Enabling Effective Delivery of Health and Wellbeing

An independent report

February 2010

Sir Howard Bernstein
Dr Paul Cosford
Alwen Williams CBE

Contents

The three co-authors of *Enabling Effective Delivery of Health and Wellbeing* are:

Sir Howard Bernstein

Sir Howard became Manchester City Council's Chief Executive in 1998.

He is known for forging partnerships with the City's key players and for successfully attracting millions of pounds into the City. He played a key role in the regeneration of Hulme, the first area in the UK to attract City Challenge status; and subsequent area regeneration initiatives including the Bridgewater Hall, the Velodrome, the International Convention Centre, the City of Manchester Stadium and City Art Gallery.

Recognition of Sir Howard's contribution to Manchester includes being awarded honorary degrees by UMIST, Manchester University and Manchester Metropolitan University. He was knighted for his services to Manchester in the New Year's Honours 2003 and was recognised with a Lifetime Achievement Award at the Regeneration and Renewal Awards in 2008. Sir Howard took up appointment as Chairman of Blackpool Urban Regeneration Company in July 2008.

Dr Paul Cosford

Dr Paul Cosford has been the Regional Director of Public Health for the East of England since August 2006. He leads the public health function across the NHS and the Government Office for the East of England, ensuring the alignment of actions to improve health across the public sector. He is responsible for the oversight of population health improvement, programmes to reduce health inequalities and emergency planning, as well as strategic responsibilities for improving the health and wellbeing of children, people with mental health and people with learning disability.

Paul has a particular interest in developing pragmatic programmes to improve health that involve the NHS, local authorities and the wider public sector, and is committed to ensuring that the full corporate efforts of these organisations support improved wellbeing across local communities. He also established the NHS Sustainable Development Unit, which leads the NHS's programme to reduce its carbon footprint and ensure sustainability of its operations.

Ms Alwen Williams CBE

Alwen took up post as Chief Executive of Tower Hamlets Primary Care Trust (now NHS Tower Hamlets) in June 2004. In addition to her role in Tower Hamlets she was this year appointed chief executive of the East London and the City Alliance, in which Tower Hamlets, Newham and City and Hackney PCTs will work together to strengthen commissioning arrangements across the sector. Alwen has worked in primary care, community and acute services, commissioning and joint planning. She was a member of the national board advising Professor Lord Ara Darzi on primary and community care development. In the 2009 Queen's birthday honours Alwen was appointed a CBE for services to healthcare.

Mary Jane Ritchie was Secretary to the Report.

Introductory letter

Dear Andy,

We are delighted to enclose our report on the delivery of health and wellbeing services in England. We found this an exciting opportunity to inform your thinking on this important topic.

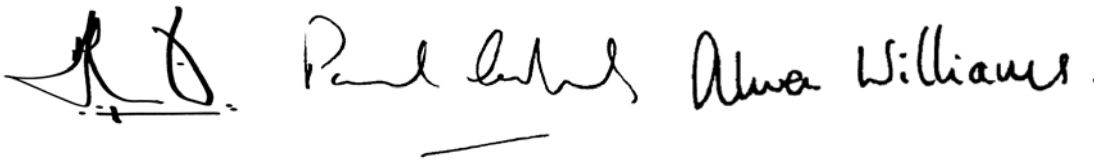
Our starting point for this report was how we can improve delivery in the current and future economic climate. It is our belief that we urgently need to strengthen the financial case for preventing ill health, and within this report we make several recommendations to support this, with better data on cost-effectiveness and return on investment. Delivery on this agenda remains crucial because of the influence that health and wellbeing has on individual motivation, achievement and productivity within the labour market.

We do not believe there is great expense needed to deliver our recommendations; it is, rather, emphasis and well-targeted changes to systems that are needed. We focus first on the need for clarity of high-level goals across systems. An overarching aim to increase the level of health experienced in life is a sensible augmentation of current life expectancy measures. Underlying this must be a strong focus on the biggest lifestyle influences on population health: physical inactivity, tobacco, alcohol and poor diet.

Health and wellbeing has a central role in creating successful places, and our recommendations on the furtherance of integrated commissioning and the role of general practitioners point the way towards service redesign and better delivery locally. Also at a local level, the power of the NHS and the local public sector to affect outcomes is substantial, and we propose stronger prevention roles and training to shift culture towards prevention of ill health and improved wellbeing. Pre-school children and those with existing long-term health conditions are population groups of paramount importance, where investment would pay significant health dividends: our recommendations seek to promote delivery and focus on their wellbeing. National and interdepartmental coherence across health and wellbeing policy is needed to underpin and support all changes, ensuring aligned front-line messages, coordinated policy and inspection processes.

If the very real links between an individual's health and wellbeing and their ability to lead a productive life are maximised, it will produce significant benefits to individuals, the NHS, the economy and the society we live in.

Yours,



Howard Bernstein, Paul Cosford, Alwen Williams

1. Executive Summary

This report offers recommendations to the Secretary of State on how better to enable the delivery of improved health and wellbeing. The Terms of Reference (provided at Annex B) for this report requested an assessment of the current opportunities and barriers in delivery systems, to identify where practical changes could be made to improve effectiveness.

This report is not a full review of interventions to improve health and wellbeing, and is not a new health and wellbeing strategy. Rather, the authors have held a series of discussions with key individuals and groups involved in delivery, and have considered why the ambitions of previous strategies have not always been fulfilled. They have come to the view that a small number of specific issues could be addressed, and that this would significantly improve the effectiveness of approaches to improve health and wellbeing.

We believe that the implementation of these recommendations could greatly support prevention as a role for the NHS and improve quality and productivity. This will be particularly significant given the challenges facing the public sector in the near future.

Our view is that physical and psychological health and wellbeing is an essential foundation for a prosperous and flourishing society. It enables individuals and families to contribute fully to their communities, and underpins higher levels of motivation, aspiration and achievement. It improves the efficiency and productivity of the labour force – critical to ensuring economic recovery. Poor health and wellbeing also costs a great deal through medical and social care costs, reduced productivity in the workplace, increased incapacity benefits, and many other calls on public services and community support. Our most deprived communities experience the poorest health and wellbeing, so systematically targeting approaches on the geographical areas and population groups at greatest need is crucial in reducing inequalities.

Four behavioural risk factors – tobacco use, physical inactivity, excess alcohol consumption and poor diet – are the biggest behavioural contributors to preventable disease. These 'top four' are responsible for 42% of deaths from leading causes and approximately 31% of all disability-adjusted life years (World Health Organization, *The European Health Report*, 2005). Tackling behavioural risk factors is often seen as an issue among younger, predominantly healthy people, but behavioural factors are also major risk factors in the onset and relapse of, and premature mortality from, long-term conditions such as diabetes, cardiac disease and respiratory disease, and for increased disability from musculoskeletal conditions and mental ill health. There is also strong evidence that reducing behavioural risk factors in older people significantly increases both quality and length of life, irrespective of any pre-existing long-term condition. With ageing of the population, it is critical that we have a strong focus on improving health and wellbeing in older people.

In addition to these 'top four', there is strong evidence that improving mental health and wellbeing significantly reduces physical (as well as psychological) ill health. This is the basis of the current national programme to increase the provision of psychological therapies (improving access to psychological therapies, or IAPT).

Of course, a range of social and economic issues underpin people's lifestyles and behavioural risk factors. This needs strong, coordinated action across the public sector, reflected in cross-government action nationally. We are of the view that, within this action, the health and wellbeing of pre-school children is of paramount importance, and has a profound impact on their later adult health and wellbeing. Supporting children and their families to improve their health and wellbeing is vital for them if they are to live healthy and prosperous lives, irrespective of their social background, and if they are to reach adulthood able to achieve their fullest potential.

Such information on health effects needs to be translated into meaningful, national and local articulation of the business case for prevention. This would illustrate the value-for-money case for interventions. Local investment in the NHS and across the public sector can then be appropriately scaled to the outcomes and benefits that the NHS, the public sector and the wider community will gain.

Underpinning this, we are of the view that there is a need to confirm an overarching policy objective to improve healthy life expectancy (and therefore health and wellbeing), against which other policies are judged. This could be termed 'Health expectancy'. Setting this as an overall policy objective would lead to prioritising action to improve health and wellbeing and so reduce the onset and relapse of long-term illness, reduce inequalities, improve the quality of life years lived, and increase years lived in good health. The health and wellbeing of those with disabilities is also vital. This overall policy objective therefore needs to include enhancing the health and wellbeing of people with disability, supporting them to live fulfilled and self-directed lives.

The current average life expectancy and disability-free life expectancy is represented by the first bar on the figure below, with the impact of many currently prioritised health interventions being to increase overall life expectancy but not disability-free life expectancy (second bar). Ideal interventions increase both disability-free life expectancy and overall life expectancy (third bar).

Improving health expectancy: policy options

Representation of current average life expectancy

– a substantial portion of lives, particularly in disadvantaged groups, spent in ill health

Impact of many current health interventions

– increase overall life expectancy by increasing life lived with disability

'Ideal' health interventions

– increase disability-free life expectancy and overall life expectancy

Many important healthcare interventions increase life years lived with disability, and achieve the outcome represented by the second bar. However, many interventions that cost less and are more cost-effective increase disability-free life expectancy, yet are not routinely implemented. For example, increasing physical activity improves mental health and wellbeing, reduces rates of heart disease and cancer, reduces the likelihood of developing diabetes in those at risk, reduces deterioration and supports fulfilled lives in people with many established long-term conditions and disabilities, and improves mobility, quality of life and life expectancy in older people. National Institute for Health and Clinical Excellence (NICE) appraisals of healthcare technologies are rightly expected to be implemented across the NHS within three months. However, NICE guidance on improving rates of physical activity, which identifies interventions that are considerably more cost-effective than many health technologies, does not have the same expectation of implementation.

However, understanding the cost-effectiveness of intervention is not always sufficient to support investment decisions. The opportunity to develop measures of cost impact of interventions and return on investment should also be explored.

It is our view that an increase in health expectancy and an improved quality of life and reduction in disability for people with long-term conditions, should be the benchmark by which to judge new policies. It should also underpin judgements on the priority to be given to different interventions by the NHS and other public sector organisations. We make three recommendations, which, we believe, will support this policy objective to become a reality:

Recommendation 1:
We recommend an overarching tier 1 vital sign to improve disability-free life expectancy (health expectancy), in addition to the existing vital sign indicator on life expectancy. This should be supported by tier 2 vital signs for local agreement on the four major lifestyle factors (smoking, alcohol, physical activity and diet) and psychological wellbeing. These metrics should also be included in national indicators.

Recommendation 2:
The Department of Health should explore with NICE the explicit identification of the impact of clinical and public health guidance on overall life expectancy and on health expectancy, and quality of life for people with disability and long-term conditions. NICE should produce rankings of the most cost-effective clinical and public health guidance, with an expectation of delivery of the most cost-effective. The feasibility to provide assessments of cost impact and return on investment should also be explored.

