

Healthcare for London: a Framework for Action

Staying Healthy Working Group Report

Introduction

This report presents the contributions of the Staying Healthy Group to the strategy *Healthcare for London: a Framework for Action*. The Group met three times (on 31 January 2007; as a workshop at the *Healthcare for London* Conference on 19 February; and on 8 March). Using the framework adopted at those meetings, our report sets out the rationale for change and makes recommendations for action to improve physical, mental and emotional health and well-being and to reduce health inequalities.

Although the primary output of the Group has been advice and recommendations to those drawing up *Healthcare for London*, a strategy for a redesigned healthcare system, there is also an opportunity for the Group to influence more widely through the Mayor's Health Inequalities Strategy.

This work is directly based on evidence from the extensive experience of the members of the Group. Although reference is made to the policy and research literature, the report does not claim to be systematically evidence-based.

Background and Framework

Prior to the 2002 Spending Review, Derek Wanless was asked to assess 'the financial and other resources required to ensure the NHS can provide a publicly funded, comprehensive, high quality service on the basis of clinical need and not ability to pay'.

The Wanless Report¹ set out three scenarios for the future - the optimum 'fully engaged' scenario being one in which the level of public engagement in relation to health is high, life expectancy goes beyond current forecasts, health status improves dramatically, use of resources is more efficient and the health service is responsive with high rates of technology uptake. The fully engaged scenario was the cheapest option modelled and delivered the best health outcomes. Further Wanless reviews in 2003² and 2004³ set out the challenges to implementing the fully engaged scenario, concluding that greater investment in public health was

¹Wanless D. *Securing our Future Health: Taking a Long-Term View*. HM Treasury London: HMSO, 2002

²Wanless D. *Securing Good Health for the Whole Population: Population Health Trends Report* [Interim Report]. London: HMSO, 2003

³Wanless D. *Securing Good Health for the Whole Population: Final Report*. London: HMSO, 2004

needed and should be targeted at interventions where the long-term impact on poor health would be greatest.

In light of these recommendations, the Group defined its remit broadly to embrace the full span of public health action. Accordingly it adopted a framework of six, inevitably overlapping, themes agreed at the first meeting of the group:

1. Tackling health inequalities

Overtly and proactively addressing London's entrenched health inequalities. This is a core cross-cutting theme, both for the Staying Healthy Workstream and for the Healthcare Strategy as a whole.

2. Population-level interventions across the broader public health canvas

This theme covers population-focused approaches and the development of healthy and sustainable local communities through, for example:

- Influencing policy formulation and implementation to address the broader determinants of health, for instance discouraging car use and improving facilities for walking and cycling; and influencing the built environment and housing to improve the public's health;
- Partnership working across the NHS, local government and the private and voluntary sectors, including joint strategic planning to meet health needs;
- Commissioning for health improvement and health and social care services; and
- Community development and action.

3. Public health programmes and pathways focused at the level of the individual

This covers interventions undertaken specifically for the purpose of improving the health of individuals, for example, smoking cessation or screening services.

4. Health improvement as an integral element of all healthcare services

This theme means services seeing patients as 'whole people', with health promotion and prevention actively built in to every part of any patient journey and core, everyday business for everyone providing health and care services. Linked to this is recognition of the integral part that other sectors – like social care, education, housing – can play in providing effective, responsive patient-centred health services.

5. Health protection

Communicable disease and infection control and resilience and emergency preparedness, which are important cross-cutting concerns for the Healthcare Strategy.

6. Corporate social responsibility of health services

Achieving health gain and sustainability through the raft of areas where the NHS has social, economic and environmental impact, for example through employment practices and the use of capital and procurement.

The recommendations and proposals that follow therefore range from specific advice about prevention and health promotion through to cross-cutting and broadly contextual concerns for the Healthcare Strategy as a whole.

Local authorities and other partners have a substantial role to play across the full breadth of this framework. However, the majority of the members of the Group were from the health sector. Broader engagement will be crucial in taking this strategy forward.

London

London is a city characterised by the diversity of its population and by stark contrasts in health and opportunities for health. Tower Hamlets, Hackney and Islington are amongst the ten most deprived local authorities in England, whereas others are amongst the best off.⁴ Many Londoners are living in poor housing (184,000 London homes are judged to be unfit to live in; one in twenty households are overcrowded)⁵ and in poverty (41% of children in London are living in households below the poverty line).⁶

A key characteristic of London is that it is highly ethnically diverse, with 40% of the resident population from a minority ethnic group (including White Irish and Other White minority groups).⁷ More than 90 different ethnic groups live in the city and 300 different languages are spoken. Both the number and the proportion of minority ethnic Londoners will continue to grow.

Population migration has always been a feature of London. However, mobility and population turnover has been increasing and this trend is expected to continue, with profound implications for health and services.⁸ Mobility can be considered in terms of international migration, movement within the UK and movement within London. There has been an increase in overseas migration to London, resulting in a net inflow of over 100,000 per annum. In 2004 London received 37% of all in migrants to the UK. The background of in-migrants will

⁴ London Health Observatory. *Health and Healthcare in London – Key Facts*. September 2006. <http://www.lho.org.uk>

⁵ London Health Commission. *Health in London: Looking Back Looking Forward. 2006/07 Review of Trends, Progress and Opportunities*. GLA March 2007. <http://www.londonhealth.gov.uk/hinl.htm>

⁶ Households Below Average Income, 3 year average 2003/04-2005/06, Department for Work and Pensions

⁷ London Health Observatory. *Health and Healthcare in London – Key Facts*. September 2006

⁸ *Population Mobility and Service Provision: A Report for London Councils* LSE London February 2007

vary, from the affluent to poorer economic migrants, refugee and asylum seekers and the homeless.

Mobility will have an impact on access to services - in particular, frequent movers have low registration levels with GPs, may not be aware of services available or how to contact them and language and translation needs may not always be met. This may be especially true for specific groups such as the homeless, asylum seekers and those with acute mental illness. Around 15% of London households had been at their current address for less than a year compared to 11% nationally; and there is a 20-40% turnover on London GP lists every year.⁹ Population mobility is a factor in low coverage rates for preventative services such as immunisation and cancer screening; and new migrants and homeless households tend to be high users of accident and emergency services. Aside from the direct effect on accessing health services, the mobile population is more likely to have adverse experiences of the wider determinants of health, such as education, housing and employment.

