London's Health

developing a vision together

The London Health Strategy

Outline Strategic Framework

March 2000

The London Health Strategy sets up a broadly based Coalition for Health and Regeneration, working to improve the health and well-being of Londoners. It builds enthusiastically on the huge amount of strategic work already under way across the capital. It pays special attention to diversity and to health inequalities, both between groups and between parts of London. This document sets out the framework.

Facilitated by the NHS Executive London Regional Office

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Foreword

The need to improve the health of Londoners, and to reduce health inequalities, is of great and growing concern to us all. Achieving this calls for coordinated action to impact on the many social and economic factors known to influence health. These include employment and income levels; quality of housing; transport issues; levels of crime; and the environment in which people live and work. It means targetting action on vulnerable groups; promoting healthier lifestyles; and ensuring that high quality health services are accessible to all.

London is unique. For all its great strengths, it is marked by high levels of deprivation, social exclusion and homelessness. It is a city showing extremes of affluence and poverty, often next door to each other. High infant death rates, levels of mental ill health, and drug misuse and addiction are of serious concern in some areas. One of London's strengths is its large and diverse range of black and minority ethnic communities; yet members of these communities are more likely than others to be out of work; to be badly housed; and to have poorer access to public services.

Public service provision is undergoing major change, to an extensive Government-led modernisation agenda. The aim is to make services more sensitive to the needs of our population, ensuring that all sections of the community, particularly in the wake of the Stephen Lawrence Inquiry, have the same access to high quality services.

A coordinated, London-wide approach can make a significant difference to the factors influencing Londoners' health. Recognising this, a broad range of organisations has formed a partnership to develop the London Health Strategy. The development process has also involved many other individuals and organisations, taking part in workshops and conferences to help shape an agreed programme of change.

The strategy is based on three fundamental principles: that health can only be improved by working in partnership; that citizens and communities need to be actively involved; and that the sharing of intelligence, about health and how it can be bettered, is essential.

In future, we want to work with the new Mayor and Greater London Assembly in taking forward the strategic agenda. To meet the need for practical collaboration on a range of issues, we have helped create a **Coalition for Health and Regeneration**. This will provide the necessary bridge between strategic thinking and action on the ground to improve people's health. Over the next few months the Coalition will be drawing up action plans, and inviting organisations and individuals across London to play their part in making London a healthier place in which to live and work.

Ian Mills
Chairman of the NHS Executive London Region
and of the London Health Strategy Steering Group
27 March 2000

Introducing the London Health Strategy

The London Health Strategy sets up a broadly based Coalition for Health and Regeneration, working to improve the health and well-being of Londoners. It builds enthusiastically on the huge amount of strategic work already under way across the capital. It pays special attention to diversity and to health inequalities, both between groups and between parts of London. This document sets out the framework.

The strategy takes account of:

(1) the many and complex factors which determine Londoners' health;
(2) the wide range of health related issues which can benefit from an enhanced London focus.

The strategy's fundamental principles are those of:

(1) working in partnership;
(2) involving citizens and communities;
(3) sharing intelligence.

Partners in the strategy look forward to working creatively with the Mayor and the Greater London Authority.

The four, closely interconnected top priorities are to:

(1) work for health and regeneration;
(2) address inequalities and poverty;
(3) promote the health of black and minority ethnic people;
(4) improve transport, and related aspects of the environment.

It is also important to:

(1) improve London by tackling housing and homelessness, crime and disorder, and water fluoridation;
(2) promote the health of these other vulnerable groups, and improve their access to services: young children, young people, and refugees and asylum seekers;
(3) promote healthier lifestyles, by reducing smoking, substance misuse, and accidental deaths and injuries.

All this must be underpinned by developing:

(1) ways of measuring progress – ten high level indicators are proposed;
(2) health impact and health inequalities impact assessments;
(3) wider research and evidence;
(4) practitioners' knowledge and skills;
(5) the London Health Observatory.

Finally, the strategy can create a better context for **improving health services in London**. Six key areas are sketched.

Two other documents are being made available alongside this one:

(1) **a summary**, presenting the strategy and the four top priorities at a glance;
(2) **a statistical supplement**, with basic facts and figures about many of the health issues, and more about the proposed set of progress indicators.

Why not join us in taking the strategy forward? Please see the contact information on the inside front cover of this document.

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Part 1: The thinking behind the strategy

Why a strategy is needed

It is abundantly clear that the health and well-being of Londoners can be improved. A great deal of local work to achieve this is already under way. So what is missing? The answer is that not nearly enough is being done at a London-wide level to work in partnership; involve citizens and communities; and share intelligence, about how things stand and what can make them better. The London Health Strategy was conceived and developed to its present stage in positive response to these shortfalls. This part of the document further explains the thinking.

Why London is unique

London faces many problems. However, the snapshot of these which now follows should of course be set against London's great and positive qualities as a world centre of finance, commerce, the arts, education, research and medicine.

(1) London's very large population of 7.5 million is partly characterised by high levels of deprivation, social exclusion, and homelessness. Yet it shows extreme contrasts, with pockets of great deprivation next door to those of great affluence. London shows a wide range of health indicators, from the very good to the very bad. Moreover, the health gap between the most affluent and the most deprived communities in the capital grew during the 1980s.

(2) As elsewhere in the UK, the major causes of death in London are coronary heart disease, stroke, lung cancer and breast cancer. Deaths from these diseases before the age of 65 are considered avoidable by timely and appropriate intervention. However, in some London boroughs the chances of dying before the age of 65 are 50% higher than in others. There is a downward trend in most of these death rates, but in the most deprived parts of London the fall is slower than that seen nationally, and in some cases rates are rising. The health gap is exemplified here by a widening gap in death rates between the most affluent and the most deprived wards in London. Infant death rates are particularly high in some parts of London. Poverty and disadvantage particularly affect children. The *Acheson Report*[1] identified the need to address inequalities in children's health and early development. This will be a key factor for future generations. Accidents and injuries are also an important public health issue in relation to young people.

(3) Mental health, and drug and alcohol misuse and addiction, are major health issues in London, and are more serious in the capital than elsewhere. Similarly, social factors associated with these, such as unemployment and deprivation, are more acute.

(4) London has a large and diverse black and minority ethnic population. In some boroughs it is now estimated that 50% of the population are members of black and minority ethnic groups. Some of these groups live in poor accommodation, and experience significantly higher levels of unemployment. Some common medical conditions, such as coronary heart disease and diabetes, are more prevalent among certain black and minority ethnic groups. In addition,

[1] *Report of the independent inquiry into inequalities in health* (the Acheson Report). Department of Health: Stationery Office, 1990.

there is evidence that these groups suffer from poorer access to health care and other public services than other groups in the population.

