) Order 2005

We welcome recent improvements in school meals, but we remain concerned about their low rates of take-up, and also about the lack of any data about whether the poorest children are benefiting from a healthy meal. We recommend that the DCSF closely monitors take-up of school meals and analyses this by socio-economic group. (Paragraph 294)

187. The Government welcomes the Committee's acknowledgement of the recent improvements in school meals and it has taken a number of steps to improve the take-up of school meals – such as through the Million Meals campaign – and, in particular, the take-up of free school meals (FSM) for the most disadvantaged children.

188. The School Food Trust (SFT) undertook focus group research with pupils to understand what deters eligible pupils registering for, and taking up, FSM and how best to reverse this. The results informed the development of learning support groups to address these issues across the country from September 2008. In addition, the intention to pilot extending FSMs across a number of local areas has been recently announced[69]. This will help look at the health and educational benefits of extending FSMs for all primary pupils, and for a wider group of low-income pupils across the age range. These pilots will be evaluated for evidence on:

- how each option affects take up of school lunch

- the impact of take up on children's outcomes including diet at school and at home, health, behaviour and attainment

- the value for money of expanding the offer of FSMs, based on a comparison of the costs and benefits

189. In terms of monitoring the national take-up of school meals, the delivery of school meals is complex and can be achieved through a number of possible providers. Schools and private contractors are being asked to cooperate with their LAs in order to get a full picture of take up to provide the SFT with data it for its annual school meals survey.

190. The SFT carries out this survey at the request of DCSF. To date, participation in has been voluntary but from this year, all LAs are required to complete the survey. The survey provides raw data for collating the national school lunch take up figure, which is part of the National Indicator Set (NI 52). It would not be feasible within the annual survey to ask LAs to request take up data from schools by socio-economic group. Such data is not available at pupil level within schools, and could not be reported at school level without undermining the robustness of the annual survey as it would be a significant additional burden on schools at a time when efforts are being made to reduce them.

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[69] Department for Children, Schools and Families, *Local Authorities to Bid for Free School Meal Pilots*, Press release: 15 January 2009

191. However, the Government will explore with the SFT the possibility of using the Index of Multiple Deprivation, or the DCSF indicator of education-related socio-economic differences, as a basis for aggregating data to look at differences in characteristics by socio-economic group.

Cooking lessons are to be made compulsory, but, unlike in other practical lessons such as science where equipment is provided, pupils will need to buy and bring in their own ingredients. We think it is likely that many pupils will fail to do this. The Government's approach seems to confirm that the proposed cooking lessons are still seen as an 'added extra', rather than a government priority. We recommend that free ingredients be provided for all school cookery lessons. (Paragraph 295)

192. The Government does not regard school cookery lessons as an added extra. It has emphasised the importance of developing cooking skills in school as an important way of tackling obesity and improving nutrition for the next generation, and in tackling health inequalities.

193. In February 2009, a contribution of £2.5 million towards the cost of ingredients for pupils on FSMs was announced in recognition of the importance of this issue. This funding will be available in 2011, when cooking becomes compulsory for all 11-14 year olds. The possibility of a partnership with supermarkets is also being explored as part of this work.

We are appalled that, four years after we recommended it, the Government and FSA are continuing to procrastinate about the introduction of traffic-light labelling to make the nutritional content of food clearly comprehensible to all. In the light of resistance by industry, and given the urgency of this problem, we recommend that the Government legislate to introduce a statutory traffic light labelling system. This should apply to food sold in takeaway food outlets and restaurants as well; currently food purchased from such outlets, despite often being very high calorie, does not have any nutritional labelling at all. (Paragraph 296)

194. The Government is continuing to address this issue and is committed to introduce front of pack (FOP) labelling that can be easily understood, and used, by consumers to make healthier choices. The obesity strategy challenges the industry to implement a healthy food code which includes delivering a single, simple and effective approach. The code also challenges businesses to provide nutrition information in restaurants and other "out of home" settings. The focus is on encouraging voluntary action. However, the case for a mandatory approach will continue to be examined where this might produce greater benefits.

195. The Food Standards Agency (FSA) has a comprehensive consumer research evidence base to determine how to:

- make healthier eating easier for consumers

- enable consumers to make healthier choices at a glance

- present nutrition information in a way which is clear and understood by as wide a range of consumers as possible (particularly with respect to age, socio-economic and ethnic group)

196. The FSA recommended a voluntary, principles-based, FoP labelling approach that included traffic light colours[70] in March 2006. By March 2009, FoP labelling use has become widespread in the UK. There are three approaches: traffic lights; monochrome formats giving percentage of a Guideline Daily Amount (GDA); and GDA/traffic light hybrids. Nine retailers, 31 manufacturers, five service providers and one restaurant use traffic light colours, or a GDA/traffic light hybrid.