Whilst, on average, health in London does not compare too badly with the rest of the UK, there are unacceptable inequalities between different population groups and within and between boroughs. Overall, life expectancy is similar in London to nationally, but this masks significant differences across the city. Kensington and Chelsea has the highest life expectancy in England, but as one travels by Underground on the Jubilee line from Westminster to Canning Town, each of the eight stops represents nearly a year's drop in life expectancy. Similarly, the infant mortality rate varies considerably across London despite London, on average, having a similar rate to England (5.4 and 5.2 per 1000 live births, respectively). The rate in Haringey (8.1) is three times that in Richmond (2.7).¹⁰

Premature deaths (under the age of 75 years) from heart disease and stroke are higher in London (97 per 100,000) than England as a whole (90 per 100,000), with the lowest London rate (in Bromley, 64 per 100,000) more than double the highest (in Newham, 146). Perhaps more worryingly, mortality is falling more slowly than in England in some of the areas with the highest rates, implying that inequalities may well widen.¹¹

1 Tackling health inequalities

Tackling health inequalities has been identified by the Government as a key priority, most recently in the White Papers *Choosing Health*¹² and *Our Health*,

⁹ London Health Observatory. *Health and Healthcare in London – Key Facts*. September 2006. <http://www.lho.org.uk>

¹⁰ *Community Health Profile*. Association of Public Health Observatories and DH, June 2007. <http://www.communityhealthprofiles.info>

¹¹ London Health Observatory. *The London Health Inequalities Forecast*. November 2006

¹² Department of Health. *Choosing Health: Making Healthier Choices Easier*. London: TSO, 2004

*Our Care, Our Say.*¹³ Targets have been set nationally for reducing health inequalities in life expectancy and infant mortality, which aim to narrow the gap between the national average and districts falling into the bottom fifth of districts with the worst health and deprivation indicators, the 'Spearhead group'. Nationally there are 70 such areas, 11 of which are in London. National health inequality targets have also been set for the major causes of premature death, cancer, heart disease and stroke.

The London Health Observatory has recently analysed trends in life expectancy and mortality to see if in London the 2010 targets will be met.¹⁴ In overall terms the Spearhead group in London, if current trends continue, will achieve the national target for life expectancy, for both women and men. However this masks differences at an individual Spearhead borough level, where the life expectancy inequality gap is predicted to widen: for men in two boroughs, for women in five boroughs. Of the major causes of premature mortality, London is predicted to be on target for cancer. However, the inequality gap is widening for heart disease and stroke.

National Health Inequalities Targets

The health inequalities Public Service Agreement target is to reduce health inequalities by 10% by 2010 as measured by infant mortality (1997-99 baseline) and life expectancy at birth (1995-97 baseline). This is supported by two specific objectives:

- Starting with local authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.
- Starting with children under one year, by 2010 to reduce by at least 10% the gap between the 'routine and manual' socio-economic group and the population as a whole.

The Government has announced proposals for additional powers for the Mayor and the Greater London Authority (GLA), including new duties for the Mayor to promote a reduction in health inequalities, in addition to his current responsibility to promote improvements in the health of Londoners. This will include developing a statutory pan-London health inequalities strategy, working with stakeholders across the city. Our expectation is that the Mayor's Health Inequalities Strategy will be the principle vehicle for tackling inequalities by addressing the wider determinants of health through political, environmental, social, economic and community action.

¹³ Department of Health. *Our Health, Our Care, Our Say: a New Direction for Community Services*. London: The Stationery Office, 2006

¹⁴ London Health Observatory. *The London Health Inequalities Forecast*. November 2006

However, the Healthcare Strategy has an important contribution to make, especially in terms of access to services and outcomes through, for example, tailoring services to meet diverse needs. Left to its own devices, 'personalised care' will always deliver a better deal for articulate middle classes. Any market needs to be firmly managed to prevent this and a universal personalised and fair service will always need to make extra effort to reach those at most risk.¹⁵ Furthermore, outreach services, including prevention initiatives, struggle to establish contact with hard-to-reach groups.

RECOMMENDATIONS AND PROPOSALS

1. **The Healthcare Strategy should make reducing health inequalities an overtly stated goal**, with the fundamental underpinning principle that access to services must be fair and equitable and based on need and on ability to benefit. London needs a deliberate and explicit strategy to tackle health inequalities backed up by a resource allocation mechanism, linked with Local Area Agreements, that moves money from well-resourced (and relative to health need, over-resourced) affluent areas to those with the greatest health needs.
2. **The Strategy will need to strike the right balance between, on the one hand, setting a 'one vision for London' blueprint for services, which risks increasing the health inequality gap; and, on the other hand, targeted and tailored approaches**, recognising that the diverse population of London – with diverse opportunities and health needs – calls for diverse approaches and service models. We need *both* inclusive universal services *and* services tailored to those who are marginalised or who have particular needs. For example, getting services right for older people is largely about universal services that prevent and adequately address 'modern' conditions like stroke, falls and dementia for everyone. But if we seriously want to tackle inequalities, we would also need to shape these services to best meet the needs of marginalised groups; and where necessary provide additional tailored, including outreach, services.

More specifically, the Group cited a number of examples where there is a powerful case for pan-London approaches and specialist services, including primary care for certain excluded groups, such as the homeless.

3. **In recognition of the risk that the Healthcare Strategy itself may actually inadvertently promote widening of the health inequality gap, it is proposed that a 'health inequality impact assessment'^{16 17} be**

¹⁵ See for example Tudor Hart, J. The inverse care law. *Lancet*,1:405-412 1974 (1971)

¹⁶ Ison E. *Resource for Health Impact Assessment*. NHS Executive London, 2000.
<http://www.londonhealth.gov.uk>

¹⁷ NICE. *Rapid Appraisal Tool for Health Impact Assessment: A Task Based Approach. Eleventh iteration*. January 2002. <http://www.nice.org.uk/page.aspx?o=525148>

carried out on the emerging Strategy itself. It is also recommended that local systematic use of health equity audits and health inequalities impact assessments be required as an integral part of the ensuing detailed redesign of London's healthcare system.

4. **The overt link with the forthcoming Mayoral Strategy on Health Inequalities is strongly supported** and the Group would wish to see its own analysis and proposals, as set out in this report, picked up within that Strategy. It is also proposed that the Staying Healthy Group members be invited to contribute to the early thinking on the Mayor's Health Inequalities Strategy, helping to ensure that the Healthcare Strategy and the Health Inequalities Strategy promote the same high-level overarching vision for health in London.

5. **The physical, mental and emotional health and well-being of children and young people should be a priority**, not only because current inequalities in child health in London are unacceptable¹⁸, but also because there is compelling evidence that improving health and tackling inequalities in childhood holds most promise for creating a fairer society for the future.¹⁹ The Group was especially keen that the Healthcare Strategy recognises the particular health and healthcare needs of young adults, since this is a crucial period in the life course that is not handled well.²⁰

ENABLERS

- Commissioning must gear up quickly to driving a shift towards prevention and health improvement and a focus on reaching the neediest groups, across all contracts. This should include building in clear financial rewards that link to better outcomes for excluded people.

- Primary care services are benchmarked through the Qualities and Outcomes Framework (QoF) according to the health and disease profiles of registered patients, known to the practice, and accessing services. No account is taken of people who are not attending services and who have health needs that are not being met. More meaningful equity profiling would take account of these unmet needs and would encourage proactive outreach and anti-discriminatory approaches to service provision.

- Currently, target setting, for example smoking cessation rates, steers improvement 'on average'. In other words, no account is taken of the additional effort and resources required to achieve the outcome for hard-

¹⁸ London Health Commission. *Health in London 2005 Update: Focus on the Health of Children and Young People*. GLA October 2005. <http://www.londonhealth.gov.uk/hinl.htm>

¹⁹ Acheson D. *Independent Inquiry into Inequalities in Health*. London: TSO, 1998

²⁰ Viner R, Barker M. Young people's health: the need for action *BMJ* 2005; 330:901-3

to-reach groups. For instance, Islington PCT²¹ has estimated that the cost per smoking cessation for certain hard-to-reach black and minority ethnic groups is three times higher than the average. There is therefore a perverse incentive for services to ignore these groups. A possible approach would be to introduce 'weights' that take notional additional cost into consideration – in this example, one cessation amongst the 'target' marginalised group would be equivalent to three cessations in the general population.

