



Tackling Health Inequalities

A Programme for Action

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Foreword by the Prime Minister

We live in an age of astonishing progress. We are more prosperous and live longer and healthier lives than ever before. In every area of life, scientific and technological advances are helping create new opportunities and vanquish old problems. In health care, new treatments, unthinkable a generation ago, are saving thousands of lives each year. Even more revolutionary medical advances are on the horizon.



But it's not all a story of unrelenting and welcome advances. Our society remains scarred by inequalities. Whole communities remain cut off from the greater wealth and opportunities that others take for granted. This, in turn, fuels avoidable health inequalities.

The statistics are shocking enough. Families in these communities die at a younger age and are likely to spend far more of their lives with ill-health. Behind these figures are thousands of individual stories of pain, wasted talent and potential. The costs to individuals, communities, and the nation are huge. Social justice demands action.

Tackling such entrenched and enduring health inequalities is, of course, a daunting challenge. But nor can we any longer ignore these problems. Previous Governments failed even to recognise, let alone prioritise action to tackle the health inequalities that had become everyday life for millions.

We have started to tackle this health gap, not least by the sustained and record investment in the NHS and our other vital public services. More fundamentally, a whole series of cross-departmental action will address the root causes of poor health and health inequalities. This *Programme for Action* builds on successes like Sure Start, our smoking cessation services and the teenage pregnancy strategy.

We also need to recognise that continued success in tackling health inequalities requires the courage to work in new ways. It means setting national standards for services but giving those responsible for delivering on the ground the freedom locally to meet these standards.

Apparently uniform national services, what's been called a "one-size-fits-all" approach to health, education and local government, have failed to combat health inequalities. This should be no surprise. While at a distance such problems and inequalities may seem similar, they are the result of different and complex causes. They need diverse, rather than identical, solutions which can only come from giving communities and front-line staff the power to redesign, refocus and reprioritise programmes to tackle local need.

It has taken decades to entrench this inequality. But this *Programme for Action* demonstrates our commitment to deliver long-term improvement, through investment, reform and local responsibility, in the health and healthcare of the most disadvantaged in our society.

A handwritten signature in black ink that reads "Tony Blair". The signature is written in a cursive style and is underlined with a single horizontal line.

Rt. Hon. Tony Blair MP

Executive Summary

1. This Programme for Action sets out plans to tackle health inequalities over the next three years. It establishes the foundations required to achieve the challenging national target for 2010 to reduce the gap in infant mortality across social groups, and raise life expectancy in the most disadvantaged areas faster than elsewhere.
2. It is ambitious. Health inequalities are stubborn, persistent and difficult to change. They are also widening and will continue to do so unless we do things differently. This means addressing not only the short-term consequences of avoidable ill health, but also the longer-term causes.
3. In response, this Programme for Action identifies action on a broad front to address the inequalities that are found across different geographical areas, between genders and different ethnic communities, and between different social and economic groups.
4. Much has already been achieved in tackling health inequalities locally through the energy and enterprise of front-line practitioners in partnership with community groups and non-government organisations.
5. The Government has also played its part through a range of national programmes. These include Sure Start – designed to support the development of pre-school children from poorer families, the National Strategy for Neighbourhood Renewal – developed to support an integrated approach to regeneration in the most deprived communities, the *UK Fuel Poverty Strategy* – formulated to support housing improvements targeted at vulnerable households. *The NHS Plan* provides a focus for the NHS on tackling inequalities through more effective prevention and improved primary care for disadvantaged populations.
6. The Treasury-led Cross Cutting Review (CCR) examined each of these programmes to identify how Government spending could be applied to greatest effect on health inequalities. Its findings provide the backbone to this programme.
7. Key lessons have been learned from this work. Above all, experience has emphasised the importance of integrating health inequalities into the mainstream of service delivery, with a focus on disadvantaged areas and groups. There is a growing recognition that “one size doesn’t fit all” and that national standards need to support a mix of local services to meet a diversity of local need.
8. The Government also recognises the need to better co-ordinate activity across traditional boundaries, and work in partnership with front-line staff, voluntary, community and business sectors, as well as service users.
9. The evidence reviewed initially in the *Independent Inquiry into Inequalities in Health*, and subsequently by the CCR, identified that in order to achieve the targets and tackle the underlying determinants of inequalities, action will be required across government. Actions likely to have greatest impact over the long term are:
 - improvements in early years support for children and families
 - improved social housing and reduced fuel poverty among vulnerable populations

- improved educational attainment and skills development among disadvantaged populations
 - improved access to public services in disadvantaged communities in urban and rural areas, and
 - reduced unemployment, and improved income among the poorest
10. For the 2010 target, the evidence suggests that there are a number of specific interventions among disadvantaged groups most likely to have an impact. Key interventions that will contribute to closing the life expectancy gap are:
- reducing smoking in manual social groups
 - preventing and managing other risks for coronary heart disease and cancer such as poor diet and obesity, physical inactivity and hypertension through effective primary care and public health interventions – especially targeting the over-50s
 - improving housing quality by tackling cold and dampness, and reducing accidents at home and on the road
11. To close the gap in infant mortality, key short-term interventions include:
- improving the quality and accessibility of antenatal care and early years support in disadvantaged areas
 - reducing smoking and improving nutrition in pregnancy and early years
 - preventing teenage pregnancy and supporting teenage parents
 - improving housing conditions for children in disadvantaged areas
12. Further evidence to support these priorities has emerged from the Wanless report on NHS spending, *Securing our Future Health: Taking A Long-term View*. For example, there are encouraging findings as to the impact of smoking cessation on hospital admissions for heart attack and stroke. And most of the preventive drug interventions, such as statins to reduce cholesterol, as well as flu vaccinations have the potential to reduce pressure on hospital capacity. Improving nutrition and increasing levels of physical activity is also known to reduce instances of cardiovascular disease, diabetes and some cancers.
13. Action should not be confined to the most disadvantaged and socially excluded. To reduce health inequalities and achieve the targets will require us to improve the health of the poorest 30–40 per cent of the population where the greatest burden of disease exists. Nor does this Programme for Action exclude assisting all groups in society from improving health. Our intention is to improve the health of the poorest fastest.
14. The programme is organised around four themes that reflect this analysis:
- supporting families, mothers and children – to ensure the best possible start in life and break the inter-generational cycle of health
 - engaging communities and individuals – to ensure relevance, responsiveness and sustainability
 - preventing illness and providing effective treatment and care – making certain that the NHS provides leadership and makes the contribution to reducing inequalities that is expected of it

- addressing the underlying determinants of health – dealing with the long-term underlying causes of health inequalities.

15. These themes are underpinned by five discrete principles that will guide how health inequalities are tackled in practice:

- preventing health inequalities getting worse by reducing exposure to risks and addressing the underlying causes of ill health
- working through the mainstream by making services more responsive to the needs of disadvantaged populations
- targeting specific interventions through new ways of meeting need, particularly in areas resistant to change
- supporting action from the centre by clear policies effectively managed
- delivering at a local level and meeting national standards through diversity of provision

16. Whilst action will be taken nationally, the main contributions will be made locally. This Programme encompasses local solutions for local health inequality problems given that local planners, front line staff and communities know best what their problems are, and how to deal with them. Leadership and social enterprise will be important to the success of the programme and help unlock the potential within communities to regenerate areas. The Local Strategic Partnerships (LSPs) have a key role in tackling health inequalities locally.

17. Effective action needs to be supported by a framework of plans, targets and milestones reflecting national priorities and linked to performance management across government. For the NHS, the Priorities and Planning Framework (PPF) has put targets and milestones in place. The freedom for front-line staff to innovate in response to community needs and external monitoring and inspection of progress to ensure high quality of services are all crucial to success.

18. In summary, this Programme sets out an ambitious agenda that spans all Government departments, regional and local bodies. It is designed to help reduce health inequalities in this country by taking an important step towards the national target for 2010 and to tackling the underlying causes in the years beyond.

1. Introduction

This plan sets out a Programme for Action for achieving two goals – the national health inequalities target and the wider challenges set by the underlying causes of health inequalities. This chapter sets the context for action.

Health inequalities – the challenge

- 1.1 Overall, health and life expectancy are still linked to social circumstances and childhood poverty. Despite improvements, the gap in health outcomes between those at the top and bottom ends of the social scale remains large and in some areas continues to widen. Some parts of the country have the same life expectancy as the national average for the 1950s. These inequalities mean poorer health, reduced quality of life and early death for many people.
- 1.2 The Government is determined to tackle inequalities to create a fairer and more just society that will allow all individuals and communities to fulfil their potential and benefit more equitably from public services investment.

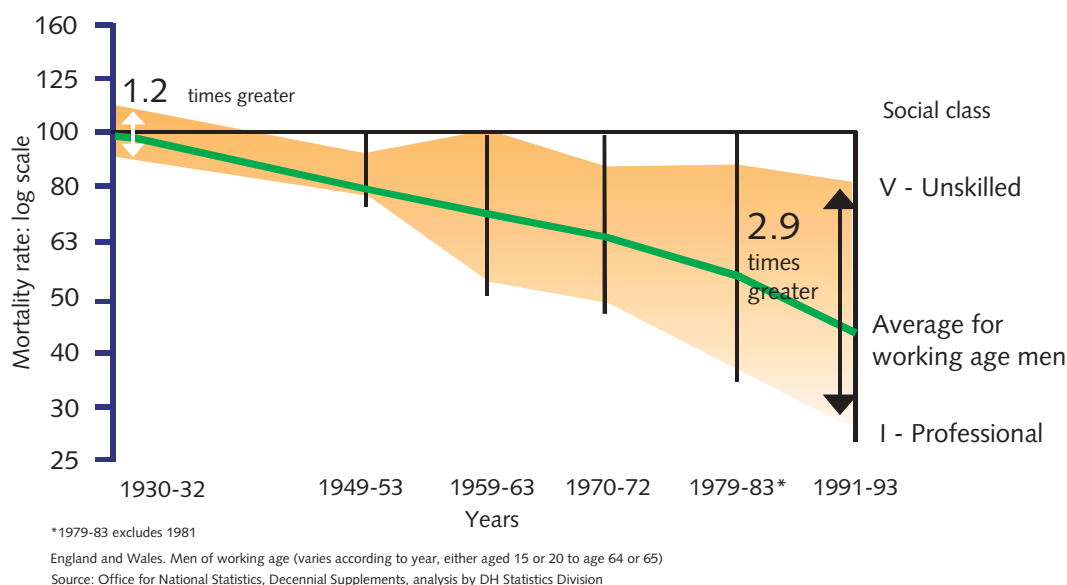
The gap in life expectancy is large and has grown since the 1970s

In the early 1970s death rates among men of working age were almost twice as high for unskilled groups as they were for professional groups. By the early 1990s, death rates were almost three times higher among unskilled groups. There are regional differences too. In 1999/2001, the difference between areas with the highest (North Dorset) and lowest (Manchester) life expectancy at birth was 9.5 years for boys and 6.9 years for girls. The highest life expectancy for girls was in West Somerset and the lowest was in Manchester. In smaller communities within these areas, the differences can be even greater.

- 1.3 Generally, the more affluent people are, the better will be their health; conversely, the poorer people are the worse will be their health. But there are wide differences among social groups. This Programme for Action does not, therefore, just address the most disadvantaged groups and areas. It also addresses the needs of a large part of the population as well as those of socially deprived groups.
- 1.4 The reasons for these differences in health are, in many cases, avoidable and unjust – a consequence of differences in opportunity, in access to services, and material resources, as well as differences in the lifestyle choices of individuals. Unfortunately, the effects can be passed on from generation to generation.
- 1.5 The challenge, therefore, will be to ensure that future improvements in health over the next 20 years are shared by all. The widening health gap reflects current realities. Experience has shown that the potential to generate and share health gains across the population by preventive action – for example, by targeting smoking and sedentary lifestyles – has yet to be fully realised. So policies need to ensure that health gains are matched by a narrowing of the health gap.
- 1.6 Measuring progress will be an important dimension of the Programme and presents particular issues given both the time-lag on the effectiveness of interventions and the developing – but incomplete – evidence of what works.

- 1.7 Figure 1 shows that the gap in mortality between professional and unskilled manual men – social classes I and V – since 1930/32 has increased almost two and a half times.

Figure 1: The Widening Mortality Gap Between the Social Classes



Health inequalities: the Government's response

- 1.8 The Government's aim is to reduce health inequalities by tackling the wider determinants of health inequalities, such as poverty, poor educational outcomes, worklessness, poor housing, homelessness, and the problems of disadvantaged neighbourhoods. This approach is supported by a national public service agreement (PSA) target:

- *by 2010 to reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth*

- 1.9 The PSA target is underpinned by two more detailed objectives:

- *starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual groups and the population as a whole*
- *starting with local authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole*

- 1.10 This Programme for Action is based on the commitments made by all Government departments in the CCR. Chapter 3 sets out the progress of existing programmes and initiatives reflected in the CCR summary.

- 1.11 This programme also sets out:

- proposals for delivering change across the four themes (chapter 4)
- the changes required in the roles and responsibilities of the key players to help deliver the national target and impact on the underlying causes of health inequalities (chapter 5)
- how progress will be measured and monitored (chapter 6)

A timescale summarising targets, milestones and commitments across Government is attached at annex A, with the detailed departmental commitments to this programme at annex B. Annex C gives further details on the national indicators.

2. Strategy

This chapter describes the Government's cross departmental strategy for tackling health inequalities and summarises the programmes, policies and resources – that will bring about real change in communities.

- 2.1 The Government has prioritised the need to tackle the causes and consequences of health inequalities as a part of its commitment to deliver economic prosperity and social justice. Action to break the cycle of deprivation and its impact on avoidable ill health is at the heart of Government policy.
- 2.2 To understand better the causes of health inequalities, and how to tackle them, the Government established the *Independent Inquiry into Inequalities in Health* (1998), chaired by Sir Donald Acheson. The report highlighted the ways in which the policies and programmes of a range of Government departments could have an influence on reducing health inequalities, and the potential of a more co-ordinated approach to achieve greater synergy and impact.
- 2.3 This report underpinned the Government's initial policies to address inequalities outlined in the *Saving Lives: Our Healthier Nation* White Paper, *The NHS Plan* and the *Tackling Health Inequalities* public consultation document.
- 2.4 The consultation emphasised that national leadership for the strategy needs to be supported by local action. This is most successful when local needs are understood, organisations work together in partnership and with political backing, and when local people are involved in the planning and management of initiatives.
- 2.5 This Programme for Action, therefore, aims to maximise the impact on health inequalities of the Government's investment in public services and programmes. It also seeks to convey that change is achievable through the energy and commitment of front-line workers, communities, voluntary bodies, business and individuals, when supported by appropriate planning, performance management and inspection systems.

The strategy

- 2.6 The high-level strategy for health inequalities across Government set out in the CCR summary endorsed the analysis of the Acheson inquiry and formed part of the 2002 Spending Review. It said that *this approach should ensure long-term sustainable change, make tackling health inequalities an integral part of policy development and implementation.*

Themes

- 2.7 The different dimensions of health inequalities are set out in this document across four themes. These themes broadly follow those in the *Tackling Health Inequalities* consultation document. They are:

- *supporting families, mothers and children* – reflecting the high priority given to them in the Acheson inquiry report
- *engaging communities and individuals* – strengthening capacity to tackle local problems and pools of deprivation, alongside national programmes to address the needs of local communities and socially excluded groups
- *preventing illness and providing effective treatment and care* – by tobacco policies, improving primary care and tackling the “big killers” of coronary heart disease (CHD) and cancer. The NHS has a key part to play in contributing to the national health inequalities targets at the local as well as the national level
- *addressing the underlying determinants of health* – emphasising the need for concerted action across Government at national and local level up to and beyond the 2010 target date

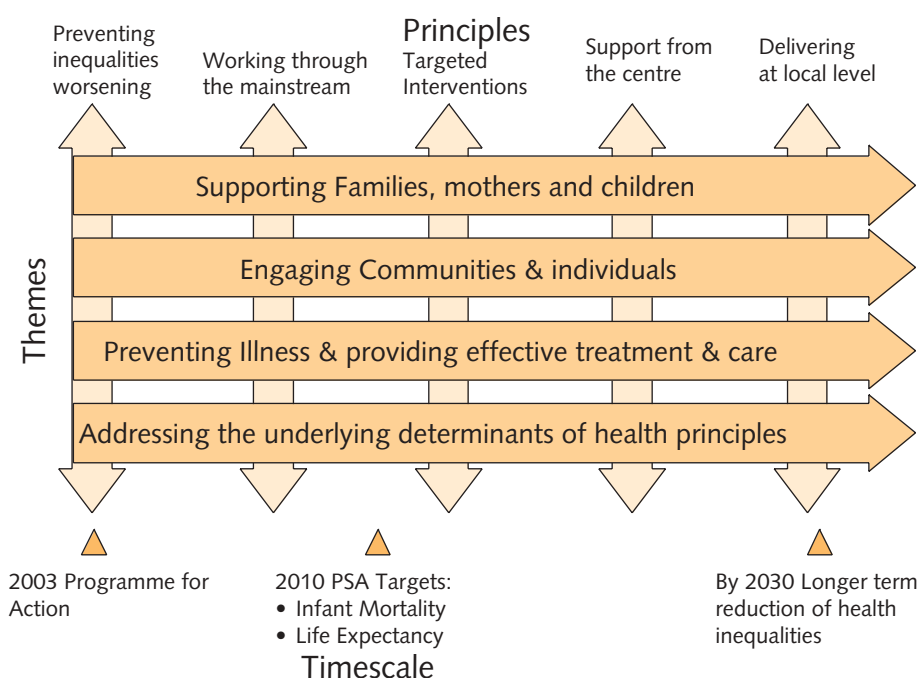
Principles

2.8 The themes of this strategy are underpinned by five principles:

- *preventing health inequalities worsening* – this is a major challenge but programmes that address this issue and reduce the consequences of health inequalities will have the greatest long-term impact. These can be directed to individuals, and families, as well as to the social, economic and environmental factors that shape individual choice and opportunity
- *working through the mainstream* – these services are often worst in the most disadvantaged areas and have not always been able to respond to the diversity of need. The scale of change required to achieve the national target will only come about if mainstream services become more responsive to the needs of disadvantaged populations, as exemplified by Sure Start
- *targeting specific interventions* – such initiatives should not be a substitute for mainstream services but offer different ways in meeting need. They can introduce innovation, tackle specific problems or support those who may have difficulty in access to services. This includes those living in remote and rural communities as well as teenage parents, vulnerable older people, black and minority ethnic groups, Looked after Children and care leavers, homeless people, asylum seekers and prisoners. The lessons learned can help improve the delivery of mainstream services
- *supporting action from the centre and through the regions* – policies need to be fully integrated into mainstream service planning, performance management and monitoring to reflect national priorities and local need – for example the NHS Priorities and Planning Framework (PPF) and the national PSA for local government
- *delivering at local level* – the differences in the way services are delivered and improvements in their range and scope will be experienced first at local level. Experience of local services can inform the development of the health inequalities programme, helping to create national standards and local diversity in service provision

2.9 Figure 2 shows the four themes working over time from now until 2010 and beyond, mediated by these five underpinning principles.

Figure 2: Health Inequalities Programme for Action: Themes and Principles



- 2.10 Over the long term, the application of these principles will require the reshaping of services, different use of resources and changes in corporate culture. The use of ‘floor targets’ for key service outcomes across Government, and the development of NSFs are examples of how to improve the quality of services in the NHS and guarantee standards for all. They will also help expedite progress in the most disadvantaged areas, and among the least well served populations.
- 2.11 These principles will inform the delivery of the health inequalities across Government departments and shape the approach to tackling the national target.

