MOST HEALTH IS GAINED AND LOST outside of medical care. The underlying determinants of good health are to be found in the environments of everyday life, people’s social and economic circumstances and the interaction of lifestyles and behaviour with those circumstances. In the North West, there is a 7 year difference in the life expectancy of people living within short distances of each other. This essential truth underpins the revival of Public Health over the past two decades and is at the heart of work which has been going on in the North West since 1984 when the first ‘Regional’ report was published on the health of people in Merseyside and Cheshire.

Since then, a series of analysis have taken forward our understanding of the extent and distribution of inequalities in health within the Region and pointed the way towards policies and programmes which if effectively implemented would make a real difference to the quality and length of people’s lives. Inequalities in Health in the North West, published in 1998, provided strong evidence and a framework for action to tackle inequalities. A series of “Health of the North West” reports focused on the needs of particular groups, and particular topics.

The North West has a long history of working to improve health, which reflects its industrial past and the social, economic, and environmental legacy it left. The national targets to reduce inequalities will not be met unless there is real progress in this region.

The North West has been actively involved in European initiatives to improve health. The “Investment for Health” concept has been adopted by the World Health Organisation’s (WHO) European Office, as the basis for collaboration between countries and regions. This Investment for Health Plan for North West England shows how the approach has been translated into action by a range of partners, and reflects the region’s collaboration with WHO and other European Regions.
With the recent publication of the national strategy, “Tackling Health Inequalities: A Programme for Action”, we have a once in a lifetime opportunity to line up the “organised efforts of society” at national, regional, and local levels, to secure a step change in programmes to improve the health of the region’s population. Improving health and reducing inequalities would make a significant contribution to wider regeneration and sustainability objectives in the North West.

We have been fortunate in the breadth of support that we have enjoyed in taking this work forward across the public sector and out into the private and voluntary sectors. It would be invidious to identify many names at the risk of excluding others, but Kath Reade, Chairman of the Cumbria and Lancashire Strategic Health Authority, Steve Machin, Chief Executive of the North West Regional Assembly, Bryan Gray, Chairman of the Northwest Development Agency, and Keith Barnes, the Director of Government Office North West, have been crucial in securing widespread ownership of this approach. My Deputy, Peter Flynn has been the author and conceptual wizard for much of the work that has gone on to date.

Professor John Ashton CBE
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1 THE VISION FOR HEALTH IN THE NORTH WEST

Good health is central to the well-being of people and communities. A healthy and educated population is the foundation for sustainable development. The definition of health which underpins this “investment for health” plan is:

“the optimum physical, mental, and social functioning that a person chooses and is capable of achieving”.

The Potential to Improve Health

The potential to improve in this definition is important in the North West, given its relatively poor health and projected demographic changes. Policies are required which improve the health of older people, those of working age, children and young people.

The Wider Context for Improving Health

A vision for health needs to relate to wider strategies for regeneration and sustainability, and to the reduction in inequalities:

“to achieve significant reductions in health inequalities between groups and areas in the North West, within a framework of sustainable development which supports economic, social, and environmental regeneration”.

The Organisational Vision

The development of regional partnerships to improve health and align strategies should be re-inforced:

“to build upon the development of regional partnerships to ensure that the improvement of the health of the population, and the reduction in inequalities, are at the heart of regional strategies and local policies and programmes”.

2 THE HEALTH OF THE NORTH WEST

Inequalities in Health

There are significant inequalities between groups and areas, which in some cases are wider than they were twenty years ago. These inequalities exist between social groups, areas, ethnic groups, men and women, throughout life, and in different causes of death.
Inequalities in the North West

The health of people in the North West is relatively poor, in comparison with other regions and against the national average. This is true of all age groups:

◆ Manchester has the lowest male life expectancy at birth of any local authority in England, at just under 70, and the lowest female life expectancy at 76.5 years. By contrast South Lakeland has a male rate over 77, and a female rate of 82.

◆ Heart disease is the largest cause of reduced life expectancy for both men and women under 75. The next largest cause for men is injuries and poisoning. For women the next largest is “other causes” which includes breast cancer.

◆ Most of the Merseyside and Greater Manchester conurbations, Lancashire towns, and Barrow-in-Furness were shown in the 2001 census to fall in the top category of local authorities where between 11% and 18% of the population rate their health as “not good”.

Area and Group Inequalities

Policies need to tackle inequalities both in geographical areas and in groups of the population. Area based initiatives will reach the majority of some priority groups, such as certain black and ethnic minority populations, but not others such as lower-income older people who are more widely spread between areas.

“Universal” area plans such as Primary Care Trust Local Delivery Plans, and Local Strategic Partnership Community Plans need to reflect the range of inequalities in different areas, as well as the targeted initiatives such as local Neighbourhood Renewal Strategies.

Demographic Change: An Ageing Population

Within a projected marginal decline in the total population to 2010 in the North West, there are significant demographic and group changes:

◆ a projected fall in the number of under 50s, with the heaviest decline in the 0 - 15 age group

◆ a rise in all age groups over 50, with the largest increase in those aged between 65 - 74

◆ a large increase in black and ethnic minority populations, particularly Asian groups

◆ an increase of over 10% in Disability Living Allowance claimants

◆ a growth in one person households of over 12%, with the increase in older single person households particularly significant.
The Impact of Ageing and Policy Implications

Policies are required to prevent ill health, and support the social and economic contribution of older people, and their quality of life:

- integrated public policies are required to ensure services relate to the needs of older people in urban and rural areas, and allow them to contribute their skills and experience to communities.

- the economic contribution of older people will become an important issue and will influence retention and recruitment policies. There will be a significant gap between those on occupational pensions, and those dependent on state benefits.

- a greater focus on prevention and healthy lifestyles is essential to improve quality of life and the demand for health and social care services.

- land use and transport policies must be developed to increase the accessibility of older people to services, including health services.

Area Based Policies and Programmes

- the “universal” strategies and plans of local partnerships should be based on equity audits and a good analysis of groups and issues in their areas.

Policies for Specific Groups

On the basis of inequalities and demographic change, the proposed priority groups for the Investment for Health Plan are:

- **children and young people.** Declining in numbers but crucial to the region’s economic and social future, and to breaking the inter-generational cycle of deprivation.

- **older people.** A major policy challenge to improve their quality of life and contribution to the region’s economic and social life.

- **black and ethnic minority groups.** A rapidly growing population, with relatively poor health, and for some groups a younger population with the potential to support economic and social regeneration.

- **disabled people.** At particular risk of social exclusion, and the numbers claiming Disability Living Allowance projected to increase by 11%.
3 THE ORGANISATIONAL CONTEXT FOR DELIVERING INVESTMENT FOR HEALTH

The New Structure of the Department of Health and the National Health Service.

The new structure introduced by “Shifting the Balance of Power”, aims to devolve resources and decisions to the local level. The organisations with a key role in delivering Investment for Health are:

- **Department of Health. Public Health Teams** in Government Offices have the main responsibility for the development of regional partnerships to improve health and reduce inequalities. The Regional Director of Public Health has the role of providing leadership for public health, and the development of capacity and networks at regional and local levels.

- **National Health Service (NHS). Strategic Health Authorities** (SHAs) in the North West - Cheshire and Merseyside, Cumbria and Lancashire and Greater Manchester - have responsibility for holding Primary Care Trusts (PCTs) and Hospital / Healthcare Trusts to account by performance managing annual agreements, within the framework of Local Delivery Plans. The three main roles of SHAs are to:
  - provide a strategic overview for their areas
  - build capacity to deliver health and service delivery improvements
  - performance manage the NHS against agreed priorities and targets

- **NHS Workforce Development Confederations** (WDCs) which were integrated with SHAs on 1 July 2003, have the responsibility to develop long term workforce planning, co-ordinate NHS learning and education facilities, and link to other education and training providers.

- The 42 **NHS Primary Care Trusts** have responsibility for providing effective health and social care services, commissioning services from hospitals and other providers, and developing a health strategy for their populations. Through Local Strategic Partnerships they provide the basis for agreeing local health priorities with local authorities and other partners.

- **NHS Healthcare and Hospital Trusts** have responsibility for redesigning local services to reflect patient need and deliver high quality services, and contribute to local health strategies to improve health and reduce inequalities. As major organisations in their local communities they have great potential to do so.
Regional Partnerships to Improve Health

The report “Health, A Regional Development Agenda”, was produced in 1999, by a task force of the Regional Assembly. It provided the framework for subsequent partnership working, and the commitment in the Regional Development Agency led North West Strategy produced in 2000, to produce an Investment for Health Plan. The main regional agencies have different functions in relation to health:

The North West Regional Assembly (NWRA)

The proposed functions of elected assemblies in the White Paper “Your Region, Your Choice” are:

◆ promoting the health of the region and scrutinising policies to ensure they have a positive impact on health
◆ developing and implementing a health strategy with other partners
◆ appoint the Regional Director of Public Health as an advisor, and strengthen the public health function in the region.

The establishment of elected assemblies is still some way off, but the Government would like to see existing arrangements strengthened to support the above functions.

The NWRA has regional scrutiny and accountability roles, which will relate to a health strategy and its integration with other regional strategies. The Assembly has the lead for two important regional strategies, Action for Sustainability, and Regional Planning Guidance. Both are important in relation to improving health and reducing inequalities.

The Northwest Development Agency (NWDA)

The NWDA is the strategic driver of regional economic development. The Regional Economic Strategy (RES), 2003, focuses on five main priorities - business development, regeneration, skills and employment, infrastructure, and image. All have implications for health, and the health and care sector. The RES recognises that poor health and inequalities will inhibit economic and social development.

The NWDA is also leading work to explore the potential impact of the NHS on achieving wider regeneration objectives. As a major player and “corporate citizen”, the NHS could use its employment, procurement, capital spending, and other activities, to achieve social and economic improvements and the reduction of health inequalities.
The Government Office for the North West (GONW)

GONW represents central Government in the region. It supports the integration of Government programmes, relating them to regional circumstances, and providing a link between national policy and local delivery.

The role of Government Offices has been strengthened with the expansion of Departments and programmes within them, and additional responsibilities for working with the NWDA and other agencies. GONW will have a key role in taking forward the Health Inequalities: A Programme for Action, and integrating it with other strategies such as those for Sustainable Communities and Neighbourhood Renewal.

Integrating Regional Action to Improve Health

Regional agencies have important and complementary roles in improving health:

- the NWDA and NWRA as the regional bodies to develop integrated strategies
- GONW as Government in the region to integrate Departmental programmes and support regional developments.

The three Strategic Health Authorities in the North West have an important role in health improvement and the delivery of policy to end inequalities. They have responsibility for developing a strategic framework for local health services, covering Primary Care Trusts, hospitals, and healthcare trusts. They have performance management and development support responsibilities which do not exist at the regional level, and responsibility for building the capacity to deliver health and service delivery improvements.

The Investment for Health Plan provides the basis for agreeing priorities and responsibilities between agencies.

4 INVESTMENT FOR HEALTH: THE APPROACH

The Social Model of Health

The causes and risk factors that influence health and inequalities are complex and reflect individual characteristics, the lifestyle choices which interact with wider influences in the local community, and the broader social, cultural, and economic environment.

Population health is largely determined by wider determinants, which require action across agencies and sectors. Public health pioneers in the North West tackled the wider causes of poor health. Infectious disease have all but disappeared, but the link between economic, social, and environmental conditions and inequalities remains.
The Investment for Health Framework

Investment for Health recognises that action across sectors is required to improve health, which in turn produces economic and social benefits, and reduces the demand for health care. It poses a number of key questions:

◆ what are the main determinants of health, and where is health promoted and maintained in the population?

◆ which investments and strategies at the regional level have the greatest potential to improve health and reduce inequalities:
  - in the whole population
  - for particular high risk groups and areas
  - for those with established illness and formal health and social care needs?

There are three activities which impact on health:

◆ prevention to keep people well
◆ treatment to shorten episodes of illness
◆ care to reduce disability and suffering.

Prevention offers the greatest potential to improve health and reduce inequalities, throughout the health system from action on the wider determinants such as housing and employment, through to the hospital setting to improve quality of life and reduce treatment and care needs. Prevention for high risk groups and areas offers the greatest potential for reducing inequalities.

Examining topics such as physical activity, transport and road accidents, and the NHS role as a good ‘corporate citizen’, allows the implications of population based measures, those for priority groups and for particular areas, and those within the healthcare system to be identified. Prevention policies which focus on reducing inequalities are investments which improve the quality of life, reduce social exclusion, produce wider economic and social benefits, and reduce the demand for services.

Investment for Health as an approach is being developed by the World Health Organisation, and by regional networks in Europe.
5 THE INVESTMENT FOR HEALTH PLAN: NATIONAL AND REGIONAL PRIORITIES

The Wanless Report on the long term future of health care concluded that a focus on the prevention of poor health was required to reduce health care demands. Improved health and a quality health service will bring significant economic and social benefits. It adopted one of three scenarios, the “fully engaged” scenario, one of whose assumptions was that reductions in risk factors would be greatest where they are currently highest, among people in deprived areas, leading to a reduction in health inequalities.

The Wanless Report conclusions were built upon by the Government’s Cross Cutting Review in 2002 on tackling health inequalities. It reviewed the evidence on inequalities and the effectiveness of interventions, and identified priority action to meet short term targets and achieve long term change.