(5) London is a common arrival destination for refugees, asylum seekers, and other persons seeking residence in the UK.

(6) London is the first city in the UK to have an elected Mayor and Assembly, which will be responsible for many of the aspects of life in the capital which determine people's health. The opportunity of working with the Mayor and Assembly, to change these factors for the better, cannot be missed.

What makes for a healthier population

It is increasingly recognised that health is far from being just an NHS issue. People having available to them at least adequate education, jobs, income, housing, social support, and environmental quality – this makes a real difference to how healthy people are. These are the determining factors; therefore, they are the things which need to improve, if Londoners are to become healthier.

For example, take two children each aged four, one the child of an unemployed labourer and the other the child of a busy professional person. The former is four times as likely as the latter to be injured in an accident in any one year.

NHS treatment and care also matter to people, particularly when they are ill, and so it is very important to get them right. Yet achieving the reductions in ill health and the improvements in health anticipated in the Government's health strategy for England, *Saving Lives: Our Healthier Nation*[2], means addressing the determining factors, not just treatment and care. For instance, one of the national targets is to reduce the death rate from cancer among people aged under 75 by at least 20% by the year 2010. Yet four fifths of this reduction has to be through preventive measures: so even if cancer treatment services were perfect, the resulting gains would fall far short of meeting the target.

Smoking, poor diet and lack of exercise are all risk factors for coronary heart disease and for cancer. Yet once again, the lifestyle a person adopts is largely determined by their social circumstances and by their environment. So healthier lifestyles can only be achieved by creating the right circumstances for people to adopt those lifestyles. In many poorer neighbourhoods it is very hard to obtain the fresh fruit and vegetables recommended as part of a healthy diet; only less healthy, processed foods are easily available.

How the London Health Strategy can make a difference

Many parties, working in partnership at all levels, can help achieve change. These include:

(1) the Government;
(2) London-wide bodies;
(3) health authorities and boroughs;
(4) neighbourhoods and communities;
(5) individuals.

For all the determining factors for health, there will be action at more than one level. The intention of the London Health Strategy is not that everything be done London-wide, but to show how London-wide action can support action at local level, which will continue to represent the bulk of the effort to improve health and reduce health inequalities. This will be led by local authorities and health authorities, via the Health Improvement Programmes,

[2] *Saving Lives: Our Healthier Nation*. Department of Health: Stationery Office, 1999.

community plans and other plans already being developed.

Work at London level will thus primarily be concerned with:

(1) drawing together and sharing what is being learned locally;
(2) addressing issues for which only a London-wide approach can be fully effective, such as the health impacts of transport and of air pollution;
(3) fostering cooperation between London-wide organisations, to enable and encourage local partnership action;
(4) developing common measures of success.

For some issues, both local and London-wide action may be needed: for example, to improve transport, and reduce smoking.

Making a start

The NHS Executive London Regional Office, along with the Association for London Government, the Social Care Region, London, and the King's Fund, have led a dynamic process to develop the London Health Strategy.

In partnership with many London-based organisations, from the public, voluntary and private sectors, they have steered a process to agree an agenda to improve the health of Londoners. Members of the Steering Group are listed at the end of this document. The process was started in May 1999, with this outline strategic framework documenting the main elements of the strategy agreed to date. Over time more action will be identified to address key issues of concern to the health of Londoners.

The extent of partnership working to produce this framework is unique in London. Never before have so many organisations and individuals from so many sectors and backgrounds been involved in developing a comprehensive health strategy for the capital.

Part 2: Building the Coalition

Three fundamental principles

The organisations and individuals who have so far contributed to developing the London Health Strategy have agreed on three fundamental principles:

(1) Everyone will work in partnership;
(2) Every effort will be made to involve citizens and communities;
(3) Intelligence about health and health related issues will be widely shared.

Working in partnership

The major new partnership will be the Coalition for Health and Regeneration, established as the mechanism for moving from strategy to practical action. More is said about this in part 3A of this document.

The challenges of establishing effective partnerships are as great at a London-wide level as they are in local areas. Sharing resources, joint development work, shared learning, and mutual facilitation of initiatives are all part of this.

Tackling the root causes of ill health in a population calls both for action by individual agencies and more holistic solutions, to be achieved by partner organisations working effectively together.

It is recognised that very specific local work with particular communities stands the best chance of achieving substantial and lasting change for the better.

The intention is that all public service, voluntary, community, and commercial bodies in London, and all interested individuals, will be given positive encouragement to contribute. Many people working in each of these sectors are already working to promote or improve the health of Londoners, for example by addressing poverty, homelessness, employment, education, and regeneration.

Professional groups who can contribute to taking the strategy forward include:

(1) health and health promotion professionals, both medical and non-medical;
(2) other professionals with a population focus, such as health visitors in the health service, and environmental health officers in local government service;
(3) others working in the NHS, in local government and in other organisations whose main focus is on individual patients or clients, but who need to address broader health issues. These include members of the new primary care groups and trusts, whose functions include improving the health of their communities; and those working in mainstream health and related services in which a focus on improving health may be appropriate.

Involving citizens and communities

It is of the greatest importance to find ways of involving London's citizens and communities, both to address their concerns and to help them make their own contribution to addressing these. The voluntary and community sectors are key.

A commitment by all London Health Strategy partners to fostering community development, capacity building and participation is essential to ensuring health

improvement in the capital. Such a commitment is therefore integral to this strategy, and to other London-wide and local strategies which have an impact on health. This carries with it implications for appropriate resourcing, information sharing, training, and evaluation, which will be further considered.

A wide range of voluntary and community organisations was invited to a series of 'Wider Soundings' workshops, held during February 2000, on the themes of regeneration, social cohesion and diversity. Participants supported the development of the London Health Strategy. They asserted that to achieve its objectives it must:

(1) be 'live' not static: not set in stone but capable of responding to changing needs;
(2) be a *strategy*, with measures in place against which success can be judged;
(3) look at health in its widest sense;
(4) create links with other strategies;
(5) be visionary and challenging.

Participants also gave their views on priorities. These can be summarised as the need to:

(1) target resources on those most in need;
(2) build on good practice, not reinvent the wheel;
(3) communicate and educate Londoners on healthy lifestyles and on what services are available to them;
(4) listen and keep on listening to what Londoners say they need and their experience of using services;
(5) work in partnership;
(6) build and develop the capacity to deliver services at local level;
(7) change attitudes and break down barriers to access.

The feedback from the workshops can be seen to support the way in which the London Health Strategy has been taken forward to date, as well as the principles the partner agencies have adopted regarding its development. Partners hope to build on these soundings, to ensure that the strategy continues to be informed by the voluntary and community sector.