197. The FSA funded an independent evaluation of the effectiveness of the three approaches in helping consumers to make healthier choices. The evaluation also examined whether having more than one approach in the market causes difficulties for consumers.

198. The findings from this evaluation were published, following peer review, on 6 May 2009[71]. The FSA's recommended principles for front of pack nutrition labelling will be revised in light of the evaluation's findings. Consideration will also need to be given to the European Commission's proposal for a new Food Information Regulation[72], which includes provision to introduce mandatory nutritional labelling.

199. An FSA survey in June 2008 found that 85 per cent of consumers agreed that restaurants, pubs and cafes have a responsibility to make clear what is in the food they serve. More than 80 per cent of respondents said that nutrition information would be most useful if provided at the point they choose or order food, such as on menus or menu boards.

200. The FSA is working with 19 companies who have agreed to introduce calorie labelling at point of choice by summer 2009. This includes workplace caterers, sit-down and quick-service restaurants, theme parks and leisure attractions, pub restaurants, cafes and sandwich chains. Independent research will assess how easily customers understand and use the system and gather feedback from the restaurants themselves to look at practical issues and the costs involved in providing the information. Gathering this data will inform the next steps for a wider roll-out of calorie labelling on menus.

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[70] www.food.gov.uk/news/newsarchive/2006/mar/signpostnewsmarch

[71] FSA (2009) *Comprehension and use of UK nutrition signpost labelling schemes*; http://www.food.gov.uk/news/newsarchive/2009/may/pmp

[72] Proposal for a Regulation of the European Parliament and of the Council on the provision of food information to consumers COM (2008) 40 final, (http://ec.europa.eu/food/food/labellingnutrition/foodlabelling/publications/3359-en.pdf)

We are pleased that, five years after we recommended it, Personal Social and Health Education (PSHE) is finally being made a statutory part of the national curriculum. However, we still have the same concerns we had five years ago about the lack of specialist teachers and assessment in this area; pupils should have PSHE taught by someone who has received appropriate training, whether this be a teacher, health visitor, school nurse, or even a peer educator. In our view OFSTED should carry out an early review of implementation of PSHE, which should include who it is being taught by. We are also concerned that elements of PSHE may remain at the mercy of 'local discretion' and that schools will be given the option to opt out of certain elements, much as one school, shockingly, has already opted out of providing its pupils with the HPV vaccine.
(Paragraph 317)

201. The Government welcomes the Committee's acknowledgement that PSHE education is being made part of the national curriculum. PSHE education is a planned programme of learning opportunities and experiences that equips children and young people with knowledge, understanding and practical skills to live healthy, safe, fulfilled and responsible lives. It encourages young people to be enterprising and supports them in making positive education and career choices and in managing their finances effectively. It covers a range of issues central to children and young people's lives including: drugs, alcohol and tobacco, emotional health and wellbeing, sex and relationships, nutrition and physical activity, personal finance, safety, careers and work related learning.

202. The intention to make PSHE statutory was announced in October 2008. At the same time, an independent review was launched to consider how the principle that PSHE education should have a statutory status can be translated into a practicable way forward. Sir Alasdair Macdonald, the Head Teacher of Morpeth School in Tower Hamlets, led the independent review and reported on 27 April 2009[73]. Ministers accepted all his recommendations, although those that relate to legislation are subject to public consultation commencing 30 April 2009. Due to the need for a full public consultation, and Parliamentary process, statutory PSHE is unlikely to come into effect before 2011.

203. In terms of training, £2 million is provided each year to train teachers and professionals who deliver PSHE education. Over 9,600 teachers and community nurses have participated or are participating in the PSHE Continuing Professional Development programme. The Training and Development Agency for Schools is working with DCSF to develop a specialist route for PSHE education teachers through Initial Teacher Training.

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[73] Macdonald, Sir A (2009) *Independent Review of the proposal to make Pesonal, Social, Health and Economic education statutory*, DCSF

204. In the Secretary of State's response to the MacDonald review, it was agreed to take forward those recommendations that do not require legislation or public consultation immediately.