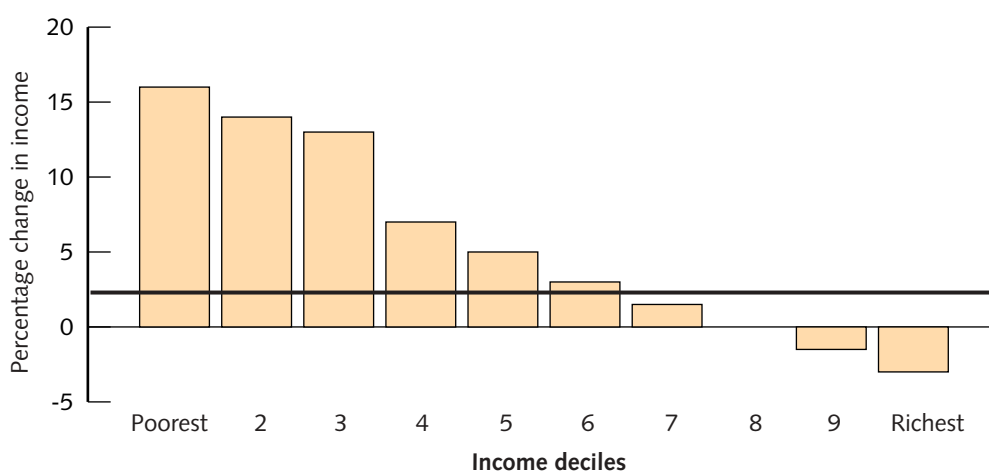
Towards the national target

- 2.12 The CCR also identified several specific interventions most likely to have an impact on the national target. For life expectancy, the key interventions are:
- reducing smoking in manual social groups through smoking cessation services and other tobacco control programmes
 - preventing and managing other risk factors such as poor diet and obesity, physical inactivity and high blood pressure
 - improving environmental health, including housing conditions and reducing the risk of accidents
 - targeting the over-50s – among whom the greatest short-term impact on life expectancy will be made
- 2.13 For infant mortality, the interventions most likely to have an impact are
- improving the quality and accessibility of antenatal care and early years support in disadvantaged areas – building on the lessons of Sure Start

- reducing smoking and improving nutrition in pregnancy and early years, including increasing the number of mothers who breastfeed
- preventing teenage pregnancy and supporting teenage parents
- improving housing conditions, especially for children in disadvantaged areas

2.14 The successful delivery of this Programme will help improve the health of the nation's poorer people at a faster rate than before – reversing a long-standing social trend. This is a considerable challenge but a start has already been made. Figure 3 shows the impact of policies on tax and benefits on different sections of the population from 1997–2002. The net impact of the changes has strongly favoured the poorest groups.

Figure 3: Impact of direct personal tax, benefit and expenditure tax changes since 1997



INCOME DECILES ranked by household income - measured before housing costs and adjusted for family size. THE BARS show the modelled impact of changes on real incomes (in October 2002 prices).

Source: The Institute for Fiscal Studies 'The IFS Green Budget: January 2003

Chart constructed from calculations by Chote, R., Emmerson, C. and Simpson, H. based on results from IFS tax and benefit model, TAXBEN, run using Family Resources Survey 2000-01 and Family Expenditure Survey 1999-2000. Illustration from The Institute for Fiscal Studies 'The IFS Green Budget: January 2003

Impact

2.15 Further progress will mean fairer access to services and a reversal of the 'inverse care law' by which people with the greatest need tend to have poorer access to poorer quality services. It will also mean a better balance between treatment and prevention, creating an environment in which all families and communities will have the chance to lead longer and healthier lives.

Engaging communities

2.16 Delivering this Programme for Action means engaging and empowering local communities. One of the key messages from the *Tackling Health Inequalities* consultation on the national targets was that sustainable change requires the support, enthusiasm and commitment of local people working in partnership with a wide range of local organisations and statutory and voluntary agencies.

- 2.17 The responsibilities and contributions of individual partners will vary. But local people should help plan and develop local services and set priorities within national plans and targets. Section 11 of the 2001 Health and Social Care Act places a duty on NHS Trusts, PCTs and SHAs to involve and consult patients and the public in the planning of services and any proposals for change.
- 2.18 In some areas, PCTs will commission voluntary and community organisations to deliver services to tackle specific inequalities in health. In other areas, health inequalities will be just one of the many factors that contribute to wider deprivation.
- 2.19 Local government and the NHS are working together to develop LSPs to encourage community involvement and ensure that action on health inequalities is relevant to local need.

3. Progress to date

This chapter describes what has been achieved and examines the lessons that will inform this Programme for Action.

- 3.1 The Government has done a great deal to promote social justice, address poverty and deprivation, and reduce inequalities through investment and public services reform. Much has been achieved and much remains to be done. This Programme for Action builds on this progress, whilst recognising the deep-rooted and persistent nature of health inequalities.
- 3.2 The Programme for Action is built around the four themes outlined in paragraph 2.7 that reflect the priorities in the Acheson inquiry report and the CCR. These themes are:
- supporting families, mothers and children
 - engaging communities and individuals
 - preventing illness and providing effective treatment and care
 - addressing the underlying determinants of health

Supporting families, mothers and children

- 3.3 The Acheson inquiry said that *while there are many potentially beneficial interventions to reduce inequalities in health in adults of working age and older people, many of those with the best chance of reducing future health inequalities... relate to parents, particularly present and future mothers, and children.* Action at this level is also essential to break the cycle of deprivation through the generations.
- 3.4 The consultation on the national targets also highlighted the importance of improving opportunity and reducing alienation among young people by giving them a greater say in their lives, strengthening the services they need, improving their skills, and reducing harmful risk taking behaviours.
- 3.5 Action across Government has been an important way of securing better health outcomes for children and young people. This is happening locally, through programmes like Sure Start and the Children's Fund.

Maternal and child health, and child development

- 3.6 Sure Start is a key component of the Government's health inequalities programme. By improving support for child development – through 489 local Sure Start programmes and related initiatives – Sure Start ensures that children from the most disadvantaged areas are ready to make the most of their education. Mainstreaming this approach will enable the programme to meet the needs of many more of those children who might benefit from it.

- 3.7 Women at the lowest end of the social scale are significantly more likely to smoke during pregnancy and significantly less likely to breastfeed their babies. Smoking during pregnancy and breastfeeding were identified in the CCR as important, modifiable risks to infant health. Breast-fed infants are five times less likely to be admitted to hospital with common infections such as gastro-enteritis during their first year of life.

Mainstreaming the benefits of Sure Start

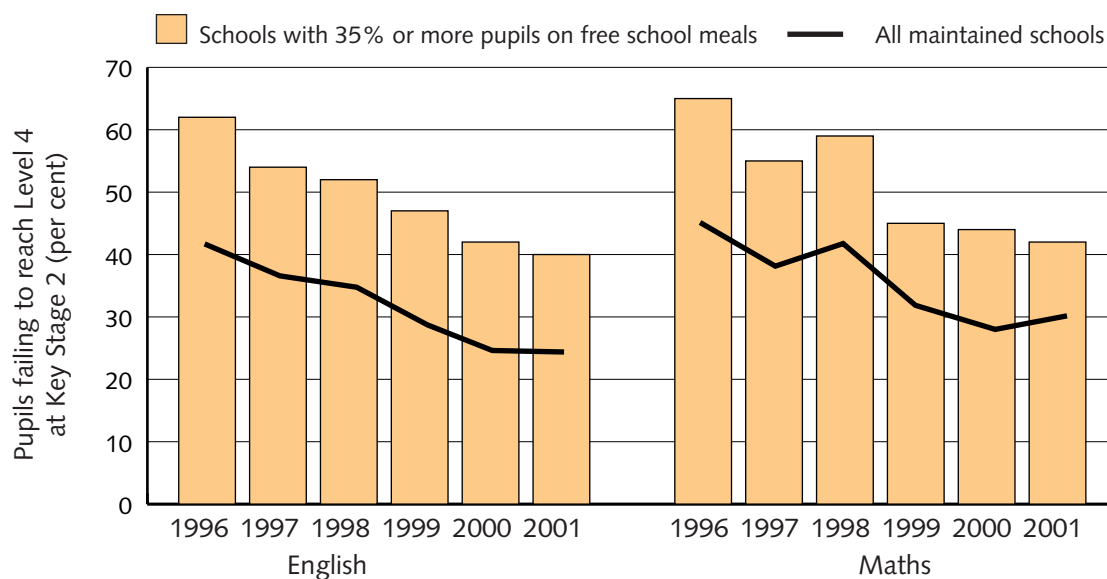
At the core of Sure Start are teams of professional home visitors brought together from local voluntary and statutory children's agencies. Bringing agencies together in this way pools expertise and helps to ensure that families can get all the help they need from one place. The Sure Start Euston Home Visiting team offers home visits to any local family with a child under four living in the catchment area. Families can request the service by telephone, through a friend or other professional. Interpreters are also provided when needed. Home visitors divide their time between visiting families and working for their own agency. The links allow them to make referrals to their own organisations as well as Sure Start's other services, so that families can access a wide range of services more easily.

- 3.8 Smoking in pregnancy fell from 23 to 19 per cent between 1995 and 2000 – and breast feeding rose during the same period from 50 to 59 per cent among low-income groups.
- 3.9 The first parts of *Getting the Right Start, the National Service Framework for Children* (NSF) cover new national standards for children's hospital services. Implementation of the NSF will improve the quality of, and access to, services for infants and children in the neediest communities.

Improving life chances for children and young people

- 3.10 The Foundation Stage for 3–5 year olds, now part of the National Curriculum, is a distinct phase of learning which gives children the best possible start to their education by developing key learning skills, knowledge and understanding. Personal, social and emotional development is one of six areas of learning.
- 3.11 Efforts have been directed to raising standards and improving educational attainment, especially by helping children in under-performing schools to achieve the higher standards in English and mathematics. Targeted programmes such as Excellence in Cities are raising the attainment of pupils at higher risk of under-achieving. The Key Stage 3 National Strategy builds on this work in the early years of secondary schooling. Some groups, such as Afro-Caribbean boys, continue to under achieve, and targeted interventions may, therefore, still be needed.
- 3.12 The Children's Fund programme supports children and young people at risk in the 5–13 age group and their families. It works to prevent criminal and anti-social behaviour, tackle truancy, promote educational achievement, develop parenting skills and help children with mental health difficulties. A key objective of the Fund is to reduce health inequalities among these children.
- 3.13 Other recent, targeted schemes to improve the life chances of disadvantaged children have included the establishment of the national Connexions Service. It provides an integrated service for advice, guidance and personal development opportunities and aims to keep young people engaged in learning. There is also the Healthy Schools programme, a range of initiatives to promote sport and physical activity among deprived groups and areas, and a Government commitment to end the use of bed and breakfast accommodation for homeless families with children.

Figure 4: Improvements in educational attainment



Source: Performance Tables, DfES, 2001

Illustration from 'Monitoring Poverty and Social Exclusion 2002' by the Joseph Rowntree Foundation

3.14 Figure 4 shows how failure rates have dropped in the proportion of all pupils reaching basic standards of attainment in English and Maths between 1996 and 2001. It compares schools with 35 per cent or more pupils on free schools meals with all maintained schools. Failure rates in English and Maths in schools with a relatively high proportion of children on free school meals fell by a third during this period.

Reducing teenage pregnancy and supporting teenage mothers

3.15 The Acheson inquiry report noted that babies born to teenage mothers are likely to have a worse start in life. *The NHS Plan* reiterated the Government's commitment to reduce the rate of teenage conceptions by 15 per cent by 2004 and by half by 2010. The Teenage Pregnancy Strategy has made significant progress. The under-18 conception rate has fallen by 10 per cent during the period 1997–2002. A third of teenage mothers aged 16–19 now participate in education, training or employment, double comparable figures in 1997.

Engaging communities and individuals

3.16 The Acheson inquiry report showed how health inequalities can affect whole communities differently throughout life. The corrosive effect of crime and fear of crime, combined with economic disadvantage and a poor physical environment has a major impact on the quality of peoples lives. Many of the responses to the *Tackling Health Inequalities* consultation wanted policies to target identifiable vulnerable groups within communities.

Working with the community

Health inequalities are part of a pattern that often combines social exclusion, low-income, poor mental and physical health and poor access to services. This link has been recognised in community-led projects across the country – such as Penwerris (Cornwall), Wren’s Nest (Dudley) and in Farley Bank (Hastings). Health and local authority and voluntary agencies have collaborated to train and empower local people, and to improve the physical environment, enhance wellbeing and boost community morale. As one long-term resident put it “Time was when Farley Bank was as low as you could go. Once you were put here you’d reached the end of the line. These days there’s a waiting list for houses”.

Strengthening disadvantaged communities

3.17 The National Strategy for Neighbourhood Renewal is the cornerstone of a more coherent and integrated approach to the complex problems of deprived communities. The strategy targets the neediest communities, seeking to improve the quality and co-ordination of local activities and services and access to them. It has highlighted the importance of improving mainstream services for achieving better outcomes in deprived neighbourhoods. Key features include:

- *ambition* – demonstrated through the challenging targets for improving outcomes in disadvantaged communities, including “floor” targets for health, educational attainment and housing quality
- *organisation* – requiring LSPs in targeted areas to produce neighbourhood renewal strategies which includes a focus on health issues
- *resources* – funding for 88 of the most deprived local authority districts through the Neighbourhood Renewal Fund (NRF) to assist mainstream services to tackle neighbourhood disadvantage
- *action* – testing out new approaches to neighbourhood renewal through the New Deal for Communities, a 10 year programme in 39 of the most disadvantaged communities, and through the Neighbourhood Management Pathfinder Programme

The major challenges will be sustaining the early progress achieved in several of the most deprived areas, and applying the emerging lessons to mainstream services.

Crime and substance misuse

3.18 Substance misuse is a difficult issue for communities. It is linked with crime – which, in turn, tends to be concentrated in areas of social deprivation and reflected in higher levels of vandalism and nuisance. And it is associated with HIV/AIDS, suicide and undetermined injury, all of which affects life expectancy.

3.19 Drug action teams (DATs) have been set up to co-ordinate local services for prevention and treatment of drug problems and the National Treatment Agency was established in 2001 to improve treatment options. Drug treatment services have been expanded, while access has improved and waiting times for treatment are shorter. Youth Offending Teams, the Connexions Service and other specialist youth agencies are providing effective early support for over 17,000 young people with drug problems. The 102 Positive Futures projects use sport as a vehicle to incentivise young people to substitute healthy physical and social activity for harmful behaviours.

Supporting vulnerable groups

- 3.20 The CCR identified the need for specific community support for several vulnerable groups, especially black and minority ethnic groups who are disproportionately affected by health inequalities. Black and minority ethnic groups are more likely to live in the poorest 20 per cent of local authority areas and have problems accessing services that tend to be of poorer quality and not responsive to their needs. It is vital to engage with these groups if the life expectancy target is to be achieved. Examples of action to address the needs of vulnerable populations are identified below.
- 3.21 For *older people*, increases in pensions, a national income guarantee for pensioners, and substantially increased winter fuel allowances which aim to reduce the number of pensioners in poverty, and to improve the material circumstances of older people more generally. This will help improve the length and quality of life. This has been done through the NSF for older people which sets out standards of care in health and social services which are designed to promote independence in old age. A joint DH/ODPM scheme funds home improvement repairs and adaptations to maintain older people's independence for as long as possible.
- 3.22 For *people who are mentally ill*, a mental health NSF has been adopted to raise standards, provide quicker and more convenient services, and improve access to effective treatment and care for people who are mentally ill. It will help reduce health inequalities by targeting the most disadvantaged groups first by improving mental health services for black and ethnic minority groups, and establishing assertive outreach services for the estimated 20,000 people living in the community with the most severe and complex mental health problems.
- 3.23 For *homeless people*, the 2002 Homelessness Act obliges local authorities to develop a strategy to prevent and deal with homelessness in partnership with local statutory and voluntary agencies. Partnerships with health service providers enable such strategies to deliver targeted interventions to this group. The Priority Need Order has been extended to include more groups of vulnerable people who will be rehoused, including families with dependent children, young people aged 16 and 17 and those with mental or physical health problems. In the last year the numbers of families with children living in bed and breakfast accommodation has fallen significantly. Specific action has also been taken to reduce the number of people sleeping rough – from 1850 in 1998, to less than 600 in 2001 and this reduction has been sustained.
- 3.24 For *prisoners*, changes to the delivery of health services offer the prospect of real improvement. Budgetary responsibility for prison health care was transferred from the Service to the Department of Health in April 2003, with the intention to transfer responsibilities for the commissioning of services to PCTs by 2006. Linking prison health to mainstream services will help meet outstanding needs, especially in areas of mental illness and substance misuse. Prison is also a setting for health promotion activities, such as smoking cessation.
- 3.25 For *asylum seekers and refugees*, efforts have been made to assess the needs of asylum seekers and refugees and provide access to mainstream NHS services and Sure Start local programmes.

Preventing illness and providing effective treatment and care

3.26 *The NHS Plan* set out the responsibilities of the NHS to provide effective prevention and treatment, and to tackle health inequalities. As a result, there is a more coherent and properly supported prevention programme, stronger and more responsive primary care services, and better access to treatment for the less well-off. Health Action Zones in many of the most disadvantaged communities have helped ensure more co-ordinated NHS service provision, and supported innovative services in many of the most deprived areas.

Reducing risk through effective prevention

3.27 *Smoking* is the main avoidable risk factor for coronary heart disease (CHD) and cancer. The availability of NHS support has made it easier than ever for smokers to receive practical, effective support to quit smoking. In 2001–2, 120,000 people quit at the four week stage, following support from NHS services.

3.28 *Poor diet, and obesity* are important risk factors for CHD, some cancers and other conditions such as diabetes, and significantly affect life expectancy. After quitting smoking, eating at least five portions of fruit and vegetables a day is the most effective strategy to reduce the risk of cancer. But consumption is lowest in low-income groups. The New Opportunities Fund supports the National School Fruit Scheme and the 5 A DAY programme aims to increase fruit and vegetable consumption in 66 of the most deprived PCTs.

3.29 Action to reduce *accidental injury* has cut deaths from fires by 20 per cent between 1988 and 2001. And it has cut road deaths in children, particularly those from low-income groups, and older pedestrians by 20 per cent. Serious road injuries have fallen by 23 per cent among the same groups over the past four years. However, there is still more to be done. The most deprived local authority districts still have five times as many child pedestrian accidents as the least deprived.

Reducing child road accident casualties in Kingston Upon Hull

Over the last 10 years, Kingston Upon Hull have been delivering the most extensive programme of 20mph zones of any local highway authority in the country. Currently there are over 100 zones in place, covering a quarter of the authority's total road network. The zones use a combination of physical measures to restrict speed, backed by the appropriate traffic signs, often designed by local children. In treated areas casualties have been reduced by around 50%, with particular success being achieved in the reduction of child pedestrian casualties.

3.30 *Immunisation against influenza* has helped cut excess winter deaths and illness. A target of 70 per cent uptake has been set for people aged 65 years and over which will also boost the uptake of the vaccine among people in the 20 per cent of areas with lowest life expectancy.

Early detection, intervention and treatment

3.31 Considerable progress has been made towards achieving the PSA target to reduce the death rate from circulatory diseases by at least 40 per cent in people under 75 by 2010. Between 1995–97 and 1999–2001 a fall of almost 19 per cent had been recorded. Progress in early cancer diagnosis has been achieved through improved screening rates for breast and cervical cancer in inner city areas by making services more responsive to cultural and language needs, improving training and spreading good practice.

- 3.32 Improving access to primary care services is essential for identifying risk factors and untreated disease. There are now over 3000 Personal Medical Service (PMS) schemes offering greater flexibility in service provision, with many of them in deprived communities. 42 Local Improvement Finance Trust (LIFT) schemes have improved primary care facilities in inner-city areas, covering 100 PCTs.

