



The East Midlands Health Strategy

Next Steps for Investment for Health

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Foreword/Executive Summary

The purpose of this document

This document has been prepared by the Regional Public Health Group on behalf of the East Midlands Regional Assembly, East Midlands Strategic Health Authority and the Government Office for the East Midlands.

It sets out the key health challenges facing the East Midlands region, and provides a strategic framework for action to address those challenges. It is not prescriptive – indeed, it places responsibility and accountability for deciding on health priorities and interventions firmly with local organisations and partnerships.

However, it does highlight those key issues, particularly the need to address health inequalities, which those local partnerships will be expected to address. It also sets out clear governance arrangements, and highlights the respective roles of regional, sub-regional and local organisations and partnerships in ensuring delivery.

It is aimed particularly at:

- **Board and Cabinet level members** of regional, sub-regional and local organisations whose activities impact on health, and
- **Commissioning/Service development managers** who have responsibility for assessing the needs of their populations and for planning, commissioning/implementing and monitoring delivery of services to meet those needs.

The strategic vision

The vision for the future of the East Midlands region, as outlined in the region's 'Integrated Regional Strategy (IRS), is that:

“The East Midlands will be recognised as a region:

- with a high quality of life and sustainable communities,
- that thrives because of its vibrant economy, rich cultural and environmental diversity, and the way it creatively addresses social inequalities,
- that manages its resources sustainably, and
- contributes to a safer, more inclusive society”.

In order to achieve this regional vision, good health is important because:

- it is a pre-requisite for a high quality of life;
- it is an important determinant of economic development, as it improves productivity and is a key factor in enabling economic participation;
- it is a basic human right;
- health inequality is perhaps the most fundamental social inequality.

The overall aim of this health strategy is therefore:

“To improve the health and well-being of everyone in the East Midlands and reduce the gap between the most and least healthy”.

Responsibility, accountability and governance

Improving health is too often seen as the sole responsibility of the NHS and health professionals. Whilst it is true that effective health-care and health-services have a significant role to play, the evidence suggests that, taken together, social, economic, behavioural, cultural and environmental factors have an even greater impact on health.

This health strategy aims improve the overall health of the population of the East Midlands, whilst at the same time reducing the stark and unacceptable inequalities which currently exist. It recognises that there are no simple solutions, and that action to tackle health inequality will require the input of many different individuals and organisations. Many of those organisations will not necessarily have 'improving health' as a priority objective. Nevertheless, they have the potential to make a big difference through their role as social, economic and environmental change agents.

Our strategic ambition will mainly be delivered at local level by local people, local organisations and local partnerships. To achieve success will require a clear understanding of local priorities, effective planning, sustained investment and effective actions.

The role of regional organisations and partnerships will be to:

- highlight and promote the vision,
- facilitate delivery, and
- co-ordinate and monitor progress towards its achievement.

To this end, regional organisations (and particularly those with responsibility for resource allocation, performance improvement and performance management) will be expected to confirm, challenge and agree the local priorities and actions mentioned above. Regional bodies will also 'hold to account' those local organisations and partnerships, ensuring that they achieve their agreed targets.

In order to meet their obligations, regional bodies themselves will need to collaborate and work in effective partnerships with one another. Working collaboratively will help ensure 'joined-up' regional and local delivery, adding value and minimizing duplication of effort.

Four Strategic Goals

In order to achieve **our strategic aim of improving health and reducing inequality**, we have identified **four strategic goals**:

- Goal 1** To secure effective leadership, governance and partnership arrangements.
- Goal 2** To promote 'better health' as a personal aspiration, corporate objective and shared responsibility for each individual and organisation in the region.
- Goal 3** To ensure that public services are designed, commissioned and delivered to include 'better and more equal health' as an outcome.
- Goal 4** To identify and promote high-impact, evidence-based interventions that will deliver better and more equal health.

