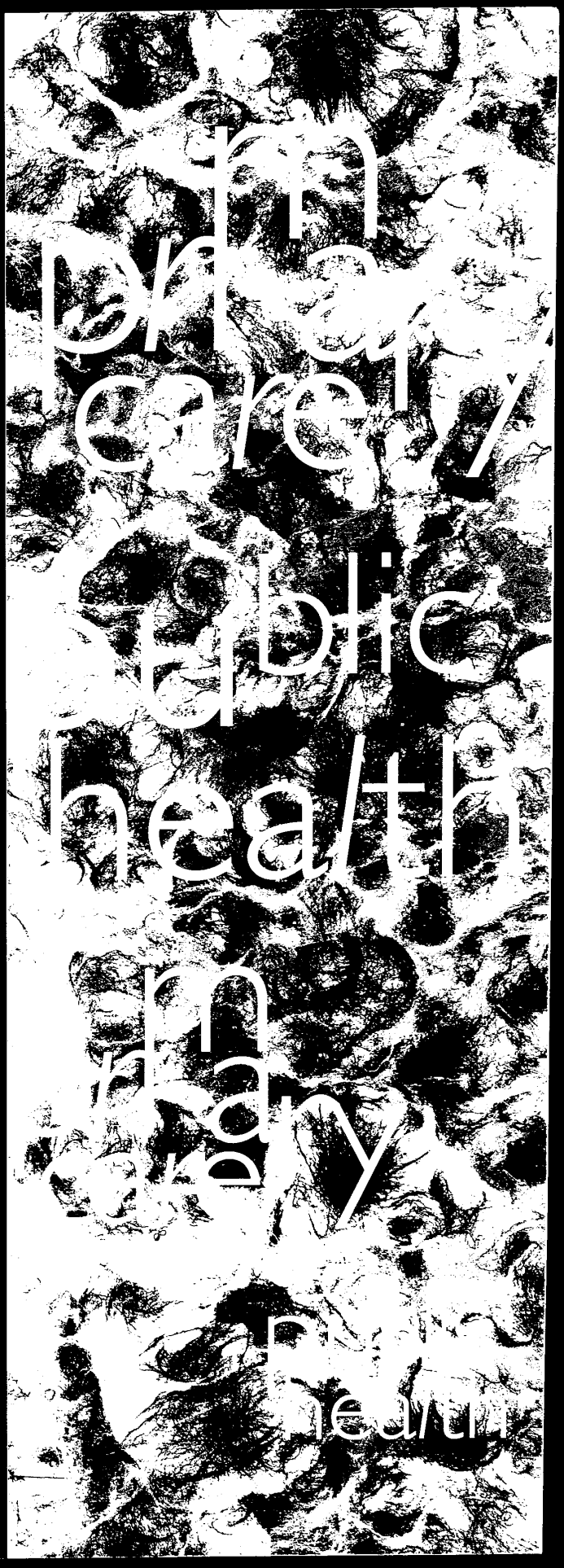
King's Fund

Developing Health Improvement Programmes

Lessons from the first year

Shona Arora
Anne Davies
Sarah Thompson



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SUMMARY

Health Improvement Programmes (HImPs) are a key innovation in the Government's health policy. They are intended to bring together the main statutory and voluntary bodies in each health authority area, to plan and deliver measures to improve the health of the local population. The first round of HImPs was completed by April 1999. The next is due for submission by September 1999.

What can be learned from the first round? What worked well and what problems have arisen? The King's Fund carried out a rapid appraisal early in 1999, exploring the experiences of selected London-based health authorities, local authorities and primary care groups. They were asked about their perceptions of HImPs, the structures and processes involved in developing partnerships, approaches to priority setting and health inequalities, and public involvement and accountability. The following themes emerged from the study as a whole.

A positive response

Across all three sectors, there is good will and enthusiasm for the concept of HImPs, especially the new commitment to tackling health inequalities, to partnership working and to addressing the wider determinants of health. There is optimism that HImPs will encourage new ways of working that have potential to improve health. However, those working in the public sector, particularly in the NHS, are at risk of being overwhelmed by the pace of change

Changing roles and responsibilities

The future of health authorities is uncertain as primary care groups develop. This has implications for their partnership with local councils, which is intended to be central to the development of HImPs. The role and location of public health expertise is also called into question. If HImPs are to function properly as strategic frameworks for commissioning services, able to influence patterns of expenditure, they must not come

to be seen merely as the property of public health departments. But public health could play a key role in ensuring that evidence on effectiveness and efficiency is collected and used to inform action generated by the HImP.

Working in partnership

Successful partnerships require tangible outcomes and positive engagement of all partners. There must be a clear, shared vision of what health improvement means in each locality, well-defined roles and responsibilities, respect for cultural differences between partners, and agreed procedures for setting priorities. Sharing information is important but raises ethical difficulties, which can be a stumbling block. It is important that partnership processes do not become an end in themselves. Leadership of the HImP process may not remain with health authorities indefinitely – it may become appropriate for local authorities to assume leadership of health improvement in some localities. But it is less likely that PCGs will be suitable lead agents in a district wide strategy. The balance between local and national priorities may be a source of potential conflict.

Public involvement

This can help to improve responsiveness to local needs, to build the capacity of local communities and to strengthen public sector accountability. Problems include: presenting information in accessible ways, showing willingness to act on the public's views, and deciding whom to involve and how. Opportunities for involving the public as citizens, rather than just as service users, remain inadequate. 'User fatigue' is a danger and there is a strong case for one partner co-ordinating public involvement on behalf of the HImP partners. Local councillors, suitably prepared, could play an enhanced role in health improvement, working closely with PCGs, and could help make the process more accountable.

Resources

For HImPs to work, resources must be channelled into appropriate activities, including those beyond health and social services. Tighter links between the HImP

and the planning cycles of other programmes would facilitate the redistribution of core resources. Since acute trusts currently command the lion's share of health resources, their co-operation is needed if funds are to be redistributed, but their traditional priorities must not be allowed to dominate. There is often a significant financial shortfall within health budgets, which will, in any event, limit the scope for funding HImP-related activities. The problem of transferring funds between health and local authorities remains unresolved. Strong political signals that health improvement is as much a priority as, say, waiting lists, could help. But leadership from the centre must not crowd out local ownership and flexibility.

Measuring progress

The HImP must be capable of translation into practical action if those in the front line of service delivery are to share 'ownership'. Each of the partners must be able to demonstrate progress. A range of indicators, including process and outcome measures, as well as health and social factors, will be needed. Some indicators can be shared across professional and sectoral boundaries. Evaluation must be a means to an end, not an end in itself, and findings should be presented to the public as a health promotion opportunity. Public understanding, support, and engagement is vital to the HImPs' success.

Key findings

Responses from interviewees in the three settings are described and analysed in the report and summarised here. These include: concerns about HImPs in general, opportunities, problems and challenges, and recommendations for action for each of the sectors involved in the study.

Opportunities provided by the HImPs

For health authorities, local authorities and primary care groups

- to spread the public health agenda more widely, not only through the health sector but also beyond it
- to share responsibility between organisations for improving the health and well being of local populations
- to address the wider determinants of health beyond the health service, tackling deep-seated social as well as health problems
- to tackle health inequalities and inequities in access to health and other services
- to extend partnership working beyond joint work between health and social services departments

In addition, HImPs provide an opportunity:

- for *health authorities* to aid the development of primary care
- for *local authorities* to develop a new role in the formulation of health strategy and to extend the scope for community development
- for *primary care groups* to improve multi-professional working, move resources from secondary to primary health care, and to improve the quality of primary care

Problems and challenges presented by the HImPs

For health authorities

- ownership across the authority – the HImP may be marginalised within the public health department
- use of resources needs to be influenced by the HImP as well as by acute service pressures
- tension between the need for strategic vision and for 'quick wins'
- possible conflict between national and local priorities
- how to involve the public effectively

For local authorities

- how to convert strategy into action
- how to engage the authority corporately, not only through social services departments
- finding social indicators relevant to the contribution the boroughs can make
- performance management and measuring progress towards agreed targets
- identifying resource implications of local authorities' role in implementing the HImP
- limited scope for diversion of funds to pursue HImP objectives – new initiatives other than social services are so far dependent on 'slippage' in existing budgets
- engaging public support – how to consult the public effectively and avoid wasteful duplication of time and effort
- developing a constructive role for elected representatives in the health improvement partnership

For primary care groups

- overload – too many changes to implement simultaneously in too short a time
- minimal infrastructures affecting the capacity to deliver – most board members have other jobs
- lack of resources to implement change

- need to measure and demonstrate progress
- developing ownership of the HImP across the whole primary care team
- limited public accountability – the need to engage with the wider community on whose behalf commissioning takes place

Action required

By health authorities

- develop a clearer vision of health improvement throughout the authority as well as with partner organisations
- develop public health capacity in partner organisations
- introduce more systematic priority setting processes
- make the links between HImPs and resources more explicit, and at an earlier stage
- develop processes that extend the sense of ownership of the HImP to partner organisations such as local authorities, trusts and PCGs
- identify appropriate performance indicators for the HImP process

By local authorities

- incorporate health improvement objectives in all areas of policy for which local authorities have responsibility
- conduct health impact assessment of local authority policies where appropriate
- rapidly acquire the necessary public health expertise to participate fully in the partnership and avoid risk of domination by the 'acute service' perspective
- establish links with PCGs
- obtain some 'quick wins' to demonstrate the value of partnership in HImPs
- pool resources with health authorities, e.g. information systems, premises, personnel, consultation mechanisms
- find a meaningful role for elected representatives (councillors), possibly linking with PCGs

By primary care groups

- develop a greater shared understanding of health improvement locally, including the roles and responsibilities of different agencies
- ensure that perspectives other than those of GPs can be expressed
- strengthen basic structures and processes, e.g. consultation, priority setting, public involvement
- use existing information from primary and community care to identify local needs and inform priorities
- involve the whole primary care team in the delivery of HImP
- develop meaningful indicators, process as well as outcome-based, to monitor progress
- use professional development opportunities to enhance both multi-professional and multi-sectoral working
- work with health and local authorities to develop and complement strategies for public participation and accountability

By primary care groups

- develop a strategy [illegible]
- the roles and responsibilities [illegible]
- ensure that people [illegible]
- strengthen [illegible]
involvement
- use existing [illegible]
and inform [illegible]
- [illegible]
- develop [illegible]
process
- use [illegible]
[illegible]
- [illegible]

INTRODUCTION

This report presents findings from a rapid appraisal of a selected sample of organisations in London to assess the development of Health Improvement Programmes (HImPs). The aims of the study were to:

- explore the process of developing the first HImP from the different perspectives of key players in the partnership
- identify and share what went well and why
- identify and explore difficulties that need to be addressed in future
- identify areas for further research

This study complemented a rapid appraisal of HImPs in the 16 London health authorities carried out by the NHS Executive London Regional Office at a similar time.[1]

We sought views and experiences of people in health authorities, London boroughs and primary care groups (PCGs) who had been closely involved with developing their HImP. We recognise that the HImP process is more inclusive than this, and must involve other partners such as hospital and community trusts, the voluntary sector, users and carers, as well as the wider public. However, for pragmatic reasons we chose to focus on the three agencies likely to be most involved in HImP development at this stage.