Sharing intelligence

Successful efforts to improve the health of Londoners will depend upon everyone concerned having access to adequate, shared intelligence concerning how things stand in relation to any given health issue, and what kinds of intervention have the best chance of changing things for the better. This sharing is unlikely to come about spontaneously; it will take planning and organisation. Working out how to make this happen will be an essential task for the next stage of strategy development.

Already there are some initiatives in place. The London public health network aims to act as a mechanism for sharing intelligence, as well as expertise and good practice. The London Health Observatory (please see part 7E of this document) will provide a mechanism for monitoring change in the health and well-being of Londoners over time, making use of information from many sectors.

Working with the Mayor and the Greater London Assembly

Introduction

The Greater London Authority (GLA) will embody a new category of local government, with explicit separation of powers between the executive (the Mayor) and the Assembly. It will consist of the Mayor, the Assembly, and staff providing common support services and expertise. It will have strategic responsibility in eight main areas:

(1) transport;
(2) economic development;
(3) spatial development;
(4) biodiversity;
(5) ambient noise;
(6) air quality;
(7) waste management;
(8) culture.

In addition, the Mayor will have a duty to promote improvements in the health of the people of London; equality of opportunity; and sustainable development. The

Assembly will work with the Mayor to improve the health of Londoners, and may wish, and will be able, to investigate specific health issues.

The Mayor will have responsibility for appointing members to, and setting the budgets for, four new organisations:

(1) Transport for London (TfL);
(2) The London Development Agency (LDA),
(3) The Metropolitan Police Authority (MPA);
(4) The London Fire and Emergency Planning Authority (LFEPA).

In the case of the LDA and TfL, the Mayor will also set their strategic direction. The expectation is that the GLA will also create a framework for working in partnership with all sectors.

Links with the London Health Strategy

It will be highly desirable for all partners in the strategy to explore ways of:

(1) introducing health onto every public agenda;
(2) developing professionalism in handling health issues, including a clear methodology for health impact assessment and health inequalities impact assessment;
(3) developing a sense of key shared priorities for Londoners' health;
(4) building relationships with the Mayor, the executive, and members of the London Assembly, as well as other key figures and organisations likely to have an influence on the public health agenda.

Part 3: Identifying the top strategic priorities

How the priorities have been arrived at

The question of setting priorities in relation to the strategy arises in two ways.

(1) Deciding which substantive issues to include in the strategy has already involved making a selection. The ones currently included have been chosen on the basis that they:

   (a) are significant in terms of their impact on the public health;
   (b) are of relevance and concern to Londoners;
   (c) have the potential to benefit from action at a London level;
   (d) can relevantly be presented to the Mayor and Greater London Authority for their early consideration;
   (e) can build on the widest possible range of existing interest and activity.

(2) It has been thought desirable to make a further selection of four issues from among those included in the strategy, designating them as the top priorities.

These have been arrived at as a result of a priority setting exercise involving members of the many organisations and interests represented on the London Health Strategy Steering Group: please see the list of members at the end of this document. These four top priority issues are presented in the remaining sections of part 3:

- 3 A Working for health and regeneration;
- 3 B Addressing inequalities and poverty;
- 3 C Promoting the health of black and minority ethnic people;
- 3 D Improving transport, and related aspects of the environment.

These priorities are closely interconnected. Thus, successful regeneration involves addressing inequalities and poverty, and improving employment and access to services for black and minority ethnic communities; conversely, reducing inequalities and empowering black and minority ethnic people supports regeneration. Transport plays a critical role in helping link communities with places of work and key facilities, particularly those communities which are poor, and those with a high proportion of black and minority ethnic people.

Part 3 A: Working for health and regeneration

Some basic facts

London has two thirds of the worst housing estates in the country, thirteen out of the twenty most deprived local authority districts, and 44% of the country's black and minority ethnic population. As the report *The Health of Londoners*[3] showed, there is a very close correlation between the areas of greatest social and economic deprivation and the incidence of ill health. Health and regeneration are thus inextricably linked, and must be pursued together.

The London Health Strategy will therefore:

(1) build a Coalition for Health and Regeneration;
(2) take health into regeneration;
(3) take regeneration into health;
(4) share knowledge and best practice;
(5) build capacity in deprived communities.

Building a Coalition for Health and Regeneration

Strong leadership is needed at pan-London level to ensure that links between health and regeneration are built and maintained; that the right framework is set; that appropriate impact measures are put in place; that the wider partnership at London-wide, local and community levels that is needed to give effect to the London Health Strategy is supported and local capacity is built; that the strategy is widely communicated; and that best practice is promulgated and shared. The Coalition aims to be particularly sensitive to the need to tackle inequalities, social exclusion and black and minority ethnic issues. Its initial membership comprises the partners to this strategy, who will be seeking to work with individuals and organisations – including the Greater London Assembly and the new Mayor – to improve health in London.

The Coalition aims to report progress in a published report within eighteen months of its launch.

Taking health into regeneration

Regeneration is not just about specialist programmes such as the Single Regeneration Budget, New Deal for Communities, European funds, or the wide range of area based initiatives such as Health Action Zones, Sure Start, Employment and Education Action Zones. Regeneration is also about the bending of all those main programmes that bear on social exclusion so as to target the most deprived areas; and about 'joined up' action between public, private and voluntary sectors to make a lasting difference to the most disadvantaged communities. For the London Health Strategy to be effective, there is a need to ensure that all these programmes, and the partners that are responsible for working together to deliver them, are fully aware of the relevance of health issues, and of the contribution they each can make to improving the health of Londoners. This will require new techniques of measuring and monitoring health impacts to be developed and widely incorporated into the various mechanisms by which funds are allocated and projects selected. It will also mean effective communication and training programmes, to ensure that the language barriers and institutional barriers between health professionals and regeneration professionals are broken down. The King's Fund, working with partners, will

[3] *The health of Londoners: a public health report for London*. Health of Londoners Project, King's Fund, East London and the City Health Authority. King's Fund, 1998.

have a key role in enabling this dialogue to take place and in developing the necessary toolkit for practitioners to use.

Taking regeneration into health

Just as those engaged in regeneration activity need to understand the importance of health issues, so health authorities, NHS trusts and primary care groups need to understand the impact their work has on regeneration. There are opportunities for them to make a real difference to the health of Londoners by contributing to regeneration partnerships, schemes and projects, and by encouraging health professionals to adopt best practice in outreach to local communities. Health bodies are also major employers in London, and have large capital and procurement budgets. More could be done to ensure that these major operational functions are fully informed by, and thus help to promote, London's emerging economic development strategy.