1. The Next Stage for ‘Investment for Health’

‘Investment for Health’ (‘I4H’), the East Midlands regional public health strategy, was published in March 2003. It set out 16 objectives, grouped under the following four ‘themes’:

- addressing the determinants of health
- supporting healthy lifestyles
- protecting health
- health service provision

That strategy is now five years old. Since its publication in 2003, much has changed, in particular:

- the introduction in 2005 of Local Area Agreements,
- the major NHS re-organisation of 2006, and
- an increasing regional focus on addressing inequalities and promoting healthy and sustainable communities.

Local Area Agreements (LAAs) have fundamentally changed the relationship between central government and local areas. They give local services and partnerships greater freedom to set priorities and to agree local solutions to local challenges. At the same time, national government has delegated to ‘regions’ many of the ‘confirm and challenge’ and ‘performance management’ roles formerly undertaken at national level.

NHS reorganisation. The 2006 NHS reorganisation has greatly improved the potential for local and regional partnership working on health. There is now a single Strategic Health Authority (NHS-EM) covering the region. The SHA is coterminous with the regional Government Office (GO-EM), Regional Assembly (EMRA) and Regional Development Agency (emda). At local level, PCTs are now coterminous with ‘Top-Tier’ local authorities.

Regional focus on inequality. Inequality, particularly in health, has been increasingly recognised since 2003 as an over-arching priority for the East Midlands.

The SHA and its key regional partners have all committed themselves to reducing inequality.

- The Regional Assembly’s ‘Integrated Regional Strategy’ (IRS) highlights tackling social inequality as a key objective.
- Similarly, the 2006 Regional Economic Strategy (RES) has ‘Achieving Equality’ as one of its three top priorities.
- The Government Office for the East Midlands has ‘tackling health inequalities’ as one of its key priorities, and has published an action plan to help deliver on this commitment.

‘I4H’ remains relevant as a guide to the main health challenges facing the region. This update aims to provide a framework for delivery against those challenges, and which:

- provides a new focus on addressing health inequalities as well as improving overall health
- emphasises the importance of effective regional and local leadership and governance arrangements
- reflects the new emphasis on robust local priority setting, effective local delivery and strong and innovative partnership working.

2. Health and its determinants

‘Health’ and ‘Well-being’

The World Health Organisation (WHO) defines ‘health’ as:

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

For the purpose of this strategy, well-being is therefore considered as an integral component of health.

The determinants of health

Many factors influence and determine the health of individuals and populations. It is beyond the scope of this document to provide an exhaustive list or to describe how they interact one with another. However, the 1998 Acheson *Independent enquiry into inequalities in health* report concluded that:

“the weight of scientific evidence supports a socio-economic explanation of health inequalities. This traces the roots of ill health to such determinants as income, education and employment as well as material environment and lifestyle”.

Dahlgren and Whitehead have identified the key determinants, and have provided a visual interpretation of how they relate to each other, to communities and to individuals (Figure 1).

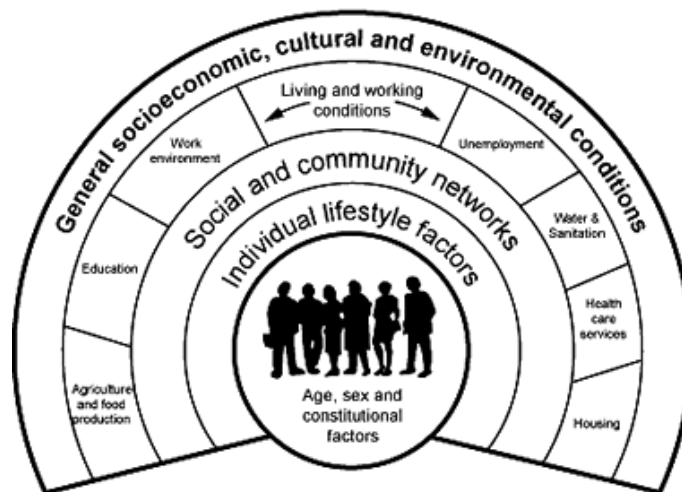


Figure 1. The main determinants of health (Source: G Dahlgren and M Whitehead, *Policies and strategies to promote social equity in health*, Institute of Futures Studies, Stockholm, 1991)

Health services and health-care are just one part of the overall picture. If we are to achieve our goal of improving health and reducing health inequality then all of the above determinants need to be addressed. That, in turn, requires concerted and integrated action by many partners.