Recommendation 3:
The impact on health expectancy should be used explicitly to judge the benefits of new policies that impact on health and wellbeing.

Supporting this overarching policy objective, we consider there to be several specific practical actions that can strengthen delivery of health and wellbeing. These are addressed in turn opposite.

Strengthened cross-government and Department of Health action on health and wellbeing

Actions to improve health and wellbeing are frequently outside the NHS, and mechanisms to ensure cross-government action sometimes appear to lack the impact needed to be most effective. Physical activity is illustrative, as there is good evidence that it is affected by the physical design of schools, school travel plans, the design of the built environment, the extent to which transport infrastructure encourages physically active travel, access to the natural environment, access to leisure facilities, and interventions in the workplace. It also has beneficial impacts on health and wellbeing at all ages, on educational outcomes and on economic productivity.

Strong policy coordination across government departments requires greater understanding of health and wellbeing and its contribution to wider community prosperity, and of the role of different government departments in improving health and wellbeing. The Department of Health has a leadership role across government. The specific responsibilities of other departments need to be clear, particularly where action is the collective responsibility of several departments. Government Offices have a clear role to facilitate integrated approaches across departments at a regional level. However, we are uncertain of the most practical way to achieve a strengthening of arrangements at a national level, and believe that ministers and other senior officials within the Department of Health will have a better view of what will work. We believe that a range of options may be appropriate, from time-limited cross-government working groups to advise on individual aspects of health and wellbeing policy, to models such as the new national safeguarding delivery unit (NSDU), which supports action to improve children's safeguarding. We make the following recommendation:

Recommendation 4:
Stronger and more innovative mechanisms are needed for cross-government actions to improve health and wellbeing, including mechanisms to identify the role of different government departments and their delivery systems.

Effective implementation of health and wellbeing initiatives needs coordinated action at a local level across all NHS activities, as well as in partnership with other public sector bodies. To support this, it is vital to identify – at a national level – the evidence for effectiveness and the economic case for action, metrics for judging success, and the means of delivery through world-class commissioning and action across the public sector. This needs to be reflected in improved coordination across the Department of Health, with input from teams working on health improvement and protection, NHS workforce, social care, primary care, world-class commissioning, system management, local and regional partnerships, inspection and standards. A single team with a single point of leadership may be an appropriate mechanism.

We have found the national support teams to be extremely valuable in supporting practical local delivery of health and wellbeing outcomes. Their experience should be used to ensure that national approaches are grounded in the reality of delivery, informing the national coordination of policy and expectations of the delivery system.

All current inspection processes should emphasise the importance to the NHS of prevention. The Department of Health should aim for inspections to be coherent and, where possible, aligned so that front-line organisations can set priorities on a consistent basis. We recommend alignment of the world-class commissioning and comprehensive area assessment processes.

Recommendation 5:
A single point of leadership should be considered within the Department of Health, able to draw on expertise across the Department, with the role of ensuring strategic coherence in all areas of health and wellbeing policy and delivery. The experience of national support teams should be used to strengthen this work.

Recommendation 6:
Local health and wellbeing goals should be articulated and reviewed consistently and together within a single approach to inspection.

Integrated commissioning model for health and wellbeing

We propose that the policy actions identified through the strengthened arrangements across government and within the Department of Health should be implemented through a new integrated local commissioning model for health and wellbeing. This needs to identify explicitly how the NHS and local partners commission jointly to deliver improved health and wellbeing, building on strengthened local joint strategic needs assessments. The specific roles of primary care and different sectors of the NHS, social care and other local authority services, and other public sector partners are key in ensuring effective delivery, as is the role of local area agreements and other partnership arrangements in supporting integrated action on health and wellbeing. We envisage this integrated commissioning model being driven by local strategic partnerships, with localised health and wellbeing strategies and delivery plans being developed in response to local needs.

The vision is that the quality of integrated commissioning would be enhanced at each stage of the commissioning cycle. To assist in this, the national support package offered to assist localities would include improved modelling of lifestyle burdens for primary care trust (PCT) and local authority areas, support for needs assessment (for example, through a needs assessment tool), tools to tailor NICE guidance on health and wellbeing to local populations, more robust information on links between investments and outcomes, and a supporting basket of indicators for health and wellbeing.

Strong leadership across the local public sector is needed to ensure integrated commissioning of health and wellbeing. Local public sector leadership development programmes will support this strengthened delivery. Children's trusts would be well placed to lead on integrated commissioning for children.

Recommendation 7:
A new integrated commissioning model for health and wellbeing should be developed to improve health and wellbeing outcomes. This model should, as a priority, be applied to the 'top four' lifestyle issues, children's health, and prevention and effective management of long-term conditions.

Recommendation 8:
We recommend the development of integrated public sector leadership development programmes at the local level to ensure delivery of improved health and wellbeing.

Integrated public sector delivery at a local level – with a particular focus on children

Integrated commissioning will drive better integration of delivery at a local level. The example of children is illustrative, where different professions from various public sector bodies work with the same children and families of greatest concern, and potentially at greatest risk of a poor start in life. We believe that integrated delivery of public services for children under 5 is of the highest priority, given that patterns of behaviour and their impact on health and wellbeing are established in the very early years of life.

Children's access to interventions to promote their wellbeing is patchy, and under the age of 5 (when school attendance becomes compulsory) is most often dependent on parental engagement. This frequently leads to a situation where the children most in need of health and wellbeing assistance do not receive it, as their parents are the least engaged.

We are of the view that a strengthened children's workforce, with better integration between professions such as health visiting and social care, is needed to underpin interventions for children up to the age of 5 in these settings and build on the invaluable platform of children's trusts. One possibility that could be considered is a new profession of children's worker, integrating health and local authority roles.

People in the children's workforce need to be skilled in signposting health and social support, parenting skills, wider skills, and support services where necessary, intervening assertively when required, and providing cross-agency coordination and expertise in early years support. The authors welcome the targeted approach to public sector intervention for 0–5s where this is needed, such as in the Family Nurse Partnership Pilots, with their greater emphasis on parenting skills. We consider that the learning gained from these pilots needs to underpin the development of the children's workforce.

Better data on children is required for the public sector to systematically assist those with greatest needs. Sweden operates a system where a single national identifying number – used across all partners – enables all services to know from birth where children are living, and to record information on what services are being accessed for that child. This allows monitoring of children, with intervention scaled to level of risk. At present, England has two comparable information systems. The first system, ContactPoint is being rolled out nationally following a successful early adopter phase in 2009. It holds

basic information that allows professionals to contact other professionals working with the same child. The second system is the electronic enablement of the Common Assessment Framework (eCAF). This is due to be rolled out to early adopters from spring 2010. National eCAF is a tool to aid assessment of children's additional needs, and to support joint working to meet those needs. Consistent use by health professionals of both these systems would promote safeguarding and enhancement of children's health and wellbeing, and have significant benefits in terms of time saving for practitioners.

We also consider that increased support for delivery through general practice would be of benefit. Steps that could support this include consistent training for all GPs on health and wellbeing in children, better data sharing, shared incentives through alignment of vital signs and national indicator set measures, and joint training on basic skills and understanding of health and wellbeing, recognising the importance of motivation and behaviour change skills. Language to describe the health and wellbeing agenda needs to be inclusive and overtly aim to avoid alienating key partners in the delivery of health and wellbeing.

Recommendation 9:
We recommend strengthening the integration of the workforce for children's health and wellbeing, reflecting an emphasis on health and wellbeing outcomes, early intervention, and intensive case management wherever needed.

Recommendation 10:
We recommend stronger support and encouragement for NHS staff to record their involvement with children on ContactPoint, and to use it to support their practice in working with other practitioners, as well as to assist child protection.

Renewed vision for primary care and general practice

While health and wellbeing requires action across the whole public sector and government, the role of general practice is fundamental to prevention at an individual and community level. It is acknowledged that its unique role and access to the population can allow for improved case management, self-care and coherence with other local professionals.

We would recommend enhancing the role of GPs in supporting change in behavioural risk factors and mental wellbeing. There need to be weight management services appropriate to children and their families, as well as to adults, interventions to improve diet and physical activity, support to stop smoking and to drink within sensible limits, and psychological therapies.

To ensure that service provision meets evidence of best practice, we consider that each PCT should develop a list of approved health and wellbeing services for GPs to access for their patients. Inclusion of health and wellbeing services in Choose and Book would promote referrals and intervention on issues of health and wellbeing.

We consider that models for general practices should be explored, in which the 'deal' for signing on with a particular practice includes the GP assertively addressing behavioural risk factors with patients – similar to the approach taken by some health maintenance

organisations in the USA. This could be identified explicitly as a reason for patients choosing their GP. It should be supported by the development of tools to identify the reductions in healthcare expenditure that will result from reductions in behavioural risk factors in the practice population (such as smoking), in order to illustrate the potential savings to practice-based commissioning budgets.

Systematic approaches to early intervention on risk factors and to secondary prevention to support improved wellbeing in people with long-term conditions is also vital. The role of general practice in targeted case finding and proactive management of major long-term conditions should be strengthened. This, and improved support for self-care, has the potential to save considerable health and financial cost by bringing about a reduction in complications and emergency admissions.

We are concerned that the Quality and Outcomes Framework does not offer an incentive to provide care for the whole population, reflected in the targets for many quality indicators of covering 70% to 80% of the practice population. While we understand the rationale, the most needy, with the poorest health and wellbeing, are significantly over-represented in the other 20% to 30%. We are not sure of the best solution to this, but we consider that primary care professional groups, including the Royal College of General Practitioners, the NHS Alliance and others, should be invited to co-produce a renewed vision for primary care, including the role of primary care teams in both the individual health of their patients and the health of the communities that they provide care for.

It will not be possible to have practices that support people to stay healthy with intervention on behavioural risk factors without improved skills at the practice level, reflected in enhanced roles for nursing, pharmacist and other practice staff.

Recommendation 11:
A renewed vision for the future role of general practice needs to be developed in consultation with the Royal College of General Practitioners, the NHS Alliance and other key partners.

Recommendation 12:
The Choose and Book system should be expanded to offer GPs the option to refer to health and wellbeing services. A directory of approved services for the major behavioural risk factors and psychological therapies should be developed; this would point GPs and other health professionals to where evidence-based services are available.

Recommendation 13:
Tools should be developed that enable practices to understand the business case for improved health and reduced costs of healthcare by addressing behavioural risk factors in the practice population. These will support practice-based commissioning and underpin a potentially assertive model of practice intervention.

Recommendation 14:
The role of general practices in targeted case finding, proactive management of long-term conditions and support for self-care should be prioritised and supported through commissioning arrangements.

Focusing the NHS on prevention

There is a strong commitment across the NHS to improve health and to be fully engaged in prevention, as well as treatment. However, there is still a gap between this commitment and the practical reality of NHS performance and delivery. For example, patients in acute hospitals are routinely asked whether they smoke, but it is rare for support to be offered to help them stop, despite the fact that staff want to be able to help and patients usually expect to be offered support. The reasons appear to include a lack of knowledge of what evidence-based services are locally available, and a lack of skills and confidence in the NHS workforce to support behaviour change.