Improving access to effective treatment

- 3.32 The siting of new services in previously under-served areas is also improving access to health care and treatment. Examples include the £300m programme in specialist heart surgery units in areas where they are most needed, such as Blackpool, Liverpool, Central and South Manchester, Southampton, Leeds and Plymouth, and improved access to radiotherapy services through £70m investment in linear accelerator treatment machines.
- 3.33 The NSFs and *The Cancer Plan* are driving up standards of service provision while clinical networks are standardising protocols for clinical assessment and treatment, and peer review and support. These have resulted in tangible improvements in health outcomes in primary care, and cancer services.

Addressing the underlying determinants of health

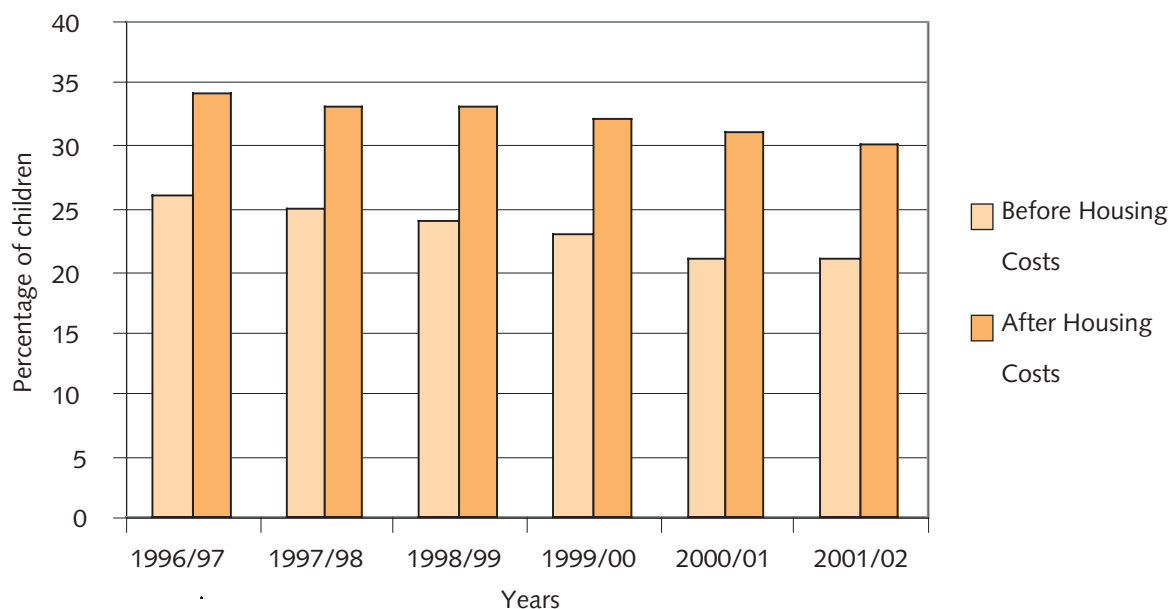
- 3.34 The Acheson inquiry report emphasised the need for effective interventions to address the wider influences on health inequalities. Government departments have contributed to progress in addressing these determinants, such as improving educational attainment and tackling low basic skills, improving the quality of poor housing, improving the accessibility, punctuality, reliability and use of local transport, tackling worklessness and inactivity, and improving access to social and community facilities and services. Regional Development Agencies (RDAs) have been set up to act as the strategic drivers of regional economic development.
- 3.35 Access is a key issue for all public services. Improving access to good quality legal advice and information through the Community Legal Service helps the public learn more about their individual rights. This is essential if people are to tackle their problems and resolve disputes effectively, whether in relation to welfare benefits, debt, housing or employment. The provision of such services plays a part in addressing some of the causes of health inequalities.
- 3.36 The New Opportunities Fund has awarded grants to 257 Healthy Living Centres (HLCs) in England and all address the underlying causes of ill health in their own communities, as well as their effects on behaviour. Examples of some of the activities and services provided by HLCs include debt advice, basic skills training, ICT facilities and support, food co-ops and parenting skills, and fitness and exercise programmes.

Child poverty

- 3.37 The Government is committed to reducing by a quarter the number of children in low-income households by 2004–05 (from a baseline of 1998–99) as a contribution towards the broader target of halving child poverty by 2010 and eradicating it in 2020.
- 3.38 The child poverty strategy has focused on helping to ensure decent family income, with work for those who can and support for those who cannot. It also seeks:
- to provide support for parents, so that they can provide better support for their children

- high quality services in all neighbourhoods, with targeted interventions for those with additional needs
- harnessing the power and expertise of voluntary and community sectors promoting innovation and good practice

Figure 5: The percentage of children in low-income households 1996/97 to 2000/01



Source: Households below Average Income 1994/5 – 2000/01, Department for Work and Pensions

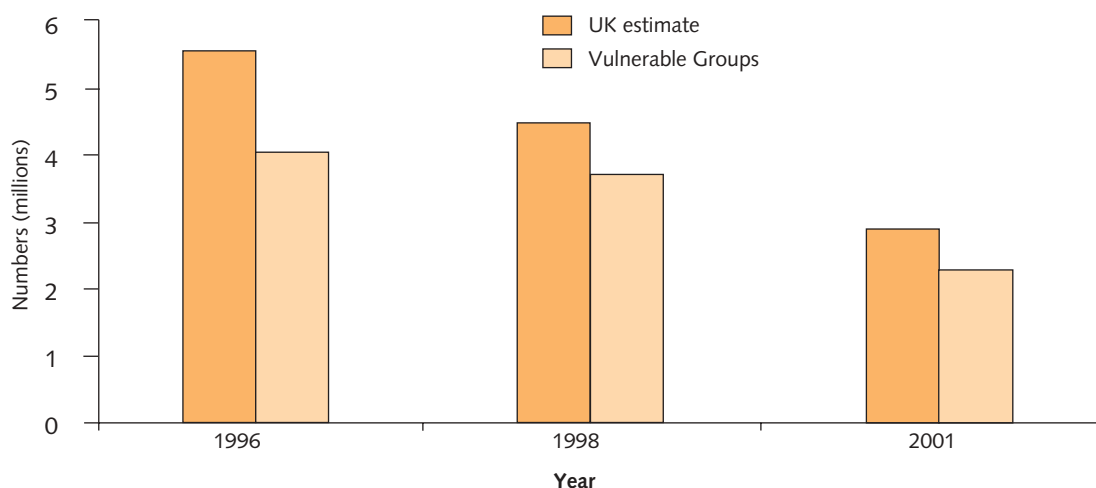
3.39 Figure 5 shows that this is producing results – by 2001–02 there were over 400,000 fewer children in low-income households compared to 1998–99. Continued progress in reducing child poverty is essential if the long-term target to reduce inequalities is to be achieved. The new Child and Working Tax Credits launched in April 2003, provide a system of support to help families, tackle child poverty and make work pay.

Housing

3.40 There has been significant improvement in the quality of homes. The number of homes that fail the ODPM decent homes standard in the public and social sector has fallen from 2.3 to 1.6 million between 1996 and 2001. The long-term programme set out in *Sustainable Communities: Building for the Future* (2003) aims to improve the living environment in all communities. This applies to housing and the quality of public and green spaces in and around the places where people live, work and play.

3.41 The number of fuel poor households – households that need to spend more than 10 per cent of their income on fuel to heat their home to an adequate standard of warmth in England – fell from 4.3 million in 1996 to 1.8 million in 2001. Figure 6 shows this fall in the numbers of households estimated for the UK as a whole and the numbers in vulnerable groups. The *UK Fuel Poverty Strategy* (2001) sets out the Government’s approach to tackling this issue and helping to reduce excess winter deaths.

Figure 6: Number of households in fuel poverty in the UK



Source: The UK Fuel Poverty Strategy: First Annual Report 2003

Transport

- 3.42 The 10-Year Plan for Transport has brought about some significant improvements in public transport. It sets out a long-term increase in transport spending to improve public transport and address social exclusion. Minimum half-fare discounts on local bus services have been introduced for older and disabled people and the rural and urban bus challenge schemes have enabled provision of innovative bus services.
- 3.43 The ability to get to work and key services is critical in addressing health inequalities and other forms of disadvantage. The Social Exclusion Unit report *Making the Connections* (2003) introduces the need for accessibility planning. This will help eliminate the obstacles faced by disadvantaged groups and communities in accessing work, schools, healthcare, and shops. Local Transport Plans submitted in 2005 will include a more systematic assessment of whether people can reach the services they need. Health service providers will have a key role in supporting and contributing to the accessibility planning process.

Education, training and skills

- 3.44 *Skills for Life* – the national adult literacy and numeracy strategy – has helped improve the job prospects of over 300,000 learners in the two years since its launch. Government action has been directed to raising these and other skills among disadvantaged groups to enhance opportunities for work. The Acheson inquiry report noted that education was a traditional (and one of the most important) route out of poverty and disadvantage to a good job and adequate income. Employment prospects are bleak without at least a grounding in basic skills.

Jobs and incomes

- 3.45 The New Deal programme has provided targeted help for those without work to find and retain jobs, and the National Minimum Wage (NMW) has boosted incomes for low-paid workers. The Low Pay Commission estimates that 1.7 million workers will benefit from the planned increase in October 2004. The NMW has also helped to narrow the pay gap between men and women. Almost 5.75 million families with children are expected to benefit from the new tax credits. The combined effect of these policies has been to boost the weekly post-tax income of a single earner family with one child, working full time, from £182 per week in April 1999 to £241 in October 2003. These programmes that reduce levels of long-term unemployment and inactivity and raise incomes are central to tackling health inequalities.

Linking Up Services: Delivering benefits and other advice through the NHS

- Health Plus provides independent welfare advice in 30 GP surgeries across Bradford and raised almost £750,000 in unclaimed benefits in 2001–02. It employs 21 people and works in partnership with seven advice agencies and a mental health team.
- The rural Peak District has experienced a farming crisis that has affected local incomes. A project has been developed that includes the provision of welfare rights advice in GP surgeries, health centres and other places used by farmers in the area. Over £400,000 of previously unclaimed benefit has been secured, with the support of the High Peak and Dales PCT and East Midlands Development Agency.
- The Employment Retention Project in Walsall works with people who are employed but off work because of illness and who are at risk of losing their job. The project works out of GP surgeries and local hospitals offering an individual service to clients and advice on welfare benefits, housing and other issues.

4. Delivering change

Building on programmes already in place to tackle health inequalities, the CCR secured further commitments from across Government to help realise the national target and tackle the wider underlying causes of health inequalities. Delivering change will require active partnership at local, regional and national level.

- 4.1 Delivering change will require concerted action across Government and is primarily based around improvements in housing, education, employment, transport as well as in the NHS.
- 4.2 In the 2002 CCR on health inequalities, departments committed themselves to the Government's health inequalities strategy. The CCR was based on evidence of effectiveness but it also recognised the gaps in evidence. It identified key responsibilities for tackling health inequalities. As a result, departments have strengthened existing programmes and developed new ones with a view to contributing to the national target. These programmes are set out in detail in annex B. In addition, Derek Wanless has been asked to provide an update of the long-term challenges of implementing the “fully engaged” scenario set out in his first report. This will include considering how to implement cost-effective approaches to improving health as well as reducing health inequalities.
- 4.3 The themes of the Programme for Action will be informed by the lessons learnt from what has been done so far. Current experience has underlined the importance of adding a new dimension to service provision by mainstreaming health inequalities issues, providing better access for service users by linking up services and achieving a new balance between service users and providers by working in partnership with communities. Programmes also need to be supported by clear aims, lines of accountability and performance management systems where not already in place.

Supporting families, mothers and children

LOOKING AHEAD: What could be different?

- staff will work with children and young people from one stop centres such as extended schools, healthy living centres, sport's centres, children's centres and trusts
- primary care services will be more orientated towards young people or provided on an outreach basis
- staff will work with children and young people in multi-agency teams so reducing the duplication in information collection from individual families
- problems will be detected earlier and support given more promptly, with common assessment systems across agencies for vulnerable children and young people
- there will be early access to support services for families experiencing challenging behaviour in their children
- young people will be involved in designing and evaluating the impact of public sector services

- 4.4 The Programme looks to strengthen support for mothers, families and children – particularly in the early years – as well as further improving opportunities for children and young people.

What needs to be done ?

4.5 The strategy emphasises the importance of prevention. Policies to support and improve the position of families must be informed by this principle. The key initiatives that contribute to this work are Sure Start, including local programmes and nursery places for all three and four year olds, the introduction of the Child Tax Credit and the emerging Children's NSF. It will be important to ensure that the health benefit from these programmes and its impact on health inequalities is maximised. Action will aim to:

Maternity and child health and child development

- improve access to maternity services, focusing on early ante-natal booking and take-up rates for women from low-income backgrounds and black and minority ethnic groups. This can be done by working with communities to identify their needs, ensuring services are culturally appropriate and accessible, providing better information. *Responsible department: Department of Health (DH), delivery mechanism: PCTs* – key role for GPs, midwives and health visitors
- increase the take up and duration of breast-feeding for new mothers, especially those in low-income groups through training health professionals and encouraging peer support programmes. *Responsible department: DH, delivery mechanism: PCTs* working in partnership with voluntary organisations and community groups – key role for midwives health visitors and peer group networks
- reform of the 60 year old Welfare Food Scheme by 2004 will help ensure that 800,000 women and young children from low-income families have access to a healthy diet, and provide increased support for breastfeeding mothers. *Responsible department: DH, delivery mechanism: PCTs* with Sure Start local programmes – key role for health professionals, including GPs, midwives and health visitors
- promote the Brushing for Life scheme to reduce inequalities in the dental health of young children in Sure Start areas without water fluoridation. *Responsible department: DH, delivery mechanism: PCTs* with Sure Start local programmes – key role for health visitors, dentists
- develop multi-disciplinary family support teams that reflect the needs of local children and families, drawing on and developing the skills of local parents and community workers as well as those of a range of health and social care workers. Many Sure Start local programmes employ trained local volunteers to help health professionals in supporting families. *Responsible department: DH, delivery mechanism: local authority social services* with Sure Start local programmes, PCTs and voluntary organisations – key role for social workers, GPs, health visitors, lay support workers

4.6 The learning and good practice from Sure Start local programmes are being applied to mainstream children's and health services. This includes the use of multi-skilled teams and lay volunteer workers. This will ensure better access to more flexible and responsive health services, which reflect user needs – taking account of the views of children and young people – and the provision of community based services where families are more comfortable and are able to access professional services.

The direction and commitment of Government can be seen in action to

- expand Sure Start and establishing children's centres reaching at least 650,000 children – led by the Sure Start Unit
- provide better access to high quality nursery and childcare in disadvantaged areas – led by the Sure Start Unit
- improve educational standards among the disadvantaged – led by the Department for Education and Skills
- establish the foundations of healthy, active lives by providing children with at least two hours of PE and sport a week – led by Department for Education and Skills and Department for Culture, Media and Sport
- promote local partnership to deliver preventive services for children at risk through the Children's Fund and local Network Fund – led by the Children and Young People's Unit

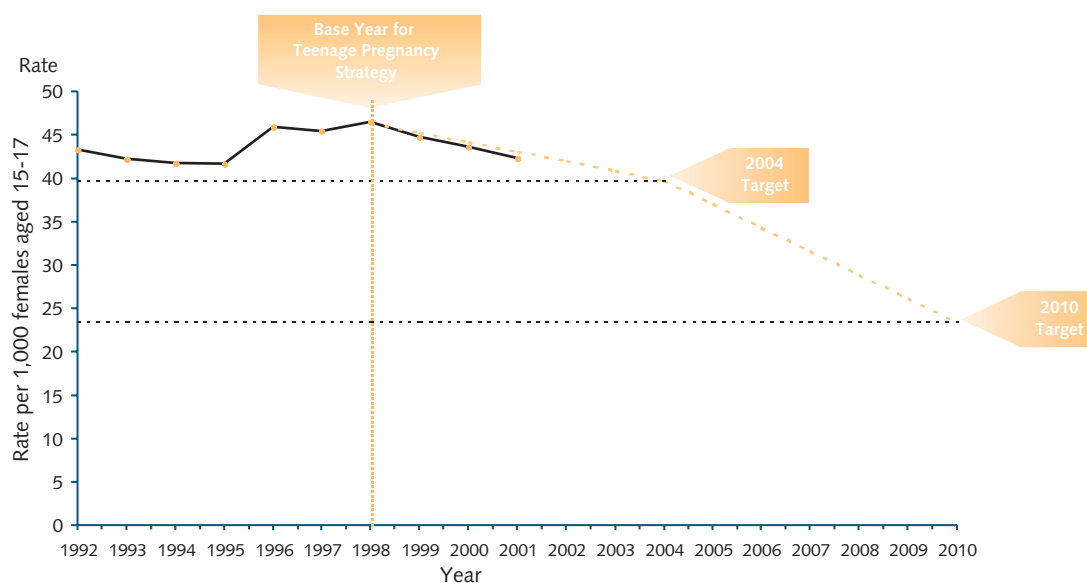
- 4.7 The Children's Green Paper will examine ways of making mainstream services more preventative and more responsive to the needs of children of all ages at risk from educational under-achievement; poor physical, mental or sexual health; victimisation, bullying and abuse, and offending. It will also look at the provision of specialist services.
- 4.8 Local preventative strategies to prevent social exclusion and co-ordinate service delivery are being developed in all top tier and unitary local authority areas in England. They will include the development of Identification, Referral and Tracking systems that will identify children at risk and support improved communications within and between agencies.
- 4.9 Children's Trusts will combine health, social care and education to foster better communication and closer co-operation. The focus of local authority activity includes Special Educational Needs for 0–19 year old children. Better integrated services will enable all those working with children in the Trust to respond to their needs more quickly, effectively and coherently.

Improving life chances for children and young people

- narrow the gap in educational attainment for young people from disadvantaged backgrounds, including black and minority ethnic groups and Looked After Children through improved targeting through the Foundation Stage and national literacy and numeracy strategies so that more young people will have better qualifications and better employment prospects, with improved engagement with, and support for, parents. *Responsible department: **Department for Education and Skills (DfES)/Sure Start Unit**, delivery mechanism: **local authorities and schools** with social services and Connexions – key role for teachers, early years practitioners, social workers, and career advisers and community volunteers*
- focus the Healthy Schools programme on disadvantaged areas, and strengthen the teaching of personal, social and health education – including education on drugs, alcohol and tobacco and sex and relationship education – to improve social and health skills, and behaviour so as to improve the opportunities for learning. *Responsible department: **DfES** with DH, delivery mechanism: **local authorities and schools** with health professionals, voluntary and community organisations – key role for teachers, school nurses, health visitors, health promotion staff*
- act locally to reduce truancy so as to improve basic skills and learning opportunities to improve job prospects, and prevent crime. *Responsible department: **DfES**, delivery mechanism: **local authorities and schools** with social services, the police and Connexions – key role for teachers, social workers, the police, and community volunteers*

- develop sports facilities through the New Opportunities PE and Sports programme and roll out the school sport co-ordinator infrastructure so that young people have the opportunity to develop physical literacy and maintain active lifestyles through a range of sports. *Responsible department: Department for Culture Media and Sport (DCMS), DfES and DH, delivery mechanism: local authorities and schools* with school sport co-ordinators, teachers, health professionals and community volunteers
- use culture and creativity to increase engagement and improve school attendance among pupils at risk of low educational attainment in disadvantaged areas. *Responsible department: DCMS/DfES, delivery mechanism: local authorities and schools* through Creative Partnership programmes
- assess health needs and provide comprehensive health promotion to young people (15–17) who spend time in prison. *Responsible department: DH with Prison Service, delivery mechanism: PCTs and prisons*
- develop clear guidance on arrangements for all homeless families and their children to ensure that their health, education and social service needs are met. *Responsible department: Office of the Deputy Prime Minister (ODPM) with DH and DfES, delivery mechanism: local authorities and PCTs*

Figure 7: Under-18 conception rate in England and teenage pregnancy strategy targets



Source: Office for National Statistics – Analysis by DH Teenage Pregnancy Unit

4.9 Figure 7 shows the teenage pregnancy rates from 1992 to 2001 with a linear trajectory from the baseline to targets for 2004 and 2010. Progress since 1998, the base year for the Teenage Pregnancy strategy, has been encouraging and is on course to meet the 2004 target.