Sharing knowledge and best practice

There is a bewildering amount of regeneration activity, by way not only of main programmes but also of various Government initiatives and programmes aimed at the worst hit areas; at raising educational standards; and at getting people off welfare and into work. There is also a host of different partnerships engaged in these activities. There is an equally bewildering array of health bodies, programmes, policies and performance management targets. There are numerous examples of good practice throughout London: the work of a health authority with a housing action trust on two of London's most deprived housing estates; pioneering work by a neighbourhood development trust; the creation of 'digital learning rings'; and the development of social enterprises. There is also a wealth of information on measures of deprivation and health at borough level and below, of which bodies like the London Research Centre, the Health of Londoners Project, and the King's Fund are major repositories. All this needs to be brought together, and networks of contacts set up linking health bodies with regeneration partnerships at the appropriate levels to facilitate the exchange of best practice. Maximum use will be made of the more effective means of communication; in particular, priority will be given to setting up an interactive website.

Building capacity in communities

Capacity building is essential, because neither regeneration schemes nor health initiatives will be successful unless they are owned by communities. This means more 'bottom up' initiatives. There is also a considerable need for greater cultural diversity in service provision.

Consideration will be given to means by which black and minority ethnic people can deliver services to their own communities. Moreover, there is a need to take account of the transient nature of some of London's population, including those who are homeless, refugees and asylum seekers; and to focus on the causes and characteristics of unemployment and disaffection amongst young people.

Part 3 B: Addressing inequalities and poverty

Some basic facts

There is a five year difference in life expectancy between the best and worst boroughs; a twofold variation in self assessment of fair, poor or bad health between the best and worst boroughs; and a sixfold variation in burglary rates. Nearly 20% of dwellings are unfit for habitation in some boroughs, compared with practically none in others.

Overall approach

Addressing health inequalities across London is a major challenge. Poverty and low income in particular can have a major impact on people's health. The London Health Strategy will not be able to achieve everything on its own, which is why the approach being adopted aims to fit alongside the Government's plans to tackle inequalities nationally. These have been set out both in *Saving Lives: Our Healthier Nation*, and in *Opportunity for All*[4].

Nationally, Government initiatives such as Welfare to Work and the 'New Deals' for young people, lone parents and disabled people will play an important role, as will the Working Families Tax Credit and the increases in child benefit and other similar measures to tackle poverty and low income.

The links between income and health are increasingly acknowledged, and initiatives at national, regional and local levels will need to be monitored to ensure that they achieve a real impact on levels of income and poverty, and that the associated health impacts fully assessed.

[4] *Opportunity for All: Tackling Poverty and Social Exclusion*. Stationery Office, 1998.

The London Health Strategy aims to make an important contribution to targetting and monitoring efforts to address these issues.

There is a clear need to reduce what has for too long been a widening health gap in London between the best off and the poorest off.

Inequalities in London

Recognising and addressing the marked inequalities between population and geographic groups, both in indicators of their health and in their access to services, is of fundamental importance to the strategy. Whilst it is unlikely that a totally uniform situation will ever be achieved, ways must be found of substantially reducing the currently widening gaps.

Health impact and health inequalities impact assessments should be recognised as important appraisal methods, able to inform decisions likely to have such impacts on specific groups, such as black and minority ethnic people, and older people.

Detailed information demonstrating marked health inequalities across London is being prepared by the NHS Executive London Regional Office, concerning rates of:

(1) unemployment;
(2) housing;
(3) educational attainment;
(4) crime;
(5) deaths of infants;
(6) smoking;
(7) self-reported illness;
(8) cancer registration;
(9) accidental death and injury;
(10) death from other causes.

Some of this information can be found in the statistical supplement to this framework document.

In most instances rates are calculated at London borough level, but some will in addition be available for primary care group areas. For some rates, comparisons – some favourable, some unfavourable – will be drawn between London as a region and other regions.

Specific ideas for making a difference

Participants in a multi-agency workshop held in March 2000, under the auspices of the London Health Strategy Steering Group, put forward the proposals set out below.

There are opportunities to create a visible difference within eighteen months in the areas of:

(1) better ways of planning – as organisations and collectively;
(2) better access to services;
(3) targetting of specific groups.

Suggestions on how to work better in the future included:

(1) promoting cross-sector good practice – exchanging ideas on voluntary/statutory sector working;
(2) expanding the existing public health network to all sectors.

Inputs needed include:

(1) resources;
(2) leadership;
(3) an agreed mandate from all interested parties.

There needs to be clear agreement between all agencies as to which areas of work and which groups to focus on.

To underpin this aspect of the strategy, the following are needed:

(1) analysis of current data;
(2) mapping of current activity;
(3) better links between the public, voluntary and community sectors;
(4) a 'bank' of good practice.

Key ideas to make a difference in the next eighteen months include:

(1) mounting a London-wide programme to foster social inclusion, starting with families and children and including help with advice (assess the level of advice services across London), benefits, and pathways to work;
(2) training frontline staff in all sectors in basic information about inequalities;
(3) promoting food cooperatives in conjunction with the private sector, with a view to relieving 'food deserts' in deprived areas;
(4) learning from others – for example, the Birmingham Family Support Strategy, Lambeth, Southwark & Lewisham Health Action Zone, Children First;
(5) influencing London's Economic Development Strategy, with a view to the inclusion of an inequalities dimension.

Part 3 C: The health of black and minority ethnic people

Some basic facts

London's black and minority ethnic population

London's population is both large and diverse, with 45% of the entire black and minority ethnic population of Great Britain living in the capital.

Within London, some areas have much higher proportions of black and minority ethnic people than others: for example nearly half the population of Brent and Newham are from minority ethnic groups. Indians form the largest non-white community in London, followed by Caribbean, African, Bangladeshi, Pakistani and Chinese communities.

Ethnic diversity

There are some 37 countries outside the UK each of which was the birthplace of more than 10,000 Londoners. The six largest groups in 1991 were those born in the Irish Republic (214,000), followed by those who were Indian born (152,000), Jamaican born (76,000), Kenyan born (57,000), Bangladeshi born (57,000) and Cypriot born (51,000). The proportions of those born in the UK range from 17% of the Irish community, to 21% of the 'Other' group, to 53% of Black Caribbeans, to 84% of the 'Black Other' group as identified in the 1991 census.

Also according to the 1991 census, every London borough has at least one community of more than 2,000 people from one of the nine black and minority ethnic groups taken as census categories, with many boroughs having seven or eight such communities.

Introducing the strategic issues

The greatest strategic challenges to agencies across London are to create a coherent approach, and to derive the maximum value for black and minority ethnic people from all the ongoing initiatives.

All public sector partners in the London Health Strategy recognise the importance of meeting the needs of black and minority ethnic people across the capital, as a priority for improving health and reducing inequalities; yet greater leadership and a clearer focus are needed. London is also fortunate to have a relatively well developed, articulate, engaged and innovative voluntary sector, which provides critical links in the chain of achieving appropriate involvement, service delivery, and improved health. However, its potential role and capacity have not yet been adequately researched or resourced.