The first round of HImP development occurred at a time of considerable change in both the health and social sectors, one example being the formation of PCGs, which were beginning to function in 'shadow' form by early 1999. Because of this, and the

short timescale of the study (March to May 1999), the findings refer to 'work in progress' rather than a definitive assessment of Health Improvement Programmes. Nevertheless, we believe that they provide insights into the challenges that need to be overcome if current policy is to fulfil its promise.

THE POLICY CONTEXT

The Government's proposals for HImPs were first set out in *The New NHS: Modern and Dependable*[2] in December 1997. The White Paper outlined a raft of radical changes to the overall structure of the NHS, and placed HImPs at the centre of its health improvement policy. Other elements of reform included proposals for a statutory duty on health authorities to improve the health of their population and a statutory duty of partnership placed on all NHS bodies to work together for the common good. This will extend to local authorities, strengthening existing requirements under the NHS Act 1977. A new duty will be placed on local authorities to promote the economic, social and environmental well being of their areas:

> *'This will ensure they have clear powers to develop partnerships with a wide range of other organisations, including NHS bodies, to address the needs of local communities'*

The White Paper also proposed the establishment of primary care groups (PCGs) to take on responsibility for commissioning health services and for developing primary and community services. Their development will have a significant impact on the role of health authorities, which are likely to become more concerned with strategy and monitoring.

Our Healthier Nation[3] sets out the Government's strategy on public health, and replaces The Health of the Nation policy of the former Conservative Government. The aims of *Our Healthier Nation* (*OHN*) are to increase life expectancy, reduce disability and reduce health inequalities. Four national priorities are proposed: *coronary heart disease* and *stroke, cancer, mental health,* and *accidents.*

The subject of priorities is also dealt with in *Modernising Health and Social Services: National Priorities Guidance 1999-2001*,[4] which sets out Government plans for tackling inequality and improving health over the next three years. The national priorities contained in this document include the priorities described in *OHN*, together

with other areas for action. Although health and social services are expected to work in partnership for some priorities, for others the lead is specified as either one or the other (see Box 1).

Box 1

Social Services Lead	*Shared Lead*	*NHS Lead*
Children's' welfare	Cutting health inequalities	Waiting lists/times
Inter-agency working	Mental health	Primary care
Regulation	Promoting independence	Coronary heart disease
		Cancer

Source: National Priorities Guidance 1999/2000 – 2001/02

National priorities must be taken into account by health authorities in their financial plans before any local priorities are selected. Health authorities are required to develop action programmes with measurable outcomes, which local services must pursue.

Health authorities are required to produce Service and Financial Frameworks (SaFFs), which must reflect the HImP. The two documents are submitted simultaneously to Regional Offices of the NHS. Joint Investment Plans, as required in *EL(97) 62 / CI(97)24 Better Services for Vulnerable People,*[5] are also an integral part of the HImP process.

Another important element of Government policy is the development of National Service Frameworks (NSFs), which deal with standards of care required in specific health services. An NSF for cancer is already published, and frameworks on CHD and Stroke, and Mental Health are expected mid-1999. These frameworks must be taken into account in local HImPs, as well as any guidance from NICE (National Institute for Clinical Excellence).

Local government reforms were described in *Modern Local Government: In Touch with the People,* a White Paper from the Department of Environment, Transport and the Regions.[6] It planned to give councils discretionary powers to engage in partnership arrangements with other bodies, including NHS bodies. It also placed new emphasis on councils' role in economic and social regeneration, and on greater public participation in services. The White Paper *Modernising Social Services*[7] amplified the partnership theme and signalled the Government's intention to surmount problems caused by the 'Berlin wall' dividing health and social services. It also recognised the need to extend partnership to housing, employment, education and criminal justice systems. The White Paper also introduced a Social Services Modernisation Fund to cover major changes and new grants to promote independence as an objective of adult services.

The purpose of partnership working between health and local authorities (among other agencies) is to develop services which are 'user-based' rather than 'producer-led'. Its importance is further emphasised in the Government discussion document *Partnership in Action.*[8] This focuses on joint working between health and local authorities and envisages the HImP as an important vehicle that will replace previous joint working structures such as Joint Consultative Committees. It aims to encourage 'innovative cross-sectoral working' and proposes a number of innovations:

- 'pooled budgets', which will enable health and social services to pool resources in a joint budget accessible to both commission and provide services
- 'lead commissioning' whereby one authority transfers funds and delegates authority to another for the commissioning of both health and social care (e.g. for a specific group such as the elderly)
- 'integrated provision', which allows a provider to deliver services beyond the level possible under current powers

Specifically relating to HImPs, the transfer of money under section 28A of the NHS Act 1977 will be extended to a wider range of local authority services, and a

reciprocal power will enable local authorities to transfer funds to NHS bodies to support objectives set out in the HImPs.

On the subject of monitoring, *Partnership in Action* states that joint national priorities guidance for both the NHS and social services will be issued, as well as new performance frameworks, and the Government has stated its intention to explore how health and social services could jointly review their services 'at the interface' as well as considering how the Commission for Health Improvement, the Social Services Inspectorate and the Audit Commission can jointly inspect services.

A tight timetable was imposed for the development of the first HImPs. They cover the period 1999-2000 and were expected to be ready by mid-January 1999, at the same time as the first SaFFs. It was acknowledged that the first HImP would not be comprehensive but would have limited objectives. It was seen as a key priority for the first year to build and strengthen local partnership arrangements. For subsequent years the HImP will work to 'a less tight timetable'.

Guidance on the development and delivery of Health Improvement Programmes is contained in *Health Improvement Programmes – Planning for Better Health and Health Care*,[9] which sets out a rolling programme for fully-developed HImPs to be in place by 2002. It describes the basic function of HImPs as embodying the Government's aim of building high quality services and strong communities:

> *'They are, in essence, the local plan of action to improve health and modernise services. The HImP process should bring together the local NHS with local authorities and others, including the voluntary sector, to set the strategic framework for improving health, tackling inequalities, and developing faster, more convenient services of a consistently high standard'.*

HImPs will provide a strategy for action on local as well as national priorities. Each HImP will run for three years (to be reviewed annually) and must focus, for one year

at least, on two national priorities from *Our Healthier Nation*, and two local priorities. These must be developed by local partners in the HImP using local information on health need, and taking guidance from such sources as the Acheson Report, *Independent Inquiry into Inequalities in Health,*[10] and the local annual report of the Director of Public Health.

The guidance also sets out core contents of the HImP, which will be:

- needs assessment
- resource mapping
- identification of priorities for action
- strategies for change
- a Service and Financial Framework (SaFF) for the NHS

As well as being action focused, the HImP must include summaries of how each partner organisation will work to achieve its objectives. They are intended to be inclusive by bringing together all those with an interest in and responsibility for health. Although health authorities will lead the development of the HImP, emphasis is placed on:

> *'the widest possible involvement from the outset, rather than consultation on a near-final product'.*

Health authorities must work not only with partner organisations but with a wide range of local interests, which include not only users and providers of local services but others 'with an interest or a contribution to offer', which includes universities, Training and Enterprise Councils, Trade Unions, local schools, employers, businesses and the Health and Safety Executive.

Guidance anticipates the local authority being engaged corporately,

> *'since action on the determinants of health will span the range of local authority responsibilities'.*

Guidance on monitoring and accountability arrangements focuses on performance management, and on:

> *'annual public reporting of progress against objectives and targets as the HImP is rolled forward'.*

As part of *Our Healthier Nation* strategy there will be plans to measure progress towards health targets:

> *'Local authorities may want to set goals in terms of wider determinants of health, such as air quality, the housing stock, or progress on anti-poverty strategies, that in turn will contribute to health improvement targets'*

The Government has also stated that it is considering ways in which crosscutting indicators may be developed within the core 'general health' indicators, which will:

> *'give expression to the overall effectiveness of the local authority'*

HImPs are also required to show how resources will be spent to modernise services and achieve better health for local people.

The development of the first HImP coincided with the setting up of PCGs, a programme of change that presented a formidable challenge to health authorities.

There are four options for the form which PCGs may take:

Box 2 : The four levels for PCGs

1. (At minimum), to support the health authority in commissioning care for its population, acting in an advisory capacity
2. To take devolved responsibility for managing the budget for healthcare in their area, formally as part of the health authority
3. To become established as free-standing bodies accountable to the health authority for commissioning care
4. To become established as free-standing bodies accountable to the health authority for commissioning care and with added responsibility for the provision of community health services for the population

Source: the new NHS White paper

PCGs have started at either stage one or two, whichever is appropriate for them, and they will be expected to progress towards greater responsibility. A new type of trust will be set up – primary care trusts – for those PCGs wanting to be free-standing at levels three or four. The board membership of trusts will be dominated by lay members, unlike PCGs, which have only one lay member.

PCGs are intended to develop around natural communities but take account also of the benefits of coterminosity with social services. They serve around 100,000 patients, but in London, this ranges from half to over twice that size.

According to the White Paper *The New NHS: modern, dependable,* each PCG is required to:

- be representative of all the GP practices in the group
- have a governing body which includes community nursing and social services as well as GPs drawn from the area
- take account of social services as well as health authority boundaries, to help promote integration in service planning and provision
- abide by the local Health Improvement Programme
- have clear arrangements for public involvement, including open meetings
- have efficient and effective arrangements for management and financial accountability

Government guidance requires HImPs to:

> *'Engage PCGs in the strategic planning process, ensuring that the HImP is guided by the perspective and knowledge that they are able to bring to bear, and take proper account of locally determined needs, as well as national priorities'* (HSC 1998/167)

Government policy would appear to have been informed by the evaluation of *Health of the Nation,*[11] which showed that gaining the commitment of those in primary care is essential to the success of a nationally developed health policy. It also pointed to the need for local authorities to be more involved in local health improvement strategies.

Box 3: Lessons learnt from *Health of the Nation*

The Government needs to:

- provide leadership by sending out clear, consistent corporate signals and ensuring cross-departmental ownership
- establish shared ownership at all levels both vertically and horizontally – ensuring that chief executives in heath and local authorities are fully committed and engaged
- within a performance management framework, spell out agency expectations, tasks and responsibilities
- consider the roles of health and local authorities (should they share the lead role)
- stress the importance of joint targets and joint monitoring, with each stakeholder playing to its particular strengths
- ensure that primary care practitioners are on board with the strategy

In 1998 the Department of Health published a discussion document *In The Public Interest*,[12] which aimed to present ideas 'for general debate and to influence thinking'. It refers to the needs for public participation in the NHS as 'urgent', and sets out a number of models. This is presented as part of a wider commitment by the Government to rebuilding confidence in public services:

> *'In all parts of the public sector, action is being taken to open up decision-making processes and find new ways of including citizens in the planning and provision of public services'*

'We need to move to a situation where public participation is no longer a "bolt-on" but a core purpose of the health service and its staff and a way of achieving health and health service objectives'

Reference should also be made to another policy initiative, which is likely to have an impact on health in London, namely, the introduction of an elected Greater London Authority (GLA) and a directly elected Mayor in the year 2000. Without any strategic responsibility for health, or any role in the delivery of health services, the new Authority will, nevertheless, have a brief to consider the health implications of its policies. The various executive agencies, which will be accountable to the GLA, will have to take health improvement issues seriously and there will be considerable scope for developing action at the pan-London level. The Mayor will have wide executive powers and will need a popular mandate, so it is likely that any holder of the office will take an interest in health.