We consider that it is possible to develop a service – which could be called 'NHS Prevention' – that will help translate into reality the aspirations of NHS staff to address health and wellbeing. This was identified as a priority in the NHS Next Stage Review, but the model for implementation has not been consistently identified. Each PCT would draw up its directory of approved services for health and wellbeing, as identified in recommendation 12. Health trainers (or health advocates), trained in supporting people to change behaviour, would work with individuals and help them address these risk factors, referring to services, as appropriate, from the directory of approved services. The health trainers (or health advocates) would include people based within communities (such as the currently prevailing health trainer model, targeted on the most deprived communities), but the model could be extended so that existing staff could develop this role – for example, nurses or other staff within practices, staff on acute hospital wards or within mental health services. This would act as a professional development to existing staff roles, and trusts and practices could identify this service as a reason to choose their hospital or service for care.

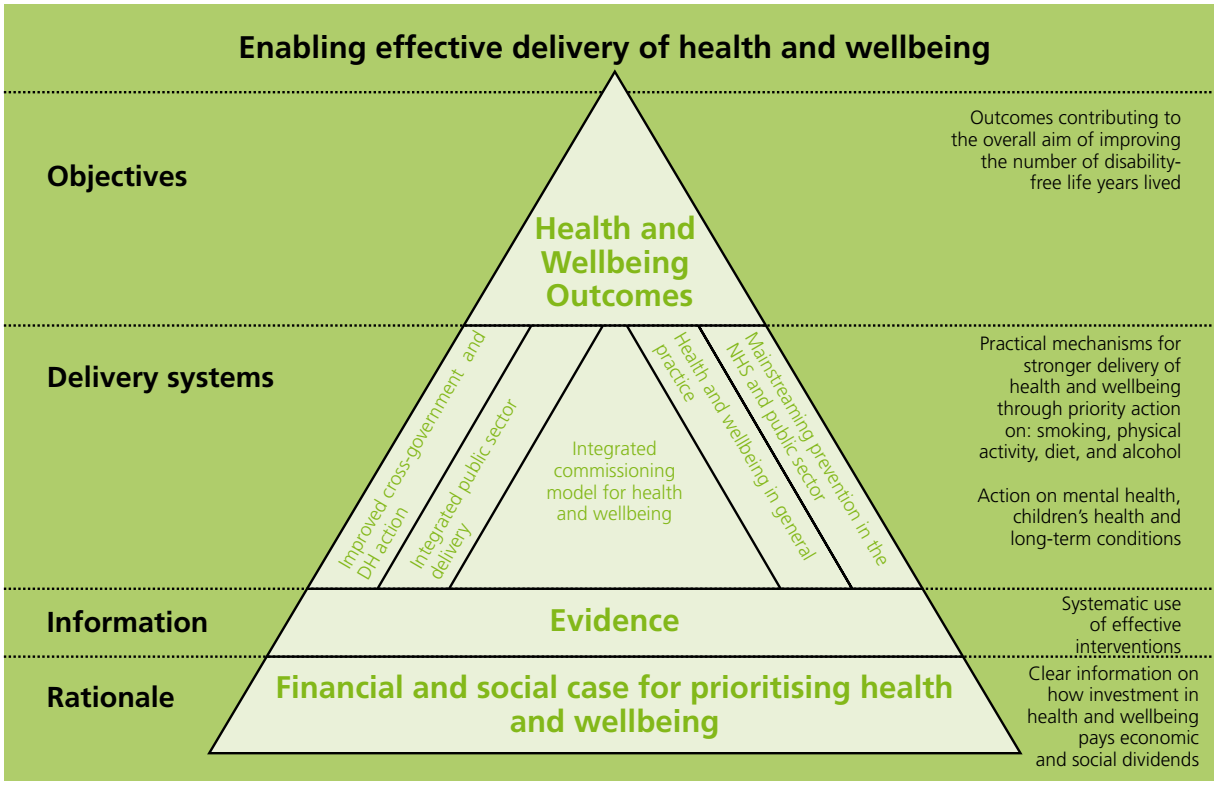
'NHS Prevention' developed in this way could support changes to behavioural risk factors in patients with other health conditions, such as heart disease, and form part of the range of interventions available following NHS life checks. The health advocates could champion and offer support to other NHS staff to improve their own health, and therefore contribute to future work based on the interim report of the recent review of health of the NHS workforce by Dr Steve Boorman. The model could also be extended to social care and public and private sector employers, to improve the health of their staff.

The business case to support this model needs to be fully worked up. However, we consider it likely that there is a strong case for developing the model for 'NHS Prevention' on the basis of an extension and development of existing staff roles, given existing evidence of the high cost-effectiveness of reducing the major behavioural risk factors for health, and of improving psychological wellbeing.

To underpin this, the Department of Health could encourage the embedding of health and wellbeing components into undergraduate, postgraduate and continuing professional training for all health and social care professionals.

Recommendation 15:
The model for 'NHS Prevention', and the business case to support it, should be developed urgently, as a means of embedding health and wellbeing further into the culture of the NHS.

It is the authors' view that these proposed changes to delivery systems will significantly reduce barriers to the ability of front-line organisations to improve health and wellbeing. This conceptual framework for the delivery of health and wellbeing is illustrated in the figure below.



2. Introduction

This report was commissioned by the Secretary of State for Health in April 2009, with a remit to:

- make recommendations on the future priorities for health and wellbeing; and
- make recommendations on what the Department of Health can do to best enable effective delivery on the front line.

This report sits alongside two other reports on health and wellbeing policy, exploring the appropriate role of the state and approaches to behaviour change. It does not reiterate prior vision statements, but aims to build on these with strong upstream and downstream measures to enable delivery.

Our task has been interpreted as primarily concerning health improvement, rather than the full breadth of health and wellbeing policy. Health inequalities and maximisation of the contributions to health and wellbeing made by public service organisations are a focus across all areas of the report. It is accepted that, across these aspects of health and wellbeing, it is necessary to work harder to deal with the needs of the most excluded than of those who are not disadvantaged. It is also necessary to take steps to eliminate discrimination and unfairness between different groups.

We see this report as addressing wider wellbeing. We see health, wellbeing, aspiration and motivation as inputs to economic and societal prosperity.

We acknowledge that major progress has been made in some areas, such as tobacco and cardiac disease mortality. There is, however, potential to do more on these behavioural risk factors, as well as on others, including obesity and physical activity.

Delivery across the agenda is piecemeal at present, and not as good as it could be. There are substantial benefits to be gained in terms of the quality of life and wellbeing of the population.

Greater leadership is desired for health and wellbeing, to help avoid conflicting messages being received at the front line.

We make no recommendations in this report on ringfenced budgets. These can clearly be helpful in protecting investment, but they also tend to identify health and wellbeing as separate from the mainstream function of the NHS and other public sector bodies. Whether or not budgets for health and wellbeing programmes are ringfenced, we consider it vital that the full corporate endeavours of the NHS and the wider public sector are applied to this purpose.

Key stakeholders and groups for delivery have been engaged in the development of this work. A summary of the consultations undertaken is provided at the end of the report (Annex C).

There are many previous and extensively researched reports into similar issues, including the Wanless Reviews;[1] *The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function* in England;[2] *Choosing Health*;[3] and *Closing the gap in a generation*.[4] The report will not duplicate these efforts, but will highlight some areas where delivery against previous reports is still needed.

We have been convinced that the existing work of the NHS, local authorities, other public sector organisations and the third sector needs to address health and wellbeing more strongly. The report considers how current mechanisms can be aligned to support delivery of public health through the mainstream agenda of all those organisations that have a role to play.

The report is explicit in proposing strategic changes to organisational drivers, delivery processes and approaches. Current systems have not been used to their utmost. Therefore, we do not consider major structural change, but instead focus on radical improvements in the application of current resources and delivery systems.

In this light, we propose a small number of key recommendations. These have been drawn up with an eye to and concern for those changes that will achieve the greatest improvements in health and wellbeing for the population.

This report is structured to provide initially our rationale for focusing on specific objectives and priority groups, namely:

- improving the health expectancy, as well as the life expectancy, of the population;
- focusing on the 'top four' behavioural risk factors with the greatest impact on life expectancy (tobacco, physical activity, diet and alcohol) and mental health and wellbeing;
- prevention of the onset of long-term conditions and deterioration, and improvements in quality of life and fulfilment for people with disability; and
- strengthened focus and approaches to improving the health and wellbeing of children under the age of 5.

It then addresses delivery systems, from which our recommendations are drawn:

- strengthened cross-government and Department of Health action on health and wellbeing;
- the need for a new integrated commissioning model for health and wellbeing;
- integrated public sector delivery at a local level – with a particular focus on children;
- a renewed vision for primary care and general practice; and
- focusing the NHS on prevention.

Health and wellbeing in older people is a critical issue, given the ageing of the population and the importance of maintaining independence and quality of life.

Section 1 Priorities and Objectives

3. Health Expectancy

> ***Focus and measurement of health and wellbeing should now reflect a desire to promote improved health and quality of life for the population as well as additional life expectancy.***

There are key factors that determine whether or not health and wellbeing receives sufficient investment or attention at the national, regional and local levels. Particularly in the present economic environment, the issue of cost and operational efficiency of action is central to decision making. Additionally, the importance and resonance of the outcomes of policy are critical. We will address these issues in turn.