Health intelligence

Currently available analyses of death rates by country of birth suffer from not identifying second generation black and minority ethnic people, and will thus be less useful as time goes on, with the age profile of communities affecting rates. There is a case for ethnic group to be added to death registration (civil registration is currently being consulted on by the Office for National Statistics).

There needs to be a better understanding of why death rates are as they are, and of other outcomes than that of death rates. For example, more research is needed into how treatments may work differently for members of different black and minority ethnic populations.

Recording of the ethnicity of patients is still too low; and there is limited monitoring of black and minority ethnic health by reference to key indicators.

All the relevant intelligence, understanding and initiatives need to be coordinated and disseminated across London. A very good way of doing this would be to set up a London Centre for Black and Minority Ethnic Health. Important lessons could be drawn from the experience of the US Office for Minority Health. One particular benefit of such a centre would be that momentum could be maintained even if at any time black and minority ethnic concerns were to slip down the political agenda. The London Health Observatory could make a valuable contribution, but it has yet to be confirmed whether it could carry out the whole of what is needed.

Further information on the health opportunities of black and minority communities in London is required in two key areas, to enable public sector services to meet the needs of these communities appropriately and sensitively:

(i) research into cultural differences for first and subsequent generations of immigrants to this country;

(ii) research to disentangle the relationship between economic status and health as distinct from that of ethnicity and health.

Health service issues

The NHS needs to develop a more strategic, mainstream approach to black and minority ethnic health issues. At present, it often happens that specific individuals are given responsibility for taking issues forward, with no strategic framework. There are only pockets of information on good practice. In response to this the NHS is establishing a steering group, with a non-executive chair, whose membership is comprised of voluntary sector as well as Department of Health representatives, in addition to London NHS members. The group will monitor the effective implementation of the NHS programme of work to address race equality across the capital, and make recommendations to the NHS Executive London Chairman and Regional Director. A programme of work is currently being drawn up.

Current activity

Activity aims to improve:

(1) equality in employment, or the commissioning and delivery of services in a specific area of concern, such as health, education, crime and disorder;
(2) the links between sectors as they affect specific communities, for example in the area of community development.

Common activity themes include:

(1) incorporating values of making diversity a mainstream feature of organisations and work processes, and tackling institutional racism;
(2) developing accessible and appropriate services;
(3) improving language, interpreting and advocacy services and provision;
(4) developing monitoring, performance management and regulatory frameworks;
(5) developing workforce competence, and diversity in the workforce profile;
(6) building sustainable community participation;
(7) achieving equitable allocation of resources.

Potential in London

The focus in the London Health Strategy is to complement the activity of separate organisations and sectors across London, in instances where a London-wide focus can

add value. The following priority themes are suggested, in relation to which London-wide developmental work could make a contribution:

(1) The Coalition for Health and Regeneration aims to bring together partners across London, to commit themselves to and to take forward actions to improve the health and well-being of black and minority ethnic people. This initiative should be led and facilitated in the first instance by the NHS Executive London Regional Office in association with the Coalition.
(2) Collaboration to promote the health of black and minority ethnic people should focus on:

- developing intelligence across sectors, and making it available to all partners across London;
- developing shared programmes to tackle institutional racism across organisations, involving for example mentoring, secondments, and joint recruitment to increase the diversity of workforces;
- reconciling health and broader social inclusion outcomes and programmes;
- developing appropriate standards of advocacy services and training.

(3) Within 18 months there should be visible improvements by way of:

- workforce profiles of public services more representative of the local population;
- good recruitment practice from elsewhere (eg the Army) being adopted in the public sector in London;
- benchmarks for service provision, and culturally appropriate services in health and social care;
- the London public health observatory including intelligence on black and minority ethnic health and well-being from statutory and voluntary sectors as central to its priorities;
- strategic commissioning and capacity building of the black voluntary sector, particularly on service and policy issues that require a London wide focus;
- sharing of good practice across organisations and sectors.

Measures of success

It is recognised that some of the outcomes of the London Health Strategy will be unexpected, but may still be of value, and so the potential for observing such outcomes will be necessary. The following are suggested as measures of success:

(1) unemployment among black and minority ethnic people to fall to the London average;
(2) executive and non-executive workforce profiles of organisations to show year on year progress towards being representative of their local populations;
(3) all frameworks for proposals, monitoring, performance management and regulation to include recognition of diversity;
(4) intelligence to become available providing understanding of health inequalities between ethnic groups; the table below provides a framework for developing this. Some information is already available, some is partial, and some non-existent at present;
(5) a sustainable black voluntary sector, influencing policy and service issues that require a pan-London focus;
(6) a clear and measurable relationship between pan-London and local networks, with a visible impact on local activities;
(7) a report on culturally sensitive and appropriate NHS and social care services produced within eighteen months;

(8) intelligence on black and minority ethnic health to be established as central to the London Health Observatory's priorities within eighteen months.

Table: Aspects of health where ethnicity and health inequalities may be linked

Determinants of health	**Prevalence of ill health/ health behaviours**	**Service use**	**Health/service outcomes**
Age Sex Genetics Income Employment Education Housing Social networks Mobility and migration	Prevalence of specific diseases, eg diabetes, renal failure, cardiovascular disease Limiting long term illness Health behaviour and lifestyle	Health services: • hospital • primary care • community services Social services Voluntary and private sector services	Mortality Health status Satisfaction

Part 3 D: Improving transport, and related aspects of the environment

Some basic facts
Currently more than half of those who work in inner London come from outer London or from outside London. Although the majority of journeys into London are by public transport, about half a million cars come into central London daily, and there are predictions that this will increase further over the next decade.

Transport policy and its impact on health

Transport can have an impact on health in a range of ways, both directly and indirectly; and there is increasing acknowledgement of the potential for transport policies positively to influence health.

Whilst transport can directly affect the health of individuals, it also has a key influence on economic, social and environmental development, both within neighbourhoods and across London.

Transport can have a range of adverse effects on health, such as causing injuries, sometimes fatal; noise and air pollution; contributing to poor mental health; reinforcing inequalities; and potentially reducing levels of physical activity.

Some impacts, such as physical injuries, are relatively straightforward to measure, although there can be under-reporting of minor cases. Others, however, such as the impact on mental health, can be more complex and difficult to quantify, as there can be many interrelated and confounding factors. For example, poor access to transport can have consequences in terms of social isolation and lack of access to community support.

Much of the available evidence relates to road transport; yet air and other transport can also have important impacts, for example the problem of noise on those living near airports or under flight paths.

Access to workplaces and other facilities can also be influenced, both directly through transport provision and indirectly through integrated transport and land use planning measures. For example, facilities such as GP surgeries should be located conveniently for public transport, walking and cycling within regeneration areas.