Reducing teenage pregnancy and supporting teenage mothers

- provide early ante-natal booking and smoking cessation services in suitable settings for teenage mothers and their partners. *Responsible department: DH, delivery mechanism: PCTs* – key role for midwives, health visitors and voluntary organisations

- deliver specialist support and advice through Sure Start Plus advisers (a role being piloted in 35 local authority areas in England) who develop individual packages of support for teenage parents and pregnant teenagers to help improve their health, educational attainment and life chances. *Responsible department: DfES/DH, delivery mechanism: Sure Start Plus* – key role for Sure Start Plus advisers
- help teenage parents secure access to education through the Vulnerable Children grant. Personal advisers will be the link with other agencies to ensure parents have the best opportunities to re-engage in education and training. *Responsible department: DfES, delivery mechanism* – key role for personal advisers

The local response: what local bodies can do

- PCTs can encourage low-income mums to initiate and continue breastfeeding by targeting support at low-income and black and minority ethnic groups, using link workers and community mothers schemes
- schools can participate in the Food in Schools programme, improving the diet and nutrition of children
- PCTs and local authorities can work together to reduce smoking, providing tobacco education programmes and smoking cessation clinics
- local authorities can work to reduce injury and deaths from accidents, particularly road accidents among children from disadvantaged areas
- local authorities can encourage exercise among young children by increasing the use of abandoned or low-grade green spaces and promoting sports centres and leisure facilities
- social services can provide early access to support services for families experiencing challenging behaviour in their children
- local authorities can promote and fund pedestrian safety and cycle training for children
- all local bodies can involve young people in designing and evaluating the impact of public sector services
- school nurses can work with Connexions personal advisers to ensure that the appropriate support is in place to help a young person with mental health needs
- specialist health care staff can work from outreach centres including schools and neighbourhood nurseries
- local housing authorities can prevent homelessness through effective homelessness strategies working with local partners from the statutory and voluntary sectors

Engaging communities and individuals

LOOKING AHEAD: What could be different?

- local people will be involved in identifying local needs, influencing decision making and evaluating their local services
- jointly funded (health and local authority) community development teams will work in areas of greatest need
- health and social care services will be provided by the community and voluntary sector within the principles of social enterprise
- services will be reshaped to meet the needs of vulnerable groups
- patients with long-term illness will manage their own conditions, supported by health staff
- black and ethnic minority communities will be active partners in addressing mental health needs

- 4.10 It is vital that community and voluntary organisations are involved in service delivery. This will help people take control of their lives, promote a better local environment and quality of life and provide more appropriate services for the community. This will depend on the further development of skills and capacity to tackle the barriers and obstacles to this.

The direction and commitment of the Government can be seen in action to

- drive forward the National Strategy for Neighbourhood Renewal – led by the Office of the Deputy Prime Minister through the Neighbourhood Renewal Unit
- implement the National Drugs Strategy – led by the Home Office
- develop a national physical activity strategy – led by Department of Health and Department of Culture, Media and Sport
- implement the Homelessness Act 2002 and other measures to tackle and prevent homelessness, and taking forward the commitments set out in *Living Places* (2002) and *Sustainable Communities* (2003) – overseen by the Office of the Deputy Prime Minister
- expand the role of Sure Start transforming education, health and family support services for pre-school children and their families – led by the Sure Start Unit

What needs to be done ?

- 4.11 The National Strategy on Neighbourhood Renewal addresses the considerable problems of disadvantaged communities. Local Strategic Partnerships (LSPs) will be instrumental in bringing together service providers and communities. Action will help

- develop new ways of engaging communities in the planning and provision of services, and promoting community networks to stimulate greater community participation in decision making, taking account of the learning from Sure Start local programmes. *Responsible department: ODPM, delivery mechanism: local authorities* through LSPs with PCTs, Sure Start local programmes and community groups – key role for local authority and PCT chief executives and senior officers
- encourage greater use of school facilities to deliver services for the local community e.g. through Creative Partnerships, school sports co-ordinators and Extended Schools programmes. *Responsible department: DfES with DCMS, delivery mechanism: local authorities* with other service providers – key role for local officers and community groups
- underline the links between the quality of local environments and people's physical and emotional wellbeing reflecting the action plan set out in *Sustainable Communities*. *Responsible department: ODPM, delivery mechanism: local authorities* with regional housing boards – key role for housing officers, voluntary and community groups
- support local enterprise, including social enterprises and business development, and encourage community entrepreneurship by working with RDAs to improve local job opportunities and skills development. *Responsible department: Department of Trade and Industry (DTI)/Small Business Service, delivery mechanism: Business Link* with RDAs
- improve access to, and raise awareness of, local drug and alcohol misuse services, particularly in disadvantaged areas. *Responsible department: DH with Home Office, delivery mechanism: Drug Action Teams* with Youth Offending Teams – key role for health professionals, teachers, community groups

- improve the quality of life for older people through the NSF by co-ordinating and adequately staffing services that enable older people to maintain their health and retain their independence. *Responsible department: DH, delivery mechanism: PCTs* with local authority social services, the independent and voluntary services – key role for health professionals and social workers, and community groups
- improve access to mental health services by reducing the associated stigma so encouraging people to seek help, provide triage for people in the community who may need urgent specialist help and work with black and ethnic minority communities on mental health issues. *Responsible department: DH, delivery mechanism: PCTs* with local authority social services – key role for health professionals
- eliminate the use of B&B accommodation for homeless families with children, except in short-term and urgent cases. Tackle and prevent all forms of homelessness. *Responsible department: ODPM, delivery mechanism: local authorities* with PCTs – key role for housing officers, health visitors, social workers and voluntary agencies
- ensure NHS specialist mental health services and primary care services, including dentistry, are available to all prisoners and provide better detoxification services. *Responsible department: DH, delivery mechanism: PCTs* – key role for prison –in-reach teams, health professionals
- share and promote good practice in the care and treatment of asylum seekers and refugees so that their health care addresses their particular needs. *Responsible department: Home Office* with DH, *delivery mechanism: PCTs* – key role for refugee advisers, health professionals, community groups
- work to implement the recommendations of the *Valuing People* White Paper to tackle the health inequalities for people with learning disabilities. *Responsible department: DH, delivery mechanism: local authorities* with PCTs – key role for social workers, GPs, health facilitators
- improve access to local services by improving transport and the location of service. *Responsible department: DfT* with ODPM, DH and others, *delivery mechanism: local authorities* – key role for transport and other planners, service providers, community groups

The local response – what local bodies can do

- communities and neighbourhood wardens can introduce walking buses for school children, and provide escorts for elderly people afraid of walking alone
- get local people involved in identifying local needs, influencing decision making and evaluating their local services
- health and local authority community development teams working in areas of greatest need can be jointly funded
- provision of health and social care services by the community and voluntary sector within the principles of social enterprise
- local authorities can work in partnership with local communities to improve green spaces so that they can be used for exercise and provide children's play areas
- PCTs and local authorities can sign up to and implement a common local Compact
- develop new or reshape existing services to meet the needs of vulnerable groups
- PCT staff can work with transport planners to improve access to health services for those in disadvantaged groups and areas
- set up integrated neighbourhood teams including health staff, police and education in disadvantaged areas

Preventing illness and providing effective treatment and care

LOOKING AHEAD: What could be different?

- PCT resources will match need – by 2010 all PCTs will have reached their target allocation of resources that fully reflect local need
- prevention and treatment will be more equally balanced, particularly for the diseases which will have most impact on health inequalities, such as cancer and CHD
- service provision will be based on evidence of need, focusing on disadvantaged groups and sectors of the population with high levels of certain diseases, and improvements in outcomes are measured in order to inform future action
- increased levels of physical activity, particularly among disadvantaged groups, women and older people
- services will be tailored to take account of culture, language and religion and provided in the community, with outreach lay workers helping to improve access
- the NSF programmes and the work of the National Institute of Clinical Excellence (NICE) will level up of the quality and quantity of care

- 4.12 Service provision must be better matched to need if the national target is to be met. The “one size fits all” NHS has not produced equitable health outcomes. Year on year some areas and groups have been subject to poorer access to services, a postcode lottery of care, more ill health and earlier death.
- 4.13 Greater equity in the NHS will be strengthened by several steps. This will include the introduction of NSFs to raise the quality of services, NICE to tackle postcode prescribing, the NHS Modernisation Agency to innovate and share good practice, and the establishment of Commission for Health Care Audit and Inspection (CHAI) as an independent inspectorate for the NHS.
- 4.14 Improvement starts at the local level. Within the national framework of standards and inspection, power has shifted to PCTs so that services can be more responsive to local communities. The greater freedoms and local accountability of NHS Foundation Trusts should produce more innovative and responsive local services which gives them the potential to improve services in poorer areas.
- 4.15 Local health organisations need to make tackling health inequalities a central part of achieving their nationally set targets and standards of care. This would mean identifying geographical areas or groups not receiving treatment and care according to need, such as coronary artery by-pass (CABG) referrals or statins prescribing. It also means focusing on, and investing in, preventive measures in primary care as a way of reducing demand on services, such as A&E and waiting times for elective surgery. This approach, reflecting the Wanless analysis, not only benefits individuals, but also makes sound economic sense because it cuts demand for expensive interventions.
- 4.16 A better balance between need and provision and between prevention and treatment will not only help meet the national health inequalities and other targets, such as those for cancer and CHD, it will also maximise the benefit of the additional resources invested in the NHS.

The direction and commitment of Government can be seen in action to

- raise levels of physical activity and sport participation by cross government action – led by Department for Culture Media and Sport and Department of Health
- implement the National School Fruit Scheme to give children aged 4–6 a free piece of fruit every school day within the 5 A DAY programme– led by the Department of Health, supported by the New Opportunities Fund
- tackle road casualties among children and older people in disadvantaged areas through a series of initiatives – led by the Department for Transport

What needs to be done ?

4.17 The scale of change needed to achieve these targets will only be realised if mainstream services and systems are altered to recognise the needs of disadvantaged areas and groups. Clear planning, performance monitoring and accountability arrangements through the PPF will help provide the catalyst for action within the NHS and key partnerships. Action will aim to support and

Reducing risk through effective prevention

- develop more smoking prevention and cessation services for low-income groups and pregnant women in line with PPF targets in order to reduce morbidity and mortality from cancer, CHD and respiratory disease and to reduce infant death and illness, as well as for black and ethnic minority groups and young people. *Responsible department: DH, delivery mechanism: PCT* with charities – key role for GPs and health professionals, including health visitors and midwives, community groups, employers
- improve the nutrition of families and children, and other groups in disadvantaged areas by increasing access to and consumption of fruit and vegetables through the 5 A DAY programme and by increasing take up and length of breastfeeding. *Responsible department: DH* with NOF, *delivery mechanism: PCT* with local authorities – key role for health professionals, Sure Start, community groups, retailers and food suppliers
- raise levels of physical activity, particularly among disadvantaged groups, including action to increase cycling and walking. Evidence to inform this will be generated through forthcoming Local Exercise Action Pilots (LEAP). *Responsible department: DH and DCMS* with DfES, DfT and NOF, *delivery mechanism: PCTs and local authorities* – key role for health professionals, teachers, leisure services
- reduce illness and death caused by accidental injury (including through fires) and especially among children in low-income families and vulnerable older people. *Responsible department: Home Office* with ODPM and DfT, *delivery mechanism: local authorities* – key role for fire service, transport planners, road safety officers, community groups

Early detection, intervention and treatment

- improve access to, and quality of primary care services in currently under-served areas, for example by making greater use of community settings and services, including community pharmacies. *Responsible department: DH, delivery mechanism: PCT* – key role for health planners and health professionals, community pharmacists and dentists, Sure Start

- continue to upgrade local primary care facilities, particularly in disadvantaged areas through the LIFT programme. *Responsible department: DH, delivery mechanism: PCTs* with local authorities – key role for health and local authority planners
- expand early intervention services so that every young person with a first episode of psychosis be treated promptly and receive the intensive support they need during the first three years of their illness, with the aim of keeping them in or helping them to return to education or employment. *Responsible department: DH, delivery mechanism: PCTs* with social workers and community nurses

The local response: What local bodies can do

- PCTs can work with communities and charities to introduce more comprehensive smoking prevention and cessation strategies targeted at low-income groups, black and minority ethnic groups, young people, pregnant smokers and prisoners
- trading standards officers and police can tackle tobacco sales to minors and smuggling
- primary health care professionals and local authorities can collaborate to promote exercise on referral schemes for individuals whose health is being seriously put at risk by physical inactivity
- local planners can map food deserts so local 5 A DAY programmes can improve food access
- PCTs can support the expert patients programme which provides self management training for people with long-term conditions
- PCTs with poor rates of dental health can consider fluoridating their water supply as part of their overall health strategy and invite the SHA to carry out the necessary consultation
- local authorities can integrate health care issues into wider regeneration initiatives, such as Supporting People strategies and LSP community plans
- PCTs can work closely with local authorities on the delivery of Sure Start local programmes and other local strategies in their areas
- PCTs can match staffing to levels of health need

Improving access to effective treatment

- tackle the ‘inverse care law’ by matching need with high quality services and by monitoring and improving the uptake of services in areas with high levels of illness but low referral rates. *Responsible department: DH, delivery mechanism: PCTs* – key role for health planners, health professionals, community groups
- prevent falls in older people by introducing national guidelines on falls and osteoporosis to ensure treatment and care are based on evidence and to equalise differences in access. *Responsible department: DH, delivery mechanism: PCTs* with voluntary organisations – key role for health professionals, social workers, safety officers and community groups

Addressing the underlying determinants of health

LOOKING AHEAD: What could be different?

- Action on inequalities could result in
 - the opportunity of a decent home for all
 - neighbourhood services accessed from a single point
 - strong social networks and high-levels of volunteering
 - end of fuel poverty for vulnerable groups
 - cleaner, safer, greener environments for local communities
 - abolition of adult illiteracy with basic skills universal
 - a narrower gap in school performance
 - improved rates of benefit uptake among vulnerable groups
 - better public transport and better access to services

4.18 If programmes on housing, education, employment and transport are to lead to better health outcomes, stronger links between them will be needed. The CCR stressed that a way to narrow the gap in health outcomes was by *taking concerted action through joined up policy making and implementation across departmental boundaries*. The UK Fuel Poverty Strategy is an excellent example of greater synergy – with several departments playing their part in taking the strategy forward. The RDAs with their remit to promote regional growth through co-ordinated action on employment and regeneration can also advise on transport and housing which are key issues for sustainable development. This effective co-ordination of policy will help achieve programme targets and reduce health inequalities.

The direction and commitment of Government can be seen in action to

- raise housing quality standards and improve local environments and quality of life – led by the Office of the Deputy Prime Minister working closely with other relevant departments, including Department for Environment, Food and Rural Affairs and the Home Office
- ensure more people take up welfare benefits and tax credits – led by Department for Work and Pensions, with Inland Revenue
- create a better and safer working environment which reduces the risk of accidents and illness among the workforce – led by Department for Work and Pensions with Health and Safety Executive
- develop a sustainable policy towards the local environment, covering waste management, air pollution, waste quality and street cleaning – led by Department for Environment, Food and Rural Affairs
- take forward the strategy to improve access to key services (*Making the Connections: Final Report on Transport and Social Exclusion*) – led by Department for Transport

What needs to be done?

4.19 More co-ordinated and coherent Government programmes across all sectors are essential if the maximum health gain is to be secured. The *UK Fuel Poverty Strategy* is an excellent example of the synergy among different departments. But impact of these wider programmes on health inequalities will need to be constantly reviewed and, if necessary, modified to ensure they are actually narrowing and not widening the health gap. Action will aim to:

- reduce further the number of children in low-income households and tackling child poverty. Budget 2003 announced that the Government will examine both the welfare reform and public service changes needed to expedite its long-term goals to halve child poverty by 2010.
Responsible department: HM Treasury/DWP

- ensure that all social housing meets the decent housing standard by 2010. As an interim target, action will aim to ensure that between 2003–04 and 2005–06, 400,000 fewer homes rented from social landlords will fall below the decent homes standard. *Responsible department: ODPM, delivery mechanism: local authorities* – key role for housing officers
- ensure that between 2003–04 and 2005–06 80,000 vulnerable households in the private sector will have been helped to make their homes decent. *Responsible department: ODPM, delivery mechanism: local authorities* – key role for housing officers, housing associations and landlords
- introduce a housing health and safety rating system to enable local authorities to take action against bad housing conditions on the grounds of health and safety, focusing particularly on multiple occupation housing. *Responsible department: ODPM, delivery mechanism: local authorities* – key role for housing officers
- tackle some of the causes of ill health associated with living in poorly insulated homes and reduce excess winter deaths *Responsible department: Defra with DTI, DH, ODPM, delivery mechanism: local authorities* – key role for housing officers, health professionals, social workers
- create better and safer local environments, particularly in disadvantaged areas, so that people are more able to engage in social and physical activities in the public spaces close to where they live and work, in pleasant clean surroundings, without fear of crime. *Responsible department: ODPM with Defra, Home Office and others, delivery mechanism: local authorities* – key role for local authority officers, police, community groups
- improve basic skills and provide improved workforce training and education. *Responsible department: DfES with DWP, delivery mechanism: Learning and Skills Councils* with local authorities and prisons – key role for education and skills officers, employers
- improve employment prospects in the worst areas by tackling employment rates and addressing the issue of inactivity and incapacity. *Responsible department: DWP, delivery mechanism: JobCentre Plus* with local authorities – key role for employment advisers
- improve the job prospects of black and ethnic minority groups. *Responsible department: DWP with DfES, delivery mechanism: JobCentre Plus* with Connexions Services and local authorities – key role for employers, careers and employment advisers
- develop consistent transport and land use planning policies that improve people’s ability to access work and key services, and encourage greater exercise. *Responsible department: DfT with ODPM, Defra, delivery mechanism: local authorities* with RDAs – key role for transport and land use planners, service providers, employers, community groups
- continue to develop and implement an integrated and sustainable approach to regional economic development which takes into account the needs of disadvantaged areas and communities. *Responsible department: DTI, delivery mechanism: RDAs*
- reform Patient Transport Services and Hospital Travel Costs scheme to reflect better the needs of patients. Physical access to health care will have a higher priority in decisions about the location of health care facilities. *Responsible department: DH, delivery mechanism: PCTs* with local authorities – key role for health and local authority planners