To sum up, the policy background against which HImPs are developing is innovative and continues to evolve towards to a range of ambitious objectives. As well as tackling health inequalities, addressing the wider determinants of health by involving local government on a corporate basis, and opening up public participation, policy seeks to tie in the commissioning of services to a progressive health improvement strategy. Any one of these objectives would be demanding but, taken together, they are a formidable yet exciting challenge.

Equally challenging is the balancing act, which must be achieved between HImPs as local action plans and HImPs as the vehicles of a national strategy. Their development thus far has been heavily dependent upon central guidance, but the pursuit of greater public involvement and an enlarged role for local government is likely to lead to better articulation of local needs and wishes. The development of HImPs is taking place within this dynamic policy environment.

METHODS

This rapid appraisal was carried out by the King's Fund, with the aim of finding out how health authorities, primary care groups and local authorities contributed to the development of their Health Improvement Programmes for the year 1999/2000. It is based on a series of semi-structured interviews and analysis of local HImP documents.

A purposive sampling method was used to identify five out of the sixteen Health Improvement Programmes being developed in London. Criteria used to identify sites were:

- geography (inner/outer London, north Thames/south Thames)
- Health Action Zone status (HAZ/non-HAZ site)
- number of local authorities contributing to a HImP
- number of primary care groups contributing to a HImP
- level of PCGs (level one/level two)
- degree of coterminosity between health authorities, local authorities and primary care groups

In all five sites, the Director of Public Health (DPH) at the health authority and the chief executive(s) of the local authority/ies were approached to ask if their organisation would be willing to participate. Health authorities were also asked about their corresponding PCGs.

Four health authorities (I-IV), seventeen primary care groups (1-17), and eight local authorities (A-H) agreed to participate. One health authority and its four corresponding PCGs decided not to participate. Two local authorities involved with another HImP also declined to be interviewed.

Semi-structured, face-to-face interviews were conducted with representatives from across the organisations, and these included:

- *Within health authorities*:
  Health Improvement Programme lead officers, either the DPH or someone nominated by the DPH.
- *Within primary care groups:*
  Chief executives (or in their absence, chairs) of PCGs were asked to nominate an appropriate person to be interviewed. This involved variously, chief executives, GP chairs, GP HImP leads, nurse HImP leads and a lay board member.
- *Within the local authorities:*
  The chief executive and the Health Improvement Programme lead officer.

Interview schedules were prepared and piloted in February 1999.

A consistent range of questions was asked of each interviewee across the respective organisations. The nature of questions was open-ended so as not to constrain the responses, and they covered the following range of topics:

- perceptions of Health Improvement Programmes
- structures, processes and institutional relationships
- priorities
- health inequalities
- public involvement and accountability

In addition to finding out how each organisation had addressed these topics, the interviews were used to explore respondents' hopes and concerns about HImPs. The interviews were completed over the period March to April 1999.

The analysis of the qualitative data collected used a matrix based on the topics in order to establish key issues and emerging patterns and trends.

FINDINGS

In the following sections we present the findings from interviews, grouped by the three types of agency we interviewed:

- health authorities
- local authorities
- primary care groups

In order to aid comparisons between the three sectors, each set of findings is ordered in the same way and deals with *Perceptions, Structure/Processes/Institutional Relationships, Priorities, and Public Involvement.* There is a summary after each section.

HEALTH AUTHORITY PERSPECTIVES

In the four health authorities, interviews were carried out either with the DPH, or a HImP lead nominated by him/her. The HImP lead was invariably a senior manager directly accountable to the DPH. In one health authority, the lead with responsibility for co-ordinating PCGs' inputs into the HImP was interviewed, as well as the DPH. Although each HImP document was different in style, tone and emphasis, they had all been influenced by national and regional office guidance.

Perceptions – understanding and attitudes

Interviewees from health authorities perceived health improvement in a variety of ways, indicating the complex nature of the concept:

> *'A dynamic concept – everyone has to keep moving in terms of improving their health, but it must be about narrowing inequalities' (I)*

> *'It's about tackling inequalities – but does that mean levelling up or levelling down?' (III)*

> *'A means to get partnership going' (III)*

> *'No one answer. Is it about health services, resource allocation, disease prevention and increasing the quality of life' (II)*

Respondents from all four health authorities were cautiously optimistic about HImPs:

> *'It's good to have the freedom to talk about health gain' (I)*

> *'The health authority is still focused on treating people ... the HImP provides an opportunity to do something different, so there's a lot of enthusiasm' (IV)*

There were some warning notes, based on difficulties already encountered, and it was felt important to be realistic as to what the HImP might deliver. The need for extra resources to bring about change was raised – so far, there was no new money for HImPs. One health authority had been hopeful of using part of their modernisation fund for HImP actions, but had been obliged to use this to meet NHS pay awards instead. The challenge of reconciling so many different interests was considerable.

In leading the HImP process, health authorities had been keen to adopt an inclusive and facilitative style in keeping with partnership working.

> *'The health authority hovers between leading and facilitating ... we have been criticised for doing both' (III)*

Although respondents expected the roles of other agencies and stakeholders to increase in future, one was clear that a single agency would need to have responsibility for taking the HImP forward; this could be a chief executives' forum and not necessarily the health authority.

Health authorities saw their main role as:

- providing a strategic framework from which action plans could be developed, perhaps by other organisations such as PCGs or trusts
- managing the balance between national and local priorities and ensuring that these were addressed
- establishing appropriate structures and processes that ensured the contribution of different stakeholders could be heard

Supporting structures, processes and institutional relationships

Guidance on HImPs was issued late in the process, and health authorities felt that, initially, they had been 'making it up as they went along', with little steer from the Regional Office.

In the four health authorities, HImP development had been led by the public health directorate, usually with one person working almost full-time on it. There were some concerns about the ownership of HImP within the rest of the organisation, despite the fact that the HImPs had gone to health authority boards for approval.

'There is a lack of input and ownership from other Health Authority directorates' (II)

'The whole organisation needs to think differently' (IV)

The relationship between the HImP and the Service and Financial Framework (SaFF) was difficult in most districts. This was partly because of the timing, but partly because of all the other commitments that needed to be met through the SaFF (for example, addressing waiting list targets). These often left few resources for activities associated with health improvement.

'At the moment the HImP complements the SaFF – it needs to re-orientate it'. (III)

'The HImP needs to drive the SaFF in future' (II)

Health authorities were beginning to make connections between the HImP and other initiatives such as Health Action Zone bids and Joint Investment Plans and Single Regeneration Budget bids, although in some instances these were still tenuous.

Relationships with others

All four health authorities felt that building up partnerships with others was vital to the success of HImPs.

> *'Top down is not the way to win hearts and minds ... we are trying to be facilitative. The health authority can't do this on its own' (IV)*

In some cases, health authorities made use of existing 'Healthy Alliance' groups to discuss the HImP with others. In other places, specific HImP working groups were established, and public meetings held, which generally seemed to work well.

Health authority and local authorities

All four health authorities said that their local authorities had played an important and strong role in shaping the HImP. The involvement of local authority officers was welcomed by health authority HImP leads.

> *'We've had excellent officer involvement from the local authorities – it has shaped it for the better' (III)*

> *'The local authorities have been very active, and important in setting priorities ... our relationship with them has strengthened' (II)*

Despite the strengthening of this partnership, there were some concerns. One local authority was felt not to have taken the HImP seriously because of the lack of resources. Also, as some local authorities were undergoing reorganisation, it was likely to take some time for health authorities to work out who to relate to it the new structures. This is likely to work both ways as health authorities reconsider their existing structure in the light of the emergence of PCGs. In one health authority with Conservative-led councils, the HImP lead felt that it had been harder to engage the local authority members who viewed this as a centrally driven political agenda (III).

In another authority, the DPH had met with the elected councillors, which was felt to have been helpful in ensuring collaboration on the HImP (I).

Health authority and PCGs

The extent of involvement of PCGs in the HImP process reflected their level of development as organisations. Those that were better established, for example with chief officers appointed or with a history of pre-existing primary care groupings (such as multi-funds or locality commissioning groups), had made more effort to engage in dialogue with their health authority, and to develop their own local HImP priorities. Those that were less well established had been given 'seats at the table' but had had relatively little impact on shaping the HImP so far. It was generally felt that this situation would improve, given time and further organisational development, but some issues gave cause for concern:

> *'PCGs need to have a more public health focus – they need to look at their local communities and think about how to prevent or avoid problems' (II)*

> *'PCGs tend to focus on [health] service issues ... the transition from fundholding has forced them into doing this more' (III)*

> *'It's difficult to engage PCGs in a big strategic process ... we'll lose the GPs if it's not action-focused' (I)*

All four respondents felt that it was important to develop the public health capacity of PCGs, and that the HImP presented a great opportunity to do this. It was unclear whether the health authority was likely to be able to provide sufficient public health input to its PCGs; it might need to re-orient PCG and community-based staff to do this instead. This is in itself a significant challenge. For example, health visitors have public health perspectives and skills, but it might be difficult to realise this potential given all the other calls on their time.

One health authority respondent felt that PCG structures would prevent them taking on wider health promotion and community development, and they would inevitably be reactive organisations responding to demands of the patients who came through the surgery door, and to acute health service pressures.

The four health authorities anticipated greater involvement from their PCGs in future, although as one respondent said:

> *'PCGs want to do everything themselves – they need to learn that they are part of a system and to work within it. They don't need to flex their muscles' (IV)*

PCGs have a key role both in developing better primary care services, and in helping to identify local needs. This approach to needs assessment was described by one respondent as 'HImP by anecdote' grounded in a 'community oriented primary care approach to needs assessment' (III). In this health authority each PCG was planning to undertake a local health needs assessment in the next few months.

Health authority and trusts

Acute and community trusts were involved through the partnership forums. It was recognised that they are important players, particularly in the implementation of the local HImP, and that there is scope for increasing their participation. In one health authority (I), they had been involved to the extent that their business cases had arisen through the HImP. It was widely recognised that better ways of including trusts needed to be developed.

Priorities

All health authorities were strongly influenced by the national priorities set out in *Our Healthier Nation*, the *National Priorities Guidance 1999/2000 – 2001/02* and the *Independent Inquiry into Inequalities in Health*. Thus coronary heart disease/stroke,

cancers and mental health were mentioned by all. Tackling inequalities provided an overarching theme, but the detail of how this might be approached was yet to be worked out. In one HImP, tackling inequalities and decreasing social exclusion were highlighted as the starting point for all actions under the HImP. In another, the approach to inequalities was more low key.

Local priorities were identified on the basis of pre-existing work, health strategies and the Director of Public Health's annual report. Topics chosen for local Health Action Zone (HAZ) bids also featured – children and young people were a priority for two of the health authorities (III) (IV), and this had been the topic of choice for their HAZ bid. The needs of older people were usually mentioned in the context of Joint Investment Plans.

HImP documents at this early stage represent a list of issues to be addressed over the next three years. Almost all of them alluded to the need for further work to refine this list, and to identify specific objectives within their chosen priorities that could be met in the first year. One health authority (II) was planning to establish a priorities forum, involving key stakeholders, to address this.

Two respondents questioned the significance of what it meant to be a HImP priority, given the uncertainty about how these would be addressed, and the probable lack of resources to do anything new.