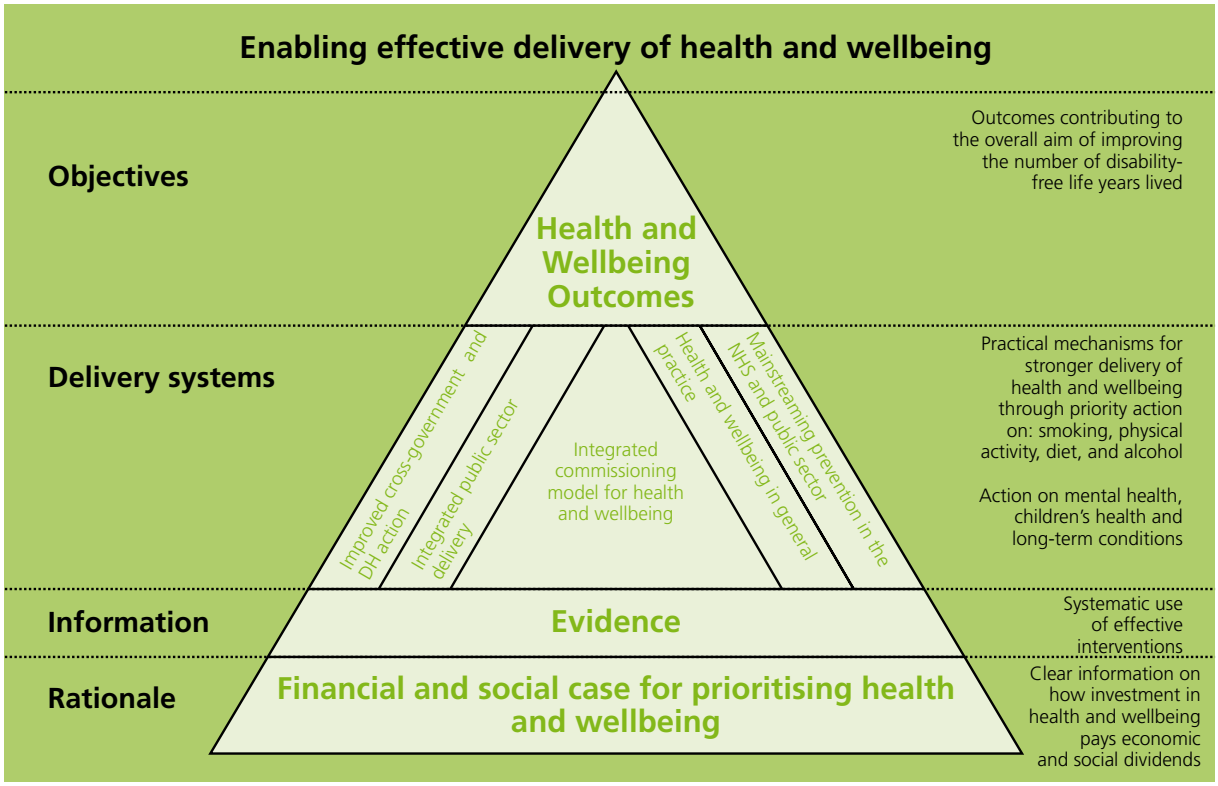
As illustrated in the following chapter on lifestyle interventions and mental health, a range of facts, cost-effectiveness data and financial data is available at the national level. Data on costs and health outcomes for health and wellbeing are also available through epidemiological evidence and National Institute for Health and Clinical Excellence (NICE) publication of economic information. There is, however, a lack of information to consistently help commissioners and local leaders perceive the financial case for intervention in prevention activity.

Examples of local-level efforts to draw together the financial case have been identified (example provided below), but such calculations are currently made on the basis of a historic, or estimated, level of provision. They do not articulate the full effects on the entire population if it were to receive the most effective package of interventions to prevent ill health.

An example of current return on investment calculations for a primary care trust[5]

TOPIC	INTERVENTIONS	Total investment after 5 years	Best case net saving after 5 years
ALCOHOL	• Provide screening of patients in primary care and appropriate advice for those with excessive drinking levels. • Provide brief interventions and facilitate behaviour change in those drinking at hazardous levels. • Refer to specialist treatment services as appropriate.	£812,000	**£3,349,000**
SMOKING	• Expand the current local services to target deprived and hard-to-reach communities. • Increase home visits to support pregnant women in their quit attempts and further develop support through midwifery services. • Promote tobacco control policies in public places and workplaces, including a Smoke-free NHS.	£305,000	**£1,248,000**
OBESITY	• Implement locally enhanced services in primary care to target all patients with a body mass index (BMI) of over 30 (or 28 with other health problems) in order to: – record BMI and offer advice and support for weight management; – provide motivational support for behaviour change; and – follow up patients.	£1,984,000	**£2,183,000**
TOTAL		£3,101,000	**£6,780,000**

Modelled effects for the benefit for the local area should include morbidity, mortality, economic and broader social effects on issues such as working time lost due to illness. Return on investment calculations for each geographical area should include modelled effects of intervening on tobacco, alcohol, physical activity, diet and nutrition, long-term conditions and health of children under the age of 5.

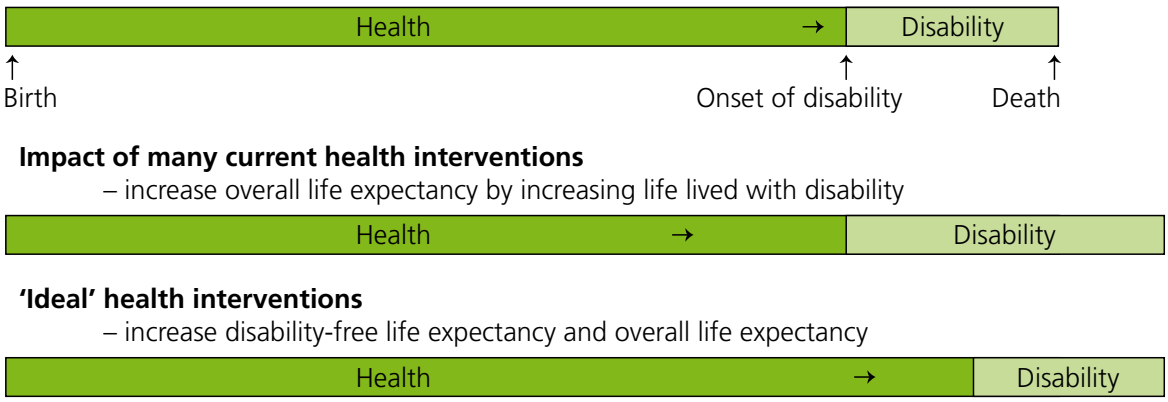


Health-burden information and evidence need to be tailored to local populations, so that assumptions made and interventions selected are appropriate to the demographic and societal context.

The Department of Health should help draw together a package of analysis to assist localities in making the broad financial and social case across the range of public sector investment in health and wellbeing.

Both conceptually and practically, systems and organisations require clear and meaningful objectives for health and wellbeing. We are of the view that an overarching policy objective to improve health expectancy (which takes account of the number of years lived without disability and with a good quality of life) should be added to the current objective to improve length of life. This reinforces the aspiration to add life to years, as well as years to life.

Improving health expectancy: policy options



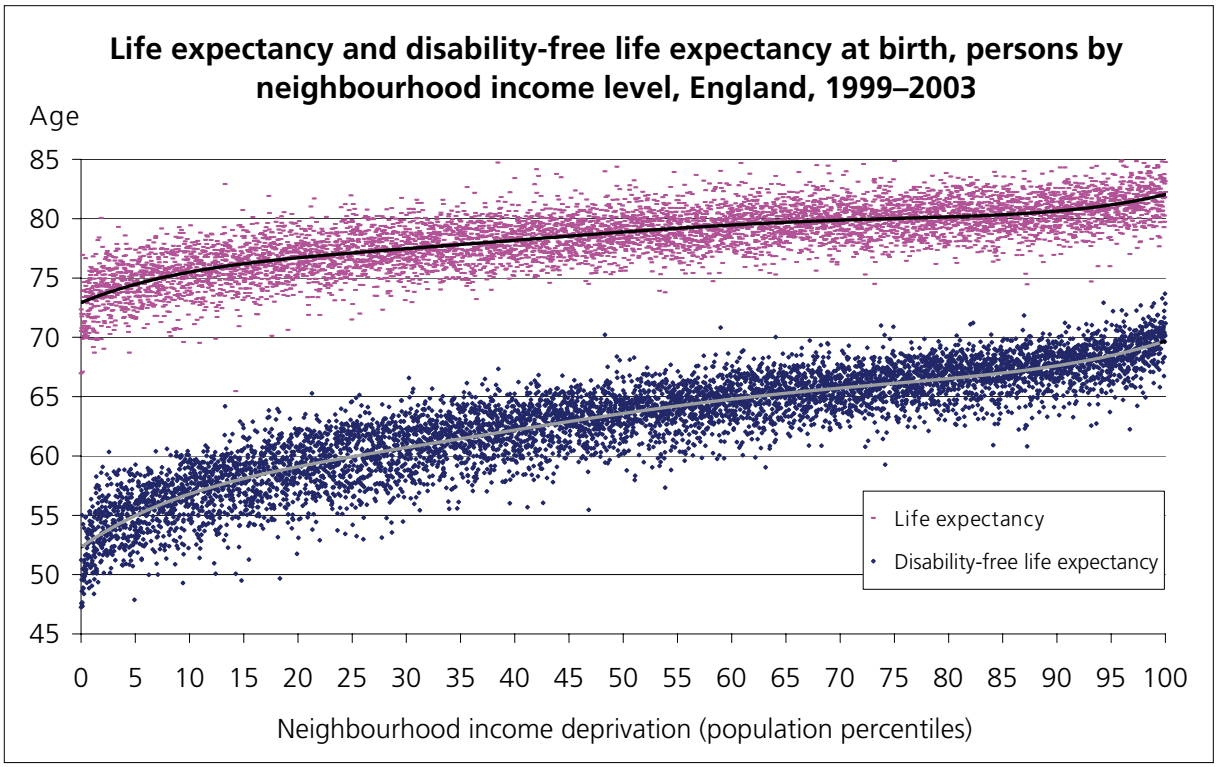
The current average life expectancy and disability-free life expectancy (health expectancy) is represented by the first bar of the figure above, with the impact of many currently prioritised health interventions being to increase overall life expectancy but not disability-free life expectancy (second bar). Ideal interventions increase both disability-free life expectancy and overall life expectancy (third bar). Furthermore, we believe that most people may value an increase in disability-free life expectancy over an increase in absolute life expectancy.

Many important healthcare interventions increase life years lived with disability, and achieve the outcome represented in the second bar of the figure. However, many interventions that cost less and are more cost-effective increase disability-free life expectancy (health expectancy), yet are not routinely implemented. For example, increasing physical activity improves mental health and wellbeing, reduces rates of heart disease and cancer, reduces the likelihood of developing diabetes in those at risk, reduces deterioration in people with many established long-term conditions, and improves mobility, quality of life and life expectancy in older people. NICE's appraisals

of healthcare technologies are rightly expected to be implemented across the NHS within three months. However, its guidance on improving rates of physical activity, which identifies interventions that are considerably more cost-effective than many health technologies, does not have the same expectation of implementation.

Health expectancy is also a valuable indicator of inequalities. The diagram below, courtesy of the Strategic Review of Health Inequalities in England Post-2010 (the Marmot Review), shows the difference between life expectancy (the top line) and the point at which a person develops ill health (the bottom line). While the universal aim is for people to have poor health at a later age than at present (raising the bottom line for all), it is clear from this diagram that those in disadvantaged groups (on the left-hand side) are presently living far more years of their lives in disability than are those who are not disadvantaged (on the right-hand side). This means that not only are the disadvantaged dying sooner than their more advantaged counterparts, but they are also on average living for over 20 of those years in poor health.[6]

We recognise that, taken in isolation, this argument can appear to undervalue the fulfilled lives of people with disability or long-term conditions. We consider that improving the health and wellbeing of people with disability and with long-term health conditions, and enabling them to live more fulfilled lives, is also a vital policy objective.



Source: Office of National Statistics

For action on health expectancy, the Department of Health and other departments must know which interventions impact on life years lived without disability. Present guidance does not overtly rank interventions on this basis. NICE guidance should, therefore, be ranked on impact for both life expectancy and health expectancy, so that prioritisation and action across government can be directed at the interventions with most impact. The wider determinants of health should be included in this consideration.