The local response – what local bodies can do

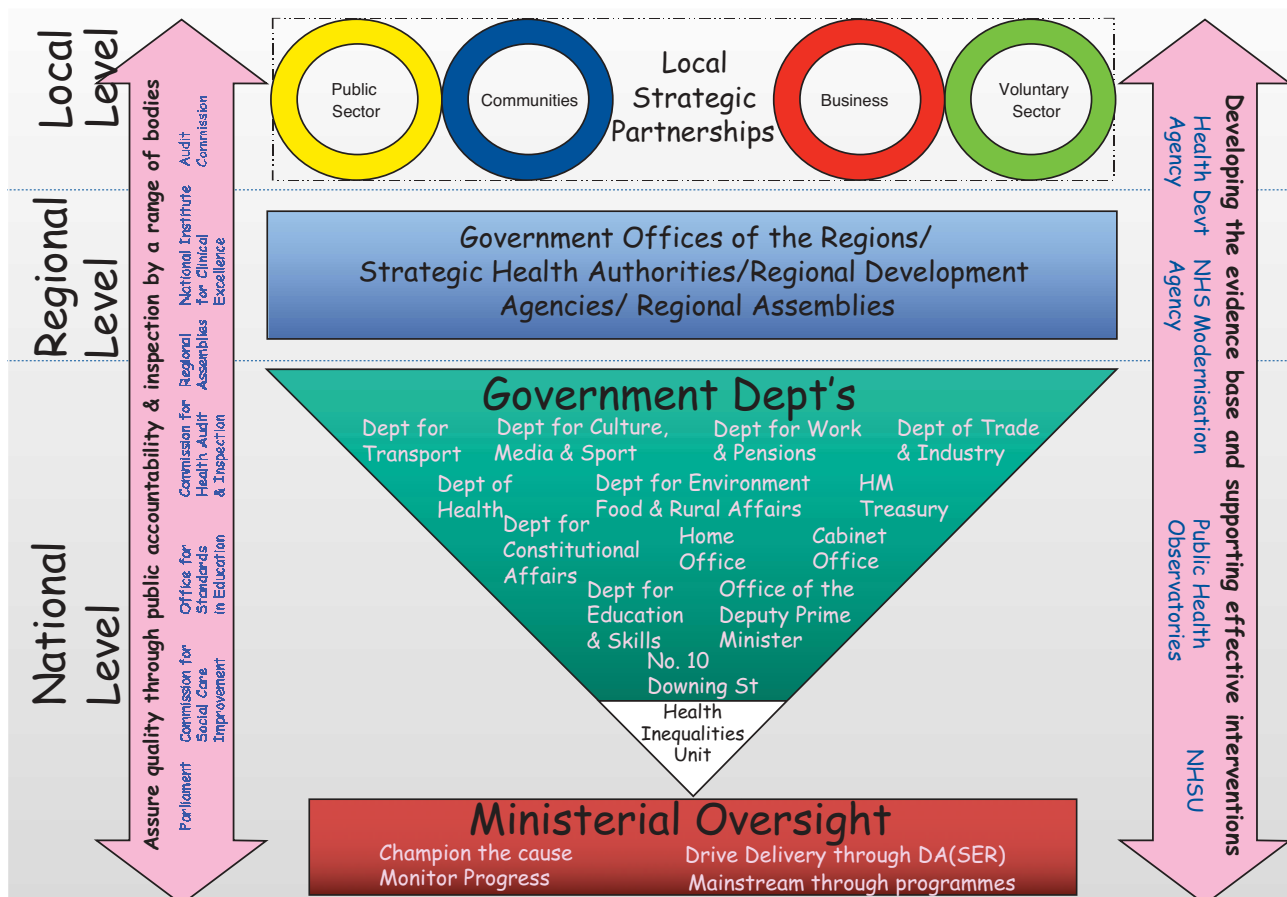
- PCTs can work with partners to promote access to welfare advice and support in health and outreach facilities
- local authorities can ensure that staff regularly visiting the over 60s know what energy efficiency measures are available in their area
- PCTs can work with local people and agencies to set up home safety, energy efficiency and repairs scheme for vulnerable families and older people
- health professionals can make referrals to energy efficiency programmes to address fuel poverty
- local authorities can buy goods and services from deprived areas in the locality
- neighbourhood wardens can mobilise communities to create clean and safe environments for local people
- transport planners can carry out child safety audits
- GPs and health professionals can take account of the wider determinants of health in their consultations

5. Roles and responsibilities

A clear understanding of roles and responsibilities will be crucial to the delivery of this Programme for Action in meeting both the national health inequalities target and tackling the wider determinants. At national, regional and local level, the key challenge will be to work in partnership across traditional boundaries at a time of change in the NHS and other services, and to effectively involve local communities.

5.1 Achieving greater synergy and maximum impact will require effective partnerships at every level. Locally, focus will be on Local Strategic Partnerships (LSPs) and will require a range of different forms of citizen participation and engagement if change is to be successfully introduced and sustained. Regionally, the Government Offices (GOs) will foster greater partnership and a regional response to health inequalities, led by the regional directors, with the professional support of regional directors of public health (RDsPH). Nationally, the health inequalities strategy will be co-ordinated and driven by a Cabinet sub-committee chaired by the Deputy Prime Minister. Things will need to be done differently if the health gap is to be narrowed. Figure 8 illustrates these arrangements for partnership at local, regional and national level, together with Ministerial oversight. Public accountability, inspection and quality assurance operates at each level.

Figure 8: A Framework for Tackling Health Inequalities



Local action

5.2 Clear roles and responsibilities will be needed at local level. These will be shaped by the following principles:

- local leadership from local authorities and PCTs, working with others through LSPs and collaborating as necessary through networks or other local arrangements
- joint commissioning of services to reduce duplication and increase the quality and efficiency of local services
- joint local planning to co-ordinate the many different local plans and maximise health gain while closing the health gap
- wherever possible, taking action on the basis of what works, e.g. by drawing on advice, good practice and evidence provided by the HDA and the Improvement and Development Agency (IDeA) and using health information on websites health.action and renewal.net
- involving the community to ensure participation in planning and delivery of action on health inequalities
- regular measuring, monitoring and reporting on progress and marking of local success

Incentives also have a part to play in engaging local partners and delivering this agenda, such as through potential funding streams or new freedoms and flexibilities.

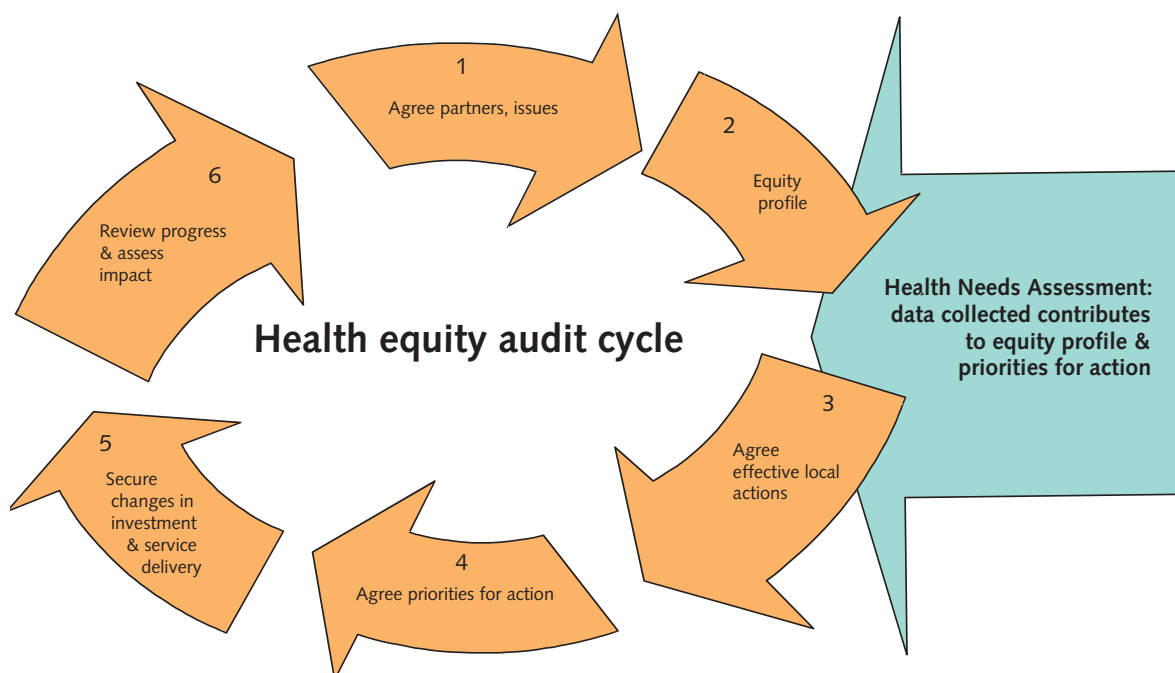
Local Strategic Partnerships

5.3 Locally, LSPs are central to tackling health inequalities. Their effectiveness will depend on a committed, collaborative and systematic approach to local issues.

5.4 There is no blueprint for how LSPs should co-ordinate their approach, this will depend on local needs and priorities. All LSPs have sub-groups or thematic partnerships (often referred to as “the LSP family” of partnerships) which are responsible for effective targeting of resources to the neediest communities. These will be linked up across other branches of the LSP “family” to ensure that health agencies feed into issues like community safety, education and economic regeneration. Some health inequalities groups have kick-started and supported better joint working by pooling budgets, or by sharing funding from sources like PCTs’ Health Inequalities Adjustment or the Neighbourhood Renewal Fund (NRF) to promote a more collaborative approach.

5.5 The Priorities and Planning Framework included a requirement that future NHS service planning should be informed by a health equity audit. Figure 9 sets out the health equity audit cycle, a mechanism to use evidence about health inequalities to inform service planning and delivery. The cycle is not complete until changes have been made in the way services are delivered, including any necessary shift in resource. The audit provides a cycle for improvement, with action year on year to address inequalities. It can be used to address both the national target and local priorities. To make this process effective, great care will need to be taken to identify the priority actions that will have most impact.

Figure 9: Health equity audit cycle



- 5.6 LSPs allow the various partners to work together to reshape their services to narrow the health gap locally, consistent with their own responsibilities. Within the LSP, the PCT(s) should lead work to agree a set of local priorities to address health inequalities that all partners can sign up to and support. LSPs in areas receiving the NRF should have addressed the issues of poor health and inequalities in their local neighbourhood renewal strategies with clear commitments by partners to delivering agreed plans.
- 5.7 Progress should be measured against a local basket of indicators, selected and agreed by the LSP (see chapter 6). Performance measures for tackling health inequalities through LSPs will be included in the guidance to be issued in 2003 and will be clearly linked to the national targets. Relevance to need will be an important factor.

Local authorities

- 5.8 Tackling health inequalities is a priority for local government. This is reflected in the PSA for local government. The national health inequalities target is also included in the list of local PSA (LPSAs) “national” targets. This means that local authorities are able to set LPSAs to deliver specific improvements in performance on tackling health inequalities. Manchester, for example, has adopted a local life expectancy target. Local authorities, especially those with the poorest health outcomes, are encouraged to develop such LPSA targets.
- 5.9 Promoting healthier communities and narrowing health inequalities is one of four projects developed so far under the “Shared Priorities” programme of co-operation which have been agreed between central and local government in a bid to improve local service delivery. This approach will also fit into local government’s statutory duty to promote community wellbeing.
- 5.10 The new power of health scrutiny means that local councillors on the Overview and Scrutiny committees (OSCs) are able to explore how local health services are provided in their locality. The new powers will enable councillors to scrutinise how local needs are being addressed, how health services are run and how they can be improved. It also provides an opportunity for local councillors to offer practical solutions or ways forward. The remit of OSCs includes public health and inequality issues, and it

encourages the council to build on its community leadership role to promote the social, environmental and economic well being of its area.

- 5.11 OSCs can also look at the wider public health and health inequality picture. The varied background of OSC members enables these wider issues to be looked at and also encourages the council to build on its community leadership role to promote the social, environmental and economic wellbeing of its area. Health scrutiny is an opportunity to build a constructive, mutually beneficial relationship between local government and the NHS on a wide variety of issues that encompass acute and primary care as well as public health and health inequalities.

Action – local authorities

- promoting healthier communities and narrowing health inequalities is one of seven Shared Priorities agreed between central and local government
- local authority transport planners will conduct accessibility planning in partnership with PCTs and other local bodies to improve access to jobs and services for disadvantaged groups and areas in Local Transport Plan areas
- local authorities can assess LSPs and ensure that their continuous performance improvement incorporates a health perspective and the need to address health inequalities
- local authorities can prioritise reducing health inequalities in their statutory community strategies and plans
- local authorities and PCTs will work together more closely on the delivery of Sure Start local programmes and Children's Centres
- regional policies, including regional economic and housing strategies can also be assessed for their impact on health and health inequalities

The NHS

- 5.12 The NHS has three key roles in tackling inequalities in health. First, PCTs have the lead locally in driving forward health inequalities work with a range of partners. They are responsible for leading and supporting partnerships in this area and influencing partners so that their services support improvements in health and narrowing of health inequalities.
- 5.13 Secondly as planners, commissioners and providers of health care, PCTs and NHS Trusts should ensure that service modernisation narrows health inequalities – and does not inadvertently make them worse. Service planning will be based on the six PPF targets that reflect the 2002 Spending Review commitments, as well as draw on evidence through health equity auditing to ensure the impact on health inequalities is reflected in this work.
- 5.14 Thirdly, the NHS also has a role alongside other public services in contributing to the local regeneration agenda by being a good 'corporate citizen'. Within the NHS, employment and procurement policies, the capital build, and training and skills programmes provide opportunities to link health with regeneration by supporting local economies and make the best use of the extra investment in the NHS.
- 5.15 NHS Trusts that achieve all their objectives and demonstrate effective management and good quality care may become Foundation Trusts – earning greater freedom to respond to local needs and develop the local health economy. Some Pilot Foundation Trusts are considering what they can do differently. The Calderdale and Huddersfield NHS Trust is consulting with the local communities they serve, and working together with the RDPH and local PCTs to determine how they can reduce inequalities in the health of the population they serve.

- 5.16 Both PCTs and NHS Trusts, as major providers of health care, must work together across care pathways to improve access to high quality services for people from disadvantaged communities or where health needs are high, for example to meet the needs of ethnic groups with high prevalence of particular conditions.
- 5.17 As the headquarters of the NHS locally, SHAs need to ensure that tackling health inequalities is a NHS priority and it is addressed strategically. They should highlight action on inequalities in the way the NHS delivers its services, as well as the wider NHS contribution to the regeneration of deprived communities. Health inequalities should be central to their planning and performance management, and they should support NHS organisations in meeting the targets and in contributing to effective partnerships. They should also build the capacity and skills of staff and others throughout SHA public health networks to promote better understanding of inequalities issues and what can be done to address them.
- 5.18 SHAs will want to ensure that PCTs and public health networks have the necessary staff and skills to deliver this agenda. Pan-PCT approaches to health inequalities will be sometimes be needed, as with public health networks. SHAs will have the opportunity to performance manage health equity audits and see that they influence patterns of service delivery. SHAs also have responsibilities for strategic capital and other investment. A health impact assessment can help ensure that the potential of such investment to reducing health inequalities is maximised. Workforce Development Confederations will help ensure that local communities benefit from local job opportunities in the NHS.
- 5.19 Chief executives have lead responsibility for health inequalities within PCTs, supported by directors of public health (DsPH) and others including directors of finance, planning and commissioning. Some DsPH are jointly appointed with local authorities, providing a tangible link to the process of joint working between these two key organisations. These changes need to be supported and fostered by
- ensuring that areas with high health needs have adequate capacity for delivering quality care, in particular GPs, health visitors and other community-based health professionals
 - providing responsive services, focusing on the skills of key professionals on reaching groups and individuals that access services late or not at all
 - supporting health professionals to develop skills needed to involve the community in key decisions about services and to meet their needs
 - recruiting staff locally so that services reflect the diversity of communities served, improving cultural sensitivity, and supporting regeneration

Local Regeneration on Merseyside through the NHS

A health impact assessment (HIA) helped match local need for regeneration and planning for a major new NHS capital programme. The programme was to redevelop ageing healthcare facilities across St Helens and Knowsley – two of the most deprived districts in the country. Recommendations were developed with local health community and partnership groups to address the impacts of vulnerable populations, use of natural resources, environmental protection, crime prevention, public involvement and improving lifestyle choice and the local economy such as local procurement, and development of start-up accommodation for business.

The results of the HIA exercise helped identify:

- key-worker accommodation in local Housing Investment Plans and local housing associations bids for national funding.
- business continuity for Major Incidents during construction phase at Whiston (major receiving centre for Liverpool airport).
- involvement of staff and patients in the design of high- risk crime areas such as A+E and reception.
- develop a local purchasing scheme for goods and services to promote inward investment in local economy

- 5.20 For the first time ever, health inequalities were identified as a priority in the Priorities and Planning Framework (PPF) for 2003–06, alongside other core NHS priorities, and were part of the most recent planning round for PCTs and SHAs. Health equity audits will be introduced and developed to support future planning rounds, providing a sound evidence base on need, provision and outcomes which will support robust service planning, resource allocation and delivery through to outcomes. These audits should focus on local action needed to support achievement of the national target. The regional Public Health Observatories (PHOs) will support PCTs in this work.
- 5.21 SHAs should also ensure PCTs and NHS Trusts work together to ensure that a shift towards prevention takes place and that access to services for people from disadvantaged communities or with unmet need is provided to high quality standards. A concerted effort needs to be made to reverse the effects of the inverse care law by which those with the greatest need receive the poorest services. Effective prevention in primary, secondary and tertiary care will affect the demands made on acute and emergency care, and on resources.
- 5.22 The effectiveness of interventions will be vital, and best practice needs to be widely implemented. Using the HDA's publications, mainstreaming the lessons from the HAZs and the Modernisation Agency's Healthy Communities Collaborative and Changing Workforce programme across PCTs and other key agencies will help ensure that health inequalities is tackled effectively.
- 5.23 The performance management arrangements in SHAs will help ensure that existing plans are addressing inequalities. This will also help sustain the importance of health inequalities as a management issue and support the underlying principle of the NHS as a service which is there for all, by addressing the needs of the traditionally under-served areas or those with the poorest health outcomes. SHAs will need to set in place formal and robust review processes. This could include an annual performance review of local health communities performance on their role and achievement in reducing health inequalities. The review would be conducted with health partners including PCT and local Trusts.

Action – the NHS

- PCT chief executives taking account of health inequalities in the planning and delivery of services, informed by health equity audits and the annual public health report, supported by the DsPH
- PCT chief executives ensuring that the PCT is taking a lead to ensure that the LSP is working effectively and leading work with other partners to develop agreed priorities
- PCTs monitoring local progress, including the use of a basket of indicators (see chapter 6)
- SHA chief executives managing PCT performance on health inequalities in line with local delivery plans using an appropriate basket of local indicators
- RDsPH providing professional leadership, supporting SHAs and PCTs to identify priorities and deliver change
- PHOs producing regional intelligence to support focusing of priorities and resources, and monitoring local progress

- 5.24 The new Commission for Healthcare Audit and Inspection (CHAI) will assess the performance of PCT and hospital trusts in tackling health inequalities and providing high quality services. SHAs will performance-manage PCTs to ensure action has been taken in response to CHAI reports.
- 5.25 The modernisation of the NHS will lead to new ways of working and create employment opportunities across the country, including in some of the most deprived areas. NHS Trusts and PCTs should work with other agencies to ensure that local unemployed people are equipped for these opportunities. An example of this is in London, the NHS Skills Escalator links with the London Development Agency, Learning and Skills Councils, and JobCentre Plus.

Schools

- 5.26 As well as their vital role in raising educational attainment and the delivery of personal, social and health education (PSHE), schools will be involved in supporting the health inequalities agenda through:
- National School Fruit Scheme
 - Extended Schools
 - Provision of sporting activity, including New Opportunities for PE and Sport in Schools
 - National Healthy Schools Programme
 - Participation in local teenage pregnancy strategies
 - The Food in Schools programme
 - Mentoring programmes by local business
- 5.27 Schools and colleges will also have a wider role to play through Lifelong Learning.

Business Sector

- 5.28 The business community will have a major role to play in regeneration and health initiatives from occupational health measures to local employment and procurement and beyond into supporting increased diversity in local recruitment and wider involvement in community development and regeneration – for example, by investing in health and fitness centres accessible to those most in need. Jobcentre Plus can help with recruitment and retention issues but also plays a wider role developing job opportunities for people within local communities, as well as playing its part in LSPs.
- 5.29 The business sector has a key role to play in tackling health inequalities. There is a growing understanding that good health is good economics, and good economics leads to better health. By focusing on the “wealth creators” (the business sector) as “health creators” and the “health creators” (NHS and other public services) as “wealth creators”, the potential to make an impact positively on health and regeneration in our communities is huge. For example, a scheme being piloted in London will
- encourage employers to take responsibility for health in the workplace through better access to information on health matters at work
 - support best practice health policies (e.g. mental health) and organisational policies on issues such as recruitment/retention, improving the health of the workforce, and helping to regenerate the community
 - match companies/business leaders with community health-related projects and/or with health care organisations to maximise the potential impact of both sectors on health inequalities.