3. Health and health inequality in the East Midlands

Sources of information

This section is intended to give a brief summary of the key health issues and challenges facing the East Midlands.

More detailed information is available from:

- The East Midlands Public Health Observatory (EMPHO) web-site <http://www.empho.org.uk>
- The annual report of the East Midlands Regional Director of Public Health <http://www.emphasisnetwork.org.uk/publications/rdphreport.htm>
- The annually updated local authority health profiles, available at: <http://www.communityhealthprofiles.info/>

Overall health in the East Midlands

In many respects, the experience of health by people in the East Midlands reflects that of England as a whole. Life expectancy at birth is close to the English average at 76.9 years for men and 80.7 years for women. It is improving at a similar rate to the rest of the country. People are living longer, mainly because fewer people are dying early from the major killers. Heart disease, stroke, cancer and Infant deaths are at an all time low within the region.

However, within this overall figure are some worrying statistics and trends.

High levels of tobacco use

Smoking remains the main avoidable cause of premature death in the UK and in East Midlands. On average, around 1 in 4 men and women in the region smoke, and around half of those individuals will die early as a direct result. Smoking-related ill health and disease is estimated to cause 16 out of every 100 deaths in the region. Smoking is the cause of enormous personal, social and economic loss.

High levels of obesity

Proportionately, more people are obese or overweight in the East Midlands compared with the national average. This is a problem not only among adults but also among children in the region. Obesity rates are rising rapidly, with serious implications for future rates of diabetes, cardiovascular disease and other conditions. Some commentators believe that the situation is so serious that the long-term improvement in overall life expectancy may be halted or reversed.

Low levels of physical activity

As few as 1 in 3 men and 1 in 4 women in the region participate in physical activity at a level sufficient to benefit their health. Participation rates decrease further as people get older.

High levels of harmful alcohol use

Moderate amounts of alcohol are enjoyed by many, and cause no ill effect. However, alcohol misuse, hazardous, harmful and binge drinking can lead to increases in violent and accidental injury, chronic alcohol abuse and long-term ill-health including chronic liver disease. In the East Midlands, it is estimated that alcohol misuse contributes to an estimated 2,000 deaths each year.

High levels of avoidable injury and death

Avoidable injury is a major cause of death and disability in the East Midlands. Around 1,000 people in the Region die each year from injuries sustained in accidents and death rates from avoidable injury in the East Midlands are among the highest in England. Around 37,000 people are admitted to hospital in the region each year as the result of an avoidable injury. Many more attend Accident & Emergency departments, visit their GP or have time off work or school.

Health inequality in the region

As noted above, the overall health of the East Midlands population is close to the English average. However, this overall picture hides significant variation and inequality.

It is not possible to give a comprehensive account of health inequalities here. What is clear, however, is that many communities and individuals (e.g. those living in more deprived areas, the disabled, unemployed people, travellers, migrants, etc.) suffer worse health compared with the regional average, and much worse health when compared with the healthiest people in the region.

The following examples illustrate the problem.

Life expectancy

Life expectancy is the most widely quoted indicator of health inequality. On average, people living in the more deprived areas of the East Midlands die younger than those living in more affluent areas. For example, in 2003-2005 a baby born in Rushcliffe (an example of an affluent local authority area) would expect to live, on average, around 5 years longer than a baby born in neighbouring Nottingham City.