The priorities for the NHS were included in the Department of Health’s Priorities and Planning Framework 2002, to be delivered through the Local Delivery Plans of Primary Care Trusts. The wider priorities across Government and for local authorities and Local Strategic Partnerships are set out in 'Tackling Health Inequalities: A Programme for Action'. It has two interlinked goals:

◆ achievement of a focused 2010 Public Service Agreement target to narrow the gap in life expectancy between the worst fifth of local authority districts and the population as a whole (by 10%), and to narrow the gap in infant mortality between social class V and the population as a whole (by 10%);

◆ addressing the wider determinants of health inequalities, including access to key services, education, regeneration, housing, worklessness, and transport, to redress the inequalities that lead to greater ill health through life and shortened life expectancy for certain groups and areas.

The strategy as a whole is underpinned by four key principles:

◆ the primacy of prevention, on the basis that interventions which prevent the causes, and reduce the consequences of health inequalities, will have the greatest long term impact

◆ ensuring that mainstream services are responsive to the needs of disadvantaged populations

◆ using targeted interventions to test innovative approaches, or to tackle specific problems and to reach particular priority groups

◆ using mainstream planning, performance management, and monitoring of services to support local and national action.
The strategy sits alongside other long term strategies to reduce wider inequalities, including the child poverty strategy, the Sustainable Communities strategy, and the National Strategy for Neighbourhood Renewal. The strategy identifies action under four themes:

- supporting families and children
- engaging communities and strengthening their capacity to tackle problems
- preventing illness and providing effective treatment and care, particularly primary care
- addressing the underlying determinants of health, such as inequalities in housing provision, education, and access to services.

The Programme for Action also identifies the short term measures required to meet the life expectancy and infant mortality targets. Interventions to increase life expectancy are: reducing smoking in manual social groups; prevention and management of risk factors in primary care; housing improvements to reduce cold, dampness, and accidents; preventing road accidents among old and young road users; and targeting measures at people over 50. To meet the infant mortality target, the measures are: building on Sure Start; reducing smoking in pregnancy; reducing teenage pregnancy; improving housing conditions for children in disadvantaged areas; and early interventions by the NHS for priority groups.

**The Regional Investment for Health Plan, and Regional Priorities**

The North West Investment for Health Plan reflects national priorities, the particular circumstances in the region, and specific initiatives which have resulted from regional partnership working. The approach is to emphasise prevention in the whole population, high risk groups, and areas, and the formal healthcare system, for all policies. Within this framework there is a focus on prevention for high risk groups and areas, and within the healthcare system, to reduce inequalities.

The priorities for the North West to reduce inequalities are:

- tackling the wider determinants of health
- developing the NHS’s corporate citizen role
- mainstreaming action to reduce inequalities within the NHS
- strengthening primary care.

The priorities for integrating action to deliver in the four areas are:

- developing the health dimension of regional strategies
- area based policies
- priority group programmes
- delivering health improvement in the settings of everyday life.

A separate action plan has been produced to translate priorities into specific programmes.
6 DELIVERING INVESTMENT FOR HEALTH

Arrangements to support partnership working on health and inequalities have been established nationally, regionally, and locally.

Nationally, 'Tackling Health Inequalities: A Programme for Action' sits alongside other strategies such as the National Strategy for Neighbourhood Renewal, and Sustainable Communities: Building for the Future. Co-ordination mechanisms have been established across Departments, and Public Service Agreements agreed across Government and with local authorities.

At the regional level the Investment for Health Plan will re-inforce existing partnership working, and provide joint priorities through:

◆ the incorporation of a health dimension in the Northwest Development Agency (NWDA) led Regional Economic Strategy (RES), and the definition of an action plan

◆ a joint work programme being agreed between the Department of Health Public Health Team co-located with Government Office for the North West (GONW), and GONW Departments

◆ liaison with the North West Regional Assembly on the health dimension of Action for Sustainability (AfS), and Regional Planning Guidance (RPG), and the Assembly’s accountability and scrutiny role.

The Investment for Health Plan is a regional document which focuses on value added activities at this level. These include:

Regional Strategies

◆ developing the health dimension of the major, over-arching regional strategies, - Action for Sustainability (AfS), the Regional Economic Strategy (RES), the Regional Planning Guidance (RPG), and Sustainable Communities: Building for the Future.

◆ working with the NHS (Strategic Health Authorities, Primary Care Trusts and Healthcare) to support their work on the development and implementation of health and health service strategies

◆ contributing to the alignment of the wide range of regional strategies, and supporting a focus on health and inequality issues, and the use of Health Impact Assessment (HIA) and Integrated Impact Appraisal (IIA) for strategy and policy development.
Regional Level Functions

- information and intelligence. The North West Public Health Observatory (NWPHO), the Regional Intelligence Unit (RIU), and the Health Development Agency (HDA) have important roles in providing support to regional and local partnerships for key development areas such as:
  - appropriate indicators and targets to measure progress
  - evidence of the effectiveness of interventions
  - analysis of data, including the 2001 Census
  - incorporating major regional studies findings into policy development
  - identifying and mainstreaming good practice
  - the use of impact assessments, equity audits, and other policy tools

- communications. A regional communications strategy is being developed to support wider involvement and participation in policy development and service delivery.

Regional Framework for Local Partnerships

- performance management. Regionally, the Government office and Strategic Health Authorities have an important role in ensuring that measures to improve health and reduce inequalities become part of mainstream performance management systems, particularly those used for local government and the NHS.

- leadership and capacity building. The Regional Director of Public Health has responsibility for providing leadership in the development of health policy, and for building individual and organisational capacity to deliver it.

- scrutiny and accountability arrangements. The Assembly is developing scrutiny and accountability arrangements at the regional level. There is regional support for the development of the new local authority scrutiny role.

- social cohesion and community development. Social cohesion is a policy priority for the Government office, other regional agencies, and local partnerships in parts of the North West. ‘Sustainable Communities: Building for the Future’, provides a regional framework for social cohesion and wider community development policies.
What is ‘health’?

Good health is central to the well being of people and communities. It has a direct impact on people’s quality of life, and their ability to participate in social and economic activities. A healthy and educated population is the foundation for sustainable development, which balances social, economic, and environmental progress.

Developing a vision for health in the North West requires a shared understanding between agencies of what health is. Health policy is often equated with the delivery of health and social care services. However, improvements in health, and the reduction in inequalities, can only be achieved through the actions of a wide range of organisations, and people themselves. This shift in emphasis in no way devalues the importance of effective health and social care services, which are a pre-requisite for a civilised society, and provide vital prevention, treatment, and care services for the population.

The concept that health, and health and social care are synonymous, has led to mainly negative definitions of health. For a long time health has been measured by the incidence of illness, and by mortality rates. “Health” statistics therefore measure negative events, and support the idea that the “health” sector delivers services for those who are ill. The World Health Organisation (WHO) attempted to counter this emphasis by defining health as:

“a state of complete physical, mental, and social well being, and not merely the absence of disease”.

Although this was a positive move, the definition is not a useful one to support the formulation of health policy, or to set targets and monitor progress. It describes an unattainable state for many, if not all people. The definition of health which underpins this “investment for health” plan is:

“the optimum physical, mental, and social functioning that a person chooses and is capable of achieving”.

The Potential to Improve Health

This definition of health moves away from negative concepts of illness, and unattainable states of complete well being. It is relevant to people whatever their apparent state of health, and it is dynamic in stressing potential, and the ability of people to maintain, improve, or lose their level of functioning and quality of life. It applies as much therefore to a person with an established disability or who has had a serious accident, as it does to someone with no apparent symptoms of ill health. The concept of health potential can be extended to groups and areas, within broader frameworks for regeneration and sustainability.
A definition of health which underpins the potential for choice and improvement is particularly relevant for the North West, which as a region has both relatively poor health and an ageing population. The next section on the health and demographic characteristics of the North West illustrates its poor health, low life expectancy, the decline in age groups under 50, and the increase in age groups over 50.

This context underlines how vital preventing poor health is for:

- older people, both to improve their quality of life, exploit their experience, and to allow them to participate fully in economic and social life
- the working age population who are central to achieving economic regeneration. This age group currently contains the “baby boomer” generation which will age through to retirement over the next ten years. Without more effective preventative measures and changes in lifestyle, trends such as increasing levels of obesity will see a significant rise in illness, particularly diabetes
- children and younger people are the future workforce but with a falling birth rate there will be fewer of them. Without a healthier and better educated young population, the region will not achieve its objective for economic and social regeneration.

**The Wider Context for Improving Health**

The vision for health in the North West therefore needs to relate to wider objectives for regeneration and sustainability. “Action for Sustainability” is the North West’s framework for a better quality of life for the region’s population. Its vision is a healthy, safe, and socially responsible region where all people have access to basic necessities and are enabled to improve their quality of life. The 20 year vision of the Regional Economic Strategy is of the creation of a region which, among other objectives, brings everyone into the mainstream of community life.

The Government’s Cross Cutting Review on Health Inequalities, and the Cross Government Health Inequalities: A Programme for Action provide an important framework for a regional Investment for Health Plan. The vision from the Cross Cutting Review was of: “a country in which everyone has the same chance of a long and healthy life, regardless of where they live and their social circumstances”.

**Reducing Inequalities in Health**

Achieving this vision, and achieving the national inequalities targets, will require significant progress in the North West given the levels of deprivation and poor health in the region. It is estimated that a half of the national population in the lowest 10% of life expectancy, both male and female, live in the North West. There are of course many areas in the North West where levels of prosperity and good
health are higher than the national average. In these areas improvements in health will continue and they will benefit from the overall success of regeneration and sustainability policies. The focus therefore needs to be on those groups and areas where health is poor, particularly given the demographic trends which have already been described. The Wanless Report and the Cross Cutting Review have identified that policies and actions which address inequalities are cost effective and can have significant social and economic benefits.

The Vision for the Health of the Population

The vision for the health of the North West’s population should reflect the link between reducing inequalities and supporting regeneration:

“to achieve significant reductions in health inequalities between groups and areas in the North West, within a framework of sustainable development which supports economic, social, and environmental regeneration”.

The Organisational Vision

Regional partnerships have developed over a number of years to support improving the health of the population and reducing inequalities. Regional agencies have set an agenda, and adopted an “Investment for Health” framework, to integrate strategies and programmes. An organisational vision should recognise and reinforce this process:

“to build upon the development of regional partnerships to ensure that the improvement of the health of the population, and the reduction in inequalities, are at the heart of regional strategies and local policies and programmes”.

A Radical Plan

These visions provide the basis for a radical plan for health in the North West which:

◆ focuses on health, prevention, and inequalities
◆ strengthens the emphasis on tackling the determinants of health, and establishes the role of the NHS as a good “corporate citizen”, contributing as a major group of organisations and stakeholders
◆ develops a long term strategy and the definition of short term action to meet inequalities targets
◆ supports the development of performance management and resource allocation systems to match policy goals
◆ aligns the strategies and programmes of regional agencies, and provides the framework for local partnerships.
Inequalities in Health

The Government’s 2002 Cross Cutting Review identifies that despite increased prosperity and reductions in mortality over the past twenty years, significant differences in health status persist between groups of the population. In some cases the gaps are wider than they were twenty years ago.

It identifies that a gap in health status exists:

- **between social groups.** The difference in life expectancy at birth between men in social class I and V widened from 5.5 years in 1972-6 to 7.4 years in 1997-9.

- **between different areas in the country.** Male residents in Manchester can expect to live nearly 8 years fewer than those of Kensington, Chelsea and Westminster, and its female residents can expect to live nearly 7 years fewer. The death rate in men under 65 years is 1.6 times higher in the North West Region than in the South East. In Manchester, the death rate for people under 65 years is over three times higher than in Kingston & Richmond.

- **between the population as a whole and different Black and minority ethnic groups.** In 2000, infant mortality among babies of mothers born in Pakistan was more than double the infant mortality rate for all babies.

- **between men and women.** Men live, on average, about five years fewer than women.

- **throughout the lifespan, starting at birth.** The infant mortality rate of 8 deaths per 1000 live births among children in social class V in 1998-2000 was double that for social class I. For lone parents the rate was 7.6 deaths per 1000 births. Children in social class V are five times as likely to suffer accidental death than their peers in social class I, including being five times more likely to be killed as pedestrians in road accidents than children in social class I. Residential fire deaths for children are 15 times greater for children in social class V compared to those in social class I.

- **in different causes of death and ill health.** The death rate from coronary heart disease is three times higher among unskilled manual men of working age than among professional men. An unskilled working man was, at the time of the 1991 Census, almost four times more likely to commit suicide than his professional counterpart.

Inequalities in the North West

The health of people in the North West is poor, relative to other regions and national averages. The legacy of the Industrial Revolution is a region with a concentration of population in older, urban areas with high levels of poverty and deprivation, and a relatively poor environment, infrastructure, and housing stock. These conditions impact on all age groups:
- Older people. As well as having higher mortality rates than the national average, there are higher levels of illness. 45% of the region’s population aged 65 or over have a limiting long term illness which restricts their ability to lead a full and active life.

- The working population. The North West has higher premature mortality and levels of illness in people of working age than the national average. 16% of 16-44 year olds, and 29% of 45-64 years old have a limiting long term illness. This contributes to the North West having an employment rate for people of working age of 70.9%, one of the lowest regional rates in the country.

- Children and young people. Children in the North West are more likely to grow up in lone parent households, and those with no-one in full time employment than nationally. This is reflected in their relatively poor health. The infant mortality rate is 6.5 per 1000 live births, compared with a UK rate of 5.8.

**Figure 1** shows the inequalities in male life expectancy at birth within the region. The lowest life expectancy is found in the conurbations and Lancashire towns. Manchester’s rate of just under 70 years is the lowest of any local authority in England. Blackpool and Liverpool, with a life expectancy of 72, have the second lowest figure nationally. By contrast, eleven local authorities have life expectancies above the national average with two, Macclesfield and South Lakeland, having life expectancies at birth of over 77.