Public participation

Health authorities had involved the public mainly through consultation with their local Community Health Council, and with local umbrella voluntary organisations. All wished to see greater involvement of their local communities and voluntary sector in future, but this remains a major challenge:

'The HImP needs to become embodied outwith the health service, so that the voluntary sector can influence it in a way they feel comfortable with'.

The voluntary sector is only one means of public involvement. Voluntary organisations have traditionally worked with health authorities through the Joint Consultative Committee structures, mainly as service providers contributing to care in the community. Although health authorities increasingly attempt to involve voluntary groups in strategic planning. there are certain constraints that limit the voluntary sector's ability to contribute effectively to this, not least of which is the lack of time and shortage of staff who can be spared from delivering front-line services, often to users with complex needs.

Health authorities need to find ways of communicating their strategies in more appropriate ways to the wider public.

Summary of health authority findings

Many of the issues which emerged from our interviews with health authorities echo the findings of the NHS Executive London Regional Office rapid appraisal. There is still considerable good will and enthusiasm for HImPs, which are seen as providing new opportunities to:

- Promote the public health agenda more widely through the health sector and outside it. This includes the use of needs assessment and evidence-based interventions to improve health, as well as acknowledging the importance of wider determinants of health status beyond the health service
- Develop primary care
- Address inequities in access to basic health care services
- Strengthen relationships between the health sector and other agencies, and develop partnership working

The issues causing greatest concern to those in health authorities are:

Lack of ownership within their own organisations:
The HImP is already in danger of being marginalised to the public health department, having little impact on the rest of the work of the health authority. Acute service pressures such as waiting list targets continue to determine the use of resources. This could be exacerbated if health authorities are performance-managed on these latter issues, but are not held to account for delivery of their local HImP with the same rigour. There would then be little incentive for them to make health improvement core business.

Limited scope to redirect resources:
If the HImP turns out to be nothing more than a wish list, which cannot be shown to make a difference, then it will not be taken seriously by those who should be involved in its development and delivery. Hence the need for some early 'wins'.

Balancing inherent tensions:
HImPs, in their first year, have been strongly driven by the national agenda. Health authorities want to make them more responsive to local needs, but this could create further tensions if choices have to be made between meeting national or local priorities.

There is also a balance to be struck between developing a strategic, long-term vision, and shorter-term, focused action plans. Both are needed, but do not always appeal to all stakeholders who may rapidly lose interest if they feel that the balance is wrong.

There may be conflicts to be resolved between different partners given their very different perspectives on health improvement and resource constraints. There is a danger that the effort and cost of making the processes work are perceived to outweigh any benefits brought by HImPs.

Involving the public:

This remains a major area of development, and will require a combination of community development approaches as well as current mechanisms for consultation if public involvement is to be more meaningful.

As health authorities build on this first phase of HImPs the evidence suggests they will need to:

- develop and share a clearer vision of health improvement which engages the whole authority as well as partner organisations
- make the links between Health Improvement Programmes and resource allocation more explicit, and at an earlier stage
- develop processes that extend ownership of the HImP by their partner organisations, for example through earlier involvement in the process
- identify indicators which can be used to measure progress
- develop the public health capacity in their partner organisations

Some of these issues were already being addressed by the health authorities interviewed. However, this is against a background of considerable turbulence as they adjust to a changing role in the new NHS.

LOCAL AUTHORITY PERSPECTIVES

Perceptions – understanding and attitudes

Local authorities' perceptions of the HImP appeared to have been influenced by a number of factors:

- the role of interviewees in developing the HImP programme
- history of joint working with the health authority
- the extent and complexity of the local agenda for action
- the nature of the local health challenge
- the political environment of the council

Health Improvement Programmes were perceived by all the boroughs interviewed as a strategic document or action plan, rather than a mission statement. They are, as one put it:

> *'An expression of two things: a set of local targets agreed on a partnership basis for improving the health of the population and reducing inequalities in health, and secondly, an expression of how those targets will be met by different players' (H)*

As a strategic, partnership-based approach to health improvement, the HImP is one of several multi-disciplinary policy initiatives which local government is now obliged to deploy. Other examples include Quality Protects, Sure Start, Education Action Zones, New Deal For Communities and Youth Offending Teams. In one borough (H), the HImP is one of 12 strategies the council is seeking to deliver. Another (A) had enough strategies to make it useful to have a 'plan of plans' which it was in the process of compiling, and another (C) was currently involved in some 50 plans and was aware of a tendency to what it called *'zone-itis'*.

Seeing and understanding the linkages with other agendas, so as to maximise the potential of other funding opportunities, was considered by all to be important. This was particularly so in relation to Health Action Zones, Healthy Cities Projects, Crime and Disorder Plans and Healthy Living Centres.

In the majority of cases, the structures used to implement community care policies – Joint Consultative Committees – or their derivatives, were used as the basis for HImP development.

Five of the boroughs interviewed had secured Health Action Zone (HAZ) status, which put the HImP in a different perspective. The HAZ brought the promise of funds, and it meant partnership working had already been intensified in those boroughs. This provided the mechanisms for them to take forward the HImP. Two boroughs (B and E) saw the HAZ as providing a framework for:

> *'a portfolio of HImPs ... in selected priority areas; a mix of diseases and age/client groups'.*

Pressure of work on local authorities is nothing new, but they are currently implementing change in relation to several major Government policies. This appears to be driving a process of rationalisation of work in progress, and, together with funding pressures, encouraged the boroughs to be highly selective in deciding which areas of the HImP programme they could contribute to.

The local authorities' contribution to HImPs has to be assessed in its financial context. Planned reductions in the budgets of some boroughs, as much as £1 million over two years, are leading to shortfalls in key local services, such as housing, which will impact on the population's health.

Generally speaking, the more diverse the population of a borough, the more wide-ranging the needs and the greater the challenge for health improvement. There were as

many as 47 languages spoken in one borough, together with a significant number of refugees and homeless people. The freedom to adapt national policies such as HImPs to suit local requirements is highly valued by local authorities. One borough saw one of the benefits of the HImP as the stimulation of local 'creativity'.

All the boroughs perceived the HImP in positive terms, as a worthwhile new challenge. Any early reservations appear to have been overcome:

> *'At first it felt like something that was foisted on us, but we are wholly in favour of it now' (F)*

The same borough felt that in the process of producing the first HImP, a lot of trust had built up between it and the health authority, and looked forward to playing a bigger, more constructive role in the next round. There is a widespread perception of the policy as a genuine attempt to extend partnership working. It is seen as inclusive and co-operative, and a welcome departure from the internal market, which was considered divisive.

The objective of reductions in health inequalities, written into HImPs, has also been well received by the local authorities interviewed, most of which are led by councils of the same political party as the Government. Three of them have some of the least healthy and most deprived population groups in the country. One borough had a Lib-Lab council and another had a hung council and relied on the Mayor's casting vote.

The boroughs generally saw work on the HImP as encompassing several other agendas, such as regeneration, social inclusion and New Deal policies. They tended to see their contribution to health in broad 'quality of life' terms, or with reference to social and community services, whereas the health authorities were regarded as inevitably dominated by their responsibilities for commissioning acute services, and the so-called 'medical model'.

As the interviewee from one borough (H) said, the role of the health authorities is set to change radically. When primary care groups come into being and take over commissioning,

> *'Co-ordination and delivery of the HImP will become the health authority's primary role'.*

This contrasts with the view from a small number of PCGs who felt they should drive the HImP in future (see PCG Findings). As far as the boroughs are concerned, the PCGs remain something of a wild card, and much of the success of the HImP will depend on local authorities forging partnerships with them, a process that has scarcely begun.

The fact that the HImP is a rolling programme was welcomed by all the boroughs, who attached importance to evaluation and subsequent modification of objectives and targets. The view was expressed that the HImP,

> *'needs to remain a mix of broad-brush objectives and short term targets. A statement of what we should be doing, not just a description of what we are doing'. (H)*

For those boroughs with limited experience of joint working with the health authority, the HImP was seen as an opportunity to work differently. They tended to be more cautious and sceptical about what they could contribute or achieve. For those who had well established joint working arrangements, the HImP tended to be viewed with greater trust, as the continuation of a productive approach.

Supporting structures, processes and institutional relationships

The pressure of time in which to produce the first HImP has meant that the majority of local authorities have used existing structures for liaison with the health authority and any other boroughs involved. These structures were usually those set up for joint planning between health and social services, or the consultative forum type used for existing borough-wide, health improvement policies.

Some boroughs are now planning major restructuring as a response to local government reforms, or as part of health and social services modernisation policy. Several are already moving away from the traditional committee system. One has renamed its social services committee 'Social Services and Health Committee' in response to its role in the HImP and the council's new duties of partnership.

Most health authorities set up a steering group for the HImP, often chaired by the Director of Public Health. It was accepted by the boroughs as more or less inevitable that, for this first round, the health authority should have been the prime mover, and even, in some cases, the dominant player:

> *'In three years' time the HImP will be very good. In the first year it was necessarily professionally dominated'. (G)*

Two boroughs participating in a Heath Action Zone had worked within a steering group whose membership consisted of:

- local authorities – officers and some elected members
- health authority
- NHS trusts
- voluntary sector – umbrella organisations
- community and service user groups
- Community Health Council; and more recently

- chairs of the primary care groups

Borough-based groups with similar membership, plus other associated organisations such as the local university fed into this overarching group.

Partnership arrangements in one borough were considered well established at the strategic level (A). There the challenge was:

> *'to make sure we achieve more integrated change at the service level. The user perspective needs to become paramount'.*

It was hoped that the development of PCGs would further that end. The same interviewee spoke of the need for a more flexible work force, with leaders who were able to work in both health and social sectors, if joint working is to develop substantially.

The new PCGs were seen as crucial in integrating local authority services with primary care services. The development of the first HImPs has coincided with the appointment of chairs of PCG boards, and chief executives. The view was generally held that the primary care groups had not been involved in the process to date, but were starting to engage. Their importance and contribution was not underestimated, but there was a lack of clarity about how they would contribute. A concern was voiced by an interviewee from one borough (D) that the influence of PCGs may perpetuate a medical approach to health indicators.

> *'A variety of service providers are not a problem as long as proper, holistic assessments are made. More than just health and social services needs must be taken into account'.*

The participation of elected members in the formal structures was found to be variable. In one borough (B) seminar sessions had been organised by the health authority at an early stage to which members had been invited. Their ongoing

participation was through regular committee briefings by the HImP lead officer. In other examples, a small number of members were active in contributing to partnership working by chairing meetings, and sitting as non-executive members of local health organisations.

The participation of the voluntary sector was considered by all those interviewed to be important, but for ease in this first year of the process had tended to include the umbrella organisations rather than a broader-based representation. One HImP lead spoke of '*user fatigue*' – so many policies required the involvement of users that the voluntary sector was beginning to feel pulled in too many directions to be able to respond adequately.

All boroughs work with their health authorities at the strategic level through joint chief officers' meetings. One borough (A) with a particular cohesive partnership with the health authority acknowledged that they had been greatly facilitated by coterminosity – one local authority and one health authority sharing the same population. The great majority of local authorities, whether in London or outside, do not have this advantage.