The health sector has a substantial transport 'footprint' in London because of the concentration of NHS hospitals, primary care facilities and research institutions in the capital. Their location can directly influence the travel patterns of patients, staff and supplies to and from premises.

Potential for improvement in London

A range of transport related interventions could have a positive influence on health. These can broadly be divided between:

(1) technical measures – such as fuel quality improvements or design of zero emission vehicles;
(2) transport planning – influencing options for road, rail and other transport systems.

The first of these tends to address only one or two health outcomes simultaneously, such as improvements in air quality. However, the second has the potential to address a range of health outcomes.

Examples of transport policy initiatives likely to be beneficial to people's health:

(1) reducing motor vehicle use, emissions and speed;
(2) actively promoting walking and cycling, for example by improving safety through separating cycles from motorised traffic;
(3) improving the quality and accessibility of public transport, particularly for elderly, disabled and disadvantaged people, with the potential added benefit of increasing the extent to which people walk to and from transport facilities;
(4) ensuring that policies help improve accessibility to employment and other key facilities, particularly in deprived areas.

Priorities for London

To succeed, the London Health Strategy will build on existing initiatives and knowledge, and help promote exchange of good practice between authorities, focussing particularly on issues that would benefit from a London-wide approach.

The development of the Mayor's transport strategy, along with other strategies that have implications for transport, and the creation of the Coalition for Health and Regeneration, provide important new opportunities to address transport and health issues. They can:

(1) identify the best scientific evidence linking transport and health, making explicit where it is possible to quantify impacts and where this is difficult;
(2) research the links between health, transport, and access to employment and other key facilities – seeking better to align objectives for economic development, social development, transport and health;
(3) ensure that all policies and plans involving transport include a health impact assessment, taking into account all potential health factors as well as economic costs and benefits;
(4) ensure that potential impacts on health inequalities are taken into account, especially the need for integrated, safe, accessible and reliable transport for disabled, elderly and other socially marginalised people, with practical acknowledgement that disabled people and their carers have a greater need to use cars;
(5) integrate transport plans with regeneration, economic development and spatial planning activities, for example to improve access to employment, shopping and leisure facilities;
(6) address the needs of children, by encouraging them to be physically active, enabling them to go to school safely and gain access to amenities;
(7) address the impact of the NHS on transport, by improving joint planning and promoting healthy transport options.

Some important next steps

Under the auspices of the London Health Strategy, there will be ongoing consideration of all aspects of transport and health. However, some important next steps have been identified:

(1) develop and test a framework for health impact assessment in the transport sector which can be applied to a few case studies. Work has already been commissioned, initially examining inequalities; accidents; air quality; noise; and physical activity;
(2) increase understanding of the links between health and transport, both among key players across London and also among the public as a whole, to ensure that the value of healthy transport policies and planning is fully recognised. It will be particularly important to identify and widely share

examples of good practice and of ‘what works’; help ensure key players are kept up to date on intelligence on the links between transport and health; and develop effective health impact assessments;

(3) further encouraging healthy modes of transport, for example by developing action plans to encourage walking and cycling in their own right, not just as means to reaching public transport.

The key players are:

(1) London-wide bodies, to consider promoting public transport, and access to it;
(2) local authorities, to promote cycling and walking and car reduction;
(3) the private sector, to lower air pollution by reducing movements of
(4) vans, lorries and taxis;
(5) the NHS, to promote healthier transport for staff, patients and visitors;
(6) the NHS Executive London Regional Office, to fund statistics, research and information on transport and health to help underpin this priority.

Part 4: Working to improve London

Part 4 A: Housing and homelessness

Some basic facts

It is widely acknowledged by politicians, professionals and the public at large that housing conditions have a significant impact on public and personal health. The first Public Health Act in 1848 acknowledged the health gain from eliminating unfit homes. Since the latter half of the twentieth century there has been a role for housing, not only in preventing or curing disease, but also in promoting health, delivering care and promoting independence.

The past twenty years saw a reduction in public housing investment and an increase in support for private owners. The creation of quasi markets in the public sector had an impact upon housing as the sector that most lent itself to this commoditisation. Social housing providers were focussed on reducing levels of homelessness, sometimes at the expense of ensuring that people were well housed.

Over the same period there has been a widening of health inequalities. The Independent Inquiry into Health Inequalities (the Acheson Inquiry) recommended development of policies to :

(1) improve the availability of social housing for the less well off;
(2) improve housing provision and access to health care for homeless people;
(3) improve housing quality by creating safe environments, increasing space standards and improving heating and insulation to reduce fuel poverty.

The Government itself has accepted the need to take a wider look at the impact of social, economic and environmental determinants of health within its policies. The White Paper, *Saving Lives: Our Healthier Nation*, acknowledges this and

commits the Government to a greater emphasis on reducing health inequalities through a focus on 'upstream' issues; this includes consideration of the impact of the home and the wider living environment on the public health.

Current activity

'Downstream' issues

The Local Government Association and others have reported on the increasing concentration of low income households in local authority and housing association homes. This has meant that housing, health and social care services are increasingly delivered to the same people.

Housing providers have been quick to respond to the introduction of the NHS and Community Care Act, emphasising through this work the importance of good housing to the promotion of independence and the provision of care in a community setting. This has required a high degree of cooperation between housing, health and social care agencies and professionals.

The inclusion of Lifetime Homes Standards in the Housing Corporation Scheme Development Standards; their inclusion in local planning criteria by local authorities; and the extension by Government of Part M of the Building Regulations, will lead to the development of a housing stock that is

accessible, visitable and adaptable for people whose mobility is impaired, or who have children. There is currently no such requirement to include these standards in refurbished property; this will require further attention.

This is an area where partnerships are well developed. 'Care and repair' agencies, hospital discharge schemes, floating support projects, and supported housing schemes are appropriate to the caseload systems of different sectors and also, with some areas of difficulty, to their financial frameworks.

'Upstream' issues

Arguably, agencies have had much greater difficulty in addressing the part that housing and the built environment have to play in the promotion of health and well-being and the prevention of ill health. Much of the debate has been bound by the need to provide a rigorous evidence base, and a sufficient understanding of how to prioritise interventions.

The interaction between housing and health is complex. The harmful effects of draughty, damp, cold, mouldy, and overcrowded homes are well documented and generally accepted. However, there is a very large step to be taken from accepting such a link, to any measurable shift in investment. One has to question how far demonstrations of causal links are necessary or even possible. Certainly in the nineteenth century, pioneers of effective action on housing and health, such as Edwin Chadwick, did not base their work on a correct understanding of causal mechanisms. Nonetheless, the current debate has been very much predicated on questions of proof and evidence.