**Figure 2** shows the equivalent, and similar pattern for female life expectancy at birth. Manchester has the lowest life expectancy in the country at 76.5 years, and Liverpool the second lowest at 77.3 years. The range of life expectancies is not as great for males, but there are six local authorities with expectancies over 81, with the highest at 82 being South Lakeland.

**Figure 3** shows the contribution of different causes of death to the reduced life expectancy of men and women under 75 in the North West, compared to the average of England and Wales. It shows that coronary heart disease is the largest cause of reduced life expectancy, with almost four months lost for both men and women. The second largest cause for men is injury and poisoning, while for women it is “other causes”, which includes breast cancer. Chest disease and lung cancer are the next most significant causes for both men and women.

**Figure 4** shows the national pattern of an important new health measure, self reported health status from the 2001 Census. The percentage of people who classified their health as “not good” ranges from 4.6% of the population to 18.1%. A high proportion of local authorities in the North West fall into the top two ranges. Most of the Merseyside and Greater Manchester conurbations, the Lancashire towns, and Barrow-in-Furness, fall in the top category where between 11% and 18% of the population rate their health as not good.
Area and Group Inequalities

Policies in regional and local strategies will need to address both area and group inequalities. In some instances the heavy concentration of groups in particular areas means that area based policies will cover the majority of a priority group. This is true of some Black and Minority Ethnic communities. For other groups, such as lower income older people, their distribution is such that only a minority would be covered by targeted area based initiatives.

The Acheson Report, and the Cross Cutting Review, emphasised that there is a gradient to inequalities, both for groups and areas. In an earlier report on inequalities in the North West an analysis of ten distinct types of social area provided a description of the extremes of inequalities. The “Affluent Professional” areas in the North West had rates of limiting long term illness, standard mortality ratios, and infant mortality which were less than half those in the “Lowest Income Household” areas - the most deprived inner city areas and outer council estates.

Between these extremes which tend to be the focus for describing inequalities, and for targeted programmes at the most deprived end of the scale, there are other areas which require specific policy responses. For example, areas containing better-off older people are found in the suburban and rural parts of the counties, and the coastal resorts. There are equally areas of lower income older people in urban and rural areas, and the resorts. The ratios of limiting long term illness and standardised mortality for the better off areas were 88 and 87, relative to North West average of 100. The ratios for lower income areas were 123 and 124.

Area plans such as NHS Local Delivery Plans, and Local Strategic Partnership Community Plans need to recognise these gradients and area types. Initiatives such as Neighbourhood Renewal Strategies target the worst off areas, but will not address the extent of needs of particular groups such as lower income older people.

The requirement for Primary Care Trusts to undertake equity audits to inform priorities for tackling inequalities, will help to ensure that inequalities are addressed across the region, and not just in priority areas. At the regional level children and young people, older people, Black and Minority Ethnic groups, and disabled people have been identified as priority groups for action.
Figure 1 - North West Region

Male Life expectancy at Birth for Local Authority Areas 1991 to 2001

<table>
<thead>
<tr>
<th>Male Life Expectancy 1999-2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>76.01 to 77.6  (9)</td>
</tr>
<tr>
<td>75.01 to 76   (8)</td>
</tr>
<tr>
<td>74.01 to 75  (12)</td>
</tr>
<tr>
<td>73.01 to 74  (9)</td>
</tr>
<tr>
<td>69.7 to 73   (5)</td>
</tr>
</tbody>
</table>

Revised to agree with 2001 census estimates.
Figure 2 - North West Region

Female Life expectancy at Birth for Local Authority Areas 1991 to 2001

Female Life Expectancy 1999-2001

- 81.01 to 82.1 (8)
- 80.01 to 81 (8)
- 79.01 to 80 (11)
- 78.01 to 79 (11)
- 75.5 to 78 (5)

Revised to agree with 2001 census estimates.
Figure 3

Reduced Life Expectancy by Cause of Death - compared to England and Wales average.
Persons under 75 dying in the North West region 1996-2000

<table>
<thead>
<tr>
<th>Category of Death</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>infants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>chest disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>coronary heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>digestive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lung cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>other circulatory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>other cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>injury and poison</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Average months lost compared to England And Wales
Figure 4

General Health

People whose general health was ‘not good’ as a percentage of all people

- 10.79 - 18.10
- 9.19 - 10.78
- 8.06 - 9.18
- 7.00 - 8.05
- 4.61 - 6.99
Figure 5

North West Region - Projected population changes by age band normalised to 2001 projection = 100

Demographic Change: An Ageing Population

The relationship between social and economic conditions and projected demographic change will have an important influence on the formulation and implementation of policies to improve health and reduce inequalities.

Figure 5 shows the changes in the total population, and specific age groups. The region is projected to have a marginal decline in population between 2001 and 2021, of 63,000 or less than 1%. The declines in Merseyside (-10%) and Greater Manchester (-1.9%) is largely offset by increases in Cheshire (+5.0%), and Cumbria (+3.6%), and Lancashire (+2.9%). The population in 2021 is projected to be just over 6.8 million.

Age Group Change

The population aged under 50 is projected to decline significantly from 67% of the total population to 60%. The heaviest decline will be in the 0-15 age group, with a fall of 13% between 2001 and 2021 (184,000 people).

All age groups over 50 are projected to increase. The largest increases will be in the 50-64, and 65-74 age groups, of 20% (217,000 people), and 26% (252,000) respectively. The number of people aged 75-84 is projected to increase by 13% (50,000), and those over 85 by 17% (23,000). Across the region the dependency ratio - the number of children and retired people relative to those of working age - increases in Cheshire and Cumbria, but decreases in some Merseyside and Greater Manchester local authorities, and in much of Lancashire. In the North West the population aged 65 or over is projected to increase by 19% with greater increases in Lancashire (+20%), Cumbria (+26%), and Cheshire (+29%).

Ethnic Group Changes

Black and ethnic minority group populations are projected to grow significantly, although they will remain a small minority except in parts of Lancashire and Greater Manchester. In Greater Manchester the black population is projected to rise by 57%, the Asian population by 71%, and other groups including Chinese, by 34%. Despite these increases the population of Greater Manchester would remain predominantly white, declining from 93.3% to 88.88% of the total population by 2021. By contrast with the white population where the largest age groups will be those in late middle age, in the Asian population in particular, the largest age groups will be the younger ones. These differences in age structure will be most marked in areas like Blackburn, which have large Asian populations.
Disability

There are major variations in the percentage of the working population claiming disability benefits, with generally higher rates in urban areas. The number of Disability Living Allowance claimants is projected to increase by 10.8% in the North West by 2021, from 334,500 to 370,000. There are important policy implications in terms of improving the quality of life of disabled people, and supporting their participation in the economic and social life of the region.

Households

The growth in one person households is projected to continue. The number of households will increase in the North West by over 12% despite the decline of under 1% in the population. The growth in households will be greater in Cheshire (+17.8%) and Lancashire (+15.1%), and lower in Greater Manchester (+8.9%), and Merseyside (+1.7%). Although there is an increase in one person households generally, the growth of older single person households is the greatest influence and has significant policy implications.

The Impact of Ageing and Policy Implications

While ageing is not necessarily synonymous with ill-health and dependency, many older people experience problems of frailty and 70% of disabled adults are over 60. Policies will be required to strengthen prevention of ill health as well as providing effective care, and to address the wider issues which will determine the social and economic contribution of older people within the region, and their quality of life. The potential impact of population change was addressed for four key policy areas - social, economic, health, and physical planning - in the study of ageing in the North West. The main conclusions were:

Social Policy Implications

It is the interaction of age and social, economic, and cultural systems which will create specific issues for particular groups and localities. Focused policies will be required to create social capital, improve health, and reduce inequalities. Integrated transport, housing, and employment policies will be required to ensure the delivery of community based care in urban and particularly rural areas. There needs to be a focus on the opportunities created by an ageing population, including harnessing their skills, experience, and energy. Older people will have valuable purchasing power, and an increasingly articulate group of consumers will have the ability to influence policy.
Economic Policy Implications

◆ Current trends will see more dependants than active members of the workforce.

◆ The potential to employ older people will increase in line with the increased need for skilled workers.

◆ Incentives for later retirement will help to maintain an older skilled workforce. Labour shortages will occur in the residential and community care sector in particular. Home working should be promoted, and volunteering encouraged.

◆ Differences in the ability of older people to finance their old age are likely to increase, with the gap between those on occupational pensions and those reliant on state benefits marked. Lower income older people in urban, rural, and retirement area will require particular support.

Health Policy Implications

A greater focus on prevention and healthy lifestyles will improve health experience and care needs in later life. Working beyond retirement age would create a culture of active ageing and influence the health of older people. Self-sustaining rural communities provide the best support for older people. Healthcare for ethnic minority communities must recognise their diverse needs, and include increased recruitment from those communities. Improved links between public, private, and voluntary providers are essential. The healthcare system will need to improve the provision of geriatric services.

Physical Planning Implications

Significant population shifts have serious cost implications. A “metropolitan renaissance” would mitigate these effects, and encourage higher density, mixed use developments which would benefit older people by increasing accessibility to services. Public Transport should be safer, reliable, efficient, and affordable. Improved Information Technology in more remote areas would benefit older people and the rural population in general.

The significance of demographic change, and its potential impact on the social and economic conditions of areas and groups, has not been sufficiently taken into account in strategic planning by regional agencies. For the NHS itself the changing pattern of health and social care needs will need to be reflected in a significant re-orientation of services. The ability to recruit staff to support care will require major changes in policies and practice. More widely, regeneration will not be achieved unless there are integrated policies across sectors to meet the needs of particular groups and areas.

Priorities which will be addressed in the Investment for Health Plan, flowing from the analysis of inequalities and demographic change are:
Area-Based Policies and Programmes

- universal mechanisms such as Primary Care Trusts’ Local Delivery Plans, Local Strategic Partnerships, and Community Plans, need to provide integrated responses for specific groups and combinations of characteristics in their areas. A good example is the concentration of lower income older people in retirement and resort areas, and in the old overspill areas and New Towns.

- targeted area based initiatives such as Neighbourhood Renewal Strategies in the most deprived local authorities will need to have health as a central dimension of integrated policies if they are to achieve regeneration.

Policies for Specific Groups

A number of groups should be priorities in the Investment for Health Plan:

- children and young people. The reduction in birth rates and therefore in the region’s young population make them even more important as an investment in the future. They are crucial to the region’s economic and social future. Developing a healthy and educated young population is also central to breaking the cycle of deprivation, and is a priority of national policies, including the plan to tackle health inequalities.

- older people. The ageing of the population represents a major policy challenge. Effective and integrated measures are required to improve the quality of life of older people, reduce the burden on health and social care services, and secure their full contribution to social and economic development.

- Black and Minority Ethnic groups. Although the black and ethnic minority population will remain a small minority in the region, their numbers will grow significantly and their influence in parts of Greater Manchester and Lancashire will be important. The health of black and ethnic minority populations is worse than that of the population as a whole, and they have specific health needs. The Asian population in particular will be a young one, and an important resource to support regeneration and social cohesion.

- disabled people. People with disabilities are at a particular risk of social exclusion. Lack of access to services and exclusion from the labour market are among the barriers to achieving greater independence, and to contributing fully to social and economic development. The Regional Assembly is leading a major initiative on disability which could contribute to maintaining their health and independence. The number of Disability Living Allowance claimants in the region is expected to increase by 10.8%.
The new structure of the NHS, and the roles and responsibilities of the regional agencies with a key role in improving health, are poorly understood by other regional and local organisations, and the public. This section sets out:

- the re-structuring of the Department of Health and NHS, and the roles which are important in contributing to regional and local partnership development
- the roles of the main regional agencies and the mechanisms for joint working and integrated action.

The New Structure of the Department of Health and the NHS

The fundamental changes to the structure of the NHS introduced by “Shifting the Balance of Power support a vision of the NHS which:

- empowers front line staff to use their skills and knowledge to develop innovative services
- empowers patients to become more informed and active partners in the design, delivery, and development of local services
- devolves power and decision making to frontline staff and Primary Care Trusts (PCTs), led by clinicians and local people.

Figure 6 sets out the new structure as it impacts on delivering improved health in the North West.
DH / NHS, Context for Regional and Local Partnerships

- Department of Health (DH)
- Other Government Departments
  - Government Office North West
  - Regional Director of Public Health Public Health Team
  - Northwest Development Agency
  - North West Regional Assembly
- NW Strategic Health Authorities
  - Cheshire and Merseyside
  - Greater Manchester
  - Cumbria and Lancashire
- Healthcare / Hospital Trusts
- Primary Care Trusts
  - Local Delivery Plans
- Local Authorities
  - Community Plans
  - Local Strategic Partnerships
  - Neighbourhood Renewal
DEPARTMENT OF HEALTH

Public Health Teams in Government Offices

Regional Directors of Public Health, and their Public Health Teams, are co-located in each of the nine Government Offices for the Regions. They have the main responsibility for the development of regional partnerships to improve health and reduce inequalities. Their role is:

◆ in April 2003 a national Health Protection Agency was established, which will integrate a range of current agencies and programmes. The Regional Director of Public Health retains responsibility for a regional overview of the health protection capability, which aims to manage risks to health, including emergency planning arrangements.

◆ building regional partnerships to tackle the wider determinants of health such as housing, transport and education, and to ensure that health issues are integrated into major policies. The role of the NHS as a major organisation and regional stakeholder in supporting wider regeneration is an important element of this policy agenda.

◆ providing support for clinical developments, and the delivery of health and social care services.

◆ providing leadership for public health in the North West and the development of capacity and networks.