In many boroughs new partnership mechanisms are currently under consultation. With reference to both the HImP and the local Health Action Zone, one borough (H) referred to:

> *'the crucial need to performance manage common objectives'.*

The interviewee from another borough (F) said it did not feel that it 'owned' the HImP, although this view was not shared by other boroughs within the same health authority. One of them said:

> *'Local authorities need to assert their position more. They can be involved in health if they want to be. It has been all too easy to blame the health authorities'. (H)*

Another borough (G) raised the subject of marginal capacity. A lot is being asked of local authorities, for example in terms of demands on senior management time:

> *'Partnership is working well in terms of policy-making, but not at (the level of) deployment of resources'.*

Specific reference was made to the considerable amounts of time at HImP development meetings that dealt with specialist health subjects in which local authority people had no expertise.

The chief executives of the boroughs within the sample had all made internal arrangements to support the implementation of the HImP work programme, and assigned lead officer responsibility to an executive director who was able to 'drive the process'. Several boroughs have given the lead role to directors of social services. This makes sense for service-related reasons, as health and social services have a history of working together, as well as a statutory obligation to do so, but there is a growing recognition that HImPs must be extended to cover all the determinants of health, which go beyond health and social services. In one borough, the lead is shared between the director of social services and the chief environmental health officer; in another it has been retained as a corporate responsibility within the chief executive's office, in two others the director of leisure services has a lead role. The practice of shared leads between departments is common.

In one borough (A), where the lead was shared with an officer below the level of director, he expressed the view that this impeded efforts to drive the HImP up the council's agenda. Clearly there needs to be commitment at every bureaucratic level.

Most boroughs have made at least one specialist appointment in relation to development of the HImP. Generally these are health policy planners or health managers. Two boroughs had obtained the services of a public health specialist on secondment from the health authority.

The boroughs were well aware of the pressures under which health authorities were operating, in relation to the HImP, which had to be ready in draft form by mid-January 1999, and to the simultaneous setting up of primary care groups. Ultimately, the success of partnerships is largely attributable to the commitment of individuals, and the boroughs recognised the contribution made to the HImP by those in health authorities with responsibility for liaison with local councils. There was no doubt that health authorities genuinely want the boroughs to share responsibility for health improvement.

Having got the first HImP under way, and selected the first set of priorities, the nature of the HImP as a rolling programme should enable the boroughs to take a less reactive, more prominent role in the second and subsequent years. All respondents agreed that they needed to make up a lot of ground if priorities and indicators used in the HImP were to avoid health service domination.

All the boroughs interviewed expressed concern that the objectives set out in the HImP should translate into action.

> *'Action plans need to be developed without delay ... with indicators relevant to the services which boroughs can contribute'.*

> *'The biggest challenge for the borough is to understand its role in the HImP and set up mechanisms by which it can be effectively monitored and evaluated'. (A)*

Although no boroughs reported insurmountable structural or procedural obstacles to their involvement in the HImP, reservations were expressed in relation to the compatibility of planning cycles, and the continuing pressures on time. After the rush to produce the first HImPs, most of which were ready in April, the second HImP must be drafted by September if they are to influence the 'Service and Financial Framework' (SaFF) of the health authorities.

Concern was expressed about the continuing barrier between health and social services caused by charging, which will continue to make integration of services difficult. More broadly, there was concern that the HImP process does not bring in any funding – 'we have to rely on slippage all the time'. The boroughs were also doubtful that funds would ever be channelled away from acute health services to prevention and health promotion.

> *'Will the HImP really influence spending on medical services? That's an important question quite beyond the borough's influence'. (A)*

At present, the main lever for diverting funds from health spending is the Joint Investment Plan (JIP), which informs the drawing down of funds available under the Government's modernisation programme for health and social services. Social services departments must reflect HImP objectives in their community care and children's service plans, and in the JIP, which they draw up with the health authorities (see Policy Background). The JIP covers areas of joint working and planning across health and social services, and funds are available for new initiatives, such as those that reduce hospital admissions. (The Government acknowledges this is a long-term strategy, which will take a decade to achieve.) Proposals set out in *Partnership in Action* should enable health and social services to pool budgets, or transfer funds and delegate functions, but they are regarded with some scepticism by the boroughs, because of the barrier between free health services, and charged-for social services.

Some funds may become available to health improvement measures via the modernisation fund, and may even be transferred from health to social services sharing the same objective. However, measures to improve health, which may be taken beyond the domain of either health or social services, remain dependent upon unspent existing budgets. For example, one borough (F) envisaged contributing to the aim of coronary heart disease reduction adopted in the HImP, through deployment of its leisure services, but could not see where money for these additional services might come from. Another borough (A) said they could not get long-term funding from the

health authority for an 'Active Lifestyles' programme (which included prescription activities) and so had to rely on regeneration funds instead.

Priorities

HImPs are an amalgam of national and local priorities. Local authorities must select two from each set. One borough (H) felt this was an arbitrary 'pick and mix approach', and prevented the HImP from being a 'bottom-up, needs-based programme'. Another expressed a desire for the HImP to be more 'locally driven' (A). Anxiety was expressed that HImPs could go the way of Housing Investment Programmes (HIPs) which were originally intended to be individually tailored to fit local needs but had ended up being squeezed into a national template (H). Another view was that more systematic needs assessment is required to establish priorities (G).

One borough (A) explicitly chose priority areas with a view to 'early successes', seeing it as important to reward the efforts of new partners and players with encouraging results.

In one Health Action Zone the priorities chosen for the HImP were the same as for the HAZ – a mix of diseases (e.g. cancer) and priority groups (e.g. older people).

> *'A Health Action Zone programme to reduce smoking will contribute to the HImP for cancer and heart disease, and to meeting health targets for reducing death and illness resulting from these conditions.'*

This client group and disease-based approach may be contrasted to an approach that seeks to get the processes in place first. To this end, two other boroughs (C and D) identified the key tasks that they will undertake as being:

- gathering and analysing information
- public involvement

- community development
- selecting and ranking priorities
- organising the partnership
- developing and reviewing strategies and action plans

All boroughs confirmed the different perception of priorities between health and local authorities, but as one put it:

> *'How can we argue with cancer as a priority?'(G)*

Having no responsibility for delivering health services, local authorities are free to advocate more priority for prevention and health promotion, but they remain doubtful whether there can be any substantial shift of resources from one to the other:

> *'This means taking risks by pulling back from services. So we need to monitor carefully' (A)*

One of the HImP lead officers commented that he saw a role for academic organisations in collaboratively developing meaningful health indicators, and in drawing up mechanisms for monitoring and evaluating the HImP process.

Although primary care groups have not been actively involved in the HImP this year, it was generally recognised by the boroughs that they would seek to influence the priority setting agenda in future years.

Information to support both the priority-setting process and individualised care was considered to be essential, together with the view that information was probably available but not currently accessible or in a format that could be easily used. Basic information to identify the care pathway, for example to track a child as s/he passes between health and social care, is fundamentally necessary, but not readily available.

Resource mapping to support the overall process forms an essential part of the baseline, and has acted as the catalyst for two boroughs (C and D) to establish a joint intelligence group between them. The function of this is information gathering and data analysis in order to respond to the health authority's data in the future.

Several boroughs said that problems of information sharing between services would have to be overcome if services were to be better integrated and 'closer to people'.

> *'Most strategies adopted by councils are targeting the same people, so we have converging interests. We need to aim for single gateways to services'. (F)*

On the same theme, another borough described an initiative to develop a property strategy to have more one-stop shops and call centres, using shared premises for services delivered by both health and local authorities:

> *'We are looking at operational ways of joining the health authority and local authority together in the public mind' (A)*

All the boroughs interviewed saw the reduction of health inequalities as central to the purpose of their partnership in the HImP. They were both optimistic and realistic: it would take far longer than one or two years to make any impact – not less than five years and possibly as much as 25 years – but the HImP was the right way to proceed:

> *'The big questions are: Will it change anything? Can it translate into measurable programmes, will it deliver health improvement? The policy has the borough's support'. (G)*

At the very least, it was acknowledged that there is more optimism about reducing health inequalities than two or three years ago (F). The same borough anticipated making measurable progress in improving equality of access to services via the HImP. It was felt that both the boroughs and health authorities now understood the issues

better and that there was wider acceptance that the determinants of health must be addressed.

One borough queried whether the HImP would have an impact on health inequalities if it were too disease-specific. All the boroughs spoke of the need for health improvement to be an integral part of a wider social inclusion and regeneration programme, particularly in areas of deprivation.

More optimistically, one respondent thought the action plans for delivery of the HImP would, if taken together with the local HAZ,

> *'have a very significant impact indeed, if taken to fruition because the HImP is clearly targeted at people whose health and opportunities for health are poorer'. (G)*

This belief was qualified by the hope that the HImP would, unlike previous health improvement strategies, provide a strategic framework within which resources could be redirected.

Public participation and accountability

Involving the public in HImP development, either through direct consultations, or via their elected representatives, is, as yet, an underdeveloped area, for all the boroughs interviewed. There are three broad reasons why this is important:

- as a way of getting the public to sign up to the objectives of the HImP
- as a means of identifying needs and preferences
- for purposes of public accountability

The time frame within which the first HImP had to be produced made public consultations difficult. Some boroughs were able to take advantage of the efforts they had made when drawing up the HAZ. One borough (G), with a good record of

community involvement, reported using a citizens' panel, and another (A) plans to set one up, despite anxiety about the projected cost of £70-100,000. They hoped to share the use of a citizens' panel with the health authority. Several boroughs already had 'alliances' or forums for health improvement that involved voluntary organisations representing users and carers.

There was no reporting of any public consultation specifically relating to HImP priorities – shortage of time being largely responsible. However, boroughs were able to make use of information gleaned from previous consultations, for example about services to specific groups such as the elderly or children.

One borough (A) expressed the view that the health authority had a better record of public consultation than the local authority. This may be partly explained by health authorities' awareness of their local 'democratic deficit', whereas local authorities can always refer to the mandate given to their councils at local elections (however low the turnout).

All the boroughs expressed interest in finding new ways of involving the public in the HImP. Some were soliciting the views of local residents, through opinion polls (written, telephone and focus group) as well as by setting up citizens' panels.

Action plans for implementation of HImPs are now being developed. Who will be held accountable for their delivery? With partnership working this is a particularly salient question since it is easy for each to assume that the other partner(s) are responsible, or to have potentially conflicting accountabilities for different stakeholders. Holding health authorities locally to account is difficult. They are structured to account upwards through the Secretary of State, who is accountable to Parliament. PCGs offer a limited kind of public accountability through single lay members, who are appointed by the health authorities. In view of the importance of the role they will be carrying out in commissioning services and spending substantial

publicly funded budgets, it must only be a matter of time before more questions about their public accountability are raised.

Local authorities are the only partners in the HImP with direct democratic accountability to the population served by the HImP. Hence it might be argued that one of the boroughs' unique and important contributions to the process of developing and delivering HImPs is the provision of local democratic accountability. Supporting this view, all the boroughs interviewed gave priority, now the process has begun, to the greater involvement of their elected members. Councillors are already showing an increasing interest in HImPs, although, as one borough pointed out,

'many local authorities have lost sight of their role in preventive health'. (A)

There is a widespread tendency for councillors to concentrate on 'parish pump' issues, such as parking and traffic, at the expense of the less tractable, more strategic issues such as health improvement. Elected politicians tend to be interested in short-term, tangible results, and the challenge of health inequalities built in to the HImP is scarcely amenable to any kind of 'quick fix'. Several boroughs saw it as one of their most important challenges to involve councillors more actively in health; continued exposure to the issues of health improvement would help.