Engaging the community

- 5.30 The full and effective participation of local people, voluntary and community organisations, and the private sector is crucial to the success of this Programme for Action. As a first step, this means local communities contributing to the development, planning and priority setting process of all organisations likely to have an impact on local health.
- 5.31 The Shared Priority project is looking to develop models of good practice where local authorities, in partnership with other key stakeholders, can tackle health inequalities in their locality, and to see how these models can be adapted for other areas of the country. The aim is to raise awareness of, and commitment to, health inequalities across local government, co-ordinate support and information at the national, regional and local levels, and improve the capacity for local action.
- 5.32 Community involvement is a focus of the work of Healthy Living Centres (HLCs). All HLCs are required to involve potential users and beneficiaries, as well as the wider community, in developing their plans and designing activities. They can also provide an avenue for local authorities, LSPs and PCTs to connect with local communities, particularly the hard to reach groups.
- 5.33 It will be important to ensure the participation of groups such as local black and minority ethnic communities and faith groups, who have not traditionally been given a voice. The new Patient’s Forums, supported by the Commission for Patient & Public Involvement in Health will be a key resource in this regard. The PCT Patient’s Forums will provide training and support to empower local communities, and in particular excluded groups, to identify issues affecting their health, and take action to influence change on those issues.

- 5.34 Local people as well as community and voluntary organisations are an invaluable source of knowledge about the appropriateness and effectiveness of local services. Tapping this knowledge will be crucial to strategic planning and the development of a coherent and effective local response to health inequalities.
- 5.35 Action on health inequalities is a key strand in the Government's programme of social justice. The statutory sector can provide support to disadvantaged communities and give communities a voice. This will help ensure an approach that reflects community engagement, relevance to local need and action on health inequalities.
- 5.36 Individuals also have to be responsible for their own health and that of their children by making appropriate and informed lifestyle choices on smoking, diet and exercise, all of which can widen health inequalities. It is essential that such choices should be informed by clear and accurate advice. Schools have a vital part to play while charities and health care professionals, including community pharmacists and dentists, can advise how to quit smoking, offer exercise on prescription, identify patients at risk of heart disease and provide services for substance misusers.
- 5.37 There is an opportunity for building practical links between the communities and local services by drawing in lay health workers and providing them with training to provide basic health advice and family support. This was a strong message from the responses to the *Tackling Health Inequalities* consultation.

The regional role

- 5.38 The Government is committed to a national programme implemented through local action plans engaging local partners. Between the national and local levels sit three regional organisations: the Government Offices (GOs), the Regional Assemblies and the Regional Development Agencies (RDAs). The GO and Regional Assembly will have specific roles to play in leading joint action in the regions, to support local implementation, working with RDsPH. The work of the RDAs is also relevant in addressing the underlying determinants of health inequalities.

Government Offices

- 5.39 GOs have a crucial role in promoting social inclusion through public sector modernisation and regeneration. They are well placed to co-ordinate action to promote inclusion and tackle inequality by bringing together the work of different departments that oversee a broad range of activity.
- 5.40 The co-location of RDsPH in GOs creates an opportunity to focus on inequalities in health, in bringing together the different strands of work. For example, the co-ordination of drug misuse services in the South West brings together several partners including the regional public health group, the National Treatment Agency, the Home Office and the Probation Service.
- 5.41 GOs have the ability to co-ordinate different initiatives that tackle the wide range of inequalities facing vulnerable groups of people – as is happening in GO South East with services to children. Children's Groups co-ordinate and support work at regional level, and include public health staff, Sure Start and Children's Fund representatives, and DfES advisers.

Action – the Government Offices

- Regional Directors should produce a GO action plan for tackling health inequalities across the broad range of GO activity, advised by RDsPH, and informed by policy developments across the region
- RDsPH should advise on the action plan and provide the main link to the NHS and promote the integration of health impact assessment in the sustainability appraisal of regional strategies
- GO Neighbourhood Renewal teams should support LSP networks in promoting good practice on health inequalities
- GOs should provide input to the inclusion of health inequalities targets within the next round of local PSAs.
- GO public health staff should work with their counterparts in other areas, such as the Home Office, to integrate health needs in support programmes for vulnerable groups
- GOs should build the capacity, awareness and skills of their teams towards health and tackling health inequalities

5.42 GOs can also identify what is happening already in the regions, and by emphasising the health benefit of cross-cutting priorities they can add impetus to this work – going far beyond the remit of the NHS. They can look for a specific commitment to tackle the worst examples of health inequalities in their work with LSPs and in reviewing regeneration strategies. For example,

- the West Midlands GO has made health improvement an integral part of the New Deal for Communities programmes
- the GO for the East Midlands has a ‘mainstreaming project’ which has developed a method of assessing the effect of departmental policies on health, crime, rural affairs and young people

5.43 The GOs can develop action plans that join up national strategies at a regional level. For example, integrating Defra’s Sustainable Food and Farming Strategy and the Department of Health/New Opportunities Fund 5 A DAY programme, as in happening in the East of England region. GO and RDA colleagues could also encourage the use of planning conditions and other mechanisms to work with major employers to ensure that the employment opportunities afforded by growth delivers benefits to deprived communities. They can ensure that work with co-located departments is consistent and in keeping with the White Paper *Your Region, Your Choice*.

Regional Assemblies

5.44 The White Paper on devolution to the English regions, envisages an important part for regional assemblies in promoting health and tackling inequalities through a regional strategy for health, developed jointly with the RDsPH. One model is the Greater London Authority (GLA). It has recognised its key role in addressing inequalities in the capital by appointing the RDPH to act as the health advisor to the Mayor and the GLA, and by the London Health Commission undertaking health impact assessments on the Mayoral strategies.

5.45 In some regions, such as the East Midlands, regional strategic planning for health and well being is happening already, where RDsPH are working closely with the regional assemblies and their constituent partner agencies and local authorities. In the North East GO, a senior NHS manager has been placed within the assembly to explore the potential for closer working as the region prepares for referendum on devolution. Much of the action needed to tackle the wider determinants of health inequalities rests with local authorities. In some areas RDsPH are working closely with local authorities to develop innovative approaches and a new role, championing action to reduce inequalities – for example, in Kirklees in Yorkshire and the Humber.

Regional Development Agencies

- 5.46 The third regional organisation is the RDA. By leading the development of regional economic strategies and through allocating an integrated pot of funding they provide leadership and practical support in promoting economic regeneration sustained by developing social infrastructure – in areas such as skills development. Sustainable work and education are important determinants of health inequality, and targeting development opportunities at the most deprived communities will be an important way to break the cycle of disadvantage. Investment in health is a strong theme in the work of some RDAs – such as the North West – seeing health as ‘everybody’s business’.
- 5.47 RDAs need good advice about the impact of economic development on the health of their population and its workforce. PHOs have been developing links and some RDAs have strengthened their health assessment capability. They have a critical role in ensuring the sharing of experience between different sectors, such as in promoting a wider ‘corporate citizen’ approach. The RDAs are increasingly working with the NHS to make the most of the NHS investment by linking it into local skills development and encouraging local procurement.

The national framework

- 5.48 The shared responsibility for health inequalities across Government is clear from departmental commitments in the 2002 Spending Review and was reflected in the publication of the CCR summary:
- the Domestic Affairs cabinet sub-committee on Social Exclusion and Regeneration DA(SER), chaired by the Deputy Prime Minister will spearhead the Programme for Action across Government
 - the Secretary of State for Health and Minister for Public Health will champion the plan within Government
 - a working group of senior officials will drive progress in departments and ensure that their programmes contribute to the wider strategy. A separate programme board supported by a small number of reference groups will oversee action in the NHS
 - the Health Inequalities Unit, based at the Department of Health, will foster and co-ordinate work within central Government, and work with the National Forum for Non-Governmental Organisations and local champions to find out and disseminate what works locally to inform local plans. The unit will be supported by the HDA and others
 - progress will also be monitored across Government by HM Treasury and overseen by the Prime Minister’s Delivery Unit

Developing the evidence base

- 5.49 Through the CCR and elsewhere, it is clear that the evidence base for health inequalities is patchy, and that pockets of good practice do not readily spread to other areas. New skills will be needed to deliver change. In order to improve the impact of action to narrow health inequalities and the capacity for it, there are key roles for mainstream organisations:
- Government departments, other funders, and the wider research community need to extend the evidence on the impact of a wide range of interventions and programmes on health inequalities,

not only through commissioning and evaluating new projects, but also by reviewing existing evidence and applying it to mainstream services

- PHOs need to analyse and interpret information to support local action
- the HDA needs to act as the national authority and information resource for “what works” to reduce inequality, producing guidance about effective action and helping practitioners get evidence into practice
- the NHS Modernisation Agency needs to use its expertise to support the implementation of best practice and effective action locally
- the NHSU, the new corporate university for the NHS needs to develop the skills of NHS staff to tackle health inequalities through practical learning opportunities
- Workforce Development Confederations on behalf of SHAs need to ensure that there are appropriate numbers of appropriately skilled staff to tackle health inequalities to meet strategic objectives
- the Sport and Physical Activity Board led by DH/DCMS has a specific remit to strengthen the evidence base around physical activity interventions which are effective

5.50 In order to have maximum impact, these organisations should work closely together to tackle this complex issue.

Building capacity

5.51 Developing a body of knowledge and experience of what works and disseminating it widely will be crucial to the success of this Programme for Action. The NRU is pivotal in ensuring that learning from experience in the neighbourhood renewal areas eventually permeates through mainstream services:

- The neighbourhood renewal learning and development strategy will support the expansion of the skills and knowledge base across the country, with Renewal.net available as a resource to transfer knowledge of what works as it continues to develop.
- 147 Neighbourhood Renewal Advisors (NRAs) have been appointed to local neighbourhood partnerships and LSPs with their work across the range of key issues, health, crime, housing, education and employment and with their general strategic development.
- Funding has been allocated to PCTs in HAZs to 2005/06 to support the dissemination of HAZ learning into mainstream activity and beyond HAZ areas.

5.52 Approaches to tackling problems through mainstream services and funding to disadvantaged areas, supported by the NRE, will be shared beyond neighbourhood renewal areas. Guidance on *Health and Neighbourhood Renewal* has been issued by DH and the NRU.

5.53 Local capacity is being developed through a range of programmes such as Sure Start, The New Deal for Communities, Neighbourhood Management programmes and the Healthy Communities Collaborative.

6. Performance management and inspection, measuring progress and managing risk

Performance management will be crucial to the success of the health inequalities programme. Indicator sets have been developed to measure progress and help ensure that the programme remains on track. Managing performance needs to be done nationally and locally.

Performance management and Inspection

- 6.1 In order to ensure that the action being taken is having the desired effect, and to inform future policy, a strong framework to assess how well this is being achieved will be required. In line with the mainstreaming approach of the strategy, health inequalities will become part of mainstream performance management and inspection systems, particularly those used for local government and the NHS.
- 6.2 Since the publication of the CCR report, health inequalities have been included in the PPF and in local NHS delivery plans. But the complexity of health inequalities throws up challenges for monitoring and measuring performance across government. Further work using currently available data may be one way of strengthening the priority given to health inequalities locally.
- 6.3 Performance will need to be tracked both nationally and locally. At national level, a high-level cross-Government set of indicators, to be published annually, will enable DA(SER) and the Prime Minister's Delivery Unit to track progress.
- 6.4 Locally, SHAs will manage the performance of PCTs, focusing on the health inequality targets in their local delivery plan. Future plans will be supported by a health equity audit, strengthening the inequalities perspective of the plans. Specifically, they will want to be reassured that success in meeting activity targets is not at the expense of widening inequalities in access to health care. PHOs and RDsPH will support SHAs to manage performance by analysing and interpreting data and providing professional public health support.
- 6.5 Part of the modernisation agenda is to promote innovation at the front line, and this is backed up by national inspection to ensure that services are of high quality. Driving improvement through mainstream systems means that health inequalities initiatives will be inspected by mainstream inspectorates including CHAI and the Audit Commission for local government. Their work will be supported by the increasing prominence of health inequalities in:
 - The NHS Performance Indicator set
 - Clinical Governance Reviews of the NHS
 - The Best Value Indicators for local government
 - Comprehensive Performance Assessment (CPA) for local government

- 6.6 In addition, action on health inequalities is a joint priority for both the NHS and local government and a prime candidate for scrutiny under the new powers given to local authority scrutiny of the NHS. The contribution Foundation Trusts make to the reduction of health inequalities would be one possible area for such scrutiny.

Measuring progress

- 6.7 Tackling health inequalities is highly challenging and measuring the impact of individual interventions and programmes even more so. The degree of challenge is reflected in the patchy evidence on the effectiveness of interventions to reduce health inequalities. Measuring progress is hampered by:
- a time lag between policy implementation and the achievement of improved health outcomes – for example, the impact on health inequalities of programmes to raise educational attainment will only be seen in the long-term
 - uncertainty about the impact of particular interventions when a host of factors contribute to a specific cause of health inequalities.

National measures

- 6.8 The headline measure of progress is the 2010 PSA target: *by 2010 to reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth*. While it is a yardstick against which to measure progress, it has some limitations. The time lag between interventions and achievement of results means that it is difficult to assess the short-term contribution of individual programmes towards the target. The impact of programmes is likely to be most visible toward the end of the decade.
- 6.9 Effective measures of progress will be needed in the interim to demonstrate that the strategy is on track and to show the contribution that programmes across Government are making to the target and to tackling the underlying causes of health inequalities.
- 6.10 National indicators will be needed to measure progress at national level. Indicators will also be needed at local level, to measure progress in local areas and to support local action.
- 6.11 A set of national indicators has been developed to support the 2010 target and they perform two key roles:
- enabling regular reporting on progress by Government, with short-term proxy measures of long-term trends in reducing inequalities
 - offering simple, summary snapshots of progress on key interventions, to provide a clear indication of progress
- 6.12 The 12 headline indicators provide a broad summary of the areas to be monitored and reflect data already collected. The areas are those where programmes, policies and interventions are expected to make a significant impact on the problem. At present, the headline indicators represent the best set given the available data. Work is continuing to map available data, identify gaps, and assess which are crucial to delivery. A summary table of the indicators is set out below, with fuller details in annex C.

The national headline indicators

Access to primary care – the number of primary care professionals per 100,000 population

Accidents – road accident casualties in disadvantaged communities

Child poverty – proportion of children living in low-income households

Diet – 5 A DAY – proportion of people consuming five or more portions of fruit and vegetables per day in the lowest quintile of household income distribution

Education – proportion of those aged 16 who get qualifications equivalent to 5 GCSEs at grades A* to C

Homelessness – number of homeless families with children living in temporary accommodation

Housing – proportion of households living in non-decent housing

Influenza vaccinations – percentage uptake of flu vaccinations by older people (aged 65+)

PE and school sport – percentage of schoolchildren who spend a minimum of two hours each week on high quality PE and school sport within and beyond the curriculum

Smoking prevalence – manual groups/in pregnancy – prevalence of smoking among people in manual social groups, and among pregnant women

Teenage conceptions – rate of under-18 conceptions

Mortality from the major killer diseases – age-standardised death rates per 100,000 population for the major killer diseases (cancer, circulatory diseases), ages under 75 (for the 20% of areas with the highest rates compared to the national average)

- 6.13 There are local data for many of the headline indicators, so that these indicators can also be used to measure progress in local areas. Where local data are not available – the child poverty, diet, and manual group smoking prevalence indicators, for example – efforts will be made to identify proxy indicators for use at local level.
- 6.14 There will be an annual report based on the headline national indicators produced by the Health Inequalities Unit but drawing on information from a range of other Government departments. These indicators are expected to remain the same except where additional indicators could help provide a more effective guide to progress and/or reflect new developments in the health inequalities strategy.
- 6.15 The report on the headline indicators will monitor, where possible, the difference between performance at national level and performance in geographical areas with poorer health. These areas will be identified in different ways. Possibilities include areas with low life expectancy, deprived areas, and areas with poor performance on the headline indicator. The report will also assess – subject to data availability – other dimensions of inequality, for example the impact on black and minority ethnic groups.

Local indicators

- 6.16 Indicators have a crucial part to play locally. They can support:
- local need assessments
 - monitoring of progress and performance management
 - equity audits
 - comparisons and benchmarking against other areas

- 6.17 Some indicators are relevant to all areas. However, given the differences in health inequalities across the country, each area will want to use local indicators relevant to its own needs.
- 6.18 A wide-ranging list of local indicators will be published by the Department of Health to support this approach. Each area will be encouraged to select relevant indicators to create a local basket. Two examples of local baskets are set out below. The inner city area list is based on an example taken from the London Health Strategy.

Inner city area, high-levels of deprivation, large minority ethnic population

- Unemployment rate
- Unemployment rate among black and ethnic minority groups
- Percentage of pupils achieving five GCSE grades A*-C
- Proportion of homes unfit to live in
- Burglary rate per 1000 resident population
- Air quality indicators (NO2 and PM10)
- Road traffic casualty rate per 1000 resident population

Rural area, elderly population

- Uptake of influenza immunisation (%) of over 65s
- Fuel poverty
- Access to services
- Local authority buildings (%) suitable for, and accessible to, disabled people
- Mortality from accidents over 65 years

Other indicators

- 6.19 The use of a basket of indicators offers an effective means of measuring progress. Other measures of impact can include qualitative feedback on progress that can help to gauge the views of individuals and communities, and evidence of improvements in mainstream services as part of a strategy to tackle inequalities.
- 6.20 GOs, including RDsPH and SHAs will have a unique perspective on progress within their region or sub-region and should be involved in helping to interpret local information.

Managing risk











- 6.21 All projects and programmes are vulnerable to risk and obstacles to implementation. The health inequalities programme is complex and challenging and will need effective responses to handle potential or emerging risks. The Acheson inquiry report also recognised that the unintended consequences of policy change could actually widen health inequalities.

- 6.22 The effective and systematic handling of these risks will be crucial to sustain the momentum of the programme. Account will need to be taken of:
- the nature of the risk
 - the probability of the risk becoming reality
 - the potential impact if risk becomes reality, including its effect on inter-dependent programmes elsewhere in the strategy
 - contingency plans with measures to tackle problems, and stages at which plans should be implemented.
- 6.23 The risks to the delivery of the programme will be reviewed regularly by the cross-Government steering group of senior officials and by the Prime Minister's Delivery Unit. The kind of risks that might impede progress include:
- monitoring systems failing to capture the total impact of the strategy
 - insufficient progress made in clarifying evidence on "what works"
 - conflicting priorities so that Government departments fail to work in a co-ordinated and synergistic way
 - delays and difficulties so that local partners fail to work in a co-ordinated and synergistic way, reducing the overall impact of the strategy.
- 6.24 An appropriate assessment of risks as well as effective arrangements for measuring and monitoring progress will help keep the Programme for Action on track. The challenge remains considerable – to start reversing the health gap is a crucial step towards the 2010 target. The themes and principles in this Programme provide a framework to encourage and underpin local, regional and national action. In particular, mainstreaming health inequalities and working in partnership across traditional boundaries will help drive this Programme forward across Government and meet the target and tackle the underlying causes of health inequalities.