NATIONAL HEALTH SERVICE

Strategic Health Authorities (SHAs)

There are three Strategic Health Authorities (SHAs) in the North West - Cheshire and Merseyside, Greater Manchester, and Cumbria and Lancashire. The Health Authorities, as the local headquarters of the NHS, have responsibility for holding to account Primary Care Trusts and Hospital / Healthcare Trusts. Health Authorities will do so by:

◆ creating a coherent strategic framework for health improvement, and the delivery of health and social care

◆ agreeing annual performance agreements with acute, mental health, ambulance, and Primary Care Trusts which they will performance manage

◆ building the capacity of NHS organisations and supporting performance improvement.
Workforce Development Confederations (WDCs)

NHS Workforce Development Confederations (WDCs) operate on the same boundaries as the Strategic Health Authorities. The WDCs and SHAs have a business plan agreement which reflects the “close but separate” nature of their relationship. SHAs will performance manage the WDCs which were integrated into SHAs on 1 July 2003.

The functions of the WDCs are to:

◆ lead the planning of future healthcare workforce needs and develop an integrated approach to how they will be met
◆ establish relationships with other organisations and particularly education and training providers
◆ co-ordinate the strategic management of local learning and education facilities in the NHS.

WDCs will have a key role in linking employment and training to wider regeneration activity in the region.

Primary Care Trusts (PCTs)

The strengthening and development of Primary Care Trusts (PCTs) is central to the objective of “Shifting the Balance of Power” of devolving resources and decision making to the local level. Figure 7 show the forty two PCTSs in the North West, and the three SHAs. PCTs have co-terminous boundaries with local authorities, with a few exceptions.

The main functions of the PCTs are to:

◆ provide effective primary care services and integrate health and social services
◆ commission services from other providers for its local population
◆ develop a strategy and policies to improve the health of the community, and to reduce inequalities in health and the provision of services.
Healthcare and Hospital Trusts

Healthcare and hospital trusts have responsibility for:

◆ redesigning local services to reflect patient needs, and deliver safe, high quality services

◆ providing more opportunities for the involvement of patients, staff, and the public

◆ developing strategies to reduce health and health care inequalities, and delivering national and local priorities to improve the health of the local population.

Trusts will be performance managed by SHAs and will need to work closely with PCTs and other local partners. Most trusts are major employers and organisations in their local communities, and have the potential to contribute significantly to economic, social, and environmental development.

Regional Partnerships to Improve Health

Joint working between the main regional agencies, and a task force involving a wide range of regional interests led to the production of a report, “Health, A Regional Development Agenda” in 1999. Its purpose was to set the “health” agenda for the North West Regional Assembly (NWRA), and the Northwest Development Agency (NWDA) on their establishment in 1999. The NWDA led strategy, “England’s North West: A Strategy towards 2020”, contained a commitment to produce an Investment Plan for Health for the region. Following the re-structuring of the NHS, a North West Health Group was established to steer the production of the Investment Plan.

In addition to the Department of Health’s Public Health Team at Government Office North West (GONW) and the three SHAs, representatives of the Government Office for the North West (GONW), the North West Regional Assembly, and the Northwest Development Agency have worked together to produce the Investment Plan.

The North West Regional Assembly (NWRA)

The Government’s White Paper, “Your Region, Your Choice”, sets out the vision for prosperous and thriving English regions, including proposals for elected regional assemblies in those regions where people wish to have them. The public health functions proposed for an elected assembly recognise the wider economic, social, and environmental influences on health, and the role elected regional assemblies would need to play to secure improvements in health.
The proposed functions of elected assemblies are:

- to promote the health of the population including scrutinising the assembly’s own policies and strategies to ensure they have a positive impact on health, and the reduction of inequalities, and produce more integrated and better health outcomes

- to develop and implement a health improvement strategy for the region, working with the Regional Director of Public Health and partner organisations

- to appoint the Regional Director of Public Health as the assembly’s advisor to support a co-ordinated public health group and strengthen the public health function in the region.

The establishment of elected assemblies requires legislative change. There would be a review of local government structures to recommend the most effective way of implementing the wholly unitary arrangements the Government believes are necessary with the establishment of a regional tier. A referendum will be held to establish support for an elected assembly and if there was a “yes” vote this would lead to local government restructuring and the setting up of an assembly.

The White Paper recognises that the pace of change towards elected assemblies will vary, and that there is a need immediately to enhance the existing arrangements for joint working between the Regional Development Agencies, the Regional Assemblies, and Government Offices for the Regions. An elected assembly would be able to build on the strengthening of existing arrangements.

Regional assemblies were established to ensure that broader regional interests were represented in relation to the development of economic strategies and on other cross cutting issues, including health and quality of life. The RDAs are public bodies directly accountable to Government Ministers and Parliament. Assemblies provide the basis for scrutinising the plans and work of the RDAs, and to develop their position as the strategic focal point for the region. Members of the Assembly are drawn from local authorities, and a range of other interests in the region. They are not currently directly elected.

Increased funding for the Assemblies was provided in 2001 to broaden their scrutiny and accountability roles. In addition to their scrutiny in relation to the Regional Development Agencies, their responsibilities are being strengthened to include in the future:

- co-ordination and integration of regional strategies

- a closer relationship with Regional Directors of Government Offices, and senior officers in other government funded bodies in the region, to provide better liaison on Government activities within the region

- input to the Government spending review process, through Government Office.
The Assembly has the lead for two important regional strategies:

- **Regional Planning Guidance.** The NWRA is the recognised planning body, to produce regional planning guidance, including regional transport strategies and regional waste strategies, to be approved and issued by the Government.

  Under new proposals, a regional spatial strategy will have greater status than the old style regional planning guidance. The new style local development plans and local transport plans will be required to be in general conformity with the statutory regional spatial strategy.

- **Action for Sustainability.** The NWRA leads on “Action for Sustainability”, published in 2000, the North West’s framework for a better quality of life. It sets out the basis for sustainable development which balances social progress, economic growth, and environmental protection and improvement, by setting targets and defining targets under four headings:

  - live, achieving social progress and a better quality of life
  - protect, ensuring effective environmental protection
  - save, managing the regions use of natural resources
  - grow, achieving economic growth and sustainable regional development.

The NWRA therefore leads on two of the three overarching strategies in the region, and has a scrutiny role in relation to the third. Regional Planning Guidance’s spatial strategy has important implications for the health of the population. Achieving a better balance between where people live, work, learn, shop, take their leisure, and access services, has implications for the determinants of health. The NHS itself has not planned its hospital and primary care facilities within the context of demographic change, and changes in the distribution of the population and the transport infrastructure.

The sustainable development framework set out in Action for Sustainability provides an overarching context for improving the quality of life and health of the population, and reducing inequalities between areas and groups. It aims to integrate social, economic, and environmental development in a way which would achieve balanced progress on the main determinants of health. It has adopted specific programmes, such as the strategy to improve the social and economic integration of disabled people in the North West, which have a direct impact on improving health and reducing inequalities. The NWDA and the NWRA are the agencies established to develop regionally based co-ordination, partnership, accountability, and governance.
The Northwest Development Agency (NWDA)

The NWDA is business led and the strategic driver of regional economic development. Their main aims are to:

◆ further the economic development and regeneration of the North West
◆ promote business efficiency, investment, and competitiveness
◆ promote employment
◆ enhance the development and application of skills
◆ contribute to the achievement of sustainable development.

The NWDA has completed a review of the Regional Economic Strategy (RES) published in 2000. The revised strategy retains a 20 year vision of a skilled and innovative region, which improves its environment and infrastructure, transforms its image, and brings everyone into the mainstream of community life.

The RES focuses on five major priorities to achieve the vision:

◆ business development - improving business development to secure economic growth is a key priority
◆ regeneration - regeneration priority areas have been defined for the region. They will be the focus for urban and rural regeneration, and measures to increase economic inclusion
◆ skills and employment. Significant work has been identified to deal with identified skill shortages. The preparation of the Framework for Regional Employment and Skills Action (FRESA) provides the opportunity to improve the co-ordination of programmes to increase skills and employment opportunities
◆ infrastructure. Improved strategic transport and communications infrastructure are required to transfer people, goods, and information within the region and to UK and overseas markets
◆ image. Improvements in the image and perceptions of the region are required to influence investment decisions and choices by businesses and individuals.

All these priorities have implications for the health and social care sector, and the reduction of inequalities. Successful economic policies would improve the health of the population. Reducing inequalities in the economic position of areas and groups will reduce inequalities in health. A significant change in perspective on the link between health and economic development has occurred with the recognition that the NHS as a major organisation has an important role is supporting regeneration and sustainability directly through its own activities.
The Government Office for the North West (GONW)

GONW represents central government in the regions. Government Offices are still part of central government, accountable to Ministers, but they bring a regional focus to the activities of Government Departments. A 1999 study by the Performance and Innovation Unit on how central government could provide more integrated services at regional and local levels to improve the delivery of Government objectives, led to the 2000 report, “Reaching Out: the role of central government at regional and local level.

The report concluded that there was a need to better:

◆ integrate central government initiatives
◆ fit government service delivery to local circumstances
◆ understand local and regional issues in the design of national policy.

In response to “Reaching Out”, the Government strengthened the role of Government Offices by giving them responsibility for new programmes and policies to complement the work of the Regional Development Agencies and Assemblies. Since the report:

◆ Government Offices have taken on new responsibilities in relation to work of the former Ministry for Fisheries and Food, now within the Department of the Environment, Food, and Rural Affairs (DEFRA)
◆ they have undertaken new work on neighbourhood renewal, local strategic partnerships and local government on behalf of the Office of the Deputy Prime Minister (ODPM)
◆ Government Offices manage the regional Connexions Service contract on behalf of Connexions Service National Unit, and the Department for Education and Skills (DFES) advisors on school standards, continuing professional development in schools, and adult basic skills now have a base in Government Offices. The Education and Social Inclusion Team works on behalf of DFES to support the raising and adult skills agenda.
◆ an enhanced role on crime reduction and drugs, involving the full integration into the Government Offices of the existing Home Office crime reduction teams and the Drugs Prevention Advisory teams
◆ a new role in supporting the Home Office “community cohesion” agenda
◆ fully integrated the existing Department of Culture, Media, and Sport (DCMS) regional presence within reach Government Office
◆ supporting the drive to get government, public services, citizens and business on-line to ensure that each region derives maximum benefit from the emerging knowledge economy
◆ extra responsibilities in working with and monitoring the performance of the Regional Development Agencies.
Integrating Regional Action to Improve Health

There has already been substantial progress in the North West in:

◆ developing a health strategy. The Investment for Health Plan fills this role, by agreeing health priorities, setting out the basis for an action plan, and for identifying the lead agencies to take proposals forward

◆ the Regional Director of Public Health, and the Public Health Team have co-located with the Government Office for the North West, and will support a joint work programme on health, and regional partnership arrangements

◆ the NWDA, NWRA, and GONW have worked jointly to develop an integrated appraisal tool kit which can be used to assess the economic, social, and environmental impact of policies and programmes, including the health dimension and the extent to which inequalities are addressed.

The co-location of the Department of Health Public Health Team at GONW provides the basis for integrating the health dimension into the activities of all Government policies and programmes, and supporting the NWDA and NWRA in the development of regional strategies. The main responsibility for taking forward the health agenda lies with the Regional Director of Public Health (RDPH), and the Public Health Team, at GONW. There is a requirement for the RDPH and the Directors of the GONW to agree a joint work programme, which will set out the priorities for improving health and reducing inequalities.

The different agencies on the North West Health Group have important and complementary roles in improving the region’s health:

◆ the NWDA and NWRA as the regional bodies to develop integrated strategies

◆ the GONW as government in the region to integrate Departmental programmes and support the regional bodies

◆ the three Strategic Health Authorities (SHAs), as the providers of a strategic framework to performance manage and provide development support for Primary Care and Hospital / Healthcare Trusts. They will also have a role in supporting the development of sub-regional strategies and programmes.

This is a regional Investment for Health Plan which focuses on those activities which add value at the regional level. The roles of the regional agencies, and SHAs as the sub-regional focus for the NHS system, are recognised in ‘Tackling Health Inequalities, A Programme for Action’. Roles will be clarified further during the consultation process on the Investment for Health Plan, and as part of the process of agreeing an Action Plan.
The Social Model of Health

The causes and risk factors that produce health and health inequalities, and their interaction with each other, are complex and fall across many dimensions: individual lifestyle choices interact with wider influences in the immediate community, with access to services, and the broader social, cultural, and economic environment. In the social model of health, determinants are considered as "layers of influence", as shown in Figure 8.

Figure 8

Health Determinants

Source:
The social model recognises that population health is largely determined by social, economic, and environmental factors which are beyond the influence of medicine and health and social care services. The greatest improvements in peoples’ health have arisen from social and economic improvements which also promote health.

**Public Health Improvements in the North West**

The North West, which was at the forefront of the industrial revolution, provides a good example of the fact that it is social, economic, and environmental changes that have had the greatest impact on the health of the population. The halving of mortality rates in England and Wales, and the doubling of life expectancy, between 1850 and the present are due to environmental improvements such as the provision of clean water, better housing and nutrition, and increased income. The North West was home to public health pioneers such as Dr Duncan in Liverpool and Edwin Chadwick in Manchester, who campaigned for measures which saw a dramatic improvement in the health of the population. This was particularly true of populations of deprived urban areas. Medical breakthroughs, such as the availability of vaccines and antibiotics came after the Second World War, by which time the major drop in mortality rates had already occurred.