Whilst the differences at Local Authority level are stark, the picture at a more local level is even more worrying. Within Nottingham City, for example, life expectancy at ward level differs by 11 years (ranging between 69 and 80 years).

Although life expectancy is increasing in both deprived and affluent neighbourhoods, it appears to be increasing more slowly in the more deprived areas. As a result, the inequalities gap is widening rather than reducing. The trend in health inequality across the region is of very great concern.

Self-reported health

According to the 2001 census, the proportion of the East Midlands population describing their general health as 'poor' is close to the English average at 9.1%. However, in South Northamptonshire it is just 5.8%, whilst in Bolsover it is 13.7%. Similarly, 12.9% of South Northamptonshire residents describe themselves as having a 'limiting long-term illness', whilst in Bolsover the percentage is 20.7%.

Ethnicity

There is a lack of reliable data on the health differences between diverse ethnic groups in the East Midlands. However, we do know, for example, that:

- 7.1% of 'Chinese', 9.6% of 'White British' and 19% of 'Pakistani' women residents of the East Midlands rated their health as 'not good' in the 2001 census.
- Data from the 2003 East Midlands Life and Work Survey indicated a substantially lower-than-average prevalence of smoking among Asian respondents. However, national survey data show wide variations within Asian groups with, for example, high prevalence in Bangladeshi men and low prevalence among women.

4. Health, work and the economy

The relationships between health, work and the economy are complex. However, what is clear is that there is a reciprocal relationship between work/the economy and health.

Evidence supports the following.

The impact of work on health

- Having a job is better for health than being unemployed; the unemployed are more likely to have poor mental health, to smoke and to die younger.
- Having a good quality job, particularly one that allows the individual worker a degree of personal autonomy, is better for health than having a poor quality job
- Although work is generally beneficial to health, the workplace can be a source of significant harm: job-related musculo-skeletal disorders, the most common occupational illness in Britain, affect one million workers a year; occupational stress is the second most common occupational illness, followed by accidental injury.

The impact of poor health on work and the economy

- Approximately 160,000 East Midlands residents of working age are currently excluded from the economic, social and health benefits of work because of long-term sickness or disability: a similar number do not work because they have caring responsibilities.
- Sickness absence has a significant negative impact on productivity. The East Midlands has the third highest level of sickness absence of the English regions. Each year, East Midland's workers take an average of 7.5 days off sick, representing a total of around 7.8 million lost working days, at a cost to East Midland's employers of an estimated £380 million).
- American research suggests that the healthiest 25 per cent of the work force is some 18% more productive than the least healthy quarter.

Health and the Regional Economic Strategy (RES)

This strategy and the RES complement each other. The economic strategy – *A Flourishing Region* – highlights a vision that, by 2020, the East Midlands will be a region characterised by:

- growing businesses,
- skilled people in good jobs,
- participating in healthy, inclusive communities, and
- living in thriving attractive places.

In short, it aims to deliver a region which is flourishing, with high levels of economic wellbeing and a quality of life amongst the best in the world – aspirations which, if achieved, will have a significant positive impact on health.

5. The East Midlands Regional Health Strategy: aims and objectives, goals and roles

Aims and objectives

The overall aim and goal of this strategy is

“To improve the health and well-being of everyone in the East Midlands and reduce the gap between the most and least healthy.”

To achieve this aim, we have identified four key objectives/goals for action:

- Goal 1** To secure effective leadership, governance and partnership arrangements.
- Goal 2** To promote ‘better health’ as a personal aspiration, corporate objective and shared responsibility for each individual and organisation in the region.
- Goal 3** To ensure that public services are designed and delivered to include ‘better and more equal health’ as an outcome.
- Goal 4** To identify and promote high-impact, evidence-based interventions that will deliver better and more equal health.

Further detail of these goals is given in the following chapters 6-9.