In addition, there is growing evidence on how to measure the quality of life and fulfilment of people with disability. It would be appropriate to explore the opportunity to explicitly identify the impact of interventions to improve health and wellbeing, with the objective of applying those that are most cost-effective in terms of outcomes.

Finally, cost-effectiveness information alone is not sufficient to underpin investment decisions by the NHS and public sector partners. The opportunity to develop information on the cost impact and return on investment of implementing NICE guidance should also be explored.

Recommendation 1:
We recommend an overarching tier 1 vital sign to improve disability-free life expectancy (health expectancy), in addition to the existing vital sign indicator on life expectancy. This should be supported by tier 2 vital signs for local agreement on the four major lifestyle factors (smoking, alcohol, physical activity and diet) and psychological wellbeing. These metrics should also be included in national indicators.

Recommendation 2:
The Department of Health should explore with NICE the explicit identification of the impact of clinical and public health interventions on overall life expectancy and on health expectancy, and quality of life for people with disability and long-term conditions. NICE should produce rankings of the most cost-effective clinical and public health interventions, with an expectation of delivery of the most cost-effective. The feasibility to provide assessments of cost impact and return on investment should also be explored.

Recommendation 3:
The impact on health expectancy should be used explicitly to judge the benefits of new policies that impact on health and wellbeing.

4. Lifestyle Interventions and Mental Health

> ***It is important that clear priorities are stated for health and wellbeing. This should start with the biggest lifestyle influences on population health: tobacco, alcohol, physical inactivity and poor diet.***

Four specific lifestyle factors (tobacco, physical inactivity, excess alcohol consumption and poor diet) are among the biggest contributors to most preventable disease, across all social groups and in all areas of England.

These four factors have been selected, in part, since return on investment and cost-effectiveness in these areas make them attractive for initial focus. The prioritisation of the top four was also cognisant of areas otherwise covered by work on long-term conditions. While we propose that the focus should be on these four, we also consider other behavioural risk factors to be vitally important.

The 'top four' of tobacco, physical inactivity, excess alcohol consumption and poor diet are responsible for 42% of deaths from leading causes,[7] and approximately 31% of all disability-adjusted life years (DALYs).[8] Together they account for at least £9.4 billion in annual direct costs to the NHS.[9]

UNITED KINGDOM					
Deaths			DALYs		
	Risk factor	% of total		Risk factor	% of total
1.	Tobacco	24.3	1.	Tobacco	14.2
2.	High blood pressure	19.4	2.	High blood pressure	8.6
3.	High cholesterol	13.3	3.	High cholesterol	6.9
4.	High BMI	8.0	4.	High BMI	6.3
5.	Physical inactivity	5.5	5.	Alcohol	5.2
6.	Low fruit and vegetable intake	4.0	6.	Physical inactivity	3.1
7.	Occupational airborne particulate matter	0.6	7.	Illicit drugs	2.6
8.	Urban outdoor air pollution	0.6	8.	Low fruit and vegetable intake	2.2
9.	Unsafe sex	0.6	9.	Unsafe sex	0.8
10.	Illicit drugs	0.4	10.	Occupational airborne particulate matter	0.6

Deaths and DALYs attributable to the 10 leading causes of death in the WHO European Region, 2002. *The European health report: Public health action for healthier children and populations*, World Health Organization Europe, modified by authors.

If expenses incurred outside the NHS are included, these figures rise further. The social costs of alcohol amount to between 1% and 3% of GDP – estimated at £20 billion per annum;[10] costs attributed to poor diet (cardiovascular disease, diabetes, cancer, dental caries, digestive diseases) stand at £6 billion per annum;[11] and costs due physical inactivity at £1 billion.[12] The direct costs of smoking stand at £5.2 billion per annum,[13] not inclusive of the 34 million working days lost to British industry every year from smoking-related sick leave.[14]

The above figures illustrate the cost of the do-nothing scenario. In fact, projected future costs are higher, associated with all four major lifestyle factors. There will be an increasing burden of cost.

A 0.4% per annum reduction in smoking prevalence has been linked to £13 million[15] savings by 2010/11 through reduced emergency admissions for acute myocardial infarction and stroke. Reduction in length of stay and waiting times from pre-operative smoking cessation would provide net savings of £25 million after one year, and savings at this level would be anticipated for at least the first three years.[16]

It is calculated that brief interventions for alcohol misuse in a primary care setting reduce GP consultation and secondary treatment costs by £50–75 million after one year.[17] A reduction in problematic alcohol drinkers has the potential to reduce alcohol attendances at accident and emergency units by 4% in one year.[18]

Overall savings can be anticipated for a range of interventions linked to diet and exercise over the longer term. The Organisation for Economic Co-operation and Development (OECD) is presently working on a model of obesity prevention for the UK, in collaboration with the UK, providing estimate savings for a range of interventions.

Psychological health is, in many instances, a fundamental determinant of health. Mental health is linked to lower employment levels (estimated to cost £26.1 billion per annum),[19] and early intervention in mental health has been found to save between £64,000 and £150,000 per case through initiatives to address conduct, emotional disorders and social and emotional skills.[20] Recent thinking suggested purpose and rationale for government intervention to improve wellbeing and happiness;[21, 22] and quality of life is associated with mental wellbeing.

Investment in prevention increases the number of healthy years lived, and such investment is generally cost-effective.[23] However, we note the lack of consistent and high-quality data on the broader social effects across lifestyle diseases, and a paucity of information on governmental and NHS payback times on investment in health improvement and wellbeing. Strengthening of the evidence is of critical import.

Prioritisation within lifestyle factors, and within health and wellbeing, has been considered on the basis of currently available information. Where work is ongoing to determine the relative financial impacts and returns on investment for interventions (such as analysis of contributions to all-age all-cause mortality), this should inform future prioritisation.

The effect on important areas of health and wellbeing policy not included in this top list has been considered. The gains to be made from having health and wellbeing focus clearly, as a first priority, on a limited number of areas was judged to be substantial and worthwhile. The aspiration would be for commissioning and prioritisation to deliver against these areas, and for attention then to be turned to other issues.

5. Long-term Conditions

> ***Prevention of the onset and deterioration of long-term conditions will yield significant gains for health in the population; it is, however, vital that the current focus on risk factors is complemented by policy to address common underpinning social determinants.***

Prevention of the onset and deterioration of long-term conditions encompasses a broad range of preventative interventions, and establishment of the priority areas for work on long-term conditions has been undertaken within the Department of Health. The Department considered:

- information on prevalence;
- disease severity and mortality;
- NHS expenditure;
- optimality of treatment; and
- quality of years lost.

Five high-impact groups were identified: circulatory conditions, respiratory conditions, mental health conditions, musculoskeletal conditions and cancers.

This report will not duplicate the dedicated work on long-term conditions already in development, but it does emphasise the extent to which behavioural risk factors and health and wellbeing are core to preventing and reducing the severity of long-term conditions. Tackling behavioural risk factors is often seen as an issue among younger, predominantly healthy people, but behavioural factors are also major risk factors in the onset and relapse of, and premature mortality from, long-term conditions such as diabetes, cardiac disease and respiratory disease, and for increased disability from musculoskeletal conditions and mental ill health. There is also strong evidence that reducing behavioural risk factors in older people significantly increases both quality and length of life, irrespective of any pre-existing long-term condition. With ageing of the population, it is critical that we have a strong focus on improving health and wellbeing in older people.

Physical activity is a powerful example. Diet and exercise have been found to reduce the relative risk of diabetes by 37%.[24] Unplanned care costs and costs of poor downstream management of long-term conditions are dramatic and have large negative effects on the local health and social care economy. The cost-effectiveness of behaviour change is stark in comparison.

The authors seek, additionally, to emphasise the current imbalance in investment in health services. Investment in health services has been skewed towards the final year of life, while opportunities to prevent, delay the onset or reduce the severity of disease have, in comparison, been poorly grasped. There is the potential to shift investment in long-term conditions, where the industrial-scale application of effective preventative interventions would draw finance to the prevention side.

We believe that policy on long-term conditions should incorporate a strong sense and consideration of those people who are affected by multiple environmental and individual risk factors.

Statistical modelling of individual categories related to prevention – fruit and vegetable consumption, drinking, smoking and recreational activity – has indicated that characteristics vary consistently in association with a combination of social determinants (increasing prosperity, social capital and positive mental health).[25]

Social determinants highlighted in the pending Strategic Review of Health Inequalities in England Post-2010 (Marmot Review) should be integrated, where pertinent, into long-term conditions policy.

Section 2 Recommendations to Enable Effective Delivery

6. Strengthened Cross-government and Department of Health Action on Health and Wellbeing

Health and wellbeing requires stronger policy coordination across government and within the Department of Health.

Actions to improve health and wellbeing are frequently undertaken outside the NHS, and mechanisms to ensure cross-government action sometimes appear to lack the impact needed to be most effective.

Physical activity is illustrative, as there is good evidence that it is affected by the physical design of schools, school travel plans, the design of the built environment, the extent to which transport infrastructure encourages physically active travel, access to the natural environment, access to leisure facilities, and interventions in the workplace. It also has beneficial impacts on health and wellbeing at all ages, on educational outcomes and on economic productivity.

Strong health and wellbeing delivery through government departments requires greater understanding of health and wellbeing and its contribution to wider community prosperity, and the actions needed by different government departments to improve health and wellbeing. Other departments' specific delivery responsibilities would be clearer, particularly where action is the collective responsibility of several departments.

This requires strong advocacy and policy coordination across government. The Department of Health should invest in measures to strengthen the expertise and understanding within other government departments and agencies of health and wellbeing, as well as its contribution to wider community prosperity. The aim should be for all government ministers and departments to feel that they have a major stake

in health and wellbeing, and in promoting it through their own policies. Hence, while the Department of Health would have a leadership role, health and wellbeing would be recognised more strongly as an issue for all government departments.

Stronger and more innovative mechanisms should be created to promote cross-government actions to improve health and wellbeing. There should be a genuine ability to influence the actions required of different government departments and to promote integrated commissioning, arrangements to encourage greater shared ownership and accountability for delivery of actions, and recommendations for future shared public service agreement arrangements.

However, we are uncertain of the most practical way to achieve a strengthening of arrangements at a national level, and believe that ministers and other senior officials within the Department of Health will have a better view of what will work. We believe that a range of options may be appropriate, from time-limited cross-government working groups to advise on individual aspects of health and wellbeing policy, to models such as the new national safeguarding delivery unit (NSDU), which supports action to improve children's safeguarding.

Government Offices also have a clear role to facilitate integrated approaches across departments at a regional level.

Recommendation 4:
Stronger and more innovative mechanisms are needed for cross-government actions to improve health and wellbeing, including mechanisms to identify the role of different government departments and their delivery systems.