Much has been written about the need for evidence. "The most significant relationships appear to be between the experience of homelessness and temporary accommodation and health. According to the Social Exclusion Unit 1998 report, living on the street is seen to be closely related to poor health. Both living on the street, and homelessness in general, are associated with difficulties in gaining access to health care, especially to GP services. Even here, however, there are difficulties in assessing the strength of the relationships and in determining which way the causality runs.

In London in 1997, black and minority ethnic groups were 3.2 times more likely than white groups to be found among the statutorily homeless. The London Research Centre's 1997 report suggested that young people leaving care are thirty times more likely to be homeless than other populations, and Shelter's 1999 report suggests that 40% of young homeless people have been in care at some point in their lives.

Short term action required

Two rapid reviews have identified a number of issues that are particular to London. These short term actions could be implemented at minimum cost:

(1) common licensing protocols, and an assertive programme of administration for houses in multiple occupation;
(2) common protocols and training for staff in primary care trusts and homelessness agencies;
(3) developing best practice in relation to medical priority systems that create a closer link to medical priority assessments and access to housing;
(4) a checklist for regeneration programmes to ensure best value, the assessment of health impact, and community involvement;
(5) giving priority to policies and programmes, such as the Government's home energy efficiency scheme, which

raise the energy efficiency of new and existing housing stock, especially for vulnerable groups;

(6) encouraging local authorities and registered social landlords to give priority to measuring the relative humidity of homes occupied by children with asthma, and where necessary introducing heating or air exchange ventilation systems, perhaps in all households where there is a newborn baby;

(7) reducing accident risk through fairly simple alterations such as fitting handrails, safety gates and smoke alarms, accompanied by wide promotion of such measures, especially for households occupied by children under five years of age and people over 75 years of age.

Processes required

(1) The Housing Corporation London Region has established a joint initiative with the NHS Executive London Regional Office, with the aim of developing closer links between the housing and health sectors at a regional level. A number of activities have been undertaken and projects commissioned. This initiative provides a useful basis for collaborative working at a strategic level and for encouraging innovation.

(2) There is a tension between an increasingly centrally monitored health service delivery system and the principles of health improvement. Further work is required by the NHS Executive to create incentives for primary care groups and trusts to work on ‘upstream’ issues.

(3) The Housing Corporation, the NHS Executive, the Association of London Government, and Homeless Network need to liaise with the Rough Sleepers Unit to develop integrated approaches to the health needs of homeless people, and to the ways in which health care agencies can help prevent homelessness.

(4) A London-wide electronic information directory and communication framework would provide information on legislation and policies adopted by relevant authorities; links to sources of health and housing information; and a database of contacts, specialist resources and services.

(5) The national network of health and housing projects and the good practice website, being developed by Health & Housing, could be framed to support networking on London specific issues.

Links to the fundamental principles and priorities of the strategy

Traditionally, regeneration has been housing led. There is now a better understanding of the complex interaction of issues that lead to the successful regeneration of communities and the development of social capital.

Housing organisations are not just providers of housing. They are also key players in the promotion of community development and the creation of social capital.

Health organisations are increasingly involved in regeneration initiatives in London. In Single Regeneration Budget rounds 1, 2 and 3 there was only one health project; in round 4 there were six; in round 5 there are 31 out of a total of 137 projects.

Social housing agencies are natural partners in health improvement planning and action, both in terms of identifying the health needs of their tenants and of the neighbourhoods in which they work; as service providers in their own right; and as agents for community development and area regeneration.

Part 4 B: Crime and disorder

Some basic facts

Important causes of social exclusion include unemployment, ill health, drug abuse, poverty and lack of community safety. There is emerging evidence (from Peterborough) that there is a strong correlation between ill health, poor housing and lack of community safety. This part of the strategy therefore adopts the broadest interpretation of the concept of crime and disorder.

Current activity

(1) A joint steering group for community safety in London;
(2) a pan-London mapping project – a firewalled web site holding anonymous, analysed data;
(3) an e-mail network between the police and probation services, to pass information quickly about potentially dangerous offenders (of potential benefit to all health workers);
(4) statutory partnerships between borough chief executives and police borough commanders;
(5) the mental health strategy for London – seen as an important factor in reducing crime and disorder;
(6) Health Action Zones – often high crime zones provide opportunities for pooling resources;
(7) youth offending teams – promoting youth community safety as well as providing practical diversion for youth away from crime, and opportunities for health education and diversion from substance misuse;
(8) the London children's strategy – strong links with youth offending teams;
(9) drug action teams – strong links between crime and substance abuse;
(10) drug referral scheme – the police service is spending 1% of its total budget on this scheme, which when fully implemented will produce tangible benefits to health services;
(11) police community safety units – focussing on domestic violence, racial and homophobic incidents, and crime (research in the USA shows a strong correlation between poor health and hate crime, particularly in the home);
(12) neighbourhood based projects – coordinated local partnership approaches include Single Regeneration Bid initiatives, and New Deal for Communities initiatives;
(13) a crime audit of violence on NHS premises – undertaken for the NHS by the police service;
(14) a database of dangerous offenders – a probation service initiative to keep its staff safe, linked to the e-mail network;
(15) the sexual assault referral centres project – a hospital based project pioneered in Merseyside and being negotiated for London.

Current obstacles to success

There are some barriers to successful partnership working, but by building upon the good start made in London, as reflected in the recent reports by Her Majesty's Inspector of Constabulary and the Audit Commission, none are insurmountable. They include:

(1) the lack of 'joined up' working between Government Departments when they set overarching aims for one agency that cause conflict with another agency;
(2) communication, in both its human and technical aspects, for example in the

different interpretation of terms such as ‘disorder’ and ‘community safety’;
(3) funding, with not all agencies currently in a position to pool budgets;
(4) the need to understand the culture, structure and priorities of each agency;
(5) the shortage of skilled personnel;
(6) tension between the resources devoted to prevention and to treatment of problems respectively;
(7) definitions of success, with performance measures being different and difficult to agree upon;
(8) tensions caused by the fact that agencies work to different timescales on similar projects;
(9) differences in geographical boundaries as between agencies;
(10) competing initiatives.