6. Goal 1: Securing effective leadership, governance and partnership working

Successful delivery of this strategy will require:

- a clear understanding of the key challenges and priorities, and the action required to effect change
- strong and effective leadership,
- clear lines of accountability and governance, and
- effective partnership working.

These requirements apply at both regional and local level.

Local responsibilities

The primary responsibility for delivery of the strategy will lie with local organisations and partnerships. They best understand local circumstances and the needs of their populations. They also manage much of the financial and human resource on which delivery depends.

Regional responsibilities

The regional role is primarily to

- provide strategic vision, leadership and co-ordination, taking into account regional as well as local priorities,
- challenge, confirm and agree the priorities and plans developed by local areas,
- hold local organisations and partnerships to account, and
- provide support and help as a 'critical friend'.

In addition, the responsibilities of some regional level organisations (e.g. emda, Natural England, etc.) include both regional strategic and local delivery functions. Their contribution to delivering this strategy will cut across both local and regional partnerships.

The Local Area Agreement (LAA) governance model

LAAs are the mechanism by which much of central government policy is now delivered at local level. They are intended to:

- set out the priorities for a local area as agreed between central government and Local Strategic Partnerships.
- allow greater flexibility for effective local solutions, tailored to local circumstances
- reduce bureaucracy

The LAA model therefore offers the most appropriate mechanism for delivering the cross-cutting aims and objectives of this health strategy.

Leadership, governance and partnership at local level

The primary responsibility and accountability for delivery of this strategy rests squarely with local organisations and partnerships. Whilst PCTs and the NHS have a significant role to play, improved health will only be delivered if all of the local partners act in concert.

As highlighted elsewhere in this document, a great many local partners have the potential to make a big impact on improving health through the design and delivery of their own programmes and services. Public sector organisations, the private and voluntary sectors all have their contribution to make. The local

governance arrangements should ensure that there is engagement by, and with, all of the appropriate stakeholders.

Governance arrangements for delivery of this strategy will vary between local areas according to local circumstances and priorities. However, applying the LAA model of governance suggests that the roles of Local Authorities (LAs) and of Primary Care Trusts (PCTs) will be particularly important.

Primary Care Trusts (PCTs)

PCTs have the lead responsibility for improving and protecting the health of their populations, and for ensuring the provision of accessible and high quality health-care services. They are also responsible for ensuring that the nature and delivery of those services takes full account of the need to reduce health inequalities.

At the same time, PCTs have wider partnership responsibilities in areas for which they do not have lead responsibility. For example, the PCT contribution to local transport, leisure and green infrastructure plans might offer opportunities to encourage walking or cycling in the general population. Local NHS organisations might begin to provide incentives to their own staff to encourage healthy and less polluting travel options, and to encourage other local employers to do the same.

Local authorities

Local authorities have overall responsibility for leading and developing their LAA, and for agreeing it with regional government offices acting on behalf of central government. Their role in leading the LAA process, and in providing democratic accountability for its priorities and content, means that they will be key agents in securing effective delivery of this strategy. They also have a key scrutiny role in terms of the performance of their local NHS.

Leadership

Local delivery of this strategy will require effective leadership and direction within each local area. Given the importance of LAs and PCTs in delivering this strategy, it seems appropriate that the local Director of Public Health, particularly where he/she holds a joint appointment across both organisations, be required to take on that responsibility.

Leadership, governance and partnership at regional level

The roles and responsibilities of regional level organisations are summarised above.

We expect to use the LAA governance arrangements as the primary mechanism for ensuring delivery of this strategy. However, we recognise a need for some form of formal regional health partnership group. We shall consult with partners and stakeholders regarding the function and composition of this group. It seems likely that such a group would need, amongst other functions, to:

- agree and shape the continuing vision for health in the region
- agree a joint regional work programme to underpin the strategy
- co-ordinate the work of regional bodies to ensure consistency of approach and to minimise duplication of effort
- collectively hold its members to account for those aspects of delivery which depend on regional intervention and activity.