Effective implementation of health and wellbeing initiatives needs coordinated action at a local level across all NHS activities, as well as in partnership with other public sector bodies. To support this, it would be helpful to identify – at a national level – the evidence for effectiveness and the economic case for action, metrics for judging success, and the means of delivery through world-class commissioning and action across the public sector.

This could be reflected in improved coordination across the Department of Health, with input from teams working on health improvement and protection, NHS workforce, social care, primary care, world-class commissioning, system management, local and regional partnerships, inspection and standards. A single team with a single point of leadership may be an appropriate mechanism.

We have found the national support teams to be extremely valuable in supporting practical local delivery of health and wellbeing outcomes. Their experience should be used to ensure that national approaches are grounded in the reality of delivery, informing the national coordination of policy and expectations of the delivery system.

All current inspection processes should emphasise the importance to the NHS of prevention. The Department of Health should aim for inspections to be coherent and, where possible, aligned so that front-line organisations can set priorities on a consistent basis. We recommend alignment of the world-class commissioning and comprehensive area assessment processes.

Recommendation 5:
A single point of leadership should be considered within the Department of Health, able to draw on expertise across the Department, with the role of ensuring strategic coherence in all areas of health and wellbeing policy and delivery. The experience of national support teams should be used to strengthen this work.

Recommendation 6:
Local health and wellbeing goals should be articulated and reviewed consistently and together within a single approach to inspection.

7. Integrated Commissioning Model for Health and Wellbeing

> ***Existing commissioning systems should be built upon to deliver health and wellbeing outcomes in a more powerful and systematic way.***

We propose that the policy actions identified through the strengthened arrangements across government and within the Department of Health should be implemented through a new integrated local commissioning model for health and wellbeing. This needs to identify explicitly how the NHS and local partners commission jointly to deliver improved health and wellbeing, building on strengthened local joint strategic needs assessments. The specific roles of primary care and different sectors of the NHS, social care and other local authority services, and other public sector partners are key in ensuring effective delivery, as is the role of local area agreements and other partnership arrangements in supporting integrated action on health and wellbeing. We envisage this integrated commissioning model being driven by local strategic partnerships, with localised health and wellbeing strategies and delivery plans being developed in response to local needs.

The vision is that the quality of integrated commissioning would be enhanced at each stage of the commissioning cycle. To assist in this, the national support package offered to assist localities would include improved modelling of lifestyle burdens for primary care trust (PCT) and local authority areas, support for needs assessment (for example, through a needs assessment tool), tools to tailor NICE guidance on health and wellbeing to local populations, more robust information on links between investments and outcomes, and a supporting basket of indicators for health and wellbeing.

The integrated commissioning model for health and wellbeing would aim to ensure that eight objectives are pursued:

1. Increased focus on commissioning for health and wellbeing.
2. Coordinated prioritisation across government departments for health and wellbeing.
3. Joint commissioning and planning of services by local partners.
4. Stronger use of lifestyle burdens information, feeding into health needs assessment.
5. Greater dissemination and uptake of effective interventions.
6. Creation of an overall package of services for each locality that meets levels of lifestyle burdens.
7. Development of supporting measures and indicators on which to assess performance improvement.
8. Ensuring clear links between investments and outcomes.

Leadership and development of the commissioning model should be an inclusive process, driven by practitioners from the front line. This model should, as a priority, be applied to the 'top four' lifestyle issues, mental health, children's health and the prevention of long-term conditions. This should build on existing joint strategic needs assessments and joint commissioning guidance such as that articulated for children in *Securing better health for children and young people through world class commissioning*.[26] The aim should be to deliver against levels of aspiration and opportunity at the local level for health and wellbeing.

Specific steps to achieve the integrated commissioning model include:

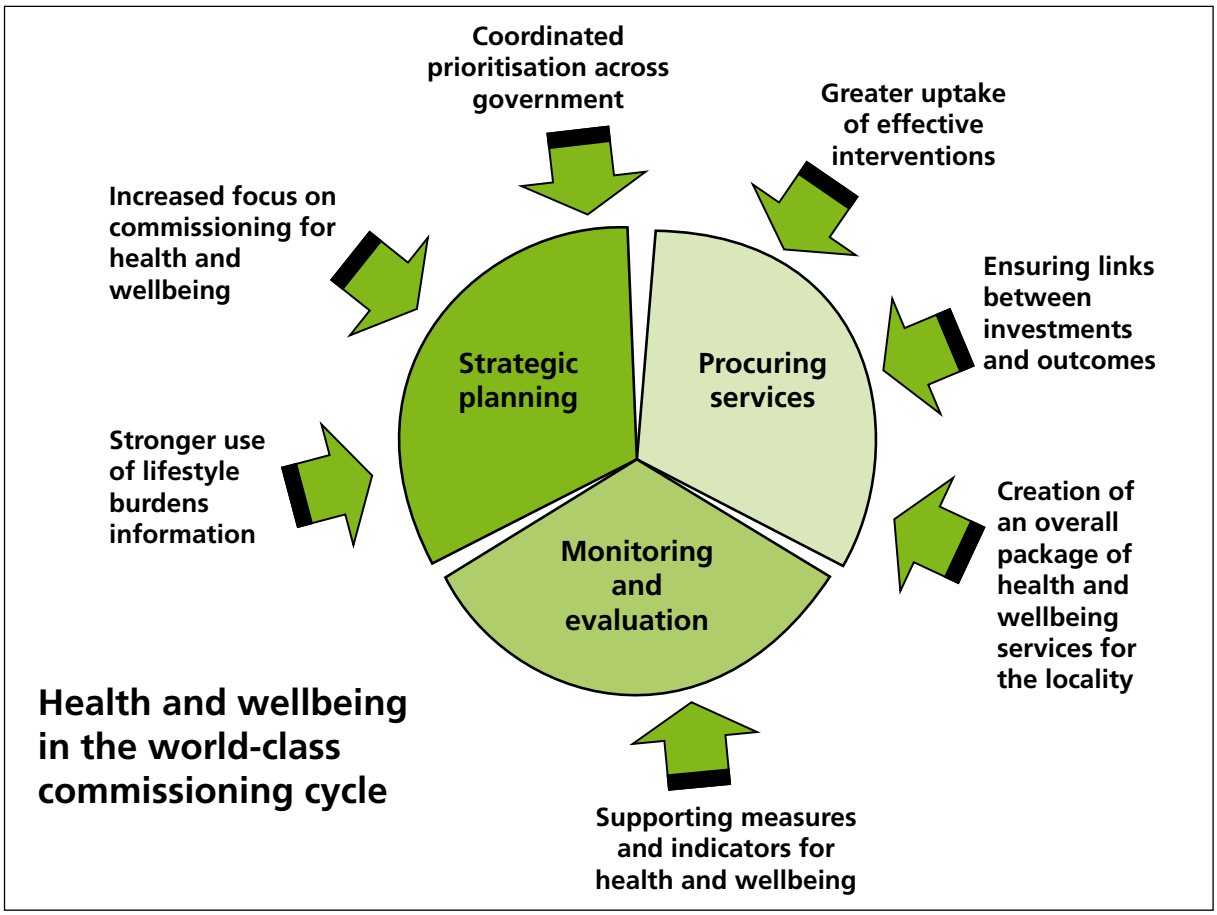
1. Production of a guide on how best to ensure effective commissioning through the use of the integrated commissioning model.
2. Department of Health provision of modelling of the burden of lifestyle factors for each primary care trust and local authority area.
3. A needs assessment tool, which combines lifestyle burden data with evidence of effective interventions, to be used at local level to determine the packages of interventions required to address prevention. This should allow each PCT and local authority to identify the interventions that are appropriate to their demography and the scale of specific services they should commission, and should be used as part of a joint strategic needs assessment.
4. Provision of a basket of indicators to support local services and assist with monitoring and assurance of delivery. This basket of indicators to support integrated commissioning of health and wellbeing should be consistent across the vital signs, national indicator set for local area agreements, Joint Area Review, and Care Quality Commission processes.

Strong leadership across the local public sector is needed to ensure integrated commissioning of health and wellbeing. Integrated leadership development programmes will support this strengthened delivery.

Recommendation 7:
A new integrated commissioning model for health and wellbeing should be developed to improve health and wellbeing outcomes. This model should, as a priority, be applied to the 'top four' lifestyle issues, children's health, and prevention and effective management of long-term conditions.

Recommendation 8:
We recommend the development of integrated public sector leadership development programmes at the local level to ensure delivery of improved health and wellbeing.

Objectives for health and wellbeing in NHS world-class commissioning cycle, 2009



Department of Health (2009), *World Class Commissioning*, DH diagram; amended by authors.

8. Integrated Public Sector Delivery at a Local Level – with a Particular Focus on Children

Fragmentation is particularly noticeable in services for children, despite the critical importance and influence of health and wellbeing in the early years. Children's trusts are an important basis on which to build integrated commissioning, a joined-up view of the children's workforce, and collective purpose.

Health and wellbeing can, and should, be clearly seen as the foundation for societal prosperity and as providing inputs to a flourishing society.

It is, for instance, an input to educational attainment, through reduced depression, anxiety and teenage pregnancy. Improvements in skills and employment are gained through better levels of self-esteem and aspiration.

There are, however, systemic barriers to forming policy across sectors for single population groups – whether defined as communities of interest or by geographical location. In both cases, the key issue is a need to simplify and strengthen focus on those groups and places where investment and reform will have the greatest impact.

Tackling major health and wellbeing issues requires aligned approaches between public sector partners. Strong PCT and local authority partnerships are a foundation for such intensively integrated services. Joint ownership of the Children and Young People's Plan by both the PCT and the local authority is a welcome development, and an important platform for delivering through partnership.

Obvious steps should be taken to establish organisational incentives for collective purpose. It is the authors' sense that local area agreements should be given sufficient time to bed down and consolidate partnership working, and that the alignment of supporting performance frameworks is required between the NHS vital signs and the national indicator set. This aims to move towards collective work for collective rewards and cross-cutting targets.

Barriers have also been noticeable in the case of planning regulations. Enhanced focus is needed at government level to secure maximum health gain from planning. This should particularly address regulations that permit obesogenic environments (such as those environments with a high density of fast-food outlets) and environments not conducive to physical activity. Planning that facilitates walking and cycling is of particular importance. This is a topic where improvements would help multiple local partners achieve healthy places and reduce inequalities in health.

Other local barriers to integrated and coherent working may be identified through the current Total Place pilots. These will look at where barriers to integration can be dismantled. In particular, those pilots that address alcohol, child obesity, teenage pregnancy and child health must be of major import. These pilots will provide feedback to the Government in autumn 2009 on local barriers to delivery and potential opportunities to align services. They will only have the desired impact if they

are evaluated in a way that provides a basis for systematic cost–benefit analysis of interventions. This is a major opportunity to seek systemic integration and motivation for communities to address resilience and achievement in health and wellbeing.