We were told by the DCSF of apparently successful initiatives to provide wider health and support in schools, such as Extended Schools and Healthy Schools initiatives. However, we were deeply concerned that no evaluation has yet been published of the Healthy Schools initiative, despite it now being in its tenth year of operation, and that claims of success are based on whether or not schools report finding the programme 'positive', while levels of childhood obesity, teenage pregnancy and smoking are persistently high. If the Government wishes to claim that the DCSF is actively engaged in the health inequalities agenda, it must be prepared to back this with hard evidence of whether policies are actually influencing health outcomes, together with information on their costs and cost-effectiveness. We recommend that the DCSF and the Department of Health collaborate to produce quantitative indicators and to set targets for the Healthy Schools programme at the earliest opportunity. (Paragraph 318)

205. The Government agrees with the Committee about the need to evaluate the healthy schools programme. The Department of Health and DCSF have jointly commissioned the National Centre for Social Research to conduct a three-year study exploring the impact of the healthy schools programme. It includes surveys of schools and pupils to assess the impact of the programme. There will also be in-depth work with a sub-sample of schools to explore programme implementation and how it is affecting pupil outcomes. The objectives of the evaluation are to:

- measure impact of the programme on behaviour, knowledge and attitudes of pupils

- explore the mechanisms by which impacts are achieved or obstructed

- identify areas of good practice and areas where the programme can be improved

206. The interim report from the first year's evaluation was published on 12 May. Early findings show that schools are using the programme to extend their focus on health and that there are early signs that schools who participate do better on a range of school outcomes. The findings are informing the direction of the programme as it moves into a new phase.

207. The development of healthy schools – or health promoting schools – was advocated in the Acheson report. The national healthy schools programme was set up as pilot partnerships between education and health authorities in 1999 to provide the context for a healthy environment from school communities before being rolled out as a jointly sponsored Department of Health/DCSF programme the following year. An early evaluation noted

the positive impact the programme was beginning to have on health and wellbeing, particularly in disadvantaged areas[74].

208. The Department of Health and DCSF have worked together on the development of the programme and have set challenging targets for the healthy schools programme for December 2009 of 100 per cent participation amongst schools and 75 per cent achieving status. As at March 2009, the programme has 98 per cent of schools participating and 72 per cent achieving status. To achieve status, schools will schools will have demonstrated to a local authority/PCT independent quality assurance group that they met the 41 criteria that cover all of the 4 core themes – healthy eating, physical activity, PSHE education, and emotional health and well-being.

209. In developing work for the enhanced healthy schools programme, the two departments are continuing to work together to roll-out the programme in September 2009, with new targets and indicators of school health outcomes.

The built environment has crucial impact on health and health inequalities and affects every aspect of our lives. We are concerned that it does not encourage good health. Particular problems raised with us were:

- **The built environment often discourages walking and cycling;**

- **High streets are awash with fast food outlets but have too little access to fresh food;**

- **Flagship health centres have been located at random with little systematic consideration of access or need; London PCTs have recently announced that they will evaluate the first of their polyclinics to see whether they are making a difference to healthcare and access, and this would seem to be an ideal opportunity to evaluate their impact on health inequalities.** (Paragraph 340)

210. The Government agrees with the Committee about the impact the built environment can have on health and health inequalities. Progress can be made by highlighting the links and benefits to physical and mental health well-being flowing from good design and coordination of activities through the spatial planning system.

211. At a national level, the Department of Health and DCLG work together to ensure that new or revised national planning policy and guidance to help ensure health benefits flow from developments in the built environment. These benefits would include tackling obesity and health inequalities, and supporting healthy communities. For example, the draft planning policy

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[74] Thomas Coram Research Unit/National Foundation for Education Research (2004) Evaluation of the Impact of the Healthy School Standard ñ Research Summary

statement on Eco Towns included a number of health related standards to promote healthy and sustainable environments and enable residents to make healthy choices easily. Planning applications for these towns should set out progress in and plans for working with PCTs and LAs to address the provision of health and social care.

212. NICE have produced guidance on promoting physical activity for children and young people as well as promoting physical activity in the workplace.

213. Public health officials at SHA level are engaging with regional planning bodies to incorporate health policy in the regional plans. However, at local level, it is recognised that much more needs to be done to achieve more tangible benefits from the built environment. Progress is being made by LAs and PCTs through the use of LAAs and JNSAs but the incorporation of health-related policies in local development frameworks remains patchy.

214. Specific issues, such as controlling the extent of fast food outlets through the planning system are now being tackled and local planning authorities (LPAs) are able to put local policies in place where they wish to control these outlets.