Poor health and mortality are now due largely to circulatory and respiratory diseases and cancers. Infectious diseases have all but disappeared. The link between social and economic conditions and health, and the potential for policies to reduce inequalities however remains strong. Analysis of small areas in the North West, by using returns from census wards, showed that the pattern of unemployment across the region “explained” almost 90% of the pattern of limiting long term illness. The correlation and relationship for mental health and social and economic factors show a similar strong link. Even more striking is the gap in hospitalisation rates for mental illness for men in the lowest income areas for example were four times more likely to be hospitalised than those in affluent professional areas.
The Investment for Health Framework

Investment for Health as a concept therefore, relates to investment across a range of sectors and agencies which has a positive impact on health outcomes. It is not new, and reflects the approach of the North West’s public health pioneers. A healthier population will make a more productive contribution to overall development, and require less social support in the form of health care and welfare services and benefits. Investment which improves health and well being brings social and economic benefits for the whole community. Investment in health is perceived more narrowly as investment in health care services. Developing an Investment for Health strategy for the North West poses a number of key questions:

- What are the main determinants of health, and where is health promoted and maintained in the population?
- Which investments and strategies at the regional level have the greatest potential to improve health and reduce inequalities:
  - in the whole population
  - for particular high risk groups and areas
  - for those with established illness and formal health and social care needs?

Figure 9 illustrates that in applying these key questions, there are three activities which impact on health:

- prevention to keep people well
- treatment to shorten episodes of illness
- care to reduce disability and suffering.

It also illustrates that prevention is relevant throughout the wider “health system” from population based action through to activities in the setting of acute hospitals. Treatment and care are vital services for those with established illness or formal health care needs, but it is prevention that has the potential to improve health and reduce inequalities.

Improvements in the wider determinants of health such as income, housing, the environment, transport, and education, would have a significant impact on wider inequalities and therefore inequalities in health. The majority of prevention, treatment, and care is carried out by people themselves in their homes and communities, for themselves and for others. The Wanless Report on the long term future of health care recognised the need for people to be more fully engaged in improving their own health, and in relating to the health care system when they need to, in an informed and participatory way. Policies are needed which improve people’s knowledge and self awareness of health through the media, in the community, and in settings such as schools and workplaces.
Economic and social improvements support the development of a more informed population, and the changes in lifestyle which improve health. The reduction of risk factors such as smoking, poor diet, and lack of exercise in the population would have a major impact on life expectancy and levels of illness.

There have been improvements in lifestyle and risk factors in the population, but these have been very uneven, and rates for lower income groups and deprived areas are much higher than those in affluent groups with greater resources and choices. Targeted approaches to reduce inequalities are cost effective, and are reflected in the range of Government programmes for priority areas and groups. Again prevention focuses on tackling the wider determinants of health through policies such as the Neighbourhood Renewal Strategy, improving education, and the knowledge and support required to bring about changes in lifestyle and risk factors.

The NHS has an important role in prevention for high risk groups and areas. The establishment of Primary Care Trusts, and the strengthening of the primary care function, will allow the NHS to:

- participate in local partnerships to achieve urban regeneration and rural renaissance, including using its economic and social weight as a major organisation to tackle agreed priorities.

- target prevention in its provision of services at priority groups. Men over 50 for example who are smokers, overweight, and have a family history of heart disease have a significant chance of having a heart attack. Targeted preventative measures in primary care, and more widely through community and workforce settings, are cost effective investments in improving health, reducing inequalities, and avoiding health care needs.
The numbers in hospitals in secondary care are smaller, but prevention is important to avoid the health of patients getting worse, and to avoid further acute episodes and the need for further hospital care. Programmes which link primary care and secondary care, provide support in the home and community, and encourage lifestyle changes through schemes such as exercise on prescription, have been shown to improve health outcomes and reduce readmission rates to hospitals.

Implementing “investment for health” in the North West will therefore require agencies applying integrated policies which focus particularly on preventative measures in the population, for high risk groups and areas to ensure inequalities are reduced. Across this spectrum there will be a need to increase personal and community skills to manage health, and to participate in policy development and implementation. Some examples for regional priorities help to illustrate the approach.
**Increasing physical activity**

In the past, traditional and narrowly defined health promotion programmes have had limited success in improving health, and have had little impact on reducing inequalities. General measures and campaigns to encourage healthier lifestyles - more exercise, better diet, stopping smoking - have been more easily taken up by more affluent groups who have the resources to make these lifestyle choices.

It is estimated that physical inactivity costs England almost £2 billion per annum. This is made up of £325 million in the direct care costs of physical inactivity, £785 million in earnings lost due to sickness absence, and £780 million in earnings lost due to premature mortality. A reduction in the proportion of adults aged 16 and over who are sedentary from 37% to 27%, could reduce direct and indirect costs by £445 million per annum.

Obesity is increasing in the population and if current trends continued there would be higher incidence of diabetes which would impact significantly on the demand for health care services. Population based measures will need not just to promote exercise, but to provide accessible facilities and safe environments for it, in a variety of settings including the workplace. This is particularly true for more deprived areas and groups. Participation in sport and exercise falls dramatically after leaving school, and continues to drop significantly with age. Levels of participation are almost three times higher for professionals than for unskilled manual groups. Women are 19% less likely to take part in sport, and ethnic minority participation is 6% lower than the national average. Disabled people have high participation rates only in certain sports. Targeted interventions are described later in the section on physical activity, and will be cost effective investments to reduce an increasingly important risk factor.

The value of exercise for people with established illness has been recognised, and is reflected in programmes such as exercise on prescription. These have been shown to improve health and prevent further episodes of illness.

**Transport and road accidents**

Effective accident prevention programmes can have a significant impact on the health of the population and the demand on health care services. Comprehensive programmes comprising enforcement, engineering, and education have been shown to both reduce mortality and morbidity, and lower the demand for Accident and Emergency, and ongoing health care services. As an investment accident prevention schemes produce benefits for the health of the population, the regional economy, and the reduced demand for scarce health care services.
The greatest inequalities in relation to road accidents are for children. Children in the lowest socio-economic group are up to five times more likely to be involved in a pedestrian accident than those in the highest group. There is also a disproportionate incidence of pedestrian accidents among children from ethnic minority families. Road safety initiatives and traffic calming measures have been shown to significantly reduce child road accidents.

Integrated programmes involving hospital care services, the police, and local authorities produce benefits for individuals and their recovery, and provide inputs and intelligence into the prevention policies for high risk groups and areas.

**The NHS as a “Good Corporate Citizen”**

The NHS is a major organisation and the largest employer nationally, regionally, and in many local areas, particularly more deprived ones. Within its mainstream role of providing good health and social care for the whole population, it can play a particular role in reducing inequalities in health by contributing to wider regeneration and sustainability policies which target priority areas and groups.

**Figure 10** from the King’s Fund report “Claiming the Health Dividend” illustrates what could be a “virtuous circle”. Focusing NHS resources to improve local economic, social, and environmental conditions, would improve the health of the local population, which in turn would reduce the demand for health services, particularly for avoidable causes. This would increase the capacity to provide quality services for less avoidable illnesses, and again reduce demand and increase resources for prevention and effective treatment and care.

There are several projects in the North West focusing on increasing recruitment into the NHS from priority areas and groups, and ensuring career development when they are in post. There are other projects relating to procurement policy, and the impact of major capital projects on the local economy.
Figure 10

A Virtuous Circle

Source:
The Basis for an Investment for Health Strategy

The adoption of an Investment for Health approach in the North West recognises that:

◆ population health is largely determined by wider social, economic, and environmental factors, which requires the involvement of a range of sectors and agencies to achieve sustainable improvements. A key task is to evaluate the impact on health of all major policies, and to align programmes to achieve health gains.

◆ the focus on prevention in the population needs to be extended to high risk groups and areas, and to the formal health care system. Prevention policies to reduce inequalities are investments which improve the quality of life in deprived areas and groups, reduce social exclusion and produce economic benefits, and reduce the demand for health and social care services from avoidable illness.

Investment for Health therefore refers to the health related investment across agencies and sectors, which aims to improve health and reduce inequalities. It requires the development of partnership working, the adoption of agreed priorities, more integrated performance review processes, and development support and capacity building to secure wider accountability, scrutiny, and participation in the health agenda.

Inter-Regional Work on Investment for Health

The World Health Organisation (WHO) have developed an Investment for Health approach, initially through the Verona Initiative. This involved three annual meetings between 1998 and 2001 which brought together participants from a wide range of interests to develop thinking on policies to improve health and reduce inequalities. Two of the outputs from these meetings were the Verona Benchmark, a methodology to evaluate the strength of partnerships to formulate and deliver investment for health policies, and the Verona Declaration to support their development. WHO have subsequently established the Venice Centre for the Investment for Health.

The Health Development Agency have recently established a network between the English regions to support the development of Investment for Health policies, and of regional strategies. The network involves a range of agencies including Government Offices, Regional Development Agencies, and Regional Assemblies.

The North West has been heavily involved in the WHO Investment or Health initiative, and is a member of the WHO Regions for Health Network which brings together representatives of 28 regions across 17 European countries. There are therefore strong national and European networks which provide the opportunity to share experience on implementing Investment for Health at the regional level.
National Policy Initiatives

The Wanless Report, published in April 2002, had important conclusions which support the basis for the regional Investment for Health Plan. They were:

- continuing to respond to increasing health care demands, particularly with an ageing population, is not an option.
- better public health measures and a focus on prevention could significantly reduce the demand for health care for avoidable illness.
- improved health and a quality health service would bring significant economic and social benefits.

It evaluated three possible scenarios of how the drivers of costs - population health needs and demands, technological developments and medical advance, and the use of the workforce and productivity - might impact on the use of delivery of the health service in 20 years time.

It selected as the basis for the settlement for the Department of Health in the 2002 Comprehensive Spending Review, the “fully engaged” scenario which assumes:

- public health improves dramatically with a sharp decline in key risk factors as people actively take ownership of their own health
- reductions in risk factors are largest where they are currently highest, among people in deprived areas, leading to reductions in equalities in health.
- health care becomes more sophisticated as the service responds to a fully engaged public..

The conclusions of the Wanless Report were accepted and built upon by the Government’s Cross Cutting Review in 2002 on Tackling Health Inequalities. It reviewed the evidence on health inequalities, particularly that provided by the Acheson Report and concluded:

- there are wide and in some cases growing inequalities in health which affect people at all stages of life, and across different parts of the country. These begin at conception and continue throughout life, setting up an inter-generational cycle of health inequalities.
- health inequalities can only be tackled effectively through co-ordinated action across sectors from the national to the local level.
- health inequalities follow a social gradient, with the health gap increasing steadily with poorer social class. Because of this gradient, and the distribution of different groups, policies are required which reach not only the most deprived areas, but all manual groups and pockets of deprivation in all parts of the country.
The Cross Cutting Review clearly set out the major risk factors and causes of health inequalities, and the areas where interventions are necessary to narrow the gap in health outcomes across socio economic and other groups. It reviewed and updated the evidence on the effectiveness of interventions to reduce inequalities from the Acheson Inquiry. On this basis it identified the interventions that it considered would have the greatest impact on tackling health inequalities.

The Review therefore provides the basis for defining the priorities within an Investment for Health Framework. It identifies the links between wider determinants, lifestyle factors, access to services, and health outcomes, which need to be taken into account in formulating and reviewing mainstream programmes. It also prioritised short term proposals for achieving national inequalities targets, by assessing possible interventions in relation to cost, the impact on inequalities, and the ease of delivery.

The priorities for the NHS were included in the 2002 Priorities and Planning Framework, to be delivered through the Local Delivery Plans drawn up by Primary Care Trusts by the end of March 2003.

The major impact on inequalities however will be the preventative measures across Government, and by local authorities within Local Strategic Partnerships, to tackle these wider determinants of health. The priorities for tackling these wider determinants are set out in the "Tackling Health Inequalities: A Programme for Action" to tackle health inequalities, and backed up by Public Service Agreements across Government Departments, and with local authorities.

"Tackling Health Inequalities: A Programme for Action", based on the findings of the Cross Cutting Review, is a long term strategy, with the aim of narrowing the gap in health between areas and groups. It has two interlinked goals:

◆ achievement of a focused 2010 Public Service Agreement (PSA) target to narrow the gap in life expectancy between the worst fifth of local authority districts and the population as a whole (by at least 10%), and starting with children under one year, to reduce by at least 10% the gap in mortality between routine and manual groups and the population as a whole.

◆ addressing the wider determinants of health inequalities, including access to key services, education, regeneration, housing, unemployment, and transport, to redress the inequalities that lead to greater ill health through life and shortened life expectancy for certain groups and areas.

The PSA target is supported by two more detailed objectives:

◆ starting with children under one year, by 2010 to reduce by at least 10% 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% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole
Principles of the Strategy

The strategy is underpinned by four key principles:

- the primacy of prevention - interventions that prevent the causes and reduce the consequences of health inequalities will have the greatest long term impact, and can be directed to meet the needs of individuals and families, as well as social, economic, and environmental factors that shape individual choice and opportunity.

- public services are often poorest in the most disadvantaged areas, and a sustained impact on inequalities will only be achieved if mainstream services become more responsive to the needs of disadvantaged populations. This requires the reshaping of services, different use of resources and changes in corporate culture. “Floor” targets for key service outcome across Government, and the development of national service frameworks to raise the quality of NHS services for all is essential, driving progress fastest in the most disadvantaged areas and among the least well-served populations.

- targeted interventions can introduce innovation, tackle specific problems, or support particular groups who have difficulty in accessing services.

- locally and nationally, progress needs to be embedded in the mainstream planning of services, and performance management and monitoring arrangements, such as the NHS priorities and planning framework, the national PSA for local government, the comprehensive performance assessment for local authorities, and local public service agreements.