The government's sub-national review (SNR) will significantly alter the regional landscape over the next few years. Governance arrangements for this strategy will need to be kept under review during this time. At the time of writing we envisage that this strategy will be jointly and formally agreed by:

- **East Midlands Regional Assembly (emra)** as the lead body for co-ordination and integration of regional strategies.
- **NHS East Midlands Strategic Health Authority (NHS-EM)** as the strategic headquarters of the NHS in the region
- **Government Office for The East Midlands (GO-EM)** as the hub of central government in the East Midlands, responsible for agreeing LAAs with local authorities and partnerships.

Regional leadership

The Regional Director of Public Health, as

- health advisor to the Regional Assembly
- member of the board of the Strategic Health Authority and
- member of the board of the Government Office

will be responsible for leading regional delivery of this strategy.

Regional partnerships

Many regional agencies and organisations will have a partnership role in delivering this strategy, and we hope to gain both their formal agreement to its aims and goals, and their commitment to its delivery.

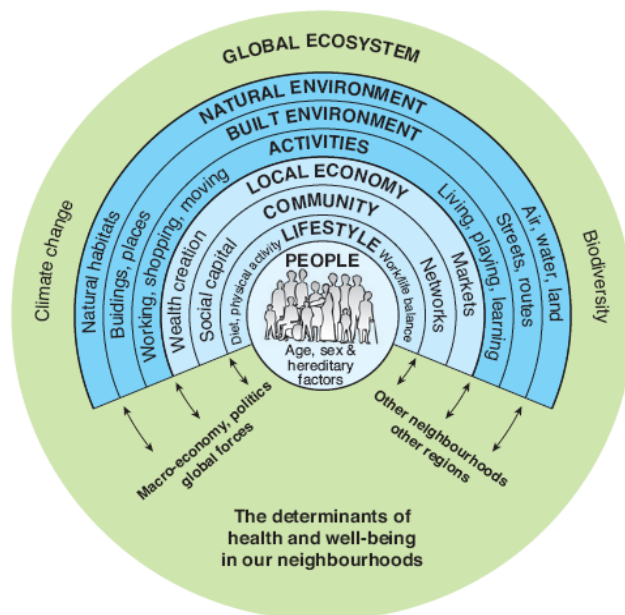
7. Goal 2: To promote better health as a personal aspiration, corporate objective and a shared responsibility

Many different factors influence the way we choose to live our lives.

Our personal feelings and interests, our family, friends and community, where and how we live and work, and our interactions with the natural world all affect our behaviours.

The figure below attempts to show this in diagrammatic form.

The health map



Our second goal is therefore to encourage and empower individuals, communities and organisations across the East Midlands to:

- want to improve health
- know how to improve health
- take action to improve health.

Individuals

Through joint action, we will encourage all individuals, young and old, within the East Midlands to aspire to better health.

People in the East Midlands will want, and know how, to achieve Better Health. They will want to ‘add years to life and life to years’ by making healthier choices and changing things to help them lead healthier lives at home, school and work.

Communities and organisations

Many of the factors affecting health are beyond the control of individuals. These factors need to be addressed by the wider community and by public, private and third sector organisations which have the necessary power, influence and resources.

In particular, we will

- encourage and empower communities to take responsibility for improving their own health

and we will encourage public, private and third sector organisations to

- design and provide their products and services in ways which will help to improve the health of clients, customers and the wider community (see Chapter 8). Health Impact Assessment is a useful tool to help with this
- take active steps to improve and protect the health of their own workforce, and
- behave at all times as 'good corporate citizens' (see also Chapter 8).

The Kings Fund publication, *Claiming the health dividend – unlocking the benefits of health spending*, highlights the ways in which corporate actions taken by public organisations such as the NHS can reap major public health benefits.