- Addressing inequalities through commissioning and provision hinges on very local approaches based on robust, timely, relevant information about local populations and their needs and about excluded and high risk groups.
- Health equity audits and health inequalities impact assessments should be used more systematically as a core part of planning and commissioning.²²
- Methodologies and tools to analyse inequalities and model trends and the impact of interventions need to be further developed, linking to the analysis for the Mayor's Health Inequalities Strategy and to the contribution of London's public health research community.²³

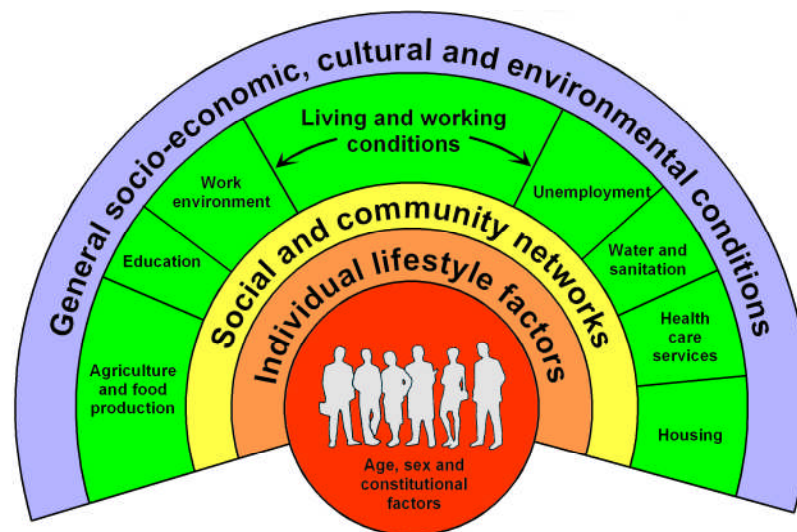
²¹ Islington PCT personal communication

²² Health Equity Audit Made Simple: A Briefing for Primary Care Trusts and Local Strategic Partnerships. Working document January 2003. <http://www.lho.org.uk>

²³http://www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx accessed June 2007

2 Population-level interventions across the broader public health canvas

The structural and social underpinnings of health and health inequalities were described by Dahlgren and Whitehead²⁴, as illustrated below; and more recently in the work of Marmot, Wilkinson²⁵ and others.



Source: Dahlgren and Whitehead, 1991

Substantial gains in physical, mental and emotional health, particularly for those at greatest disadvantage, will only be made by addressing the adverse social, economic, environmental and lifestyle factors that are at the root of much ill health. It is only through continued joint working with partners across all sectors and with the public that we can secure progress towards the national NHS targets on cancer, cardiovascular disease, life expectancy and infant mortality and make the necessary inroads into the large health inequalities that still persist in London.

Moreover, health service redesign takes place within the broader context of local partnerships and should be seeking synergy with policy in other sectors towards improving health and well-being. For example, for children's services, *Every*

²⁴ Dahlgren G, Whitehead M. *Policies and Strategies to Promote Social Equity in Health*. Institute of Future Studies: Stockholm, 1991

²⁵ For example see Marmot M, Wilkinson R (eds) *Social Determinants of Health*, 2nd edition. Oxford: Oxford University Press, 2005

Child Matters,²⁶ *Choosing Health*²⁷, and *Our Health, Our Care, Our Say*²⁸ are all pulling in the same direction towards better, integrated, community-based child and family centred services, giving powerful support to a shift from outmoded hospital based services to new community based approaches – including services delivered in schools, in children’s centres and at home. Similarly, older peoples’ requirements for inpatient or residential care are often a result of mental health problems. The development by several housing associations of housing designed to accommodate people with dementia could make a significant difference to hospital bed requirements as well as providing better quality care.

Small local communities can have a big impact, but have to struggle for funding, navigating a myriad of separate funding streams. We need fresher models incentivised through better ways of pooling effort and resources – money, people, premises – collaboratively across local partners. New Deal for Communities, Single Regeneration Budgets, Health Action Zones, Neighbourhood Renewal Fund, etc., have encouraged such innovation, but this is frequently not mainstreamed, learning is not adequately shared or acted upon and is quickly forgotten as service reorganisations come and go. Local Area Agreements offer a potential solution.²⁹

Successful city-level models range from the WHO Healthy Cities movement to more specific initiatives such as the recent trans-fats ban in New York. London has a unique identity which, together with the hosting of the 2012 Games, offers an unparalleled opportunity to create a city-wide movement for health. The London Health Commission is a vehicle through which the NHS can effectively engage in city-level partnership working as, for example, with the influential London Big Smoke Debate on tobacco control.³⁰

The White Paper *Our Health, Our Care, Our Say* emphasised the need over time for growth in health spending to be directed more towards preventative, primary, community and social care. In addition it underlined the importance of stronger joint local commissioning between PCTs and local government and improved joint working between the NHS, local government and the voluntary sector, with the need for the patient’s voice to be central to commissioning decisions. Commissioning in London is evolving and there is still plenty of scope to influence this. But there is a real danger that the focus will remain fixed on the acute sector and on demand management, or that practice based commissioning fails adequately to embrace a focus on health improvement and on excluded groups.

²⁶ Department for Education and Skills. *Every Child Matters*. September 2003

²⁷ Department of Health. *Choosing Health: Making Healthier Choices Easier*. London: TSO, 2004

²⁸ Department of Health. *Our Health, Our Care, Our Say: a New Direction for Community Services*. London: The Stationery Office, 2006

²⁹ *Strong and Prosperous Communities – The Local Government White Paper*. DCLG October 2006

³⁰ For information about the Big Smoke Debate see the London Health Commission’s website: <http://www.londonhealth.gov.uk>

RECOMMENDATIONS AND PROPOSALS

1. **The tendency has often been for health service strategies to take a narrow acute, adult, physical health focus. Given the scale of its ambition, it is important that the proposals made in this Healthcare Strategy are set against a more holistic perspective – embracing physical, mental and emotional health and well-being and covering all stages of the life course.** Across the whole Strategy, proposals will need to work for everyone and should be explicitly played through from the point of view of children and young people, adults of working age, older people and vulnerable and marginalised groups.
2. **The Healthcare Strategy should take the opportunity to energise local partnerships** – working together across sectors for quality of ‘whole life’, not simply for a narrow version of ‘health’ and not for ‘service delivery’. Without detriment to the primary focus on the health system, the Strategy might emphasise the fundamental importance of tackling the broader determinants of health through population and community level action, with the NHS playing its full potential role with partners across the range of sectors and local people. Local level commissioning, including practice based commissioning, needs to be cast firmly within the shared local framework for developing a healthy and sustainable community, including the evolving use of Local Area Agreements, with the roll-out of the Local Government White Paper.³¹ It is critical that PCTs and the NHS more broadly play a full part in these new mechanisms.
3. **A step change is called for in the level of investment going into prevention.** At a local level, we need greater transparency of relative spend across the patient’s clinical journey (prevention, primary, secondary, tertiary, etc.) and better mechanisms to facilitate the shift of investment to those at greatest need and to the most clinical and cost-effective interventions on the pathway (which is often upstream to a firmer emphasis on prevention). Programme budgeting has the potential to strengthen commissioning in this way.³²

Commissioning must get overall financial balance right, but must also take money out of the acute sector and into local commissioning for re-investment in ways that better meet very local needs. The interface between practice based commissioning and joint NHS / local authority (LA) commissioning is important new territory to develop in the context of

³¹ *Strong and Prosperous Communities – the Local Government White Paper*. DCLG October 2006

³² <http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Financeandplanning/Programmebudgeting/index.htm>

the more powerful levers that Local Area Agreements potentially offer.