There is an undoubted correlation between the health and life chances of a child in its early years and its future wellbeing, morbidity, mortality and ability to engage to the best of its ability in society. The period between birth and 5 years of age is critical.[27] Ill health or harmful lifestyle choices in childhood can lead to worse health status throughout life, and create ongoing negative individual and social effects.[28]

There is increasing momentum (through the Children's Plan,[29] the Marmot Review,[30] the World Health Organization's *Closing the gap in a generation*,[31] and evaluation of children's centres[32]) for recognition of the crucial nature of multiple-agency interventions for 0–5s. Joint policy between the Department of Health and Department for Children, Schools and Families includes the child health strategy, *Healthy lives, brighter futures*[33] and the *Healthy Child Programme: Pregnancy and the first five years of life*.[34]

There are loud calls for better coordination across agencies, the development of models of services for this age group, and emphasis on holistic 'family' thinking to prevent physical, social and mental developments that are difficult to remedy later.

There is not a single, coordinated link to each child under the age of 5, and minimal interventions are currently mandatory for this age group. As a result, current chances to intervene on a holistic and cross-cutting prevention agenda are not maximised.

Children's access to interventions to promote their wellbeing is patchy, and under the age of 5 (when school attendance becomes compulsory) is most often dependent on parental engagement. This frequently leads to a situation where the children most in need of health and wellbeing assistance do not receive it, as their parents are the least engaged.

It is possible for the platforms for intervention currently available, such as children's centres, to be further developed. This recognises the fact that pockets of deprivation exist alongside whole areas of deprivation. Children's centres are seen as a valuable potential health and wellbeing platform from which to engage with parents and raise their wellbeing, their aspirations for better physical and mental health for their children, and better outcomes for their families.

We are of the view that a strengthened children's workforce, with better integration between professions, such as health visiting and social care, is needed to underpin interventions for children up to the age of 5 across a geographical area. One possibility that could be considered is a new profession of children's worker, integrating health and local authority roles.

People in the children's workforce need to be skilled in signposting health and social support, parenting skills, wider skills, and support services where necessary, intervening assertively when required, and providing cross-agency coordination and expertise in early years support. The authors welcome the targeted approach to public sector intervention for 0–5s where this is needed, such as in the Family Nurse Partnership Pilots, with their greater emphasis on parenting skills. We consider that the learning gained from these pilots needs to underpin the development of the children's workforce.

For the public sector to systematically assist those with greatest needs, better data on children is required. Sweden operates a system where a single national identifying number – used across all partners – enables all services to know from birth where children are living, and to record information on what services are being accessed for that child. This allows monitoring of children, with intervention scaled to level of risk.

At present, England has two relevant information systems available. The first system, ContactPoint, is a universal database, which holds basic information and operates as a directory for professionals who need to know who else is working with the same child. The success of this potentially extremely valuable system hinges on the commitment of professionals to enter a record when contact is made with a child. To date, in very many geographical areas primary care trusts, health practitioners and managers have had limited engagement with their local authorities, and there is a need to improve healthcare worker recording on the system. Greater partnership work must be undertaken so that the database is well populated and at-risk children are more likely to be detected through the system. There is also a need for commitment to ensure effective use of ContactPoint by practitioners in health settings.

The second system is the electronic enablement of the Common Assessment Framework (National eCAF). CAF is a tool to support early intervention and integrated front line service delivery for children and young people with additional needs, where those needs are not being met by their current service provision. It is a process through which practitioners assess needs, identify what services need to be involved in meeting those needs and what interventions are appropriate. The process takes place with the involvement and consent of the child, young person and/or family. National eCAF is due to be rolled out to early adopters from spring 2010.

Consistent use by health professionals of both these systems would promote safeguarding and enhancement of children's health and wellbeing.

We also consider that increased support for delivery through general practice at a local level would be of benefit. Steps that could support this include consistent training for all GPs on health and wellbeing in children, better data sharing, shared incentives through alignment of vital signs and national indicator set measures, and joint training on basic skills and understanding of health and wellbeing, recognising the importance of motivation and behaviour change skills. Language to describe the health and wellbeing agenda needs to be inclusive and overtly aim to avoid alienating key partners in the delivery of health and wellbeing.

Recommendation 9:
We recommend strengthening the integration of the workforce for children's health and wellbeing, reflecting an emphasis on health and wellbeing outcomes, early intervention, and intensive case management wherever needed.

Recommendation 10:
We recommend stronger support and encouragement for NHS staff to record their involvement with children on ContactPoint, and to use it to support their practice in working with other practitioners, as well as to assist child protection.

9. A Renewed Vision for Primary Care and General Practice

The role of general practice is fundamental to promoting prevention. It is acknowledged that GPs' unique role and level of access to the population can allow for improved case management, self-care and coherence across the public sector.

Primary care has a key role to play in improving health and reducing health inequalities. General practice can build from its strengths as the main point of contact between the public and the NHS to reduce the likelihood of ill health and reduce health inequalities.

While health and wellbeing requires action across the whole public sector and government, the role of general practice is fundamental to prevention at an individual and a community level. It is acknowledged that its unique role and access to the population can allow for improved case management, self-care and coherence with other local professionals.

We would recommend enhancing the role of GPs in supporting change in behavioural risk factors and mental wellbeing. There needs to be provision of weight management services appropriate to children and their families, as well as to adults, interventions to improve diet and physical activity, support to stop smoking and to drink within sensible limits, and psychological therapies.

To ensure services meet evidence of best practice, we consider that a list of approved health and wellbeing services should be developed locally. Inclusion of health and wellbeing services in Choose and Book would promote referrals and intervention on issues of health and wellbeing.

We consider that models for general practices should be explored in which the 'deal' for signing on with a particular practice includes the GP assertively addressing behavioural risk factors with patients – akin to the approach taken by some health maintenance organisations in the USA. This could be identified explicitly as a reason for patients choosing their GP. It should be supported by the development of tools to identify the reductions in healthcare expenditure that will result from reductions in behavioural risk factors in the practice population (such as smoking), in order to illustrate the potential savings to practice-based commissioning budgets.

Systematic approaches to early intervention on risk factors and to secondary prevention to support improved wellbeing in people with long-term conditions is also vital. The role of general practice in targeted case finding and proactive management of major long-term conditions should be strengthened. This, and improved support for self-care, has the potential to save considerable health and financial costs of acute and secondary care, by bringing about a reduction in complications and emergency admissions.

We are concerned that the Quality and Outcomes Framework does not offer an incentive to provide care for the whole population (reflected in the targets for many quality indicators to cover 70% or 80% of the practice population). While we understand the rationale, the most needy, with the poorest health and wellbeing, are significantly over-represented in the other 20% to 30%. We are not sure of the best solution to this, but we consider that primary care professional groups, including the Royal College of General Practitioners, the NHS Alliance and others, should be invited to co-produce a renewed vision for primary care, including the role of primary care teams in both the individual health of their patients and the health of the communities that they provide care for.

Primary care quality is also paramount. Interventions based on the medical model, particularly for blood pressure and cholesterol, have large-scale impacts on prevention if implemented systematically. There has, however, been a failure among those potentially most in need and disadvantaged to become engaged in the process and for provision to be made to control their risk factors. Moreover, there is a rationale for any transformation of the system to focus on supporting people to stay healthy, with very early intervention on potential risk factors, in addition to case management. Recording and intervention on body mass index, diet and nutrition, levels of physical activity and tobacco use should be a priority for general practice. Intervention on the 'top four' lifestyle risks should be financially incentivised for the whole of a practice population, and incentives should increase for those patients who are most difficult to engage with.

GPs' training should be carefully considered to increase their skills for health and wellbeing, such as the ability to undertake brief intervention and motivational training. The weakness of the current training in paediatric issues should be rectified, in view of the critical import of this link to families, particularly those in vulnerable or disadvantaged groups.

This view has also been reiterated in recent consideration of the role of the doctor by the Royal College of Physicians: working group recommendations on outreach and education recommended that 'doctors could and should do more to outreach to socially disadvantaged and marginalised communities and groups; engage more in, and promote, health education; and improve the public health component of individual consultations'.[35]

GPs have a role in driving partnerships for prevention, with bespoke packages of public service intervention and effective practice-based commissioning. Practice-based commissioning should place an emphasis on GPs working with other contractors, having a key role to play in coordinated services for positive impacts on people and places at the neighbourhood level. Through their practice populations, GPs can provide a cornerstone for holistic and integrated public service engagement with local populations.

Supporting people to stay healthy with intervention on behavioural risk factors will not be possible without improved skills at the practice level, reflected in enhanced roles for nursing, pharmacist and other practice staff. Amended or enhanced roles for nursing, pharmacist and practice staff may be crucial to achieving strong multi-disciplinary teams at ward and practice-population level, equipped to provide holistic and integrated public service engagement with local populations. Provision should include the ability to navigate people to services, promote case finding, signposting and self-care.

Availability of GPs in those areas with consistently low numbers of GPs per 100,000 population remains an important factor in the quality of the health and wellbeing services that can be achieved for the population.

Recommendation 11:
A renewed vision for the future role of general practice needs to be developed in consultation with the Royal College of General Practitioners, the NHS Alliance and other key partners.

Recommendation 12:
The Choose and Book system should be expanded to offer GPs the option to refer to health and wellbeing services. A directory of approved services for the major behavioural risk factors and psychological therapies should be developed; this would point GPs and other health professionals to where evidence-based services are available.

Recommendation 13:
Tools should be developed that enable practices to understand the business case for improved health and reduced costs of healthcare by addressing behavioural risk factors in the practice population. These will support practice-based commissioning and underpin a potentially assertive model of practice intervention.

Recommendation 14:
The role of general practices in targeted case finding, proactive management of long-term conditions and support for self-care should be prioritised and supported through commissioning arrangements.

10. Focusing the NHS on Prevention

The NHS needs to be strengthened in its role as a health service rather than a sickness service, and needs to promote health and wellbeing by staff and other public sector bodies. To do this a culture change is needed towards better 'NHS Prevention'. Stronger corporate emphasis, incentives, staff skills and knowledge should be particularly emphasised.

There is a strong commitment across the NHS to improve health and to be fully engaged in prevention, as well as treatment. However, there is still a gap between this commitment and the rhetoric that accompanies it, and the practical reality of NHS performance and delivery. The profile of prevention should be improved across the NHS. The Wanless reports identify the importance of prevention and engagement of the population in their own health to ensure long-term sustainability of the NHS, and currently prevention and cross-public sector initiatives are insufficiently elaborated or prioritised through the Quality, Innovation, Productivity and Prevention process.

Awareness of main health and wellbeing drivers (such as vital signs and key performance aims) is limited across the front line. This feeds a tendency for the NHS to see this as a broader environmental and social problem. Individual professional staff, in line with the overall culture of the NHS, default to focus on performance measures related to clinical interventions.

The organisational goals for NHS Prevention should be clearly articulated (such as increased referrals across the organisation to NHS Stop Smoking Services) and awareness of them promoted. Additionally, NHS staff need assistance in identifying their individual roles in improving prevention.