Priorities for Reducing Inequalities

The programmes and policies to address the different dimensions of health inequalities are set out in the Programme for Action across four themes:

- supporting families and children, to reduce current inequalities, improve life changes, and break the inter-generational cycle of deprivation. Key initiatives include Sure Start, nursery places for 3 and 4 year olds, children’s tax credit, and the emerging National Service Framework for children. Measures will focus on supporting maternal and child health and child health development, improving life chances for children and young people, and reducing teenage pregnancy and supporting teenage mothers.

- engaging communities and individuals, in recognition of the fact that strong communities enable and empower people to take control of their lives, and help to ensure a better local environment, quality of life, and more effective services. The National Strategy for Neighbourhood Renewal emphasises the importance of this model for disadvantaged areas.
• preventing illness and providing effective treatment and care. The aim is a better match between need and service provision throughout the country, and a better balance between prevention and treatment. Action aims to:

- reduce risk in lifestyle factors such as smoking, diet, and lack of physical activity
- early detection, intervention, and treatment of illness, particularly in primary care
- reducing inequalities in access, quality, and outcomes, for health and social care services.

• dealing with long-term underlying causes of health inequalities such as housing, education, employment, and transport.

Within this range of action the strategy identifies the longer term priorities which will have the greatest impact on health inequalities, and contribute to meeting the national inequality targets:

• improving early years development for young children
• improving housing standards and tackling fuel poverty
• raising educational attainment and improving skills
• tackling deprivation in disadvantaged communities
• improving access to services in urban and rural communities
• supporting disadvantaged groups with particular needs
• reducing unemployment, tackling inactivity and raising incomes.

The strategy also identifies a number of specific interventions among disadvantaged groups most likely to have an impact on the national target. For the life expectancy element of the target, the key interventions are:

• reducing smoking in (manual) social groups through smoking cessation services and other programmes
• preventing and managing other risk factors such as poor diet and obesity, physical inactivity and hypertension
• making environmental improvements, including housing, safety and accidents
• targeting the over 50s - where the greatest short term impact on life expectancy will be made.
For the infant mortality part of the target, the interventions most likely to have impact are:

- building on Sure Start to improve early years support
- reducing smoking and improving nutrition in pregnancy
- improving access to key services for pregnant women, mothers and young children, including ante and post natal care, for high quality family and improve maternity services and increasing breastfeeding uptake and duration
- preventing teenage pregnancy and supporting teenage mothers
- improved housing conditions, especially children in disadvantaged areas.

The Regional Investment for Health Plan, and Regional Priorities

The National Plan to Tackle Health Inequalities, and related strategies on Neighbourhood Renewal and Sustainable Communities, provide a strong framework for regional action. The National Plan, building on the Cross Cutting Spending Review, also defines priorities for shorter and longer term mainstream action to improve health and reduce inequalities. It uses the best available evidence on the causes of health inequalities, and on effective interventions or investments.

Applying and implementing national priorities in the region will need to reflect both the value added by regional partnership working, and the particular circumstances in the North West which will influence the balance of action required regionally and at the local level.

**Figure 11** sets out the basis for the North West Investment for Health Plan. The Investment for Health framework emphasises the need to develop policies and programmes in the population, for high risk groups and areas, and within the formal healthcare system, which improve health and reduce inequalities.

This will involve, identifying the health dimension of all economic, social, and environmental policies, to ensure that action has a positive impact on health. Work has developed within regional partnerships over a number of years to develop this agenda, and has been re-inforced by national policy initiatives such as the Neighbourhood Renewal Strategy.

A specific contribution to developing the health dimension of policies has been the development and application of health and integrated impact assessment tools. The North West Integrated Appraisal Group, with representatives from the main regional agencies, have developed a toolkit to support the evaluation of the economic, social, and environmental impacts of major policies and strategies. A key development task for taking forward Investment for Health will be to support the application of impact assessments at the regional and local levels.
Securing wider ownership of the health agenda to ensure all agencies seek to improve health through their policies and programmes is an ongoing task. The specific focus of this Plan is on agreeing a joint set of priorities with the North West Regional Assembly, the Northwest Development Agency, Government Office North West, and three Strategic Health Authorities in the region, to reduce inequalities in health. Although there is an on-going effort to improve the health of the population, this involves identifying specific actions for high risk groups and areas, and within the formal health care system.

In line with national policies the aim is to mainstream good practice, work in partnership to align programmes, and agree action which will meet the shorter term inequalities targets, and secure longer term change. The range of national priorities identified under the five themes have been incorporated into the four priority areas for action:

◆ tackling the wider determinants of health, which has the greatest potential for reducing the large inequalities in health in the region

◆ developing the corporate citizen role of the NHS. There has been considerable progress in the North West, led by the Northwest Development Agency, in developing an agenda to support the contribution the NHS can make to wider regeneration and sustainability objectives

◆ mainstreaming inequalities in the NHS through measures which improve access, quality, and outcomes for treatment and care

◆ strengthening primary care, and the role of PCTs in developing preventative programmes within the health care system, and through wider local partnerships tackling the wider determinants of health.

◆ **Figure 12** sets out these four priority areas in more detail. It also identifies the four priority processes for integrating action, and the supporting activities which will be required to deliver this agenda. The priority areas, basis for integrated action, and activities supporting delivery reflect national priorities but also the circumstances of the North West, and initiatives developed and adopted by regional agencies.
Applying the Investment for Health Framework – prevention in:
◆ the whole population
◆ high risk groups/areas
◆ the formal healthcare system

Applying Health and Integrated Impact Assessment to major strategies and policies

Identifying the health dimension of economic, social, and environmental policies

Focusing on:
◆ reducing inequalities in health
◆ mainstreaming good practice
◆ building regional and local partnerships
◆ shorter-term targets and longer term change

Tackling the wider determinants of health
Developing the corporate citizen role of the NHS
Mainstreaming inequalities in the NHS
Strengthening Primary Care
Improving Health and Reducing Inequalities

REGIONAL PRIORITIES

TACKLING THE WIDER DETERMINANTS
Wider influences in the immediate community
- housing
- education
- crime and disorder
- transport
- physical environment

Lifestyle and risk factors
- tobacco
- diet and food
- exercise / physical activity
- accidents
- mental health
- sexual health
- teenage pregnancy

NHS CONTRIBUTION TO REGENERATION / SUSTAINABILITY
- employment
- purchasing
- capital / infrastructure
- R&D / knowledge

MAINSTREAMING INEQUALITIES IN THE NHS
- Improving access, quality, and outcomes for underserved areas / groups

STRENGTHENING PRIMARY CARE
- staffing and infrastructure in deprived and underserved areas

INTEGRATION OF ACTION ON PRIORITIES

REGIONAL STRATEGIES
- Action for Sustainability
- Regional Economic Strategy
- Regional Planning Guidance
- Sustainable Communities

AREA BASED POLICIES
- joint NHS / LA priorities within LSPs, Public Service Agreements
- NHS Local Delivery Plans / Community Plans
- urban regeneration / neighbourhood renewal
- rural renaissance
- social cohesion / community development

PRIORITY GROUP PROGRAMMES
- children and young people
- older people
- black and ethnic minority populations
- disabled people

SETTINGS
- the settings approach
- schools
- workplaces
- prisons

DEVELOPING INVESTMENT FOR HEALTH
- Developing Regional Partnerships
- Information and Intelligence
- Communications
- Performance Management and Review
- Leadership, Advocacy, and Capacity Building
- Scrutiny and Accountability
Tackling the Wider Determinants of Health

**Wider influences in the immediate community**

Action on housing, education, crime and disorder and transport is vital in the North West, given the high incidence of problems relative to national rates. The environment is an added priority because of the region’s industrial legacy and its urban nature. Work and unemployment are important determinants of health. Being unemployed is strongly associated with poor health. The type of work a person does has an impact on health risks. Action on work is included in a number of sections of this report.

**Lifestyle and risk factors**

All the defined lifestyle factors are national priorities, and their links to social, economic, and environmental factors means that significant improvements are required in lifestyle risk factors.

**The NHS Contribution to Regeneration and Sustainability**

The contribution of the NHS as a major organisation to support economic, social, and environmental regeneration has been identified as a major priority by regional agencies. The completion of a major study of the economic footprint of the NHS will provide the basis for the development of the health and social care sector as a growth cluster and for an action plan of wider action. The NHS has the opportunity to improve health directly, particularly in deprived areas, and in the process to reduce the demand for health care services.

**Mainstreaming Inequalities in the NHS**

The Priorities and Planning Framework for the NHS for 2003-2006 identifies reducing inequalities as one of ten priorities. Targets are identified to achieve service improvements for deprived and underserved areas and groups, in terms of access, quality, and outcomes.

**Strengthening Primary Care**

Strengthening primary care has a crucial role in reducing inequalities in access to services. Primary Care Trusts also have an important role within local partnerships in developing policies to tackle the wider determinants of health and to ensure the NHS supports regeneration.
Integrating Action On Priorities To Improve Health

Influencing Regional Strategies

There are three main strategies which are central to achieving economic, social, and environmental regeneration. These are the Regional Economic Strategy Action, for Sustainability, and Regional Planning Guidance. The health dimension of these has been developed, and will be developed further during their review and implementation.

Area-based Policies

Universal area-based policies through NHS Local Delivery Plans, Community Plans, and Local Strategic Partnerships are central to improving health, reducing inequalities, and achieving urban regeneration and rural renaissance. Targeted area-based policies are particularly relevant in the North West. 23 out of the 71 local authorities in the lowest fifth of life expectancy for men are in the North West. For women 26 out 71 local authorities are in the region. These authorities have been identified as ones where a local Public Service Agreement to reduce health inequalities should be adopted. Of the 88 local authorities eligible for Neighbourhood Renewal Fund, 21 are in the North West.

Priority Groups

Children and young people are a national priority group, to tackle health inequalities and to break the cycle of deprivation. The relatively poor health of this group in the North West re-enforces the need to improve their health to support longer term regeneration.

The numbers in the younger age groups are projected to decline significantly. Conversely, older age groups will increase and there is a growing gap between those dependant on state benefits and those with other sources of income. Interventions aimed at older people offer the greatest potential for meeting targets to reduce mortality.

The demographic study for the North West identified two other groups which will increase significantly. These are people on disability benefits, and black and ethnic minority groups. Effective interventions to improve their health, and social and economic conditions, would reduce significant inequalities and support regeneration.
**Settings**

The North West has played a leading role in developing ‘settings’ as a focus for improving health. The approach recognises that the settings where people carry out the majority of their everyday activities, are an important focus for prevention, and promoting a healthy lifestyle. Mechanisms have been established to promote the approach in a wide variety of settings. A particular emphasis on healthy schools and healthy workplaces reflects the potential to reach large populations, address inequalities, and support regeneration. The Healthy Prisons initiative provides the opportunity to focus on a national priority group.

**Translating Priorities into Action**

The arrangements to support the development of the identified priorities, and to deliver improved health and a reduction in inequalities, are described in the next chapter.

A separate draft action plan has been produced to support consultation on how the regional priorities, the mechanisms for integrating action, and the arrangements to support delivery, can to be taken forward. The draft action plan sets out for each priority suggested key activities, major actions, lead agencies and supporting partners, timescales, and milestones and outputs. Following consultation, an action plan will be agreed by regional partners, to support the delivery of investment for health priorities.
Arrangements to support partnership working to develop mainstream programmes to improve health and reduce inequalities, have been established at national, regional, and local level. Figure 13 illustrates the relationship between the structures and processes at these levels. The integration of policies and programmes between the levels, as well as within them, will strengthen their impact and effectiveness. The regional level has a vital role in integrating action within the North West, and ensuring that there is a link between national policy making and local implementation, and that each informs the other.

The establishment of Public Service Agreements (PSAs) to support action to reduce inequalities is a powerful tool to ensure delivery. The Department of Health’s PSA to reduce inequalities in health outcomes by 10% as measured by life expectancy at birth and infant mortality, is reflected in the Priorities and Planning Framework for the NHS for 2003 - 2006. The reduction of health inequalities is one of ten priorities, and action identified includes tackling the wider determinants of health through local partnerships, the NHS role in supporting wider regeneration, and reducing inequalities in access to health services. There is a recognition that within local partnerships, local authorities will have the key role in tackling the wider determinants. Local authorities in areas of lowest life expectancy, or in receipt of neighbourhood renewal funding, are being particularly encouraged to adopt health inequalities targets based on the national PSA for local government.

Public Service Agreements (PSAs) across Government were announced in August 2002, that support the prevention of ill-health and address key risk factors. They cover what departments are expected to deliver in return for significant higher investment in public services over the next three years. Departments will produce delivery plans for all the targets published, with clear milestones and trajectories showing how the targets will be met. The PSAs across Government which relate to reducing inequalities are set out in Appendix 1.
Figure 13

Delivering Investment for Health

NATIONAL MECHANISMS

Department of Health (DH)

- Co-ordination of the Inequalities Delivery Plan across Government
- The NHS Plan
- Saving Lives: Our Healthier Nation
- Planning & Priorities Framework

Cabinet Domestic Affairs Sub Committee on Social Exclusion & Regeneration

- Joint Public Service Agreement for DH & Local Government “by 2010 reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth
- Across Government PSAs for key risk factors – delivery plans, milestones, and trajectories

Other Government Departments

- National Strategy for Neighbourhood Renewal
- Sustainable Communities: Building for The Future
- Child Poverty Strategy

REGIONAL MECHANISMS

Strategic Health Authorities
- Cumbria & Lancashire
- Cheshire & Merseyside
- Greater Manchester

Government Office North West / Public Health Team
- North West Regional Assembly
- North West Development Agency

Regional Strategies
- Action for Sustainability
- Regional Economic Strategy
- Regional Planning Guidance
- Sustainable Communities

Regional Level Functions
- Information / Intelligence
- Communications

Regional Framework for Local Partnerships
- Performance Management
- Leadership/Capacity Building
- Scrutiny/Accountability
- Social Cohesion/Community Development

LOCAL MECHANISMS

Primary Care Trusts
- Hospital / Care Trusts
- Local Delivery Plans

Local Strategic Partnerships
- Community Plans
- Neighbourhood Renewal Strategies
- Joint Health Priorities
- Local PSAs

Local Authorities
- Best Value Performance Indicators
- Comprehensive Assessment Framework
Regional Level

Partnership arrangements to address the health of the region’s population have developed over the last five years. The Investment for Health Plan has been produced as the basis for agreeing priorities between the Government Office for the North West, the Department of Health Public Health Team at GONW, the North West Development Agency, the North West Regional Assembly and the three Strategic Health Authorities. The basis is for wider involvement in the development of the health agenda will be determined as part of the consultation on the Investment for Health Plan.