4. **Strong local public health leadership, through the PCT/LA Director of Public Health, the Director for Adult Social Services and Director of Children's Services, needs to be followed through with clear responsibility for public health at a very local level**, for example through a core primary health professional. Local level responsibilities need to be backed up with far better, joined-up, local information and intelligence to support population needs assessment and practice based commissioning and to steer action and evaluation, setting data about physical and mental health alongside information about employment, education, housing, for example within the framework of the Local Area Agreement. This plays directly into efforts to risk stratify the population and to take proactive targeted action to prevent and manage long term conditions. More sophisticated means of incentivising and enabling GPs and others to get to grips with this role will need to be devised.
5. **Focus on one major city-wide campaign – for example on food (under the umbrella of the London Food Strategy³³) and physical activity ('being fit') linked to the 2012 Games³⁴** - and do it really well. This would involve developing a coherent, focused and linked programme of action at each level of the system incorporating, for instance, implementing the NICE obesity pathway³⁵ and piloting the forthcoming physical activity pathway. Fresh ideas for engaging people might include new incentive schemes, such as a 'London Health Tax' (cf carbon tax) and imaginative use of loyalty cards with credit earned through healthy behaviour. This city-wide coordinated drive to improve food and physical activity should be underpinned by a dedicated information and knowledge management function that gets evidence into practice, gets practice evaluated and shared and tracks achievement.
6. **There are important synergies to be forged through positioning the Healthcare Strategy as a whole against the backdrop of the Mayor and GLA's broader strategic duties and responsibilities.** This could potentially strengthen the strategy itself, as well as steering future work, especially in areas such as: learning and skills; housing; planning and the London Plan; sustainability and climate change. In particular, the 2012 Games and the Thames Gateway Development bring unique opportunities to build and pilot new models of service provision, in addition to ensuring that the developments themselves encourage health improvement, for example, through incorporating active transport and green spaces.

³³The Mayor's Food Strategy. *Healthy and Sustainable Food for London*. GLA May 2006
<http://www.london.gov.uk/mayor/health/food/docs/food-strategy.pdf>

³⁴ Department of Health, and NHS London. *Health and 2012 Delivery Plan*. 2006

³⁵ <http://www.nice.org.uk/CG043>

ENABLERS

- Commissioning needs robust input from the specialist public health function, to help ensure that investment and disinvestment decisions are based on sound population needs assessment, evidence of clinical and cost effectiveness and proper clinical engagement.
- Employ and evaluate evolving social marketing techniques.³⁶
- Model and quantify the impact of interventions on disease prevalence and inequalities. For example, what level of increase in physical activity will produce what reduction in number of heart attacks?³⁷

3 Public health programmes and pathways focused at the level of the individual

The Group observed that health improvement initiatives, programmes and services need to be broken out of old, often 'clinical', moulds and recast in more varied, locally responsive ways that more meaningfully engage people who are not 'ill' and not 'patients'. This is particularly true for young people and for marginalised groups. Much more imaginative and creative, evidence-based, ways are needed to reach children at school, adults in the workplace, or older people in their homes, through a more diverse range of providers. Health improvement services could be delivered through a much broader range of practitioners (ie. pharmacists, dentists, opticians, community development workers, health trainers, environmental health officers, occupational health teams, teachers, school nurses, health visitors, hospital staff, etc.) working in a variety of settings (ie. school, leisure, workplace, prison, GP practice, etc.) and types of organisation, including social enterprise models.

Primary care is a 'hot spot' for public health action - the 'hinge' between communities and broader health action (and a local partner in delivering health improvement services and healthy and sustainable communities) and 'patient journeys' into clinical services. A particularly important overlap is that between 'self care' and support for long term conditions and disability: the public health role in delivering a fundamental shift in the ethos of services, towards local systems of services synergistically conspiring to help people get on with their lives without health problems or disability getting in the way; and towards care planning and a real partnership between professional and service user.

³⁶*Independent Review: It's Our Health*. National review of health-related campaigns and social marketing in England. National Consumer Council 2006. <http://www.nsms.org.uk>

³⁷http://www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx accessed June 2007

However, too often primary care based health improvement initiatives and services are exclusively GP practice based and ignore the potential contribution of other primary care professionals in the health and social care family, such as pharmacists, dentists, opticians and social workers. For example, dental work tends to be patch and repair. But dentists are well-placed to contribute to health promotion - healthy diet, smoking cessation, sensible use of alcohol – linking oral health to general health and well-being.³⁸ The fact that practice based commissioning is (or is perceived to be) doctor-led is a barrier.

Any momentum gained through national-level programmes is quickly lost because of often ineffectual local follow through. There is still a paucity of evidence on what works in practice to change lifestyle and behaviour; but where such evidence does exist, there is a failure systematically to translate it into practice. However, lack of evidence should not stifle action, but should prompt evaluation.

The Group observed that ‘traditional’ public health programmes, such as cancer screening and child health surveillance and screening programmes, along with ‘newer’ public health pathways, such as the NICE obesity pathway³⁹ and physical activity pathway, will need to be appropriately designed into new health systems, but there is a risk that this will be an afterthought.

People at risk of poor health, for example through cardiovascular disease and diabetes, are not being identified and not getting into the Quality and Outcomes Framework. This compares unfavourably with the much more rigorously managed approaches of, for example, Kaiser Permanente. Currently, from the (PCT) commissioner’s (financial) perspective, the problem with programmes to identify people at risk and then to intervene is that they effectively represent an ‘avoidable’ cost - both for the identification and for the intervention – and it is simply cheaper in the short term to do neither. However, lack of emphasis on prevention now means higher treatment costs at a later stage.

RECOMMENDATIONS AND PROPOSALS

1. **Integrate the local health improvement efforts of all healthcare providers.** Make much better use of the opportunities for health improvement offered through community pharmacies, dentists and opticians. See these services as ‘mainstream’ partners in health improvement. In particular, use community pharmacies and ensure pharmacists are trained to provide the expanded role.

³⁸ See *A Vision for Londoners’ Oral Health 2016*. Paper developed by the London Dental Health and Education Strategic Partnership. December 2006.