Another borough (A) envisaged non-executive members of PCGs and councillors doing more together, on, for example, 'Quality Protects' – the strategy for child care. This opens up interesting possibilities for more public accountability. The same borough said that their council's political leaders met every three months with the chairs of the health authority and the social services committee as well as the chief executive and some provider trusts, and had already become 'very seized with the HImP'. One obstacle was the lack of a council committee to which the HImP would naturally go. Although one borough has got round this, simply by adding the word 'health' to an existing title, hence a 'social services and health committee', this does not encourage other divisions of the borough which will also need to adopt healthy policies if all the determinants of health are to be addressed. There is a need to ensure

that the new emphasis on strategies delivered through partnerships, among which HImPs are prominent, does not become simply an exercise in rebranding. Hence the importance of a range of targets and agreed priorities, with careful measurement of progress in meeting them – and a convergence of services integrated to meet the needs of individuals. Whether a service is considered a health measure, a regeneration measure, a housing measure or a social services measure is only significant if there are barriers between them.

> *'Whether it's called education, crime or whatever, if it improves the quality of life it will impact on people's health'. (A)*

One borough, planning a major restructuring that includes an elected mayor who will appoint a cabinet, spoke of the need for:

> *'much more elected representative involvement, with perhaps a deputy mayor for health and social care, to make the HImP more member-driven'. (G)*

The changes about to be implemented in local government have the potential to significantly increase the influence that local authorities will exert on the health agenda:

> *'In two or three years' time, a directly elected Mayor will be taking a big personal interest in health issues, and will be actively promoting the health of the people in the borough. It could become difficult for the health authority then, with a populist mayor asking questions'. (G)*

Another factor, which may have a significant impact on the role of local authorities in health, is the change in the role of health authorities that will come about as PCGs take on commissioning of services. It has already been pointed out that the HImP will become the *raison d'être* of health authorities – a function in which local authorities will be equal partners. In some respects this will represent a return to the pre-1972

position when public health was a local government responsibility. An important challenge before then is to make sure local authorities (as well as health authorities) can influence PCGs who will hold many of the health purse strings.

Summary of local authority findings

From all the boroughs interviewed there is support for the objectives of their HImPs, and commitment to their development. Boroughs with a poor record of collaboration with health authorities have embraced the initiative, as have those with a history of joint working.

In general, boroughs see the HImP as providing an opportunity to share responsibility for improving the health of their local population, and to develop partnership working more fully than simply joint working between health authorities and social services departments. They welcome their role in the formulation of strategy, but have reservations about the contribution they will be able to make to its implementation.

Issues causing concern

- converting the strategic intent into practical plans for action
- finding the right balance between centralised control of priorities and responsiveness to local needs
- identifying social indicators relevant to the contribution boroughs can make
- performance managing and measurement of progress towards agreed targets
- unknown resource implications of local authorities' role in implementing the HImP
- limited scope for diversion of funds to further HImP objectives: new initiatives are so far dependent on 'slippage'
- planning cycles may need to be adjusted and intervals lengthened to prevent overload

- uncertainty about the nature of partners' roles, i.e. PCGs not yet developed and speculation about the role of health authorities once PCGs are fully operational
- how to engage public support – how to consult the public effectively and avoid wasteful duplication of time and effort
- developing a constructive role for elected representatives (councillors) and, in anticipation of local government reforms, learning how to accept more input from politicians

Action needed

- incorporate health improvement in all areas of policy for which local authorities have responsibility, i.e. extending beyond social services
- conduct health impact assessment of local authority policies where appropriate
- rapidly acquire the public health expertise to participate fully in the partnership and avoid risk of domination by health authority or the 'acute service' perspective
- establish links with PCGs not yet fully aware of local authority role in HImP
- obtain some 'quick wins' to demonstrate value of partnership in HImP
- pool resources with health authorities, e.g. information systems, premises, personnel, consultation mechanisms
- find meaningful role for elected representatives (councillors), possibly linking with PCGs and non-executive members of health authorities

PRIMARY CARE GROUP PERSPECTIVES

Within our small sample of 17 PCGs there was considerable variation in the extent of involvement and approaches to development of the first HImP. The more well established groups had already begun to think about a role in health improvement and were also developing their own PCG action plans (comparable to mini-HImPs). They anticipated extending their role in the HImP process in the coming year. Others were less involved and more reliant upon the health authority's suggestions and guidance. Those that had been less engaged in the process in 1999 attributed this to practical reasons, such as delays in PCG configuration, or in the appointment of chief executives and other board members.

The will to understand and engage with the concept of health improvement was universal. This is perhaps unsurprising given that the interviewees were usually people who had volunteered to take a lead on the issue. Although they spoke from a personal perspective, most felt that their enthusiasm was reflected throughout their board. It was widely accepted, however, that a major challenge would be to sustain this good will in the future.

Perceptions – understanding and attitudes

There was a range of perspectives on what health improvement might mean. To some, particularly GP respondents, it was strongly focused on the role of services in preventing and treating disease, an approach seemingly endorsed by the choice of topics in the National Priorities Guidance and *Our Healthier Nation*:

> *'A needs based package and programme of care and intervention with specific targets and measurable outcomes, to improve morbidity and mortality in five years' time' (11)*

> *'A very good tool to co-ordinate the care that people get' (12)*

However, to others, health improvement was 'not about clinical medicine' (13), but about improving people's quality of life in a wider sense, through, for example, community development approaches (17).

There was recognition of the wider determinants of health, but many were uncertain as to whether or how PCGs might influence these:

> *'I'm sympathetic to the wider determinants beyond the GP surgery, but don't necessarily know quite what to do about it' (15)*

> *'Illness management is about as far as we can go at the moment'. (10)*

One respondent clearly felt that PCGs had no capacity to affect these wider determinants and should concentrate on clinical issues.

> *'If the HImP is to include issues like inequalities which GPs and nurses can't influence, we would be better off just seeing patients' (16)*

There was also some uncertainty about what health improvement meant in terms of everyday practice.

> *'The HImP is difficult to get hold of in practical terms ... it is difficult to make it a priority because it's so big, and involves so many people' (1)*

Several respondents commented on the challenge of thinking in terms of the local population rather than of individual patients. This was identified as a 'new concept' for GPs in particular, who had little history of strategic working. However, all of those interviewed were generally positive about health improvement and the HImP, many describing it as 'exciting' and as an opportunity rather than a threat.

'The single most exciting thing about PCGs is the thrust towards joint working and partnership'. (1)

Almost all respondents felt that PCGs had a major role to play in delivering health improvement. The majority of respondents felt that the HImP should underpin all the other work of the PCG. In a few PCGs, however, it seemed to be a low priority, partly because there was so much else going on at the same time, such as the development of primary care investment plans and issues of clinical governance. A number of PCGs were still in the very early stages of organisational development, without chief executives, and in one case without a chair.

A recurring theme was the link between clinical governance and health improvement. Many saw an overlap between the two, and felt that the boundaries were blurred. One respondent quite simply said, 'clinical governance and health improvement are the same' (8).

In many PCGs, HImP leads, chief executives and chairs were trying to make health improvement 'real' and achievable by breaking it down into 'meaningful but manageable components' (14). This might explain the tendency to roll it into clinical governance, and to focus on specific clinical issues, which their constituents might more easily understand and respond to.

In all four sites, the health authority had provided a strong steer as to the broad topics and priority areas, but PCGs were generally given flexibility to work out how they might tackle these issues. PCG leads saw it as their role to develop local action plans. Many were also aware of the need to start simple, and to achieve some 'early wins' if enthusiasm and interest were to be maintained in future.

There was a stronger focus on delivering health improvement through primary care development than through their commissioning function, although some of those with previous commissioning experience were keener to shape secondary services. PCGs

were starting to draw up primary care investment plans at the time of the interviews, so primary care development was a pressing issue. There was a sense that this might be an easier arena in which to bring about tangible changes, as it was the one over which PCGs had the most direct control.

Particular challenges anticipated in primary care development included:

- equitably distributing resources between practices on the basis of greatest need. This could lead to some feeling that they were losing out
- persuading practices to function differently, particularly if this is perceived simply as 'more work'. For example, encouraging practitioners to provide services for drug misusers or homeless people could prove difficult in the absence of effective incentives or sanctions, and in the context of the independent contractor status of GPs
- increasing the involvement of the whole primary care team and strengthening multi-professional working. Continuing education and development was seen as a key means of facilitating this

Supporting structures, processes and institutional relationships

At this stage in the evolution of PCGs, many were naturally preoccupied with the challenge of organisational development, which would prove to be vital in establishing appropriate structures and processes (6 and 11). Seven PCGs had designated individuals as HImP lead. In two PCGs, it was felt that, as the HImP should underpin all other work, it should be the responsibility of the whole board. Eight had opted for a working group to take on HImP responsibilities, with two respondents commenting that it was remarkably difficult to find time for an entire working group to meet. Another respondent, who was a board member but not on the HImP working group, also expressed some concern at her lack of knowledge about the HImP.

'As a board member my knowledge of the HImP is poor. As I'm not leading on it I wouldn't expect to know everything about it but, given its importance, we do need better communication' (3)

The presence of a chief executive to work full-time on PCG business, and commitment from the PCG board, were felt to be two important prerequisites for success. There were, however, concerns about how much board members are really able to engage properly with an increasingly overwhelming agenda. Are they merely 'rubber stamping' actions? The amount of time given to discussion of HImPs varied from 'every board meeting' to 'hardly at all'. A few PCGs had held board 'away days' in which the HImP had been an important topic.

Three respondents commented that the GP-dominated board structure made it difficult for other (non-medical) voices to be heard. Whilst the proposed increase in lay membership for primary care trust boards might be viewed as an attempt to redress this, one respondent felt that it was important for local people to be truly represented on primary care groups as well as trusts if they were to be effective in meeting the needs of those most socially excluded.

'The problem is how do we get marginalised groups to find their voice? The way the Boards are currently structured militates against this as health professionals dominate ... we need a properly representative structure for the PCG population'. (10)

There had been few exchanges with other PCG (non-board) members, largely due to the short timescale and lack of infrastructure. Where these had occurred, examples included sending a questionnaire to all practices asking them to identify their priorities; running a priority-setting seminar; establishing, or using established nurses' forums to discuss health improvement issues, and using a regular newsletter to keep practices informed. One board member was planning to establish a PCG library/resource centre open to all members of the PCG. Others were hoping to develop networks using information technology. The scope for improving

communication and, in particular, multi-disciplinary involvement was recognised by many, but it was also acknowledged that a balance had to be achieved between extending ownership to as many people as possible, and taking decisions and converting them into timely action.

> *'For how long and how much do we consult? We need to get on and make decisions'. (7)*

> *'I would use the same process again: a small group of experienced people to work up short list of do-able things and feed that through to the Board. There is no other way for the HImP to be except top down. Bottom up doesn't really work, although it's politically correct, because too many people come up with too many different things to make it achievable'. (12)*

PCGs and health authorities

Health authorities, and more specifically their public health departments, had clearly led the process of the first HImP development. Few PCGs were critical of this, recognising that 'someone needed to take overall control' and that perhaps the HImP would not have happened otherwise. Most felt that their health authority tried to engender a facilitative, inclusive approach.