8. Goal 3: To ensure that public services are designed, commissioned and delivered to include ‘better and more equal health’ as an outcome

In chapters 2 and 7 we noted the wide range of influences on, and determinants of, health and health inequality. As a result, a wide range of public sector organisations are involved in, or have responsibility for, services that have a direct or indirect effect on health.

In some cases (e.g. the NHS, LA environmental health), protecting and improving health is a key function of the service. In others (e.g. transport, housing) the impact on health may be significant and yet peripheral to the primary role of the service.

Goal 3 of this strategy aims to ensure that:

- those organisations (such as the NHS) which have ‘health’ as a key responsibility, ensure that services are specifically designed, commissioned and delivered so as to both improve health and reduce health inequalities
- those organisations which have a significant but peripheral (to their key objective) impact on health are encouraged to maximise their positive impact on health and health inequality
- all organisations are encouraged to behave as good corporate citizens. This means behaving in ways that maximise the positive social, economic and environmental impacts of their activities.

The ‘Inverse Care’ law

The inverse care law was originally set out by Julian Tudor Hart in 1971. It states that

“the availability of good medical care varies inversely with the need for it in the population served”.

There is strong evidence to suggest that 37 years later, the ‘inverse care law’ still applies in many areas of the East Midlands. By comparison with more affluent areas, those individuals and communities at greatest risk of ill health frequently experience poorer levels of service. They are also less likely to access services, and when they do, they are likely to receive less effective treatment or prevention.

Although the inverse care law was formulated with medical care in mind, it almost certainly applies across a range of public services.

If our aim of reducing health inequalities is to be achieved, then we need to improve and modernise the way in which public sector services, and particularly health and social care, are designed, commissioned and delivered. We need to ensure that, in future, availability of medical care and other services is directly, not inversely, related to need.

This will be achieved through:

- a robust and thorough assessment of the needs of the population (including a ‘Joint Strategic Needs Assessment’ by the local authority and PCT)
- a full assessment of proposed service developments and delivery plans to ensure that they meet the requirement to reduce health inequality

- ongoing review and audit of services to ensure that they continue to meet the assessed needs; in particular, services need to be reviewed to ensure that those with the greatest need are indeed accessing and benefiting from the service
- a renewed focus on prevention and behavioural change, as recommended by the Wanless report to the Treasury (see Chapter 8).

Good corporate citizenship

Improving the social, economic and environmental status of the region will improve health. It is therefore important that all organisations play their part in that socio-economic improvement.

In addition to the services they provide, organisations like the NHS and Local Authorities have major social, economic and environmental roles. The NHS, for example, is the biggest employer in the East Midlands, and it accounts for up to 10% of the total regional economy. It is a major procurer of goods and services, owns a large estate of land and buildings, generates large quantities of waste, and is one of the biggest regional consumers of energy.

The ways in which the NHS and other organisations manage their affairs therefore have the potential to bring significant health benefits.

Climate change

Climate change is, according to the government's former chief scientific adviser, the greatest challenge facing human society. It is, arguably, the single greatest threat to human health over the coming decades, and its global impact will not exclude the East Midlands. The Region should therefore be at the forefront of action:

- to reduce future warming ('mitigation'), particularly through action to reduce greenhouse gas emissions, and
- to prepare for ('adaptation') the health impact of the climate change that is already inevitable as a result of human activity since the start of the industrial revolution.

9. Goal 4: To identify and promote high-impact, evidence-based interventions that will deliver better and more equal health.

The burden of ill-health in the East Midlands is due mainly to cancers, diabetes, stroke, respiratory disease and coronary heart diseases.

It is estimated that around a third of the total disease burden is linked to lifestyle and related factors such as smoking, excessive intake of sugar, fat, salt and alcohol, and low levels of physical exercise.

These lifestyle factors are, in turn, related to wider structural and socio-economic factors such as social status, education, income and poverty, housing etc.