215. The Government has considered the Committee's recommendation for a separate planning policy statement for health. The Department of Health and DCLG have agreed to jointly commission "robust evidence on how our objectives to improve the nation's health and wellbeing (e.g. through tackling obesity and the promotion of greater physical activity), to provide better access to health and social care services, and to tackle health inequalities are being delivered locally from a spatial perspective…. This evidence will provide the basis for consideration of any actions it should take to support better local delivery, focusing on the health and wellbeing delivery chain, including its spatial component"[75].

We are disappointed by Government priorities which, according to its own Foresight Obesity team, seem more concerned with promoting gym membership than promoting active travel through redesign of the built environment which would have been far more effective for all socio-economic groups. (Paragraph 341)

216. The Government recognises, with the Committee, the effect that the built environment has on health, particularly for people living in disadvantaged areas. The national obesity strategy set out our plans to help people to maintain a healthy weight. As part of this strategy, there is a focus on how to create an environment that enables people to be active as part of their everyday life.

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[75] HM Government (2009) *Healthy Weight, Healthy Lives: One Year On*

217. Following a rigorous selection process, nine "Healthy Towns" have been designated, sharing £30 million in investment. These towns will develop and implement ideas on how to make activity and healthier food choices easier for local communities. Initiatives to encourage people to walk and cycle have been taken forward through improvements in the infrastructure, for example in the 18 cycle demonstration towns and cities funded by the Department of Health and the Department for Transport (DfT) through Cycling England. In addition, the physical activity plan sets out our aim of encouraging active travel through improvements in the environment[76].

218. Further proposals from creating a healthier built environment to offering greater opportunities for active travel have been published[77]. This includes encouraging LAs to deliver active travel initiatives through the next round of transport plans.

In our view, health must be a primary consideration in every planning decision that is taken, and to ensure that this happens, we recommend that

- **in collaboration with the Department of Health, DCLG should publish a Planning Policy Statement on health; this Statement should require the planning system to create a built environment that encourages a healthy lifestyle, including giving local authorities the powers to control the number of fast food outlets.**

- **PCTs should be made statutory consultants for local planning decisions; PCTs, for their part, need to ensure they have the knowledge of cost effectiveness of alternative policies and resources to make an informed contribution to such decisions.** (Paragraph 342)

219. The Government agrees with the Committee that health is an important planning issue and recognises that this is assisted by effective partnership working between PCTs and local planning agreements (LPAs) is important at all levels. Having a good relationship with a LPA means that a PCT can discuss the impact of proposed developments on the health and well being of the local population as well as on existing and future healthcare provision. Consideration can be given to how best to tackle health inequalities and regenerate the most deprived areas with the poorest health. For example, NHS Tower Hamlets and Liverpool PCT have been successful in joint working with their local council to ensure that health service policies are included within the development plans. Further the NHS in London has secured over £10 million for additional health facilities through the planning process.

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76 HM Government (2009) *Be Active, Be Healthy*

77 Department of Health (2009) *Healthy Weight, Healthy Lives: One Year On*

220. PCTs are a specific consultation body for planning purposes. This change of status came into effect in May 2008, when the Town and Country Planning Regulations were changed[78]. Similar specific consultation status has been given to SHAs in respect of the regional planning process. While consultation status is useful, progress will be made only by PCTs being proactive and actively engaging with local planning authorities. Where PCTs have challenged planning policies and applications, public health and other benefits for the local community have been achieved.

221. The Department of Health is to be the Consultation Body for Strategic Environmental Assessment on human health impacts. Responsible authorities will, in developing plans with a significant effect on the environment – such as spatial plans, transport, waste and housing – have to consult the Department on the likely human health impact of these plans. The Department will set up a health inequalities assessment "gateway" to cover the national, regional and local plans and programmes that set the framework for development consent. The areas covered are health protection, health promotion and prevention. Responses on health impacts will be made by the PCT or relevant NHS organisation.

222. The Department has held initial discussions with DCLG regarding separate national planning guidance on health and social care. It was agreed to review the available evidence of how spatial planning can assist achieving our health and social care objectives as part of this work. This commitment to developing evidence link with health, wellbeing and planning outcomes will be reflected in forthcoming work to assess "how these objectives are articulated within development plans; the linkages between local sustainable community strategies, LAAs and development plans; and the extent to which these, when taken together, effectively promote key health outcomes"[79].