Within secondary care, the payment system provides little impetus for NHS staff to contribute to prevention. For example, hospital hand clinics dealing with broken bones from alcohol-related injury have no incentive to provide prevention advice or to refer to alcohol treatment services. A recent study showed that patients at an acute hospital are routinely asked whether they smoke, but it is rare for support to be offered to help them stop, even though nurses want to be able to help and patients expect to be offered support.[36] These are clearly missed opportunities. Mobile services and outreach services set up by secondary care are also limited by the rewards and incentives, despite the fact that hard-to-reach groups need broader outreach services in a different delivery system model.

There should be consideration by the Department of Health of introducing contractual incentives into secondary care to maximise brief interventions, referral and opportunistic intervention. There should be an incentivised tariff to inform trusts how much to pay for the provision of preventative services.

We wish to re-emphasise the Boorman Review's interim findings that all NHS professional staff should have a good understanding of staff health and wellbeing issues, and that there is a need for improved education in staff health and wellbeing.[37] We believe the NHS could be an example in this area, but also that increased staff awareness of health and wellbeing will have additional benefits for patients and the wider public.

Current pilot programmes in secondary care are showing the remarkable effects that NHS staff training and development on brief intervention, referral and opportunistic intervention can have on public health outcomes.[38] Often, there are barriers in perception: the most common reasons why staff do not undertake more brief interventions include lack of time, feeling unable to convince a patient to improve their lifestyle, worries that patients will take the advice badly, or recognition that they themselves exhibit behavioural risk factors of concern. Training can address the knowledge and skills needed to undertake brief interventions, and improve the willingness to intervene. It would be valuable to have a set of examples of practical ways of supporting people to alter their lifestyle through the training of all healthcare professionals.

Organisations other than the NHS have a very great influence on the determinants of health, major links to the public and control of the training of public sector staff. These opportunities should not be neglected, and local areas should aim to develop joint programmes to increase skills for prevention.

Consideration should be given to an accreditation scheme that rewards levels of staff training, organisational engagement in health and wellbeing, and strategic leadership on this agenda. The accreditation should also be relevant and available to other public sector bodies, particularly local authorities, where staff training and access to hard-to-reach groups are valuable.

A fundamental understanding of the importance of behavioural risk factors to levels of illness, causation of illness and the contribution to likely ill health and low quality of life should be core to all professionals' education. That would provide a grounding on which leadership on this agenda and broad NHS recognition of the importance of prevention can be based.

Skills are needed across the NHS and the public sector on behaviour change, improving motivation, understanding of health and wellbeing, confidence and ability to undertake brief and opportunistic intervention and referral.

Consideration should be given to the idea of an award to recognise that an NHS or other public sector body has achieved a certain level of staff training and engagement in health and wellbeing.

This is a large agenda. Coordination of training across front-line staff (including health and wellbeing activity across secondary care), improving employee health, seeking accreditation and realising senior stakeholder engagement will need dedicated and systematic effort.

We consider that it is possible to develop a service – which could be called 'NHS Prevention' – that will help translate into reality the aspirations for NHS staff to address health and wellbeing into reality. This was identified as a priority in the NHS Next Stage Review, but the model for implementation has not been consistently identified. Each PCT would draw up its directory of approved services for health and wellbeing, as identified in recommendation 12.

Health trainers (or health advocates), trained in supporting people to change behaviour, would work with individuals and help them address these risk factors, referring to services, as appropriate, from the directory of approved services. The health trainers (or health advocates) would include people based within communities (such as the currently prevailing health trainer model, targeted on the most deprived communities), but the model could be extended so that existing staff could develop this role – for example, nurses or other staff within practices, staff on acute hospital wards or within mental health services. This would act as a professional development to existing staff roles, and trusts and practices could identify this service as a reason to choose their hospital or service for care.

'NHS Prevention' developed in this way could support changes to behavioural risk factors in patients with other health conditions, such as heart disease, and form part of the range of interventions available following NHS life checks. The health advocates could champion and offer support to other NHS staff to improve their own health, and therefore contribute to future work based on the interim report of the recent review of health of the NHS workforce by Dr Steve Boorman. The model could also be extended to social care and public and private sector employers, to improve the health of their staff.

While the business case to support this model needs to be fully worked up, we consider it likely that there is a strong case for developing the model for 'NHS Prevention' on the basis of an extension and development of existing staff roles, given existing evidence of the high cost-effectiveness of reducing the major behavioural risk factors for health, and of improving psychological wellbeing.

Recommendation 15:
The model for 'NHS Prevention', and the business case to support it, should be developed urgently, as a means of embedding health and wellbeing further into the culture of the NHS.

It is the authors' view that these proposed changes to delivery systems will significantly reduce barriers to the ability of front-line organisations to improve health and wellbeing.

Annex A: Summary of Recommendations

Summary of recommendations	
Priorities and objectives	**Recommendation 1:** **We recommend an overarching tier 1 vital sign to improve disability-free life expectancy (health expectancy), in addition to the existing vital sign indicator on life expectancy. This should be supported by tier 2 vital signs for local agreement on the four major lifestyle factors (smoking, alcohol, physical activity and diet) and psychological wellbeing. These metrics should also be included in national indicators.** **Recommendation 2:** **The Department of Health should explore with NICE the explicit identification of the impact of the clinical and public health interventions on overall life expectancy and health expectancy, and quality of life for people with disability and long-term conditions. NICE should produce rankings of the most cost-effective clinical and public health interventions, with an expectation of delivery of the most cost-effective. The feasibility to provide assessments of cost impact and return on investment should also be explored.** **Recommendation 3:** **The impact on health expectancy should be used explicitly to judge the benefits of new policies that impact on health and wellbeing.**
Strengthened cross-government and Department of Health action on health and wellbeing	**Recommendation 4:** **Stronger and more innovative mechanisms are needed for cross-government actions to improve health and wellbeing, including mechanisms to identify the role of different government departments and their delivery systems.** **Recommendation 5:** **A single point of leadership should be considered within the Department of Health, able to draw on expertise across the Department, with the role of ensuring strategic coherence in all areas of health and wellbeing policy and delivery. The experience of national support teams should be used to strengthen this work.** **Recommendation 6:** **Local health and wellbeing goals should be articulated and reviewed consistently and together within a single approach to inspection.**
The need for a new integrated commissioning model at a local level	**Recommendation 7:** **A new integrated commissioning model for health and wellbeing should be developed to improve health and wellbeing outcomes. This model should, as a priority, be applied to the 'top four' lifestyle issues, children's health, and prevention and effective management of long-term conditions.** **Recommendation 8:** **We recommend the development of integrated public sector leadership development programmes at the local level to ensure delivery of improved health and wellbeing.**

Summary of recommendations	
Integrated public sector delivery at a local level – with a focus on children	**Recommendation 9:** **We recommend strengthening the integration of the workforce for children's health and wellbeing, reflecting an emphasis on health and wellbeing outcomes, early intervention, and intensive case management wherever needed.** **Recommendation 10:** **We recommend stronger support and encouragement for NHS staff to record their involvement with children on ContactPoint, and to use it to support their practice in working with other practitioners, as well as to assist child protection.**
A renewed vision for primary care and general practice	**Recommendation 11:** **A renewed vision for the future role of general practice needs to be developed in consultation with the Royal College of General Practitioners, the NHS Alliance and other key partners.** **Recommendation 12:** **The Choose and Book system should be expanded to offer GPs the option to refer to health and wellbeing services. A directory of approved services for the major behavioural risk factors and psychological therapies should be developed; this would point GPs and other health professionals to where evidence-based services are available.** **Recommendation 13:** **Tools should be developed that enable practices to understand the business case for improved health and reduced costs of healthcare by addressing behavioural risk factors in the practice population. These will support practice-based commissioning and underpin a potentially assertive model of practice intervention.** **Recommendation 14:** **The role of general practices in targeted case finding, proactive management of long-term conditions and support for self-care should be prioritised and supported through commissioning arrangements.**
Focusing the NHS on prevention	**Recommendation 15:** **The model for 'NHS Prevention', and the business case to support it, should be developed urgently, as a means of embedding health and wellbeing further into the culture of the NHS.**

Annex B: Terms of Reference

Following on from the Secretary of State for Health's speech on health and wellbeing of 19 March 2009, an independent piece of work has been commissioned in relation to health and wellbeing, specifically focusing on the prevention of ill health.

This work will cover three particular aspects:

- what the role of the state should be in relation to people's health and wellbeing, specifically focusing on the prevention of ill health;
- the lessons we can learn about influencing healthier lifestyle choices from fields such as behavioural economics, psychology and marketing; and
- what the Department and the NHS can do to enhance delivery of front-line services to improve people's health and wellbeing.

These three workstreams will report back to the Secretary of State, and are requested to cover the following content.

The role of the state

In the light of public attitudes and the perspectives of a range of leading thinkers:

- What narrative could we set out around the current role of the state in supporting people's health and wellbeing?
- What are the implications of public attitudes and the views of leading thinkers for our current approach?
- Where might the state do more, refocus or even do less? At what stage might the strongest forms of intervention – legislation and regulation – be justified? What would public/expert views be on this and how might we engage with the public/make the case for this?
- Provide advice on what our narrative on the role of the state should be in the future, and the policy implications of this.

Behaviour change

- Review the latest evidence and thinking on how to use insights into human behaviour to influence health choices and outcomes.
- On the basis of this, make a small number of recommendations about how the Department and the NHS could improve its approaches to health and wellbeing.

Enabling effective delivery

In the light of input from the front-line and recent evidence on which approaches work best (in terms of health impact and cost-effectiveness):

- Make a small number of recommendations on the future priorities for health and wellbeing.
- Make a small number of recommendations on what DH can do to best enable effective delivery on the front line.

Annex C: Consultation

This review held the following consultation events:

17 June 2009 Faculty of Public Health Conference, Scarborough
Workshop event with the specialist public health workforce, asking wide-ranging questions on where the barriers to delivery of health and wellbeing are at the policy and implementation levels.

16 July 2009 Tacit Knowledge Session with the Public Health Interventions Advisory Committee (PHIAC), National Institute for Health and Clinical Excellence, at the British Medical Association, London.
A seminar and dinner event discussing the current range of interventions for health and wellbeing, and their supporting evidence base. The seminar addressed the methods and rationale for prioritisation of public health interventions.

24 July 2009 Enabling Effective Delivery Seminar with front-line stakeholders, at the King's Fund, London.
Workshop and input on the key themes and proposed focus of the report, with front-line NHS, local authority, private sector and third sector stakeholders. A discussion of perceived problems with current delivery, articulation of barriers to delivering outcomes and joint working, and recommendations.

As well as these main events, the leads of this project sought views and met the following stakeholders:

David Nicholson, Chief Executive, NHS

Michael Dixon, Chairman, NHS Alliance

Steve Field, Chairman, Royal College of General Practitioners

Cross-government policy leads

Mike Kelly, Director, Public Health Centre of Excellence, NICE

Marmot Review Team, University College London

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