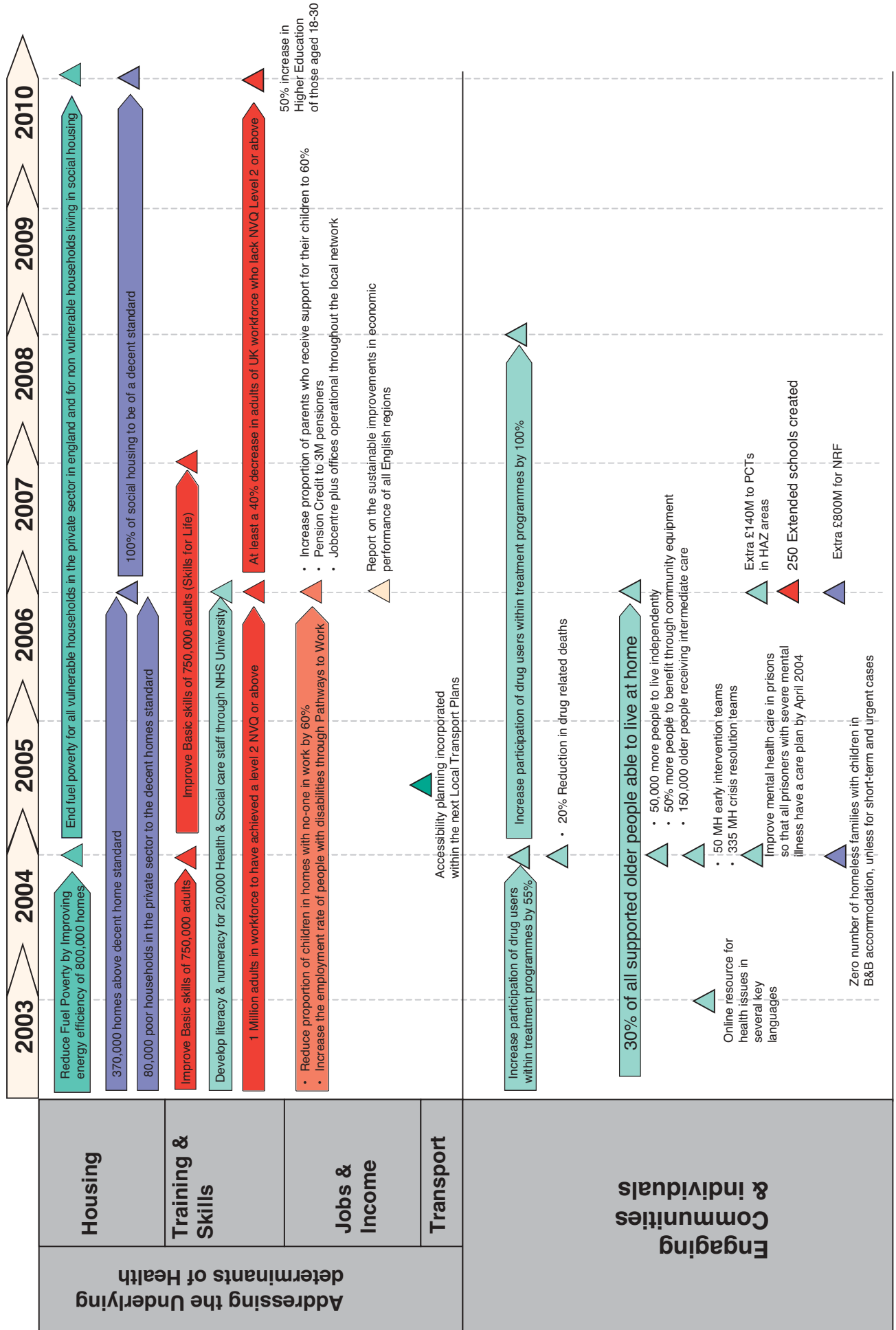
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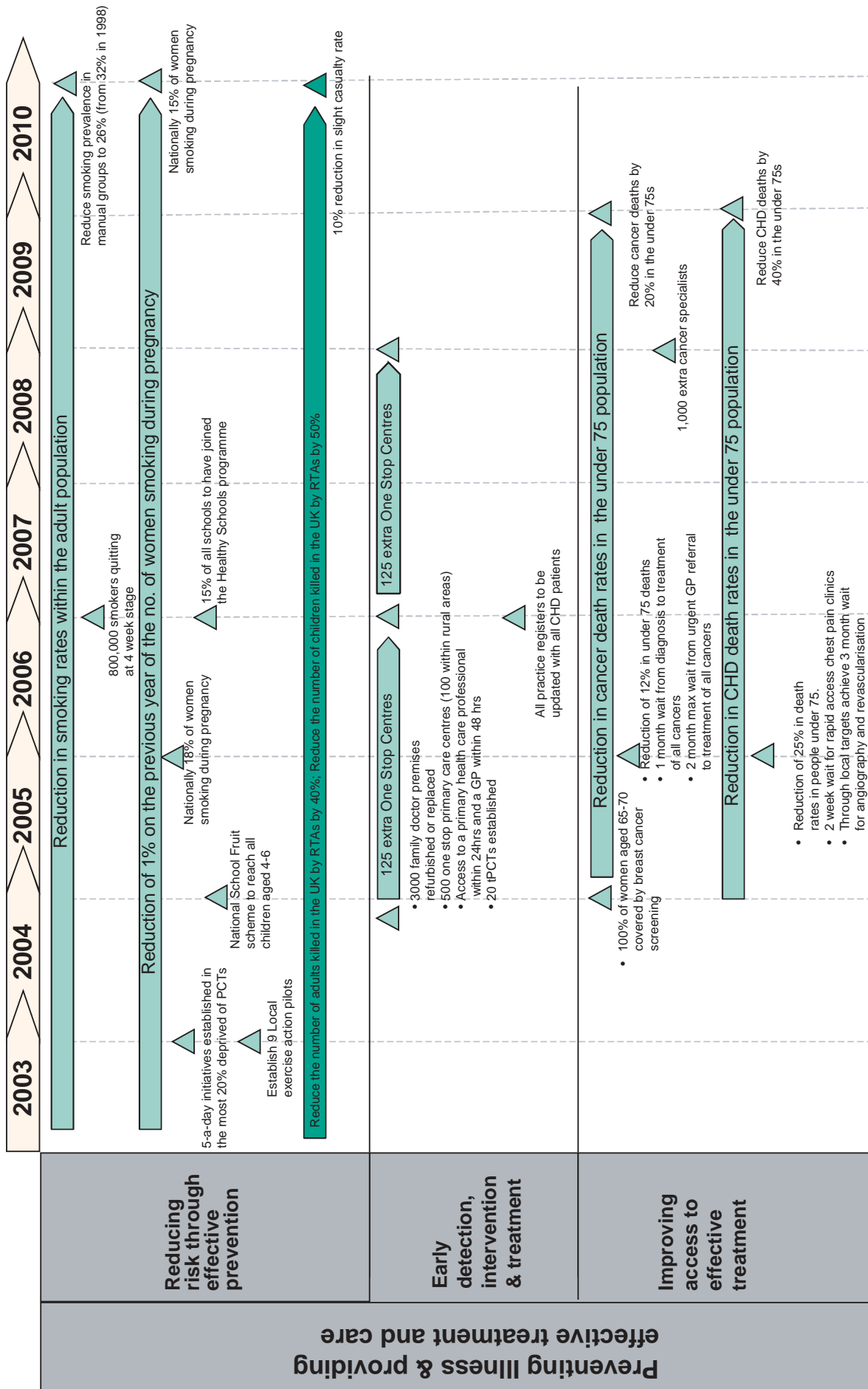
Timescales and Strategy Chart

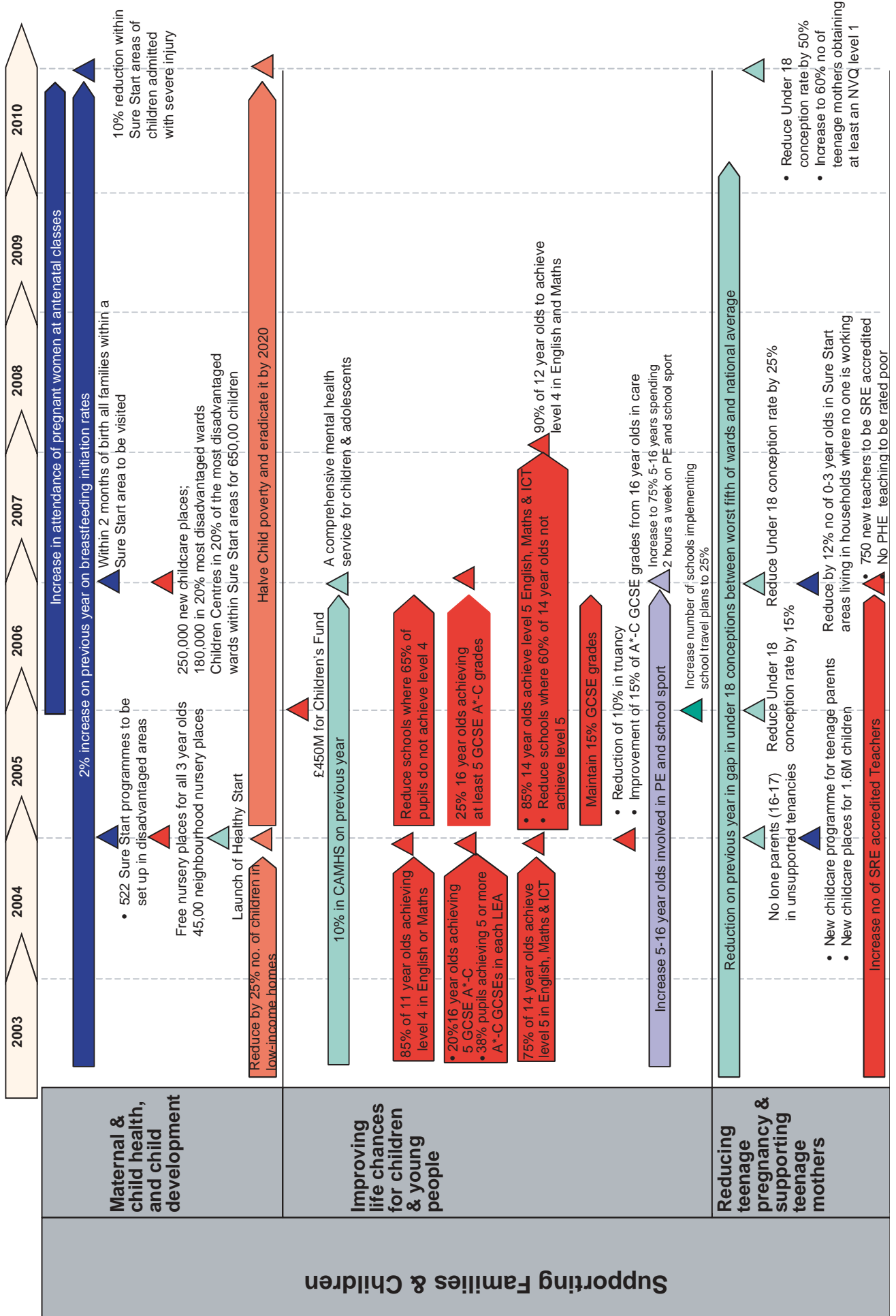
1. This Annex provides a strategy chart for the activities that together will form the Government’s programme of work to tackle health inequalities. The chart does not attempt to capture every planned activity or programme of work, only those where it is possible and credible to be used within a programme plan.
2. The charts are organised to match the discrete sections within previous chapters and to this end the work-streams are cross government. The Government departments delivering each work-stream are represented by the following key:

Government Department	
DH	
DFES	
DEFRA	
DFT	
DWP	
SureStart	
ODPM	
DTI	
HO	
DCMS	

3. Areas of work that are jointly delivered have not been shown on the chart for simplicity, but are explicitly covered within the Delivery chapter. Wherever possible commentary is attached to each work-stream, however in some cases the text has been abbreviated and reference must be made to the associated section within the Delivery chapter.







Annex B:

Departmental Commitments

This Annex sets out in more detail the commitments of Government departments over the next three years – until March 2006.

Supporting families, mothers and children

Maternal and child health, and child development

- support poorer families and children by
 - expanding Sure Start services for children under 6 and their families, Sure Start local programmes to reach 400,000 children living in disadvantaged areas, including a third of children under 4 living in poverty, by April 2004
 - developing of a network of Children's Centres in 20% of the most disadvantaged wards by March 2006 reaching up to 650,000 children and their families
 - creating a further 250,000 new childcare places by 2006, 180,000 in the 20% of most disadvantaged wards
 - establishing 45,000 new daycare places through the Neighbourhood Nursery Initiative by April 2004
 - provide free nursery education for all 3 year olds by 2004 – **Action:** Sure Start Unit with a total spend of £1.5bn
- ensure that 800,000 children, pregnant women and mothers from low income families have a healthy diet through the reformed Welfare Food Scheme, and provide better support for breastfeeding mothers – **Action:** DH by 2004, with an annual spend of £142m

Improving life chances for children and young people

- support children and young people at risk aged 5–13 through the Children's Fund – **Action:** DfES, with spend of £150m for each of three years to 2006
- address mental health needs of children by establishing a comprehensive child and adolescent mental health service (CAMHS) in all areas by 2006 – **Action:** DH, with an extra £250m over the next three years
- improve the quality of life of marginalised young people using sport to raise their aspirations and connect them back to education, training and employment through Positive Futures projects. In addition to 67 current projects, funding for a further 37 have been secured – **Action:** HO

- develop and improve sports facilities for around 2,300 schools and raise standards of physical education especially in disadvantaged areas – **Action:** DCMS/DfES with New Opportunities Fund (NOF) and Sport England, with £686m being invested by the NOF and the Space for Sport and Arts programme worth £130m which will improve sports and arts facilities for around 300 schools in the most deprived areas of the country
- expand the specialist sports college and School Sport Co-ordinator Programmes to create a network of 400 school sports co-ordinator partnerships – **Action:** DfES/DCMS Spend: £339m over the next three years to 2006
- meet the needs of disadvantaged individuals, groups and areas at school through mainstream education services and targeted action by 2004, specifically:
 - establishing GCSE floor target to ensure that 25% of pupils in every school gain 5 A*-C GCSEs by 2006 – **Action:** DfES
 - improving education of children in care to substantially narrow the gap between educational attainment and participation of their peers by 2006 – **Action:** DfES
 - improving behaviour and school attendance in the worst areas through the £470m National Behaviour and Attendance programme – **Action:** DfES
 - improving learning outcomes for pupils in disadvantaged areas through the Creative Partnerships programme. **Action:** DfES/DCMS, Spend: £27m in 2003–04 rising to £45m in 2005–06
 - improving the social and health context of school life by targeting the Healthy Schools programme on the most deprived communities – **Action:** DfES/DH, Spend: £4.7m in 2003/04
- reduce the number of 16–18 year olds not engaged in education, employment or training by 10% by November 2004 in established Connexion partnerships – **Action:** DfES, Spend: £457.7m in 2003/04

Reducing teenage pregnancy and supporting teenage mothers

- raise the quality of education in schools by the introduction of a certification programme on sex and relationship education for teachers and equivalent programmes for school and community nurses – **Action:** DfES
- share learning and best practice from the Sure Start Plus teenage pregnancy pilot programmes with Connexions personal advisers and others – **Action:** DfES
- improve access for young parents to ante-natal and post-natal care – **Action:** DH/DfES
- improve access to learning and employment opportunities through the Connexions programme – **Action:** DfES

Engaging communities and individuals

- continue to support the reshaping and redirecting of mainstream services to tackle the problems faced in disadvantaged neighbourhoods through the National Strategy for Neighbourhood Renewal supported by the Neighbourhood Renewal Fund – **Action:** ODPM through the Neighbourhood Renewal Unit (NRU), with an extra £800m to 2005/6 building on the £900m which has been allocated up to March 2004
- encourage greater communities involvement in actions to improve their local environments, and make them healthier places to be – **Action:** ODPM through an extra £40m for environmental charity Groundwork to 2006, plus £30m for a new community enablers scheme to improve local spaces
- support existing and new health initiatives through further investment to PCTs in HAZ areas to 2006 – **Action:** DH, with an extra £140m to 2006
- use schools to improve services for local people through the creation of up to 240 full service Extended Schools by 2006, targeted initially at areas of deprivation and offering a set of services including health and social care, childcare, adult education and sports activities – **Action:** DfES, Spend: £52.2m plus £81m for LEA and school staff support
- deliver services for ‘hard to reach’ groups through the 257 healthy living centres clustered round areas of deprivation, from 2003 – **Action:** DH, with £202m NOF funding
- support vulnerable groups through the Supporting People programme, including teenage parents, victims of domestic violence and ex-offenders, as well as independent living within communities for older, disabled and vulnerable people – **Action:** ODPM

Enterprise

- promote the provision of business support and finance for entrepreneurs from disadvantaged groups through the Phoenix Fund and the work of the RDAs – **Action:** DTI, Spend: £145m
- encourage community-based enterprises to provide services to the public sector through the development of a ‘good corporate citizen’ approach in the NHS and local authorities – **Action:** DH/ODPM/DTI

Crime/Drug misuse

- increase participation of problem users in treatment programmes, maintain the proportion successfully completing treatment programmes, further expand the drug treatment workforce, and improve access to treatment programmes, driving down waiting lists across all treatment – **Action:** DH and HO

Older people

- involvement of older people in both high level policy direction at a national level of policy and service development at a local level outlined in NSF for Older People – **Action:** DH
- improving access to, the effectiveness of, and integration of, falls prevention services through the direct involvement of older people and their representative organisations in local health communities and falls collaborative actions – **Action:** DH

Homeless people

- tackling and preventing homelessness through homelessness strategies and meeting the Government's targets to:
 - ensure no homeless family with children is in bed and breakfast accommodation by March 2004, unless for urgent cases and even then for no longer than six weeks – **Action:** ODPM
 - sustain or reduce the numbers of people sleeping rough at 600 people or fewer – **Action:** ODPM, Spend: £260m 2003/04–2005/06

People with mental illness

- reduce the duration of untreated psychosis to 3 months by 2004 by establishing early intervention teams and provide support for the first 3 years for all young people who develop an episode of psychosis – **Action:** DH
- provide access crisis resolution services from 2005, either from the teams or trained NHS Direct staff – **Action:** DH

Prisoners' health

- address prisoners mental health needs by providing all prisoners with severe mental health problems with a care plan by 2004 – **Action:** DH

Asylum seekers and refugees

- assess health needs through a network of induction centres, all of which will include the provision of a health assessment – **Action:** DH
- meet the language needs of this group through developing an online resource of health information in key languages and a national scoping study on models of providing interpreting services for NHS Direct, by 2003 – **Action:** DH

Preventing illness and providing effective treatment and care

Reducing risk through effective prevention

- reduce smoking, particularly among manual groups by:
 - expanding PCT smoking cessation services
 - expanding tailored tobacco education campaigns for example in prisons, hospitals, and factories
 - ending tobacco advertising, promotion and sponsorship
 - running extended mass media education campaigns
 - enforcing ban on under-age sales of tobacco

- putting new health warnings and advice on tobacco products to achieve 800,000 quitters at the 4 week stage by 2006, and reduce smoking in pregnancy by 1 percentage point a year 2003–2006 – **Action:** DH
- improve diet and nutrition among disadvantaged groups and children by implementing the Food and Health Action Plan across Government and other sectors and
 - further developing the 5 A DAY programme targeting both in the 66 PCTs in the most deprived areas of the country funded by NOF until 2005, and in disadvantaged areas in all PCTs – **Action:** DH
 - expanding the National School Fruit Scheme to reach all children aged 4–6 by 2004 – **Action:** DH
- increase participation in physical activity through the introduction of Local Exercise Action Pilots in 2003 – **Action:** DH, DCMS with Sport England, Countryside Agency
- reduce accidental injury, especially among children and young people in disadvantaged areas through environmental improvements, public education campaigns and projects to reduce child road casualties – **Action:** DfT, HO working through local authorities and Sure Start
- reduce deaths and injuries from house fires through national awareness campaigns and targeted fire service risk management strategies. **Action:** ODPM working through local authorities
- the development of co-ordinated local action programmes that improve the health and well being of older people through the NSF for Older People – **Action:** DH