The PCGs interviewed certainly anticipate a bigger role in future, but recognise that the health authority will retain a strategic role, and might be better placed to lead on some issues. A contrasting view was held by a small number of respondents who felt that the HImP should be driven by PCGs in future:

> *'PCGs can do this better than health authorities – clinicians make decisions then and there'. (16)*

Overall, however, there seemed to be a good working relationship between PCGs and their health authorities, but there were a few common complaints. One concerned the

length and inaccessibility of documents sent to PCGs by the health authorities, which PCGs felt were not adequately focused on tangible actions and outcomes.

'The Health Authority is full of phrases, PCGs are about deliverables' (11)

Another frequent complaint concerned the number of umbrella groups or stakeholder meetings PCG representatives had to attend. Almost all health authorities established, or used existing umbrella groups to bring together a large number of stakeholders.

'Big forums are a good way to meet other people, but that's not really where the work is done. The people who hold the purse strings are not there anyway' (8)

Interestingly, there were no reports of conflict between different groups at these meetings. Most of those interviewed accepted that the HImP could not be all things to everyone. Perhaps this is a reflection of the spirit of co-operation, which characterises the process of HImP development. On the other hand, it may be that HImPs are still sufficiently all embracing to appear to accommodate all the different stakeholders' concerns. If this is so, the difficult decisions may still lie ahead.

'We're still forming – the storming is yet to come' (9)

'We'll have to learn to disagree ... that doesn't mean that we can't get on with other organisations'. (4)

Local authorities and PCGs

Relationships with the local authority are noticeably less well developed than those with the health authority. The presence of a social services representative on the board was seen as one way of developing this relationship, particularly at an operational level, but others recognised that this was probably not enough to bring together local authorities and PCGs. One of them had, for example, co-opted the local authority's Director of Strategy and Regeneration on to their board. Thus the PCG had access to someone with a more strategic and corporate function at the local authority. They had knowledge of different local initiatives such as Health Action Zones, Education Action Zones and Single Regeneration Budget bids.

One or two PCGs were thinking about joint appointments between the local authority and PCG as a way of enhancing partnership working. Whilst several felt that the PCG-local authority axis could be a potentially powerful and exciting one, notes of caution were sounded, particularly as many were aware that local authorities were also facing reorganisation and budget cuts. Transferring funding across sectors may not prove as straightforward as *Partnership in Action* suggests:

> *'Why would anyone in education spend money on a "medical" project?' (8)*

The political dynamic of council politics is another factor influencing the readiness of local authorities to engage in HImPs:

> *'The flagship Conservative local authority seem unsympathetic – health seems to be shouldering the burden in terms of inequalities' (10)*

And finally there was recognition that there were significant cultural barriers to be overcome:

'It's like talking to Americans. You think you are talking the same language but you are not' (1)

Other PCGs

In some areas, there appear to be strong links between PCGs, and officers and HImP leads meet regularly to share problems and solutions. This is perceived as a way of providing mutual support as well as learning from the successes and mistakes of other emerging groups. Some PCGs preferred to develop their own *modus operandi* first, and establish local networks, but they acknowledged that, as they took on more responsibilities, it might be appropriate to strengthen cross-PCG links.

Trusts

None of those interviewed mentioned acute trusts as important stakeholders with whom they had started to develop a relationship. This may be because it is still early days, or there may be a perception that acute trusts have only a marginal role to play in health improvement. If they were mentioned it was usually as a concern that hospital spending would dominate:

'The HImP may just become a set of good ideas, pushed further down the agenda, secondary to the day to day running of services' (10)

Community trusts were only mentioned by three or four respondents. One respondent felt that they did not know whom they should be talking to – should it be someone at senior management level on the trust board, or a locality manager? Two other respondents commented on community trust relationships in the context of the move towards developing primary care trusts. There was a concern that this was more about 'saving the community trust' than developing PCGs, and this could lead to GPs feeling disaffected. Far from promoting greater unity between primary and

community care, in some places, at least to start with, the development of PCTs could potentially be the source of more division between the two.

Priorities

A number of respondents commented on the difficulty of priority setting and needs assessment, and recognised the importance of developing transparent processes to do this.

PCGs interviewed had identified between two and five priority areas. Their choice had been heavily influenced by the national agenda, relayed through their health authority. All 17 PCGs had chosen cardiovascular disease as one priority, with diabetes, mental health, and cancers being the other main 'disease-based' issues.

In one health authority, PCGs had been asked to address inequalities in whichever way they felt able to do so, and the majority opted for preventing teenage pregnancies, based on local information from their public health department, and the views of local GPs and other board members.

Two PCGs (in different health authorities) had decided to address health needs of refugees as part of tackling inequalities. One of these also planned to address the health needs of the homeless by developing different models of primary care. Two respondents felt that they would have liked to address housing as a priority, but that this was probably beyond their scope or influence. This underlines the benefits of close working with local authorities. One respondent felt that their list of priorities did not really address the subject of inequalities.

In all four sites, public health support had been provided, both by sharing local information and by assigning public health people to work with each PCG. This support was clearly valued, and there was an expectation that such arrangements would need to be formalised in the long term. The choice of priority was sometimes

pragmatic, building on existing structures or activities. For example the *Implementing Clinical Effectiveness* project in one health authority provided a strong impetus for continuing cardiovascular disease prevention.

One respondent felt that, if PCGs were to be more responsive to local needs, they would need to make better use of existing (but often untapped) information, such as health visitors' records. In one site, PCGs were planning to carry out local needs assessments during the year to better inform the next phase of the HImP.

At this stage there appears to be a strong focus by PCGs on clinical interventions, such as the secondary prevention of coronary heart disease through better monitoring of cholesterol levels and blood pressure in high risk patients. But, when questioned about primary prevention, it became clear that other agencies and non-clinical interventions were considered important. For example, with coronary heart disease, influencing children and young people's lifestyles would involve schools more than doctors. Discussions on teenage pregnancies in one PCG soon became discussions about parenting skills.

> *'If you think about the opportunities for prevention, they may lie more in schools or leisure services for example. Doctors are not much on the agenda' (14)*

One respondent felt that an important role for public health was to provide evidence of the effectiveness of interventions for health improvement, as this would help PCGs to target their efforts and actions more appropriately.

Public involvement

A small number of PCGs had already held public meetings before 1 April. Most PCGs relied on their lay member and the local Community Health Council to represent the public, and most were aware that this was an important area that needed to be addressed in developing future HImPs, and indeed in other areas of PCG work.

'Health improvement should be an issue for the public and not the professionals – but how realistic is this? Might the voluntary sector provide the link between the public and professionals in developing this?' (1)

Over half of those with a working group structure had appointed a 'public involvement group', in some cases linked to the HImP group. However, as one respondent put it, involving the public is 'an art form', which will take time, and innovation. It also assumes that professionals will be prepared to let go.

Summary of primary care group findings

The contribution of PCGs to the development of the first HImP was less significant than that of health or local authorities, but there was optimism among PCGs that this will change and their influence will increase. PCGs see opportunities in HImPs to:

- improve multi-professional working
- increase partnership with other agencies and organisations
- be more locally responsive to their populations
- develop public health skills such as needs assessment and the use of evidence-based interventions
- move resources from secondary to primary health care with more emphasis on prevention
- improve the quality of primary care (levelling up)
- help to address deep seated problems in their local population, some of which may have little to do with clinical services
- engage and involve staff in the front line

The issues causing greatest concern to those in PCGs are:

- *Overload.* There were too many changes to implement simultaneously in too short a time. The Government has underestimated the amount of work required of health authorities to get PCGs up and running at the same time as developing the first HImP.
- *Capacity to deliver.* PCGs still have minimal infrastructures, with most board members doing another job at the same time.
- *Lack of resources to implement change.* Many felt that Health Improvement Programmes would founder without extra resources being available. There was a lack of clarity as to whether there would be any extra resources, and if so, how much.
- *Being able to measure/demonstrate progress* was important to maintain motivation. Most respondents did not want to see the emphasis shift to one of performance management. They felt that if failure to demonstrate change were to be met with punitive measures, GPs would perceive HImPs as a threat and retreat to their 'day jobs' of seeing patients.
- *Developing ownership* of the health improvement agenda by those who are going to have to deliver it – the whole primary care team.
- *Ensuring that they make decisions on the basis of need and not just demand.* If PCGs simply rely on the information that GPs obtain from patients coming through their surgery door, there is a risk that they will fail to meet the needs of some of the most vulnerable groups in their patch, who are least accessible to mainstream health services. These included, for example, the severely mentally ill, the homeless, and refugees.

Some lessons may be drawn from the first year's experience to improve PCGs role in HImP development:

- develop a shared vision of health improvement locally, including the roles and responsibilities of different agencies. Ensure that different perspectives within the PCG can be expressed
- strengthen basic structures and processes – for example means of consulting and feeding back to primary care teams, priority setting processes and methods of public participation
- use existing information in primary and community care better to identify local needs and to target actions more effectively
- involve the whole primary care team in the delivery of HImP – it is not just an agenda for GPs
- develop measurable and meaningful indicators to demonstrate progress. Some of these will have to be process rather than outcome-based
- use professional development opportunities to enhance both multi-professional and multi-sectoral working

Many felt that simply having more time to establish dialogue between key players, and to build up infrastructures will make it easier for PCGs to contribute more effectively to improving the health of their local populations. This view was echoed by interviewees in health authorities and the boroughs.

DISCUSSION

Across all three sectors we surveyed, there was good will and enthusiasm for the concept of HImPs, and for the wider health policy reforms. More specifically there was evident support for a policy that squarely acknowledges and addresses issues of health inequalities and health improvement – something that was felt to have been lacking previously. There is manifest commitment to a health improvement policy that puts the emphasis on partnership and recognises that the determinants of health extend far beyond the remit of health authorities. These combined factors are perceived to be capable of leading to new ways of working which have the potential to improve health.

However welcome these health policy reforms are, they are necessarily accompanied by fundamental changes in roles and responsibilities. This brings uncertainty, particularly in the absence of a clearly articulated end-product. The consequences of so much change remain unknown and the subject of speculation. Health authorities, in particular, face an uncertain future as PCGs develop. Their role will inevitably change as responsibilities are passed out to PCGs and ultimately to PCTs. There is speculation that health authorities will be reduced in number within a national restructuring of the whole district tier of the NHS.[13] This will have implications for their partners in local government whose relationship with health authorities, to be underpinned by statute, is an important element of current health improvement policy.

The role of public health is also changing, and is likely to change further following the Government's review of the public health function, which will presumably make recommendations about the organisation of services. Since 1972 there have been arguments in favour of returning public health to local government.[14] As statutory partners in the HImP process, local authorities need public health expertise. As we found, some have obtained this through secondment of public health professionals from their health authority. Some public health appointments are now being made

jointly by local and health authorities, such as that of the DPH in Solihull.[15] While the main public health function remains within health authorities, its future must now be inextricably linked with HImPs, although some elements will be needed to advise PCGs on needs assessment, and for monitoring purposes.