³⁹ <http://www.nice.org.uk/CG043>

2. **New settings for healthcare delivery - such as diagnostic and treatment centres and 'polyclinics' - should design in co-located prevention and health promotion services.**
3. **Better align health promotion to aspirations for lifestyle and income. We need to get much better at delivering health and well-being messages to 'real' people in the 'real' world** – particularly much more imaginative ways of tailoring messages in the workplace, at school and through children's centres. Extended schools, for example, can engage with the wider community and can help develop food skills or engagement in physical activity amongst parents as well as children and young people. Focus on the big things that will have the biggest impact – food, exercise, smoking, alcohol, sexual health, mental health. Use the internet more effectively to signpost people to appropriate services. Give individuals a health promotion budget/ vouchers. Back up individual approaches with population level action: campaigns; 'brands for healthy living'; Oyster card-linked reward tokens for taking exercise – or other healthy behaviours, etc. Recognise also that personalised approaches to health improvement need to be made in the context of social, economic and environmental determinants. For example, green spaces enhance people's sense of well-being and encourage them to be more active.⁴⁰
4. **As the health system evolves, ensure that traditional (cross-organisation) programmes and pathways such as cancer screening and child health promotion and screening services are continuously reviewed and remodelled to take full advantage of service improvements and to maintain clinical governance through changes.** At the same time, attention needs to be given to increasing accessibility of these services to marginalised groups.

ENABLERS

- The level of investment going into prevention needs to increase - it should not continue to be seen as a soft target for savings, especially since this simply shores up costs for the future.
- Incentivise prevention and keeping people healthy, independent and out of hospital, for example through more sophisticated use of QoF points for health and well-being. The new General Dental Practitioner contract needs to be modified to focus on prevention with incentives to support this.

⁴⁰ Vries, S. de, Verheij, R.A., Groenewegen, P.P. & Spreeuwenberg, P. *Natural environments - healthy environments? An exploratory analysis of the relationship between green space and health.* Environment and Planning A, 2003:35;1717-31

- Integration and imaginative ways of providing services need to be incentivised and commissioned. Moreover, there is a place for pan-London commissioning and provision of some health improvement services – for example, aspects of sexual health - particularly in view of population mobility.
- Reaching groups at high risk of poor health calls for proactive targeting, driven through a mix of commissioning, incentives and targets and powerful local leadership, supported by good very local level information. This includes better, routinely available information on lifestyles.
- Consolidate, develop and disseminate the evidence base. For example, we must make sure that the forthcoming NICE review of behavioural change models informs practice.
- Build in research and evaluation. Share and learn from good practice elsewhere.
- All elements of the health and care delivery system should eventually have integrated IT, covering existing NHS providers currently not covered by the NpflIT contract, such as dentists and opticians, as well as providers working in non-traditional settings.

4 Health improvement as an integral element of all healthcare services

The Group gives very strong support for making the Wanless vision⁴¹ of a health not sickness service a reality in London, with prevention and health promotion actively built into patients' journeys. Examples include: smoking cessation as part of antenatal care; early identification and treatment of the common problems of ageing (with, in particular, hearing, vision, feet and teeth); routinely considering diet, alcohol use, exercise, etc. and referring appropriately; opportunistic immunisation of children presenting to services. For example, the London Health Observatory⁴² have estimated that if London patients admitted for planned surgery were to stop smoking prior to operation, 2,500-5,300 post operative complications would be avoided each year and the NHS would make the following savings:

- 2,600-4,000 bed days;
- £0.5-£1.1 million each year across London's PCTs; and
- £0.9-£2.8 million across London's hospital trusts.

⁴¹ Wanless D. *Securing Good Health for the Whole Population: Final Report*. London: HMSO. 2004

⁴² London Health Observatory. *Stop Before the Op!* May 2006
<http://www.lho.org.uk/viewResource.aspx?id=10495>

There is currently lack of ownership of the health improvement agenda in NHS trusts and no real obligation for services to be holistic. Prevention and health promotion are still often seen as largely irrelevant to the secondary care setting, despite the Healthcare Commission's core public health standards.⁴³ Incentives are perverse. The tariff rewards hospitals for doing things to patients; not for keeping people out of hospital beds.

In a similar way, safeguarding and promoting the welfare of children is a critical thread that must run through all healthcare provider and commissioning functions.

From a patient perspective, it is important that all health and care services along the clinical pathway (across all 'levels' of health care) work together smoothly and consistently ('vertical' integration). The financial and cultural wall between primary and secondary care mitigates against collaborative and efficient care, including prevention and health promotion, which should be an integral part of better managed and coordinated patient pathways.

Healthcare is not delivered in a vacuum. All patient care pathways take place within the local 'public health' system of neighbourhoods and communities, linked to education, housing, leisure, work place, with a myriad of services provided by public, voluntary, independent and business sectors. Every stage of any patient journey – prevention through treatment, care, rehabilitation and end of life – needs to be supported through this local system working as cohesively as possible for the individual. Critically, this means health and social care services seen as one whole. But this 'horizontal' integration extends to other sectors – for example, meeting the housing needs of the patient with TB and using hostel workers to supervise therapy; meeting the housing and employment needs of the person with a mental health problem; proper integrated hospital discharge planning; healthy schools that not only promote health and well-being, but that also proactively enable participation of children with a disability or long-term conditions and host child and adolescent mental health services.

RECOMMENDATIONS AND PROPOSALS

1. **Drive the Wanless 'fully engaged scenario' through an emphasis on prevention across the full span of the Healthcare Strategy.** Evidence based mental and physical health improvement should be commissioned and delivered as standard throughout the healthcare system – driven through contracts, training, professional and service regulation, information and performance management. There should be an expectation that it is a core role of all healthcare staff to actively seek to promote physical and mental health and well-being. This requires a

⁴³*Standards for Better Health.* Seventh domain – Public Health. Healthcare Commission
[Http://www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)

culture shift for staff and organisations towards closer and more collaborative working, with local systems of services pulling together to offer health improvement opportunistically. There is an important role for PCTs' public health teams to play in working directly with clinical colleagues in hospitals. New models of providing health improvement services as routine alongside secondary clinical care, for example through new roles such as lifestyle coaching, need to be developed and evaluated. This would include good discharge advice and follow through to community based services, enabled by the electronic patient record.

2. **Build services provided in a variety of settings and by a range of partners – such as leisure services, education, learning and skills, housing – explicitly into the menu of service options offered across clinical care pathways for treatment, care and rehabilitation.** For example, for the person with diabetes who needs to lose weight, options might include: a weight reduction group at the local mosque/ community centre, depending on circumstances; 1:1 sessions, or a group led by a dietician at the GP surgery or 'polyclinic'; weight watchers' sessions; vouchers for the local gym or swimming pool. Similarly, cardiac rehabilitation can be successfully offered in a variety of community settings like leisure settings and gyms. Patients could be offered vouchers to put the choice more firmly into their own hands.

ENABLERS

- Commission and performance manage health improvement across all healthcare contracts.
- Introduce financial incentives for keeping people out of hospital.
- A major focus is needed on training and development of clinical staff in prevention and health promotion. This needs to happen on a much more multidisciplinary cross-sector basis, with imaginative approaches, for example involving the Learning and Skills Councils. Contracts must ensure that employing organisations understand the importance of this.
- Map of Medicine supports clinical decision-making by representing best available evidence in the form of national care pathway templates, which can then be localised. Map of Medicine should be further developed to build in linkages to evidence-based prevention and health promotion across every clinical pathway.