The 'Wanless' Report and its implications

In 2001, Derek Wanless, was commissioned by the government to investigate and report on the future funding of the NHS. In his resulting report, *Securing our future health*, he identified a number of potential scenarios, from amongst which he identified what he termed the 'Fully Engaged Scenario' as the only appropriate and affordable way forward.

The fully engaged scenario is characterised by:

- an increase in health seeking behaviour
- an increase in demand for lifestyle risk prevention
- an increase in self-care
- a more equal and active partnership between health professionals and the public, and
- a high uptake of appropriate health technologies.

This strategy fully supports the Wanless conclusions. It recognises that that the only practical and affordable way of improving health is through a balanced package of:

- socio-economic development,
- 'upstream' (preventative) interventions to promote good health and healthy behaviours, and
- the appropriate use of cost-effective health technologies.

Socio-economic development is of key importance in delivering improved health. However, its impact on health is likely to be seen in the long, rather than short-to-medium term. For the purposes of Strategic Goal 4, we will concentrate on identifying and promoting the use of the 'upstream' (preventative) and 'cost-effective health technologies' strand of the Wanless recommendations.

It is not the purpose of this strategy to be prescriptive with regard to local priorities and actions – however, it is appropriate to consider briefly some of the likely key areas for intervention, and the way in which the most appropriate and effective interventions might be identified and disseminated.

‘Upstream’ interventions to promote good health and healthy behaviours

As noted above, a very significant proportion of the region’s burden of disease is as a direct result of:

- smoking
- alcohol
- diet
- lack of exercise.

In the medium to long term:

- **climate change** is probably the greatest threat to the region’s health.

It is therefore likely that most, if not all, of our local area partnerships will see these five topics as relative priorities for action.

In collaboration with local and regional partners, we will identify the key local and regional priorities. We will highlight and share those interventions that the evidence suggests offer the greatest impact and represent the best value, and we will seek to ensure that they are implemented as part of local delivery of this strategy.

We have already established a regional support group that is working with local organisations and partnerships to take this work forward.

Supporting people to give up smoking is an example of the sort of evidence-based intervention that this work-stream will highlight. The evidence suggests that smoking cessation is more cost-effective than virtually any other NHS intervention. Work undertaken in the West Midlands suggests that, by the end of year 2, all of the costs associated with supporting people to quit through support and medication will be recouped. By year 5, cumulative savings are more than four times the original investment.

Reducing harm due to alcohol misuse offers a good example where partnership working at a local level may offer considerable added value. Joint initiatives involving the NHS, police, local authorities, licensed premises owners etc. have the potential to make a significant difference.

Interventions to increase uptake of healthier food (e.g. by giving better information on food labels, changing the range of food available, and making healthy options cheaper than less healthy options) have been shown to increase healthier eating. Reducing the price of low-fat snacks in vending machines also significantly increases sales of such foods.

Increasing levels of physical activity through healthy walking and/or cycling offers a low cost, effective and inclusive intervention. Partnership focused projects, often led by voluntary sector organisations, but supported by both public and private sector bodies to ensure sustainability, offer one way forward.

Climate change interventions. The recently published *East Midlands Climate Change Programme of Action* (available on the EMRA website) provides an excellent summary of the actions required to address climate change in the East Midlands.

Appropriate use of cost-effective health technologies

Although this strategy proposes a much increased emphasis on ‘upstream’ interventions affecting lifestyle, health behaviours and health promotion, medical care and health technology will continue to have an important role in reducing mortality and morbidity in higher risk individuals and communities.

If we are to improve health and reduce inequality then we must ensure that:

- health services are designed, commissioned and delivered fairly and equitably to address health needs and to reduce health inequality
- access to appropriate and cost-effective treatment is based on an assessment of need and not on historical patterns of provision
- health technologies are rigorously appraised, and their use based on a proper assessment of cost-effectiveness
- local health services will be expected to demonstrate that they are designing, commissioning, and delivering health-care services that meet these requirements, in line with the obligations set out in 'World-Class Commissioning'.