The Investment for Health Plan is not intended therefore to be another regional strategy. Its purpose is to identify priorities for improving health which can then be taken forward through existing mechanisms wherever possible. It has been developed therefore in conjunction with:

- the review of the Regional Economic Strategy and liaison with NWDA on how regeneration can improve health, and how the NHS can contribute as an organisation to regeneration
- the co-location of the Department of Health Public Health Team at GONW and the development of a joint work programme
- liaison with the NWRA on their role in supporting health improvement and the reduction of inequalities, including the development of accountability mechanisms at regional and local levels.

The Investment for Health Plan is a regional document which needs to focus on activity which adds value at this level and provides an effective link to national and local policies and programmes. Figure 14 identifies the types of regional added value activities:

- regional strategies and policies
- regional level functions and resources which support the policy process
- regional frameworks and processes which support action and delivery at the local level.
**Regional 'Added Value' Activities**

### Regional Strategies
- Developing the health dimension of the major, over-arching regional strategies,
  - Action for Sustainability, Regional Economic Strategy, Regional Planning Guidance, Sustainable Communities, Building for the Future
- Engaging the NHS (SHAs, PCTs, Trusts) in the development and implementation of strategies
- Contributing to the alignment of the wide range of regional strategies, and a focus on:
  - Health and inequality issues
  - Supporting HIA and IIA for strategy and policy development

### Regional Level Functions
- Information / intelligence
  - Indicators and targets
  - “Evidence”
  - Analysis to identify needs, formulate and review policy
  - Background studies and research
  - Good practice
  - Impact assessment, equity audit, and other methodologies
- Communications
  - Regional communications strategy

### Regional Framework for Local Partnerships
- Performance management and review
- Leadership and capacity building for public networks
- Overview of scrutiny and accountability arrangements
- Social cohesion and community development
Regional Strategies

There are four ‘over-arching’ strategies which address economic, social and environmental issues in the region:

- The Regional Economic Strategy
- Action for Sustainability
- Regional Planning Guidance
- Sustainable Communities: Building for the Future

The health dimension of the RES has been identified as a development area and the Investment for Health Plan is the basis for agreeing priorities and producing an action plan. Action for Sustainability is currently being reviewed with a revised version due later this year. Similarly RPG has been reviewed and will be revised as part of the new planning arrangements being introduced. The Investment Plan will inform these reviews along with a fuller involvement by the health sector in the review process. A ‘Sustainable Communities’ Plan has been produced for the North West, and provides the framework for integrated action in areas of low housing demand.

In addition to the ‘over-arching’ strategies, there are a wide range of topic and group based strategies produced by regional agencies. GONW has produced a review of strategies to support greater alignment around specific themes and delivery mechanisms. The health dimension, as a cross-cutting theme, needs to be central to this process.

Regional Level Functions

Information and Intelligence

The development of more integrated policies and programmes to achieve social, economic, and environmental regeneration, has highlighted the need for more co-ordinated information and intelligence. The North West Public Health Observatory, the NWDA’s Regional Intelligence Unit, and the regional arm of the Health Development Agency, have important roles to play in developing effective arrangements within the North West.

There are a number of key development areas:

Information and indicators.

Review and development work is taking place nationally, regionally, and locally, to address the problem of a wide variety of targets and indicators which relate to specific organisations and programmes, and do not adequately support integrated policy making and programme delivery.

Regional health indicators are included in the Action for Sustainability Framework, but subsequent policy developments, and an increased emphasis on inequalities, means they need to be reviewed alongside other domains. A study has been commissioned - Vital Signs - which, with the review of AfS, will produce the basis for considering appropriate health indicators at the regional level.
The work has been commissioned by the Regional Performance Indicator Group, which has representation from GONW, the DH Public Health Team at GONW, the NWDA, NWRA, Home Office, Environment Agency, and the Regional Intelligence Unit. The project aims to provide a benchmarking tool by integrating a series of indicators from the main regional strategies into one set, to monitor economic, social, and environmental change.

Locally health indicators are integrated into wider frameworks such as the Government’s floor targets. There are subsequent developments such as PCT Local Delivery Plans, and the basket of indicators around health inequalities, which require a review of local indicators and target setting.

Evidence and effectiveness.

The Cross Cutting Review looked at the evidence on the effectiveness of interventions to improve health and reduce inequalities, which formed part of the basis for the priorities identified in the NHS Priorities and Planning Framework. The national programme of action for health inequalities sets out the wider priorities. Evidence is not strong for wider interventions, but the Health Development Agency have produced the best available guidance to support the preparation of NHS Local Delivery Plans.

Major background studies

The NHS contributed to the inter-agency regional study on ageing in the North West, which identified important policy implications. The NWDA are commissioning a study of the economic footprint of the NHS in the region, which will provide the basis for an action plan. It will be important to identify with other regional agencies the types of study which will support health and regeneration policies.

Models of good practice

Although there are models of good practice for the range of regional priorities, in general there is no systematic mechanism for identifying and pro-actively seeking to mainstream them. With the development of inter-agency working there is a need to consider what can be done jointly to support a more effective process around good practice.

Integrated Impact Appraisal

There has been considerable progress in the region in developing integrated impact assessment, which incorporates health impacts within a wider sustainability framework. There is a need to consider how the Integrated Appraisal Toolkit can be incorporated into the strategy and decision making process, regionally and locally.
Communications

The Wanless Report adopted the ‘fully-engaged’ scenario for the long term future of health and social care, which apart from a greater emphasis on public health and preventative measures, envisaged a population which was much more involved in managing their own health, and better informed to engage with the health and social care system.

A Regional Communications Strategy for Investment for Health is required to:
- Set out the basis for partnership working in the region.
- Explain and promote Investment for Health as the basis for improving health and reducing inequalities in the region.
- Inform the population and communities of priorities and programmes to improve health, and the basis for wider involvement.
- Ensure links to other regional communication mechanisms, and the Annual Reports of PCT Directors of Public Health
- Support the development of a better informed and more engaged population.

Regional Frameworks for Local Partnerships

Performance Management

Health Inequalities: A Programme for Action emphasises the need to mainstream activity to reduce inequalities in health. The challenge will be to put performance management and mainstream planning systems behind policy goals. In the past the emphasis of performance management has been largely on health and social care issues, mainly in secondary, hospital care.

The development of local partnerships, and an emphasis on both the wider determinants of health, and the NHS’s own role as a major organisation, provides the opportunity to consider the performance management process around health as well as health care. Within LSPs, the relationship between NHS Local Delivery Plans, Community Plans, and targeted initiatives, will be important in supporting partnerships around Investment for Health. The main aim is to ensure measures to improve health and reduce inequalities become part of mainstream performance management and inspection systems, particularly those used for local government and the NHS. SHAs have already started this process.

Leadership and Capacity Building

Investment for Health, in common with other regeneration and sustainability approaches, stresses action between agencies on a wide range of issues. The required integration of strategy development and programme delivery challenges existing organisational arrangements and responsibilities.
The Regional Director for Public Health has the responsibility to provide leadership in the development of health policy, and measures to increase individual and organisational public health capacity.

**Scrubtiny and Accountability**

The enhanced public health role for regional assemblies set out in the White Paper “Your Region, Your Choice” were described in Chapter 3. As well as setting out the basis for moves towards elected assemblies, the White Paper identified the need to strengthen existing arrangements for scrutinising policies to evaluate their impact on health. The Investment for Health Plan will play a useful role in establishing agreed regional priorities, and in developing scrutiny arrangements. These will be supported by the Integrated Appraisal Toolkit developed by regional partners, and the monitoring of agreed, integrated indicators provided by the “Vital Signs” project.

The establishment of a local authority scrutiny role for health and social care provides the basis for wider accountability within Local Strategic Partnerships. The guidance establishes that Councils will be scrutinising a health system or economy, not just services provided. This will include plans made in cooperation with local authorities, setting out a strategy for improving both the health of the local population and the provision of health care to that population. The scrutiny process therefore could support actions on the wider determinants of health, the NHS’s role as a good corporate citizen, and the range of jointly agreed health priorities.

**Social Cohesion and Community Development**

“Sustainable Communities: building for the future” is a programme of action to tackle pressing problems in communities across England. There is a particular focus on tackling the problem of high demand and shortage of housing in some areas, and low demand and abandonment in others. The programme however is being developed within the framework of what makes a sustainable community. The key requirements, as defined by a sub-group of the Central Local Partnership between the Local Government Association (LGA) and Central Government, include:

- working with local people, groups, and businesses, and an active voluntary and community sector
- a safe and healthy local environment
- good public transport and infrastructure
- good quality local public services, including healthcare and community facilities.
Other requirements cover economic, housing, cultural, and environmental conditions. The NHS, and the wider health and social care sector, has a vital role in supporting the development of sustainable communities. The health and social care sector is a major social and economic player; as well as a provider of services.

“Social cohesion” has become an important policy issue to address conflicts within communities, and the impact of crime and anti-social behaviour. A particular priority is responding to the serious disturbances in Burnley and Oldham. Four factors have been identified through research, as leading to high tension and the potential for serious disorder:

- long term and deep rooted social and economic problems in deprived areas
- disillusionment with the local political process, creating opportunities for outside, extreme groups to exploit community tensions
- divided communities and vulnerable groups creating prejudices and the potential for racial prejudice and conflict
- the development of illicit markets such as drugs in deprived areas, creating crime and community insecurity.

Social cohesion is a policy priority for Government Office North West, other regional agencies, and local partnerships in parts of the North West. The Department of Health and the NHS will need to contribute fully to increasing social cohesion and building sustainability by:

- reflecting the needs of Black and Minority Ethnic groups in developing local health policies and priorities, in conjunction with local authorities and other partners, within Local Strategic Partnerships and social cohesion groups within defined at risk areas
- using its resources and premises to contribute to developing community infrastructure which supports social cohesion and integrated services for priority groups
- using its influence as a major organisation, through its staff, users of its services, providers, and networks, to promote social cohesion and tackle discrimination and inequalities.
### Public Service Agreements and Health Inequalities

**1. PSAs across government concerned with socio-economic inequalities**

<table>
<thead>
<tr>
<th>PSA</th>
<th>Lead/joint departments</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 2010 reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Improve life chances for children, including reducing the under-18 conception rate by 50% by 2010.</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Reduce the number of people killed or seriously injured in Great Britain in road accidents by 40%, and the number of children killed or seriously injured by 50%, by 2010 compared with the average for 1994-98, tackling the significantly higher incidence in disadvantaged communities.</td>
<td>Department for Transport</td>
</tr>
<tr>
<td>By 2010, bring all social housing into decent condition with most of this improvement taking place in deprived areas, and increase the proportion of private housing in decent condition occupied by vulnerable groups.</td>
<td>Office of the Deputy Prime Minister</td>
</tr>
<tr>
<td>Reduce crime and the fear of crime; improve performance overall, including by reducing the gap between the highest crime Crime and Disorder Reduction Partnership areas and the best comparable areas.</td>
<td>Home Office (contributing to Criminal Justice System PSA)</td>
</tr>
<tr>
<td>Make sustainable improvements in the economic performance of all English regions and over the long term reduce the persistent gap in growth rates between the regions, defining measures to improve performance and reporting progress against these measures by 2006.</td>
<td>Office of the Deputy Prime Minister, Department of Trade and Industry and HM Treasury</td>
</tr>
<tr>
<td>Reduce the gap in productivity between the least well performing quartile of rural areas and the English median by 2006, and improve the accessibility of services for rural people.</td>
<td>Department for Environment, Food and Rural Affairs</td>
</tr>
<tr>
<td>Reduce fuel poverty among vulnerable households by improving the energy efficiency of 600,000 homes between 2001 and 2004.</td>
<td>Department for Environment, Food and Rural Affairs</td>
</tr>
<tr>
<td>PSA</td>
<td>Lead/joint departments</td>
</tr>
<tr>
<td>--------------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Reduce the number of children in low-income households by at least</td>
<td>Department for Work and Pensions and HM Treasury</td>
</tr>
<tr>
<td>a quarter by 2004, as a contribution towards the broader target</td>
<td></td>
</tr>
<tr>
<td>of halving child poverty by 2010 and eradicating it by 2020.</td>
<td></td>
</tr>
<tr>
<td>Double the proportion of Parents with Care on Income Support and</td>
<td>Department for Work and Pensions</td>
</tr>
<tr>
<td>income-based Jobseekers' Allowance who receive maintenance for</td>
<td></td>
</tr>
<tr>
<td>their children to 60% by March 2006.</td>
<td></td>
</tr>
<tr>
<td>Over the three years to Spring 2006, increase the employment</td>
<td>Department of Work and Pensions</td>
</tr>
<tr>
<td>rates of disadvantaged areas and groups, taking account of the</td>
<td></td>
</tr>
<tr>
<td>economic cycle - lone parents, ethnic minorities, people aged 50</td>
<td></td>
</tr>
<tr>
<td>and over, those with the lowest qualifications, and the 30 local</td>
<td></td>
</tr>
<tr>
<td>authority districts with the poorest initial labour market</td>
<td></td>
</tr>
<tr>
<td>position, and significantly reduce the difference between their</td>
<td></td>
</tr>
<tr>
<td>employment rates and the overall rate.</td>
<td></td>
</tr>
<tr>
<td>Reduce the proportion of children in households with no one in</td>
<td>Department of Work and Pensions</td>
</tr>
<tr>
<td>work over the 3 years from Spring 2003 to Spring 2006 by 6.5%.</td>
<td></td>
</tr>
<tr>
<td>By 2006, be paying Pension Credit to at least 3 million pensioner</td>
<td>Department of Work and Pensions</td>
</tr>
<tr>
<td>households.</td>
<td></td>
</tr>
<tr>
<td>In fully operational programmes, achieve by 2005-06:</td>
<td>Sure Start, Childcare and Early Years PSA</td>
</tr>
<tr>
<td>◆ an increase in the proportion of young children aged 0-5 with</td>
<td>(responsibility for new unit to be allocated)</td>
</tr>
<tr>
<td>normal levels of personal, social and emotional development for</td>
<td></td>
</tr>
<tr>
<td>their age;</td>
<td></td>
</tr>
<tr>
<td>◆ a 6 percentage point reduction in the proportion of mothers</td>
<td></td>
</tr>
<tr>
<td>who continue to smoke during pregnancy;</td>
<td></td>
</tr>
<tr>
<td>◆ an increase in the proportion of children having normal levels</td>
<td></td>
</tr>
<tr>
<td>of communication, language and literacy at the end of the</td>
<td></td>
</tr>
<tr>
<td>Foundation Stage and an increase in the proportion of young</td>
<td></td>
</tr>
<tr>
<td>children with satisfactory speech and language development at</td>
<td></td>
</tr>
<tr>
<td>age 2 years; and</td>
<td></td>
</tr>
<tr>
<td>◆ a 12% reduction in the proportion of young children living in</td>
<td></td>
</tr>
<tr>
<td>households where no one is working.&quot;</td>
<td></td>
</tr>
</tbody>
</table>
### 2. PSAs across government concerned with other forms of inequality (ethnicity, gender, disability, special groups)