5 Health protection

A striking feature of London compared to the rest of the UK is the high prevalence of certain communicable diseases. London has by far the highest

rate of new HIV diagnoses, accounting for just over half of all new cases in the UK, and the highest prevalence.⁴⁴ The rates of other sexually transmitted infections are also high: London has the highest rates of new diagnoses for chlamydia, gonorrhoea and syphilis in GUM clinics compared to other regions. Chlamydia diagnoses have more than doubled since 1995.

TB rates remain high, although action in some boroughs seems to be beginning to achieve a reduction in incidence. The majority of TB occurs in the new entrant population. These cases are relatively easy to identify and treatment is usually completed without any problems. Around 1 in 5 cases of TB are more complex. They occur in socially excluded groups, who may be homeless or in prison, and who find it difficult to complete their treatment. Incomplete treatment can result in the development of drug resistant TB, which requires longer treatment with combination drug therapy, at much greater cost to the NHS and disadvantages to the patient.⁴⁵

Health protection requires collaboration and an integrated response at all levels of the system, both on an ongoing basis, for example in flu pandemic planning, resilience preparedness and infection control, and also in emergency response to a major incident. The impact of remodelling and reorganisation of health services on arrangements for communicable disease control and emergency preparedness needs constantly to be borne in mind. Restructuring of organisations and services directly impacts on health protection in a variety of ways. For example, as well as the risk of disrupting and fragmenting service provision, there are also risks to public health surveillance, through loss of information that is crucial to inform public health policy and public protection.

Immunisation has among the most robust evidence bases in terms of safety, efficacy and cost effectiveness of all healthcare activities. Childhood vaccination is designed to protect for the whole of life for most of the targeted infections. The childhood immunisation and vaccination programme in London has had long-standing problems achieving good coverage. This is linked to characteristics of the health service, a highly mobile population, social, economic and cultural factors and, critically, parents' perceptions of vaccines and diseases.⁴⁶ Vaccination coverage has been consistently below national average although, anecdotally, audits have shown that data systems have under-estimated true coverage by around 10%. In the longer term, experience shows that children who miss out on vaccinations at the correct ages are likely to remain unimmunised or under-immunised because opportunistic vaccination is not well delivered by the NHS. A variety of measures have been introduced in different areas of London to address poor immunisation rates, but improvements tend not

⁴⁴ London Health Observatory. *Health and Healthcare in London – Key Facts*. September 2006. <http://www.lho.org.uk>

⁴⁵ *Stopping Tuberculosis in England: An Action Plan From The CMO*. DH October 2004

⁴⁶ See for example Samad L, Tate AR, Dezateux C, Peckham C, Butler N, Bedford H. Differences in risk factors for partial and no immunization in the first year of life: prospective cohort study. *BMJ*; 332:1312-3

to be sustained after the energy of the 'project' dies down. Because of the particularly low uptake of MMR in London, a campaign took place in 2004-05 aiming to increase the cover of MMR in school aged children.⁴⁷ As a result of this campaign a number of recommendations were made and these form the basis of some of our proposals for the Healthcare Strategy.

RECOMMENDATIONS AND PROPOSALS

1. **The Healthcare Strategy should explicitly recognise the importance of maintaining and improving health protection arrangements as an integral component of the blueprint for London's services.** This is particularly crucial in view of the continued very high level of risk of major incidents in the capital. Moreover, local systems need to ensure robust arrangements, including unambiguous clinical governance, are built into local service redesign, working closely with all local partners and, crucially, with the Health Protection Agency. These arrangements need to be commissioned and performance managed.
2. **The Healthcare Strategy could make a solid contribution to improving health and reducing health inequalities through giving prominence to redesigning the childhood immunisation programme** to be fit for purpose in today's London, recognising that continuing to accept dismally low coverage is unacceptable. Solutions to low uptake require a multi-faceted approach specifically tailored to the needs of the particular population. However, the following requirements are common across most areas:
 - Immunisation to be seen as a high priority amongst all staff concerned with the care of children
 - Dedicated named leadership for each involved organisation
 - Better information systems and better sharing of information (eventually supported through the electronic health record)
 - Opportunistic immunisation in all settings, including acute healthcare, at primary and secondary school entry, in Sure Start facilities and extended schools
 - Care pathways for complex issues
 - All staff trained to be skilled in giving accurate information on vaccines. Adequate numbers and types of staff trained in giving vaccination
 - Positive attitude of staff
 - Active public health oversight on a London-wide basis to coordinate and facilitate the programme.

⁴⁷ *Capital Catch-up: MMR Catch-up Vaccination Campaigns by London Primary Care Trusts, Winter 2004-5.* Evaluation report of the campaign technical planning group. March 2007

3. **The Healthcare Strategy for London needs a focus on redesigning services for both prevention and treatment to tackle the rising rates of sexually transmitted infections, based on⁴⁸:**
- increasing the use of contraception
 - providing a broader range of services, from a variety of providers, around sexual health care pathways, including:
 - services for contraception and abortion, particularly for young people
 - improved STI and GUM services, addressing chlamydia screening and HIV/AIDS
 - improving service access, to reduce the duration of infectiousness and onward transmission, for example through seven-day-a-week access to GUM through London-wide rotation of opening times and greater use of outreach services for at-risk populations, such as sex workers and young people
 - increasing the availability and accessibility of information on sexual health and sexual health services, particularly for young people and 'at risk' groups, for example through community pharmacies, health centres, on-line, including YouTube, and using celebrities to get messages across.
4. **TB remains a priority health issue for London. Further, the prevention, treatment and care of TB provide an excellent exemplar to work through the Healthcare Strategy's service blueprint and test proposals.** There is a need for further service improvement, with innovative new ways of case finding and treatment, workforce development, including developing specialist expertise, and appropriate accommodation for complex patients to ensure completion of therapy.⁴⁹ This will require the existing TB networks to function as managed clinical networks with the development of specialist expertise connected to local partnerships and some service reconfiguration to:
- provide rapid diagnosis
 - assess each newly diagnosed patient in terms of risk of not completing treatment and/or having drug resistant TB
 - design services on the basis of this assessed risk, including the provision of supported housing and outreach to ensure treatment completion
 - provide the specialist expertise required by some patients, for example those with co-morbidity such as HIV or substance misuse
 - deliver effective contact tracing.

⁴⁸ London Sexual Health Framework

http://www.lho.org.uk/HIL/Lifestyle_And_Behaviour/Attachments/Word_Files/London-wide_Sexual_Health_Framework_Final_October_2004.doc

⁴⁹ *Stopping Tuberculosis in England: An Action Plan from the CMO*. DH October 2004

5. **Surveillance of communicable diseases, for example sexually transmitted disease and TB, is crucial to monitor trends, to protect the public, to inform service design, commissioning and provision and to monitor outcomes.** With increased plurality of providers there is a risk that surveillance may become a low priority. Existing London-wide mechanisms for disease surveillance and service outcome data, such as the London TB register, must be maintained. It is also essential that commissioners require adequate data collection and information from all providers.

ENABLERS

- Contracts need to secure an appropriate response, including provision for active mutual aid, from all service providers, of whatever type, in the face of, for example, a major incident. This will need to be properly incentivised, for example through the QoF for GPs.
- Ensure a strategic London-wide view of commissioning services for the protection of the public's health, so that Londoners can access, for example, contraception and GUM services that are convenient to them and not according to PCT boundaries.
- New integrated information systems being deployed through Connecting for Health have enormous potential to support improved health protection, including immunisation through the new child health system.