Early detection, intervention and treatment

- increase resources available to the NHS to take account of unmet need through the new NHS resource allocation formula and devolved PCT budgets – **Action:** DH
- improve primary care facilities, especially in inner cities and urban areas, by £1b programme of refurbishing or replacing 3000 family doctor's premises and establishing 500 one-stop centres by 2004 – **Action:** DH, Spend: £1 billion
- raise the quality of service in disadvantaged areas by establishing 20 teaching PCTs by 2004 – **Action:** DH
- improve access to rural services by establishing 100 one-stop primary care centres or mobile service units by 2004 – **Action:** DH
- further improve mainstream primary care services by:
 - providing guaranteed access to a primary care professional within 1 working day, and to a GP within 2 working days, by December 2004. NHS Walk-In Centres are one of the services available to PCTs to improve access to primary care – **Action:** DH
 - creating CHD practice-based patient registers to ensure systematic treatment regimes for those at most risk by March 2006 – **Action:** DH

- extending breast cancer screening to women aged 65–70 by 2004 and agreeing local protocols to address inequalities in service provision – **Action:** DH
- meeting the target of 70% uptake in influenza immunisation in people aged 65 years and over, especially in areas of lowest life expectancy – **Action:** DH
- quality assuring screening programmes to ensure uptake is equitable and reaching those most in need – **Action:** DH
- implement NSF for Older People
 - supporting action to identify and eliminate age discrimination in access to health and social care – **Action:** DH
 - developing a local Single Assessment Process with shared information and assessment mechanisms across health and social care covering stroke care, falls services and mental health – **Action:** DH

Improving access to effective treatment

- respond to local needs and raise standards of service through NHS Foundation Trusts – hospitals in some of the most deprived areas have expressed interest in being among the first trusts, and all hospitals will be given help to become a trust over the course of the next 4 to 5 years – **Action:** DH
- improve access to health facilities by PCTs working in partnership with local authority transport planners to conduct accessibility planning, reform of patient transport services and the hospital travel costs scheme – **Action:** DH
- improve access to cancer services by treating all cancer patients within a month of diagnosis and within two months of urgent referral by 2005 – **Action:** DH, Spend: an extra £570m
- improve access to CHD services by setting a two week wait standard for rapid access chest pain clinics and a 3 month maximum wait for angiography and revascularisation by 2005 – **Action:** DH
- promote rehabilitation and supported discharge from hospital with 150,000 additional people receiving intermediate care services by March 2004 – **Action:** DH

Addressing the underlying determinants of health

Child poverty

- reduce the number of children in low-income households by a quarter by 2004/05 from 1998/99 as a contribution to the broader target of halving child poverty by 2010 and eradicating it by 2020 – **Action:** HMT/DWP, Spend: £13 billion (Child Tax Credit)

Housing and environment

- improve the quality of social housing and raise 370,000 homes above the decent homes standard by 2006 – **Action:** ODPM, with a £2 billion investment over the next three years
- address the needs of poor households in the private sector and raise 80,000 households to the decent homes standard by 2005–06 – **Action:** ODPM
- eradicate fuel poverty in England among vulnerable households by 2010 and by 2016 for all other households as far as reasonably practicable – **Action:** Defra/DTI – with a budget of £156m (2003–04)
- reduce fuel poverty by improving the energy efficiency of homes for 800,000 vulnerable households through the Warm Front programme by 2004 – **Action:** Defra with a budget of £152m out of total £156m for fuel poverty (2003–04)
- work for cleaner, safer and greener local environments and thriving sustainable communities through *Living Places: Cleaner, Safer, Greener and Sustainable Communities: building for the future*. **Action:** ODPM lead in co-ordinating the action plan *Living Places*, aided by £201m of funding for better local environments

Training and skills

- improve the basic skills of 750,000 adults through continued expansion of the Skills for Life programme by 2004 – **Action:** DfES
- develop and deliver literacy, numeracy and English language training for 20,000 health and social care staff through the NHS University by 2006 – **Action:** DH

Jobs and incomes

- enable people with health problems and disabilities to move into work through the Pathways to Work strategy on rehabilitation – **Action:** DWP
- provide extra support for people in work, families and older people through the working and child tax credits, and pension credit – **Action:** IR, HM Treasury, DWP
- help people who are unemployed (but available to work) to return to the labour market through Jobcentre Plus. The implementation of new style Jobcentre Plus offices throughout its local office network will be complete by 2006 – **Action:** DWP

Transport

- Overseeing the implementation of the SEU action plan to improve access to jobs and key services, to March 2005 – **Action:** DfT
- In areas that produce Local Transport Plans, transport planners will lead work to improve access to jobs and key services. This process, accessibility planning, will be incorporated into authorities' second Local Transport Plans, which will be submitted in 2005 – **Action:** DH
- Encouraging more children to walk and cycle, through a package of measures to promote sustainable travel to school – **Action:** DfT
- Forthcoming changes to the bus registration system will make it easier to register flexibly routed, demand responsive services. This will allow the provision of dedicated door to door bus services tailored to meet passenger needs. The regulation changes will come into force later this year – **Action:** DfT.

Annex C:

National indicators in detail

Details of how the national headline indicators will be reported, to ensure inequalities are monitored, are set out below. This will be developed further as the reports are prepared, so that year by year a wider range of relevant dimensions of inequality are monitored in the most appropriate way, subject to data availability.

NATIONAL HEADLINE INDICATORS

1. ACCESS TO PRIMARY CARE

Number of primary care professionals per 100,000 population

Analyses of data on numbers of primary care professionals will be developed to look at areas with poorer outcomes, compared to the national average (subject to data availability). Primary care professionals include GPs, and PCT- and GP-employed nurses and other healthcare professionals.

For example, current data on the number of GPs per 100,000 population can be analysed to report on the average for the 20% of PCTs with the lowest number of GPs per population, compared to the national average. Ways of extending a similar analysis to look at the wider primary care team will be developed (subject to data availability), to reflect changing professional roles and skill mix.

2. ACCIDENTS

Road accident casualties in disadvantaged communities

(The rate of decline in road accident casualties – in the 88 Neighbourhood Renewal Fund areas, compared with the rate of decline in England as a whole.)

Data will be analysed to look at the Neighbourhood Renewal Fund areas compared to England as a whole, for all ages and for children as a separate group. In particular, data will be presented showing the following, for all ages and for children as a separate group:

- Road accident casualties in England, and the rate of decline in this
- Road accident casualties in the NRF areas, and the rate of decline in this

3. CHILD POVERTY

Proportion of children living in low-income households

Data will be analysed to look at trends at national level for the proportion of children living in low-income households, as measured in terms of relative low income, low income in an absolute sense, and persistent low income.

(Note that the Department for Work and Pensions are currently consulting on developing a measure of child poverty for the long term. Preliminary conclusions from the consultation were published in May 2003. Following further methodological work, full details of a new long-term measure will be published at the end of 2003).

4. DIET – 5 A DAY

Proportion of people consuming five or more portions of fruit and vegetables per day in the lowest quintile of household income distribution

Data will be analysed to look at variation by annual household income. In particular, data will be presented showing consumption at national level and for each quintile of equivalised annual household income.

5. EDUCATION

Proportion of those aged 16 who get qualifications equivalent to 5 GCSEs at grades A* to C

Data showing trends at national level will be presented.

Analyses of data on attainment will be developed to look at attainment in schools serving deprived areas compared to attainment in all schools (for example, by looking at schools with a high proportion of children known to be eligible for free school meals), subject to limitations of available data.

Data will be analysed to look at the number of LEAs where there is at least 1 school with less than 25% of pupils achieving qualifications equivalent to 5 GCSEs at grades A* to C (linked to the DfES PSA target for all schools to have at least 25% of pupils achieving this standard by 2006).

Data will also be analysed by ethnic group.

6. HOMELESSNESS

Number of homeless families with children living in temporary accommodation

Data will be analysed to show trends at national level, and to look at geographical variation at local housing authority level (in particular looking at areas with poorer outcomes). The report will show data for homeless families with children living in Bed and Breakfast accommodation in particular, as well as those living in all forms of temporary accommodation.

7. HOUSING

Proportion of households living in non-decent housing

Data showing trends at national level will be presented.

8. INFLUENZA VACCINATIONS

Percentage uptake of flu vaccinations by older people (aged 65+)

Data will be analysed to look at areas with poorer outcomes, compared to the national average. In particular, data will be presented showing the average percentage uptake for the 20% of PCTs with the lowest uptake, compared to the national average. Data will also be presented showing the distribution of uptake at PCT level, for example by showing each decile value for the PCT uptake data.

9. PE AND SCHOOL SPORT

Percentage of schoolchildren who spend a minimum of two hours each week on high quality PE and school sport within and beyond the curriculum

Data will be analysed to look at areas with poorer outcomes, compared to the national average (subject to data availability).

10. SMOKING PREVALENCE – manual groups / in pregnancy

Prevalence of smoking among people in manual social groups, and among pregnant women

For smoking prevalence in manual groups: Data will be analysed to look at trends in prevalence in manual groups compared to the whole population.

For smoking prevalence among pregnant women: Data will be analysed to look at areas with poorer outcomes, compared to the national average.

11. TEENAGE CONCEPTIONS

Rate of under-18 conceptions

Data will be analysed to look at areas with poorer outcomes, compared to the national average. In particular, data will be presented showing the average rate for the 20% of “top-tier” local authorities with the highest under-18 conception rates, compared to the national average. Data will also be presented showing the distribution of under-18 conception rates across local authorities, for example by showing each decile value for the local authority data.

Analyses of under-18 conceptions data will also be developed to look at areas with poorer outcomes using ward level information.

12. MORTALITY FROM THE MAJOR KILLER DISEASES

Age-standardised death rates per 100,000 population for the major killer diseases (cancer, circulatory diseases), ages under 75 (for the 20% of areas with the highest rates compared to the national average)

Data will be presented for cancer and circulatory diseases separately.

Data will be analysed to look at areas with poorer outcomes, compared to the national average. In particular, data will be presented showing the average death rate for the 20% of PCTs with the highest death rates, compared to the national average. Data will also be presented showing the distribution of death rates across PCTs, for example by showing each decile value for the PCT death rates data.

The feasibility of other analyses looking at area-based inequalities will be investigated, for example analyses by area classification (such as the ONS area classification).

Annex D:

Glossary of Terms

CABG	Coronary artery by-pass
CCR	Cross Cutting Review
CHAI	Commission for Healthcare Audit and Inspection
CHD	Coronary Heart Disease
CPA	Comprehensive Performance Assessment
CVS	Community and Voluntary Service
DA(SER)	Domestic Affairs Cabinet Sub-Committee on Social Exclusion and Regeneration
DATs	Drug Action Teams
DCA	Department for Constitutional Affairs
DCMS	Department of Culture, Media and Sport
DEFRA	Department for Environment, Food and Rural Affairs
DfES	Department for Education and Skills
DfT	Department for Transport
DH	Department of Health
DsPH	Directors of Public Health
DTI	Department for Trade and Industry
DWP	Department for Work and Pensions
GLA	Greater London Authority
GOs	Government Offices
HAZs	Health Action Zones
HDA	Health Development Agency
HIA	Health Impact Assessment
HIU	Health Inequalities Unit
HLCs	Health Living Centres
HMT	Her Majesty's Treasury
HO	Home Office
HSE	Health and Safety Executive
IDeA	Improvement and Development Agency

IR	Inland Revenue
LDP	Local Delivery Plans
LGA	Local Government Association
LIFT	Local Improvement Finance Trust
LPSAs	Local Public Service Agreements
LSPs	Local Strategic Partnerships
NHSU	NHS University
NICE	National Institute of Clinical Excellence
NMW	National Minimum Wage
NOF	New Opportunities Fund
NRAAs	Neighbourhood Renewal Advisors
NRF	Neighbourhood Renewal Fund
NRU	Neighbourhood Renewal Unit
NSFs	National Service Frameworks
ODPM	Office of the Deputy Prime Minister
OGDs	Other Government Departments
ONS	Office of National Statistics
OSCs	Overview and Scrutiny Committees
PCTs	Primary Care Trusts
PHOs	Public Health Observatories
PMS	Personal Medical Services
PPF	Priorities and Planning Framework
PSA	Public Service Agreement
RCU	Regional Co-ordination Unit
RDAs	Regional Development Agencies
RDsPH	Regional Directors of Public Health
SEU	Social Exclusion Unit
SHAs	Strategic Health Authorities

Annex E:

Useful publications and contacts

Cancer Plan

<http://www.doh.gov.uk/cancer/index.htm>

Cross Cutting Review of Health Inequalities

<http://www.doh.gov.uk/healthinequalities/ccsrsummaryreport.htm>

Drug Strategy 2002

<http://www.drugs.gov.uk/NationalStrategy>

Fuel Poverty Strategy

<http://www.defra.gov.uk/environment/consult/fuelpov/index/htm>

Getting the Right Start, the National Service Framework for Children

<http://www.doh.gov.uk/nsf/children/hospitalstandard.pdf>

Health and Neighbourhood Renewal: Guidance from the Department of Health and the Neighbourhood Renewal Unit, 2002

<http://www.doh.gov.uk/healthinequalities/>

Health and Social Care Act 2001

<http://www.hmsa.gov.uk/acts/acts2001/20010015.htm>

Homelessness Act 2002

<http://www.hmsa.gov.uk/acts/acts2002/20020007.htm>

Independent Inquiry into Inequalities in Health, Sir Donald Acheson. 1998

<http://www.doh.gov.uk/ih/ih.htm>

Living Places – Cleaner, Safer, Greener (2002)

<http://www.urban.odpm.gov.uk/greenspace/living/>

Making the Connections (2003)

<http://www.socialexclusionunit.gov.uk/publications/reports/pdfs/transport.pdf>

‘More than a Roof’

<http://www.housing.odpm.gov.uk/information/homelessness/morethanarroof/>

National Strategy for Neighbourhood Renewal

<http://www.cabinet-office.gov.uk/seu/published.htm>

NHS Plan

<http://www.doh.gov.uk/nhsplan/index.htm>

NHS Priorities and Planning Framework

<http://www.doh.gov.uk/planning2003-2006/>

‘Pathways to Work’ Green Paper

<http://www.dwp.gov.uk/consultations/consult/2002/pathways/>

'Secure Borders – Safe Haven' White Paper (HO)

<http://www.official-documents.co.uk/document/cm53/5387/cm5387.pdf>

Securing our Future Health: Taking a Long Term View – The Wanless Review

http://www.hm-treasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_index.cfm

SEU Report on Teenage Pregnancy

<http://www.socialexclusionunit.gov.uk/published.htm>

Smoking Kills White Paper

<http://www.doh.gov.uk/tobacco/smokexec.htm>

Strategy for Sustainable Farming and Food : Facing the Future (2002)

<http://www.defra.gov.uk/farm/sustain/default.htm>

Sustainable Communities : Building for the Future (2003)

<http://www.odpm.gov.uk/communities/plan/main/>

Tackling Health Inequalities: Consultation on a Plan for Delivery, August 2001

<http://www.doh.gov.uk/healthinequalities/tacklinghealthinequalities.htm>

'Valuing People – A New Strategy for Learning Disability for the 21st Century' White Paper

<http://www.doh.gov.uk/learningdisabilities/strategy.htm>

Your Region, Your Choice: Revitalising the English Regions White Paper (2002)

<http://www.regions.odpm.gov.uk/governance/whitepaper/>

Useful Addresses

5 A Day

<http://www.doh.gov.uk/fiveaday/index.htm>

Audit Commission

<http://www.audit-commission.gov.uk/>

Brushing for Life Scheme

http://www.doh.gov.uk/cdo/cdodigest1/brushing_for_life.html

Changing Workforce Programme

http://www.modern.nhs.uk/scripts/default.asp?site_id=15

Child Tax Credit

<http://www.taxcredits.inlandrevenue.gov.uk/Home.aspx>

Children and Young People's Unit

<http://www.cypu.gov.uk>

Children's Fund

<http://www.cypu.gov.uk/corporate/childrensfund/index.cfm>

Children's Trusts

<http://www.doh.gov.uk/childrenstrusts/>

Commission for Health Improvement (CHI)

<http://www.chi.nhs.uk/>

Connexions

<http://www.connexions.gov.uk/>

Crime Reduction Partnerships

<http://www.crimereduction.gov.uk/>

Drug Action Teams

<http://www.drugs.gov.uk/Links/DrugActionTeams>

Excellence In Cities

<http://www.standards.dfes.gov.uk/excellence/>

Extended Schools

<http://www.teachernet.gov.uk/educationoverview/briefing/extendedschools/>

Healthaction

<http://www.healthaction.nhs.uk>

Health Action Zones (HAZs)

<http://www.haznet.org.uk/>

Health Development Agency

<http://www.hda-online.org.uk/>

Health Equity Audit

<http://www.phel.gov.uk/knowledge/equityauditfinal21.1.3.pdf>

Healthy Living Centres

<http://www.doh.gov.uk/hlc/index.htm>

Healthy Start Scheme (Reforming the Welfare Food Scheme)

www.doh.gov.uk/healthystart

Hospital Travel Costs Scheme

<http://www.doh.gov.uk/hospitaltravelcosts/intro.htm>

Job Centre Plus

<http://www.jobcentreplus.gov.uk/cms.asp?Page=/Home>

Learning and Skills Council

<http://www.lsc.gov.uk/>

Local Public Service Agreements (LPSAs)

<http://www.doh.gov.uk/lpsa/guidance-tackling-health-inequalities.htm>

Minimum Income Guarantee

<http://www.thepensionservice.gov.uk/mig/mig.asp>

National Alcohol Strategy

<http://www.doh.gov.uk/alcohol/alcoholstrategy.htm>

National Institute for Clinical Excellence (NICE)

<http://www.nice.org.uk/>

National Minimum Wage

<http://www.dti.gov.uk/et/nmw/>

National Service Frameworks

<http://www.doh.gov.uk/nsf/>

National Service Framework for Mental Health

<http://www.doh.gov.uk/nsf/mentalhealth.htm>

National Service Framework for Older People
<http://www.doh.gov.uk/nsf/olderpeople/index.htm>

National Treatment Agency
<http://www.nta.nhs.uk/>

Neighbourhood Management Pathfinder Programme
<http://www.renewal.net/Documents/Policy%20Guidance/neighbourhoodmanagementpathfinder.pdf>

Neighbourhood Renewal Fund (NRF)
<http://www.neighbourhood.gov.uk/nrfund.asp>

New Deal for Communities (NDC)
<http://www.neighbourhood.gov.uk/ndcomms.asp>

New Deal for Programmes
<http://www.newdeal.gov.uk>

NHS Direct
<http://www.nhsdirect.nhs.uk/index.asp>

NHS Foundation Trusts
<http://www.doh.gov.uk/nhsfoundationtrusts/>

NHS Local Improvement Finance Trust (LIFT)
<http://www.doh.gov.uk/nhslift/index.htm>

NHS Modernisation Agency
http://www.modern.nhs.uk/scripts/default.asp?site_id=10

NHS University
<http://www.nhsu.nhs.uk/>

Personal Medical Services (PMS)
<http://www.doh.gov.uk/pricare/pca.htm>

Renewal.net
<http://www.renewal.net/>

Skills for Life
<http://www.dfes.gov.uk/readwriteplus/>

Supporting People Programme
<http://www.supporting-people.odpm.gov.uk/>

Sure Start
<http://www.surestart.gov.uk/new/default.htm>

Teenage Pregnancy Strategy
<http://www.teenagepregnancyunit.gov.uk/>

Youth Offending Teams
<http://www.crimereduction.gov.uk/youth25.htm>

The Programme for Action will be taken forward across Government.



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Work and Pensions

Department for
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Constitutional Affairs

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