We recommend that the Government increase the proportion of the transport budget currently spent on walking and cycling. (Paragraph 343)

223. The Government welcomes the Committee's recommendation on walking and cycling. It is already investing significantly in walking and cycling through the funds made available to LAs through local transport plans. The Government is clear about the need for additional investment in walking and cycling and has committed to encouraging local authorities "to deliver active travel initiatives through the next round of Local Transport Plans"[80].

224. Government departments are working closely to promote walking and cycling as "everyday" forms of physical activity for families and the wider

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[78] The Town and Country Planning (Local Development) (England) (Amendment) Regulations 2008 (Statutory Instrument 1371)

[79] Cross-Government Obesity Unit (2009) *Healthy Weight, Healthy Lives: One Year On*

[80] ibid.

population. A range of programmes that aim to increase levels of active travel across all ages are already in place.

225. Advice and guidance is also being provided – for example the *Manual for Streets* (2007) – to help LAs make the most of the investment they do make. The economic benefits of cycling are also emphasised through a health economic assessment tool (HEAT) and *Planning for Cycling* (Cycling England). More can be done but other investment, such as that around road safety, can also encourage more walking and cycling.

226. A £140 million, three year programme to promote cycling nationally has been launched, administered by Cycling England. This includes investment in 18 demonstration towns and cities, and will provide "Bikeability" cycle training for 500,000 children by 2012. Resources have also been made available from other sources, for example, the lottery has invested in the national cycle network and currently supports the active travel consortium and private sector sponsorship is also increasing.

227. A detailed evaluation of DfT investment in cycling has been commissioned to assess those interventions that have the greatest impact and to help guide investment.

228. Increasing levels of walking is being addressed and Government, working with other bodies, is investing in a range of measures including:

- working in partnership with Natural England to significantly expand the Walking the Way to Health scheme that already benefits some 30,000 people each week.

- funding an audit of schools walking schemes to identify successes and gaps in provision.

- working with the WHO Regional European Office and UK partners to fund and develop a health economic assessment tool (HEAT) for walking, which will help assess the merits and cost-effectiveness of proposals on walking. This will complement and sit alongside the HEAT for cycling.

- implementing a families pilot walking project to assess ways of stimulating everyday walking in community settings.

Smoking remains one of the biggest causes of health inequalities; we welcome both the Government's ban on smoking in public places, and its intention to ban point of sale tobacco advertising, as evidence suggests that both of these measures may have a positive impact on health inequalities. However, tobacco smuggling, by offering smokers half price cigarettes, negates the positive impact of pricing and taxation policies. Tobacco smuggling has a disproportionate impact on the poor, particularly young smokers. Some progress has been made in this area but not enough; there has been no progress at all in reducing the

market-share of smuggled hand-rolled tobacco, which is smoked almost exclusively by those in lower socio-economic groups. We recommend the reinstatement of tough targets and careful monitoring now this crucial job has passed to the UKBA, to ensure that it remains a sufficiently high priority. We also recommend that the UK signs up to the agreements to control supply with the tobacco companies Philip Morris International and Japan Tobacco International as a matter of urgency. (Paragraph 355)

229. The Government shares the Committee's view that smoking remains one of the biggest causes of health inequalities. The crucial importance of reducing smoking for health and health inequalities has been recognised for at least the last 10 years, as is clear from the succession of programmes from *Smoking Kills* (1998) to the smoke-free legislation that came into force in 2008. The Government welcomes the Committee's support for this ban and for the intention to ban point of sale advertising.

230. Smoking remains the leading cause of preventable mortality and morbidity in England, with large numbers of smokers often concentrated in the more deprived communities and exposed to well-established health risks. As such, smoking plays a major role in causing health inequalities, accounting for up to half of the entire mortality differential between social classes.

231. Current smoking rates in England are 21 per cent overall, and 26 per cent for people in the routine and manual (R&M) groups. Smoking prevalence is highest in deprived communities. Progress against the PSA target for R&M smokers (reduction from 33 per cent in 2001 to 26 per cent in 2010) has historically been slower relative to that of other population groups. Smoking is also a major contributor to infant mortality. Smoking in pregnancy is a major public health problem, which is highly relevant to tackling health inequalities and infant mortality. Women who smoke are less likely to carry their babies to full term and there is a 26 per cent increased risk that they will miscarry or experience a stillbirth[81]. And, in terms of prevalence is one and a half times higher in R&M pregnant women than the population as a whole.

232. The Government will give serious consideration to the Committee's comments on smuggling and the international tobacco control agreements, as part of the development of a new tobacco control strategy during 2009.

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81 Poswillo, D and Alberman (1992) *Effects of smoking on the fetus, neonate and child*. OUP

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