6 Corporate social responsibility of health services

The NHS is the biggest business (spending £90 billion in 2008⁵⁰) and the largest employer in the country and has enormous potential to improve health simply through the way in which it conducts its business. In London, the NHS contributes 10% of GDP, is responsible for 5% of all journeys and will spend £7 billion on new capital building projects in the next 7 years.⁵¹ The White Paper *Choosing Health* recognised the importance of the NHS being a good corporate citizen and making a positive contribution to the health and sustainability of the communities it serves.

Progress is being made. For example, a tool kit on green/active travel plans has been produced for NHS trusts and funding has been secured from Transport for London to support this.⁵² There is good practice in food procurement at trust

⁵⁰Sustainable Development Commission <http://www.redwebdevelopment.com/sdc/>

⁵¹ NHS London data

⁵² The Department of Health and Transport for London have produced a tool kit for developing green/active travel plans based, in part, on the good practice of Trusts in London. <http://www.tfl.gov.uk/tfl/press-centre/press-releases/press-releases-content.asp?prID=118>

level and via the Hospital Food Project, a Sustain/Kings Fund initiative that aims to increase the amount of fresher, locally produced and organic food in hospitals for patients, staff and visitors. However, as recognised in the London Food Strategy⁵³, there is a need to share and roll out good practice across all trusts in London. *Building for Health*⁵⁴, a project undertaken with the Carbon Trust, enables NHS capital developments to consider sustainable and energy saving measures throughout procurement and development.

The NHS has a particularly important contribution to make through its employment practices. Compelling evidence links worklessness to poor health.⁵⁵⁵⁶ As a major employer of staff at all levels of qualification, the NHS is in a good position to target employment opportunities at local areas of deprivation and communities with high levels of unemployment. There are a number of employment projects in London that are enabling unemployed people – including those with physical or mental health problems or disabilities, or people from excluded groups, like refugees – to access jobs in healthcare.⁵⁷ But experience needs to be drawn together and good practice implemented more widely.

But finally, the Group was most anxious to stress the fundamental importance of the NHS putting its own house in order in terms of promoting the physical, mental and emotional health and well-being of its employees. For instance, within hospitals there are many opportunities to address health determinants through hospital design, organisation and management and policies, as well as through prevention and health promotion initiatives. Moreover, there is huge potential to improve the population's health and to reduce health inequalities through improving the health of NHS staff and their families. This is especially true because the healthcare workforce itself includes low paid workers and people from disadvantaged groups, minority ethnic groups and communities at greatest risk of ill health. Evidence supports the link between an empowered and supported workforce – particularly well-functioning multi-disciplinary teams – and patient benefits. Links have also been demonstrated between a healthy workforce and productivity, with savings through reducing staff absence and turnover, as well as humanitarian benefits.⁵⁸ Human capital is the most valuable resource that we have in the NHS, yet the view of the Group was that we use it badly and that currently London's NHS employers do little proactively to promote the NHS workplace as a setting for health improvement.

⁵³ The Mayor's Food Strategy. *Healthy and Sustainable Food for London*. GLA May 2006
<http://www.london.gov.uk/mayor/health/food/docs/food-strategy.pdf>

⁵⁴ <http://www.lho.org.uk/viewResource.aspx?id=10703>

⁵⁵ Health, Work and Well-Being – Caring for our Future. Joint Strategy DWP, DH and HSE 2005

⁵⁶ http://www.lho.org.uk/HIL/Determinants_of_Health/Employment.aspx

⁵⁷ For example *London Works for Better Health*. London Health Commission. <http://londonhealth.gov.uk>

⁵⁸ For example Parcelforce Worldwide healthy workforce programme reduced sickness absence and resulted in 12.5% productivity gain and 50% customer service improvement. See Business in the Community website at: <http://www.bitc.org.uk>

RECOMMENDATIONS AND PROPOSALS

1. **The Healthcare Strategy should take the opportunity to promote the Good Corporate Citizenship agenda across the range of healthcare organisations in the capital**, seeking to ensure that it receives strong board level leadership and support and that it is embedded firmly into commissioning and procurement activities. Although there is a range of good initiatives and projects already under way, the challenge is to embed and mainstream good practice in all NHS organisations.
2. **Any healthcare facility relocation or rebuild offers the opportunity to rethink the contribution to the urban environment and the ways in which facilities can contribute to improving the health of the local community**, bearing in mind that many of these are likely to be located in deprived areas. We need to ensure that buildings procured as part of redesigning London's healthcare system are sustainable, promote health, regenerate local communities and will be suitable for the hot dry summers expected in 20 to 50 years time. In particular, proposed alterations to the London Plan include challenging targets on energy efficiency and provision of sustainable energy in newly built premises and the NHS will need to build these increased costs into the procurement process. However, using the *Building for Health* processes will enable the NHS to develop sustainably and potentially reduce energy utilisation costs in the future.
3. **A major thrust for the Healthcare Strategy should be the promotion of the physical, mental and emotional health and well-being of the NHS workforce**, through valuing, respecting and empowering staff; through developing NHS workplaces as settings for health improvement; and through providing high quality occupational health services. Commissioners should contract for Healthy NHS workplaces and better incentives need to be devised. The NHS needs to learn from other sectors, including the commercial world.

ENABLERS

- Strengthen strategic links between the NHS and the Mayor and GLA.
- Require Good Corporate Citizenship and health promoting workplaces through commissioning and performance management.
- Incentivise corporate social responsibility and a healthy workforce through demonstrating the potential for financial savings.

- Learn from models of good practice, for example health promoting hospitals. Continue to develop and share models and tools, for instance to support healthy foods procurement.

London case studies

The Annex provides illustrative case studies drawn from current practice in London, organised according to the six themes of this Report.

Maggie Barker
Chair of the Staying Healthy Group
July 2007

Summary of Recommendations

1 Tackling health inequalities

1. The Healthcare Strategy should make reducing health inequalities an overtly stated goal, with the fundamental underpinning principle that access to services must be fair and equitable and based on need and on ability to benefit.
2. The Strategy will need to strike the right balance between, on the one hand, setting a 'one vision for London' blueprint for services, which risks increasing the health inequality gap; and, on the other hand, targeted and tailored approaches, recognising that the diverse population of London – with diverse opportunities and health needs – calls for diverse approaches and service models.
3. In recognition of the risk that the Healthcare Strategy itself may actually inadvertently promote widening of the health inequality gap, it is proposed that a 'health inequality impact assessment' be carried out on the emerging Strategy itself.
4. The overt link with the forthcoming Mayoral Strategy on Health Inequalities is strongly supported and the Group would wish to see its own analysis and proposals, as set out in this report, picked up within that Strategy.
5. The physical, mental and emotional health and well-being of children and young people should be a priority, not only because current inequalities in child health in London are unacceptable, but also because there is compelling evidence that improving health and tackling inequalities in childhood holds most promise for creating a fairer society for the future.