The challenge facing public health in relation to HImPs is to ensure that, unlike the former Health of the Nation strategy, the programmes develop as genuine strategic frameworks for the commissioning of services, capable of influencing expenditure and diverting funds in accordance with health improvement objectives. HImPs must not come to be seen as merely the property of public health departments, which can be disregarded by everyone else.

More specifically, a key role for public health is to ensure that evidence on the effectiveness and cost effectiveness of interventions to improve health is gathered and widely disseminated, and can inform the action plan that emerges from the HImP.

Working in partnership

Government policy states that the purpose of partnership working is to provide services responsive to the needs of the individual. There is no blueprint for successful partnership, but evidence from research into joint working over the past few years has identified a number of barriers to delivering effective user-based services. [16, 17] These include:

- a lack of knowledge and understanding of other partners' perspectives and strengths
- legislation and regulations that limit ways in which resources can be used

The same research pointed to the need to develop leadership styles appropriate to the process, and to maintain a strategic approach. At the same time it must be possible to

make and implement decisions, through the partnership, which have tangible outcomes. The engagement of all partners is required.

These factors suggest ways in which stronger partnerships can be developed for the HImP

- articulating a clear vision of what health improvement means locally
- identifying roles and responsibilities for different partners
- establishing agreed processes for setting priorities
- recognising and respecting the different cultures involved in the partnership

The need to share information across health and social sectors is important, but fraught with difficulties – for example there are ethical considerations of confidentiality. Several interviewees in both health and local authorities referred to this as a stumbling block.

The first HImPs have been produced with remarkable speed by partnerships in the earliest stages of development. Any working partnership takes time to mature, and expectations must be realistic. At this stage considerable energy is going into developing and extending partnership, and it is important that the processes of partnership do not become ends in themselves, but means to other ends. If it does not deliver tangible improvements, partnership working will rapidly descend into meaningless bureaucracy.

Local authorities and PCGs are, in a sense, the newcomers to the health improvement partnership. To maximise the full potential of their contribution to the partnership, an appropriate leadership style is essential. In the short term, the lead agency will continue to be the health authority, but this may not always be the case, and, as HImPs develop, it may become appropriate for local authorities to take on this role, or for it to rotate between health and local authorities.

The evidence suggests that it may be inappropriate for PCGs to take the lead in HImP development – by virtue of their size, constitution, remit and governance. The necessity of engaging PCGs in the HImP should not be underestimated, but it would distort their fundamental purpose if they were to act as lead agents in a district wide strategy.

Public involvement and accountability

Involving the public is an underlying principle of HimPs, and a notoriously difficult one to achieve. In discussion of health policy a distinction should be drawn between the public as *the population/the community/the electorate,* and the public as *patients/carers/service users.*

Increasing public involvement is a key theme of Government policy in respect of both these interpretations. Advancing the notion of active citizenship and revitalising democracy through reform of institutions address the former interpretation. Health policy explicitly seeks to involve the public both as members of the community and as service users. Increasing public involvement in the HImP should:

- improve responsiveness to local health needs
- increase the capacity of the local community to meet some health needs, through, for example, community development approaches
- increase the accountability of public sector organisations to their local populations

However, in light of the first year's experience of HImP development, there remain considerable difficulties in public involvement. If public views are to be sought, policies must be presented in an accessible way, and there must be a demonstrable willingness to respond to those views, even if they do not fit easily with the organisations' own perspectives and constraints.

Simply deciding who should be involved is difficult. In local government, elected members have a democratic mandate to represent their electorate's views. Non-executive members of health authorities tend to relate to the public as service users. Community Health Councils have a role as a conduit to and from the public, and Government policy also regards the voluntary sector as in some way representative of the public's views, but in reality voluntary organisations are more likely to represent users of services and their carers. Opportunities for involving the public as citizens remain inadequate.

Government policy seeks to make health authorities and PCGs in some way more representative of the public by including non-executive members on the former, and a single lay member on each of the latter, but these are all NHS appointments. More recent reforms have enabled local authority chief executives to attend meetings of health authorities.

Due to come into existence in the year 2000, the Greater London Authority and the elected Mayor of London will be in a position to influence health improvement initiatives across the capital. The precise nature of their role in health policy and strategy has been the subject of speculation[18] since powers in the GLA Bill are largely permissive. However, the many pan-London agencies to be operated by the Mayor and the new Authority will provide new partners to be engaged in the pursuit of health improvement objectives. The considerable executive powers of the directly elected Mayor provide plenty of scope for interventions as well as opportunities for London-wide health promotion.

The involvement in HImPs of the public's elected representatives, local government councillors, is at present rudimentary. There is no formula for the role of councillors in this context but many of our interviewees recognised its importance. The point has already been made that local authorities are well placed to deliver public accountability for the delivery of the HImP, and could conceivably inject an element

of accountability into PCGs, if proper links can be forged. Councillors could be members (possibly *ex officio*) of PCGs or could link with lay members of the groups.

There is a plethora of emerging models for public involvement, such as citizens' juries, patient panels and focus groups, but for both health and local authorities the issue of 'user fatigue' is becoming very real. While the responsibility to ensure public involvement remains, there is a strong case for seeking to rationalise the processes locally, as several boroughs and health authorities are already doing. It may be appropriate for one partner only to take responsibility for co-ordinating public involvement in the HImP on the basis of shared goals and agreed action plans.

Resources

If HImPs are to be more than just fine words, resources will need to be channelled into supporting activities that promote health improvement. There is little evidence from the experience of the internal health market that health authorities were able to use their role as purchasers to develop disease prevention and health promotion activities. The financial agenda has historically been driven by the need to meet acute service pressures.[19] Given that most resources are tied up in acute trusts, the need to involve them more fully in their local HImP is of strategic importance. Without their co-operation it will be difficult to redistribute the limited resources available, but it will be important not to allow trust priorities to hijack the HImP.

PCGs are taking increasing responsibility for commissioning budgets, but it is uncertain as to whether they will be spent according to needs-based, health improvement objectives. This was difficult enough for health authorities when they had responsibility for commissioning. Other evidence from the past is not encouraging: evaluation of total purchasing pilots showed that little use was made of health needs assessment, or evidence of effectiveness, to inform purchasing decisions.[20, 21] PCGs are likely to be dominated by general practitioners whose

services are traditionally demand-led, and who are not well placed to take a strategic, population-based approach to health promotion.[22]

At present, some health improvement initiatives have been funded as part of bids submitted to wider programmes such as Health Action Zones and the Single Regeneration Budget. What is needed is a reconciliation of various planning cycles, so that there are tighter links between, for example, the HImP, the Service and Financial Framework and the Joint Investment Plan. The HImP must be capable of influencing the distribution of core resources through these planning processes.

One of the findings giving cause for concern is the absence of funds for new health improvement initiatives involving expenditure by local authorities, which fall outside the social services/health field. In *Partnership in Action* the Government invites views on how the proposed flexibilities between the NHS and corporate local government – beyond social services – might be used. This issue requires some solutions, if other departments of local government, such as leisure or education, are actively to engage in the HImP. Proposals to legislate to extend the Joint Finance Initiative and allow for transfer of funds between health and local authorities should help, but they will be implemented in the context of a substantial financial shortfall within which many health authorities have to implement the first HImP. In one of the health authorities we researched, this shortfall amounts to some £17 million, a sum that dwarfs the £5 million the same authority can expect for its HAZ.

In the longer term, more pressure may be needed to bring about a fundamental shift in the way resources are distributed. One possible catalyst would be a stronger steer from the centre to make health improvement as much of a priority target as, for example, hospital waiting lists. The NHS Performance Assessment Framework[23] includes health improvement as one of its six dimensions, but it remains to be seen whether this will carry any weight. The risk of using performance management to drive progress is that ownership of health improvement may be lost by the very people who are meant to be delivering it. There is a fine balance to be struck between

orders issued from the centre that need to be followed rigidly, and allowing local flexibility.

Measuring progress

Many of those interviewed highlighted the importance of being able to demonstrate that progress had been made, and that HImPs needed to be more than just talking shops or wish lists. It will be important to develop indicators that are not only measurable, but have real meaning for those in the 'front line' involved in HImP delivery. A range of indicators, including process as well as outcome measures, and social as well as health indicators, will be needed. In particular, local authorities must be able to measure their contribution to the HImP, if their new role is to be properly tested and understood. Social indicators which relate not just to personal care services, but to the range of local government services must be deployed – housing, transport, environmental, leisure, crime prevention, employment and education. Some indicators will be needed that can be shared across professional, intersectoral and departmental boundaries. Health authorities and local authorities have a key role in developing these measures locally, with their other partners. The process of identifying and agreeing indicators is itself an aid to development, as work in cities such as Liverpool and Leeds has shown.[24, 25]

It is important that evaluation does not dominate the HImP process, and that a limited, manageable number of indicators are used to measure progress. The emerging findings should be presented to the public as a health promotion opportunity. Since much in health improvement is a matter of individual lifestyle and choice, public understanding, support and engagement is vital to the HImP's success.

In conclusion

Overall this appraisal provides cause for optimism. In building on the experience of the first HImP the aim must be to maintain motivation and sustain the processes of development which are underway. Some issues need to be addressed centrally, in the interests of all partners in the HImP.

In particular, attention should be paid to the following concerns:

- the balance between local and national priorities may be a source of potential conflict
- partnership working may be impeded by difficulties in reconciling different budget streams across different sectors
- the HImP may fail to influence allocation of resources and become a theoretical construct confined to departments of public health
- those working in the public sector, particularly in the NHS, are at risk of being overwhelmed by the pace of change
- the HImP must be capable of translation into practical action if those in the front line of service delivery are to share 'ownership'
- HImPs can only succeed it they engage the active participation of local populations

The HImP partnership will look to the Government and to Regional Offices of the NHS for practical guidance on these issues. For the different sectors involved in this appraisal – health authorities, local authorities and primary care groups – the opportunities, concerns and recommended actions are listed in the Summary at the beginning of this report.

It would be premature to predict whether HImPs will succeed. It may be a decade before any judgements can be made, but political expediency, and the need for governments to show results before election time, may not permit the luxury of

waiting that long. The initiative has been built on previous policies, such as Health of the Nation, 'Local Voices' and Joint Commissioning. The question is whether we have learnt enough from the past to avoid repeating mistakes.

It is evident that HImPs are generating considerable enthusiasm and support at the local level. Extending 'ownership' as Government policy requires, and then maintaining commitment, is difficult to achieve in any partnership. Without it, however, HImPs are unlikely to be the means of delivering the vision of reduced inequalities and better health to which the Labour Government aspires.

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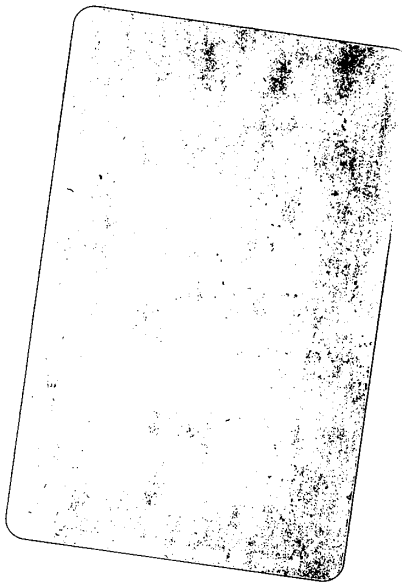

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