<table>
<thead>
<tr>
<th>PSA</th>
<th>Lead/joint departments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>Bring about measurable improvements in race equality and community cohesion across a range of performance indicators, as part of the Government’s objectives on equality and social inclusion.</td>
<td>Home Office</td>
</tr>
<tr>
<td>Improve the level of public confidence in the Criminal Justice System, including increasing that of ethnic minority communities, and increasing year on year the satisfaction of victims and witnesses, whilst respecting the rights of defendants.</td>
<td>Home Office (contributing to the Criminal Justice System PSA)</td>
</tr>
<tr>
<td>In the three years to 2006, taking account of the economic cycle, increase the employment rate and significantly reduce the difference between the overall employment rate and the employment rate of ethnic minorities.</td>
<td>Department of Trade and Industry and Department of Work and Pensions</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>By 2006, working with all departments, bring about measurable improvements in gender equality across a range of indicators, as part of the Government’s objectives on equality and social inclusion.</td>
<td>Department of Trade and Industry</td>
</tr>
<tr>
<td><strong>Disabilities</strong></td>
<td></td>
</tr>
<tr>
<td>In the three years to 2006, increase the employment rate of people with disabilities, taking account of the economic cycle, and significantly reduce the difference between their employment rate and the overall rate. Work to improve the rights of disabled people and to remove barriers to their participation in society.</td>
<td>Department for Work and Pensions</td>
</tr>
</tbody>
</table>
## Special groups

Improve life chances for children, including by:

- improving the level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75% of those achieved by all young people in the same area, and at least 15% of children in care attain five good GCSEs by 2004;
- narrowing the gap between the proportions of children in care and their peers who are cautioned or convicted.

Improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively to live at home to 30% of the total being supported by social services at home or in residential care.

Increase significantly the take-up of cultural and sporting opportunities by new users aged 20 and above from priority groups.

<table>
<thead>
<tr>
<th>PSA</th>
<th>Lead/joint departments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Special groups</strong></td>
<td>Department of Health</td>
</tr>
<tr>
<td>Improve life chances for children, including by:</td>
<td></td>
</tr>
<tr>
<td>- improving the level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75% of those achieved by all young people in the same area, and at least 15% of children in care attain five good GCSEs by 2004;</td>
<td></td>
</tr>
<tr>
<td>- narrowing the gap between the proportions of children in care and their peers who are cautioned or convicted.</td>
<td></td>
</tr>
<tr>
<td>Improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively to live at home to 30% of the total being supported by social services at home or in residential care.</td>
<td></td>
</tr>
<tr>
<td>Increase significantly the take-up of cultural and sporting opportunities by new users aged 20 and above from priority groups.</td>
<td>Department for Culture, Media and Sport</td>
</tr>
</tbody>
</table>

## 3. Public Service Agreements closely linked to Public Health

<table>
<thead>
<tr>
<th>PSA</th>
<th>Lead/joint departments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduce substantially the mortality rates from the major killer diseases by 2010: from heart disease by at least 40% in people under 75; from cancer by at least 20% in people under 75.</strong></td>
<td>Department of Health</td>
</tr>
<tr>
<td>Improve life outcomes of adults and children with mental health problems through year on year improvements in access to crisis and CAMHS services, and reduce the mortality rate from suicide and undetermined injury by at least 20% by 2010.</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008, and increase year on year the proportion of users successfully sustaining or completing treatment programmes.</td>
<td>Department of Health (contributing to the Action Against Illegal Drugs PSA)</td>
</tr>
<tr>
<td>PSA</td>
<td>Lead/joint departments</td>
</tr>
<tr>
<td>-------------------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>Enhance the take-up of sporting opportunities by 5-16 year olds by increasing the percentage of school children who spend a minimum of two hours each week on high quality PE and school sport within and beyond the curriculum from 25% in 2002 to 75% by 2006.</td>
<td>Department for Education and Skills and Department for Culture, Media and Sport</td>
</tr>
<tr>
<td>Increase voluntary and community sector activity, including increasing community participation, by 5% by 2006.</td>
<td>Home Office</td>
</tr>
<tr>
<td>Improve air quality by meeting our National Air Quality strategy objectives for carbon monoxide, lead, nitrogen dioxide, particles, sulphur dioxide, benzene and 1-3 butadiene.</td>
<td>Department for Transport and Department for Environment, Food and Rural Affairs</td>
</tr>
<tr>
<td>Reduce the harm caused by drugs by:</td>
<td>Home Office (contributing to the Action Against Illegal Drugs PSA)</td>
</tr>
<tr>
<td>◆ reducing the use of Class A drugs and the frequent use of any illicit drug among all young people under the age of 25, especially by the most vulnerable young people; and</td>
<td></td>
</tr>
<tr>
<td>◆ reduce drug related crime, including as measured by the proportion of offenders testing positive at arrest.</td>
<td></td>
</tr>
<tr>
<td>Reduce the availability of illegal drugs by increasing:</td>
<td>HM Customs and Excise (contributing to the Action Against Illegal Drugs PSA)</td>
</tr>
<tr>
<td>◆ the proportion of heroin and cocaine targeted on the UK which is taken out;</td>
<td></td>
</tr>
<tr>
<td>◆ the disruption/dismantling of those criminal groups responsible for supplying substantial quantities of class A drugs to the UK market; and</td>
<td></td>
</tr>
<tr>
<td>◆ the recovery of drug-related criminal assets.</td>
<td></td>
</tr>
<tr>
<td>By 31 March 2006 reduce illicit market share within the excise regime to no more than:</td>
<td>HM Customs and Excise</td>
</tr>
<tr>
<td>◆ 17% for tobacco;</td>
<td></td>
</tr>
<tr>
<td>◆ implement a strategy for reducing the scale of the VAT losses from March 2003.</td>
<td></td>
</tr>
<tr>
<td>Deliver more customer-focused, competitive and sustainable food and farming as measured by the increase in agriculture’s gross value added per person excluding support payments; and secure CAP reforms that reduce production-linked support, enabling enhanced EU funding for environmental conservation and rural development.</td>
<td>Department for Environment, Food and Rural Affairs</td>
</tr>
<tr>
<td>Protect public health and ensure high standards of animal welfare by reducing:</td>
<td>Department for Environment, Food and Rural Affairs</td>
</tr>
<tr>
<td>◆ the annual incidence of Bovine Spongiform Encephalopathy (BSE) to less than 30 cases by 2006; and</td>
<td></td>
</tr>
<tr>
<td>◆ the time taken to clear up cases of poor welfare in farmed animals by 5% by March 2004.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2

| A&E | Accident and Emergency |
| ABSSU | Adult Basic Skills Strategy Unit |
| AS | Action for Sustainability |
| BSE | Bovine Spongiform Encephalopathy |
| C&LHA | Cumbria & Lancashire Health Authority |
| C&MHA | Cheshire & Merseyside Health Authority |
| CAMHS | Child and Adolescent Mental Health Service |
| CAP | Common Agricultural Policy |
| CC | Cultural Consortium |
| CCC | Cheshire County Council |
| CCR | Cross Cutting Review |
| CDRP | Crime & Disorder Reduction Partnerships |
| CEDC | Community Education Development Centre |
| CGNW | Common Ground North West |
| CLHA | Cumbria and Lancashire Health Authority |
| CMHSDE | Centre for Mental Health Service Development in England |
| CPD | Continuing Professional Development |
| CRT | Crime Reduction Team |
| CYP | Children and Young People's Unit |
| DATs | Drug Action Teams |
| DCMS | Department for Culture, Media and Sport |
| DEFRA | Department for the Environment, Food and Rural Affairs |
| DEES | Department for Education and Skills |
| DH | Department of Health |
| DPAS | Drug Prevention Advisory Service |
| DTLA | Department for Transport, Local Government and the Regions |
| DWP | Department for Work and Pensions |
| FHTF | Food and Health Task Force |
| FRESA | Framework for Regional Employment and Skills Action |
| GMHA | Greater Manchester Health Authority |
| GO | Government Office |
| GODST | Government Office Drug Strategy Team |
| GONW | Government Office North West |
| HDA | Health Development Agency |
| HIA | Health Impact Assessment |
| HO | Home Office |
| HSE | Health and Safety Executive |
| HSDU | Healthy Settings Development Unit England |
| IgEA | Improvement and Development Agency England |
| IIA | Integrated Impact Assessment |
| LA | Local Authority |
| LACOTs | Local Authority Committee on Trading Standards |
| LDPs | Local Delivery Plans |
| LEAs | Local Education Authorities |
| LGAs | Local Government Association |
| LIFT | Local Improvement Finance Trust |
| LPS | Local Preventative Strategies |
| LSC | Learning Skills Council |
| LSPs | Local Strategic Partnerships |
| LTPs | Local Transport Plans |
| MACC2 | Making a Corporate Commitment 2 |
| MAFF | Ministry for Agriculture, Fisheries and Food. What is now DEFRA |
| MHAZ | Merseyside Health Action Zone |
| MHT | Mental Health Team |
| NGO | Non-Governmental Organisations |
| NHS | National Health Service |
| NHSS | National Healthy Schools Standard |
| NHSU | National Health Service University |
| NICE | National Institute for Clinical Excellence |
| NIHE | National Institute for Mental Health in England |
| NRF | Neighbourhood Renewal Fund |
| NSF | National Service Framework |
| NTA | National Treatment Agency |
| NWDA | Northwest Development Agency |
| NWFA | North West Food Alliance |
| NWP | North West Public Health Association |
| NWPHA | North West Public Health Observatory |
| NWPHT | North West Public Health Team |
| NWRA | North West Regional Assembly |
| OHN | Our Healthier Nation |
| PASA | Purchasing and Supply Agency |
| PAYP | Positive Activities for Young People |
| PCTs | Primary Care Trusts |
| PSA | Public Service Agreements |
| R&D | Research and Development |
| RDAs | Regional Development Agencies |
| RDC | Regional Development Centre |
| RDPH | Regional Director of Public Health |
| RES | Regional Economic Strategy |
| RIU | Regional Intelligence Unit |
| RoSPA | Royal Society for the Prevention of Accidents |
| RPAC | Regional Physical Activity Co-ordinator |
| RPA | Regional Planning Guidance |
| SBS | Small Business Service |
| SEU | Social Exclusion Unit |
| SHAs | Strategic Health Authorities |
| SMEs | Small and Medium Sized Enterprises |
| SSI | Social Services Inspectorate |
| UCLAN | University of Central Lancashire |
| VSNW | Voluntary Sector North West |
| WDCs | Workforce Development Confederations |
| WHO | World Health Organisation |
| YJB | Youth Justice Board |
Appendix 3

Useful Publications

A New Commitment to Neighbourhood Renewal, national strategy action plan. 2001.
Social Exclusion Unit, London.

North West Regional Assembly.


Health Opportunities for Older People in the North West.

Health Prospects for Young Citizens of the North West.


Reaching Out: the role of central government at regional and local level.

The Northwest Development Agency


Government Office for the North West / Office for the Deputy Prime Minister:


Department of Health, London


Sustainable Communities: building for the future. 2003. Office of the Deputy Prime Minister

Office of the Deputy Prime Minister


Cabinet Office, Department for Transport, Local Government and the Regions.
Copies can be downloaded from:

www.nwpho.org.uk
www.go-nw.gov.uk

**A PLAN FOR NORTH WEST ENGLAND 2003**

Further copies, including alternative formats can be requested from:

mbinvestmentforhealthplan@doh.gsi.gov.uk

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