2 Population-level interventions across the broader public health canvas

1. The tendency has often been for health service strategies to take a narrow acute, adult, physical health focus. Given the scale of its ambition, it is important that the proposals made in this Healthcare Strategy are set against a more holistic perspective – embracing physical, mental, and emotional health and well-being and covering all stages of the life course.
2. The Healthcare Strategy should take the opportunity to energise local partnerships – working together across sectors for quality of 'whole life', not simply for a narrow version of 'health' and not for 'service delivery'.

3. A step change is called for in the level of investment going into prevention.
4. Strong local public health leadership, through the PCT/LA Director of Public Health, the Director for Adult Social Services and Director of Children's Services, needs to be followed through with clear responsibility for public health at a very local level, for example through a core primary health professional.
5. Focus on one major city-wide campaign – for example on food (under the umbrella of the London Food Strategy) and physical activity ('being fit') linked to the 2012 Games - and do it really well.
6. There are important synergies to be forged through positioning the Healthcare Strategy as a whole against the backdrop of the Mayor and GLA's broader strategic duties and responsibilities.

3 Public health programmes and pathways focused at the level of the individual

1. Integrate the local health improvement efforts of all healthcare providers. Make much better use of the opportunities for health improvement offered through community pharmacies, dentists and opticians.
2. New settings for healthcare delivery - such as diagnostic and treatment centres and 'polyclinics' - should design in co-located prevention and health promotion services.
3. Better align health promotion to aspirations for lifestyle and income. We need to get much better at delivering health and well-being messages to 'real' people in the 'real' world – particularly much more imaginative ways of tailoring messages in the workplace, at school through children's centres.
4. As the health system evolves, ensure that traditional (cross-organisation) programmes and pathways such as cancer screening and child health promotion and screening services are continuously reviewed and remodelled to take full advantage of service improvements and to maintain clinical governance through changes.

4 Health improvement as an integral element of all healthcare services

1. Drive the Wanless 'fully engaged scenario' through an emphasis on prevention across the full span of the Healthcare Strategy.

2. Build services provided in a variety of settings and by a range of partners – such as leisure services, education, learning and skills, housing – explicitly into the menu of service options offered across clinical care pathways for treatment, care and rehabilitation.

5 Health protection

1. The Healthcare Strategy should explicitly recognise the importance of maintaining and improving health protection arrangements as an integral component of the blueprint for London's services.
2. The Healthcare Strategy could make a solid contribution to improving health and reducing health inequalities through giving prominence to redesigning the childhood immunisation programme to be fit for purpose in today's London, recognising that continuing to accept dismally low coverage is unacceptable.
3. The Healthcare Strategy for London needs a focus on redesigning services for both prevention and treatment to tackle the rising rates of sexually transmitted infections.
4. TB remains a priority health issue for London. Further, the prevention, treatment and care of TB provide an excellent exemplar to work through the Healthcare Strategy's service blueprint and test proposals.
5. Surveillance of communicable diseases, for example sexually transmitted disease and TB, is crucial to monitor trends, to protect the public, to inform service design, commissioning and provision and to monitor outcomes.

6 Corporate social responsibility of health services

1. The Healthcare Strategy should take the opportunity to promote the Good Corporate Citizenship agenda across the range of healthcare organisations in the capital, seeking to ensure that it receives strong board level leadership and support and that it is embedded firmly into commissioning and procurement activities.
2. Any healthcare facility relocation or rebuild offers the opportunity to rethink the contribution to the urban environment and the ways in which facilities can contribute to improving the health of the local community, bearing in mind that many of these are likely to be located in deprived areas.
3. A major thrust for the Healthcare Strategy should be the promotion of the physical, mental and emotional health and well-being of the NHS workforce, through valuing, respecting and empowering staff; through developing NHS workplaces as settings for health improvement; and

through providing high quality occupational health services.

Summary of Enablers

Commissioning

- Commissioning must gear up quickly to driving a shift towards prevention and health improvement and a focus on reaching the neediest groups, across all contracts. This should include building in clear financial rewards that link to better outcomes for excluded people.
- The level of investment going into prevention needs to increase. It should not continue to be seen as a soft target for savings, especially since this simply shores up costs for the future.
- Commission and performance manage health improvement across all healthcare contracts.
- Introduce financial incentives for keeping people out of hospital.
- Commissioning needs robust input from the specialist public health function, to help ensure that investment and disinvestment decisions are based on sound population needs assessment, evidence of clinical and cost effectiveness and proper clinical engagement.
- Integration and imaginative ways of providing services need to be incentivised and commissioned. Moreover, there is a place for pan-London commissioning and provision of some health improvement services – for example, aspects of sexual health - particularly in view of population mobility.
- Contracts need to secure an appropriate response, including provision for active mutual aid, from all service providers, of whatever type, in the face of, for example, a major incident. This will need to be properly incentivised, for example through the QoF for GPs.
- Ensure a strategic London-wide view of commissioning services for the protection of the public's health, so that Londoners can access, for example, contraception and GUM services that are convenient to them and not according to PCT boundaries
- Reaching groups at high risk of poor health calls for proactive targeting driven through a mix of commissioning, incentives and targets and powerful local leadership, supported by good very local level information.

This includes better, routinely available information on lifestyles.

- Require Good Corporate Citizenship and health promoting workplaces through commissioning and performance management.
- Incentivise corporate social responsibility and a healthy workforce through demonstrating the potential for financial savings.

Measures and targets

- Primary care services are benchmarked through the Qualities and Outcomes Framework (QoF) according to the health and disease profiles of registered patients, known to the practice, and accessing services. More meaningful equity profiling would also take account of unmet needs and would encourage proactive outreach and anti-discriminatory approaches to service provision.
- Currently, target setting, for example smoking cessation rates, steers improvement 'on average'. A better approach would take account of the additional effort and resources required to achieve the outcome for hard-to-reach groups.
- Incentivise prevention and keeping people healthy, independent and out of hospital, for example through more sophisticated use of QoF points for health and well-being. The new General Dental Practitioner contract needs to be modified to focus on prevention, with incentives to support this.

Information and intelligence

- Addressing inequalities through commissioning and provision hinges on very local approaches based on robust, timely, relevant information about local populations and their needs and about excluded and high risk groups.
- Health equity audits and health inequalities impact assessments should be used more systematically as a core part of planning and commissioning.
- Methodologies and tools to analyse inequalities and model trends and the impact of interventions need to be further developed.
- New integrated information systems being deployed through Connecting for Health have enormous potential to support improved health protection, including immunisation through the new child health system.

- All elements of the health and care delivery system should eventually have integrated IT, covering existing NHS providers such as dentists and opticians as well as providers working in non-traditional settings.

Getting evidence into practice

- Consolidate, develop and disseminate the evidence base.
- Build in research and evaluation. Share and learn from good practice elsewhere.
- Map of Medicine supports clinical decision-making by representing best available evidence in the form of national care pathway templates, which can then be localised. Map of Medicine should be further developed to build in linkages to evidence-based prevention and health promotion across every clinical pathway.
- Employ and evaluate evolving social marketing techniques.
- Learn from models of good practice; for example health promoting hospitals. Continue to develop and share models and tools.

Education, training and development

- A major focus is needed on training and development of clinical staff in prevention and health promotion. This needs to happen on a much more multidisciplinary cross-sector basis, with imaginative approaches, for example involving the Learning and Skills Councils. Contracts must ensure that employing organisations understand the importance of this.

Staying Healthy Group - Membership

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