Findings of a rapid review

A rapid review was commissioned by the NHS Executive London Regional Office, to explore the growing body of research concerned with the connections between crime and health. Its key findings are that:

(1) crime is associated with social disorganisation, low social capital, relative deprivation, and health inequalities. The same social and environmental factors which predict geographical variation in crime rates may also be relevant to explaining community variations in health and well-being;
(2) violent crime is associated with income inequality. For example, recent US research found that the greater the degree of income inequality in a given state, the higher the rates of homicide, aggravated assault and robbery;
(3) crime can and often does damage the physical and mental health of victims. The effects include acute as well as chronic health needs;
(4) crime may also have an impact on the health of those who are not directly victims, but who witness traumatic events or are affected by the victimisation of others close to them;
(5) fear of crime is a real and debilitating factor in many people’s lives;
(6) health care workers fail to recognise the victims of crime and are unable to respond adequately to their needs;
(7) there is an urgent need to improve the identification of victims of domestic violence and hate crimes, which have long term effects on the physical and mental health of their immediate victims, as well as affecting the mental health of children who witness them;
(8) little is known about the impacts of crime on health service costs, but there is agreement that they are substantial. Accurate information is vital to develop strategies for reducing costs;
(9) levels of drug and alcohol use are key variables in the prevalence of crime.

What would make a difference in London

(1) Contacts, information sharing and intelligence between health and police services need to be made more systematic. Protocols are needed to reassure staff about their responsibilities for sharing information about their patients.
(2) Continue working closely in partnership to gain a clear understanding of each other’s culture, structures and priorities.
(3) Aim to develop and implement the concept of ‘crime resistant communities’. People have to be asked what they want.
(4) Identify areas where crime has an impact upon health, and vice versa.
(5) Identify activities that work, then look at the inputs and outputs in the short term, and outcomes in the longer term.

(6) Establish agreed common data sets, so that information can be shared more effectively and efficiently.
(7) Establish 'joined up' work processes and budgets. Opportunities should be identified for services concerned with health and those concerned with crime to work jointly on issues of social exclusion.
(8) Expand the protocol for the risk management model which is currently being successfully developed between the probation and police services.
(9) Develop protocols for dealing with different situations.
(10) Establish an agreed common set of performance indicators.

Measures of success

(1) Measures to assess the 'crime resistance' of a community – through data on crime, health, education, the environment, and surveys of residents' views.
(2) Achievement of effective information sharing; this will lead to better identification of the causes of crime and disorder, and provide feedback to ensure improved management of problems.
(3) Creation of a 'master plan' based on defined outcomes and coordinated inter-agency planning of objectives.
(4) Ability to measure outcomes and outputs.
(5) Ability to set and monitor targets, using a 'building block' approach.
(6) Identification of what works, and sharing it through a properly coordinated and agreed network.

Short term action required

(1) Resolve the tension between the findings of the Caldicott Review and Section 115 of the Crime & Disorder Act. This will allow the pan-London mapping project to proceed.
(2) Explore 'risk management' with a view to 'joined up' working.
(3) Explore 'partnership gateways' through primary care and Accident & Emergency departments.
(4) Undertake neighbourhood safety audits.
(5) Set up a personal medical services pilot.

Links to the fundamental principles and priorities of the strategy

Research and information

The following should be explored:

(1) the ethical, resource and policy implications of identifying the victims of crime;
(2) appropriate responses by the NHS to the health effects of crime;
(3) the direct, indirect and comparative costs of interventions;
(4) what high quality multi-agency working would look like;
(5) the part which could be played by primary health care services in recognising repeated presentations by patients at surgeries which have their roots in crime.

Working with communities

This is linked to the concept of developing 'crime resistant' communities.

Values and social ethics

Communities must be asked what they want to determine their conception of 'community safety'.

Developing the knowledge and skills of practitioners

There are skills shortages in the drugs field. Training is needed in early recognition in primary care settings of the signs of domestic violence or victimisation. It is important to reflect the ethnic characteristics of the local community in the workforce.

Part 4 C: Fluoridation of the water supply

Some basic facts

As with many other diseases, dental caries (tooth decay) is associated with inequalities. More disease is experienced by people in social classes 4 and 5, whereas it is members of social classes 1 and 2 who go most frequently to a dentist. So the very ones who need most preventive and therapeutic care are least likely to get it. That is where water fluoridation assumes great importance as a major public health preventive measure. Fluoride strengthens the teeth against caries, by increasing the resistance of the enamel surface to the acids which attack them. Particularly important is the fact that this preventive effect is active even in families who do not visit a dentist.

The consultation process

Most Londoners receive their water supply from a ring main which circles much of the capital. Once the go ahead is received, the water only needs to be fluoridated at about two places, which makes it relatively simple. Before fluoridation can proceed, there must be public consultation. Instruction is awaited from the Department of Health as to exactly how that consultation will take place. As the ring main supplies a large population outside London, as well as much of the population within London, many health and local authorities must be involved in the consultation process. Further, as more than one health region is involved, it is essential for the planning of this exercise to be coordinated at a regional level. As London's children have been deprived of this oral health giving measure for so long, it is to be hoped that the process can proceed soon.

Saving Lives: Our Healthier Nation identified the need for a national review of fluoridation, which is due to be published imminently. The outcome of this review will inform the next steps for London.

Part 5: Working to promote the health of vulnerable groups

Part 5 A: Promoting equity of access to services

There is serious and often-expressed concern that some population groups suffer from much poorer access to public services of all kinds than do other groups. This issue has therefore been identified as calling for priority attention in the next stage of development of the London Health Strategy.

Part 5 B: Promoting the health and well-being of children in their early years

At the major London Health Strategy conference held in December 1999, concern was expressed that promoting the health and well-being of children in their early years should form one important focus of the strategy. It will therefore receive priority attention in the next stage of development of the strategy.

Part 5 C: Young people's health and parenthood

Some basic facts

There are about 1,000 conceptions among young people aged under 16, and 10,000 conceptions among teenagers every year in London, with important variations between and within districts.

Conceptualising the issue

There is often a narrow focus on teenage pregnancy, but this is in fact only part of a much wider set of concerns, having to do with listening to and empowering young people; hence the title of this section.

Concerning pregnancy as such, planned, wanted and unwanted pregnancies among young people need to be distinguished. Pregnancies among those aged under 16 are the most likely to be both unplanned and unwanted. However, there should not be an exclusive focus on this age group.

Parents and guardians of young people need to listen to, encourage, advise, and empower young people, and where appropriate be helped to do these things.

A culture of respect for young people should be encouraged. They should be asked their opinions.

The social context is important with some areas having very different cultures from others. There could be a need to focus on risk taking behaviour; on increasing assertiveness and the ability to make choices; and on creating stability and a sense of purpose.

The message should be about health rather than morality; the interest of the London Health Strategy is in reducing the risk of long term social exclusion of young parents. Implications for the babies of young parents, and the health risks of unprotected heterosexual sex, need to be spelt out.

A broader focus is needed on drugs and alcohol, since these can remove choice; and also on better access to information.

School is not always the right environment for addressing this issue, particularly for young people excluded from school. However, some of the relevant concerns should be raised in school too, for we know that pregnancy rates are higher in deprived areas, but much higher in some deprived areas than in others.

We need to know why pregnancy rates in some parts of London rates are so high, and what benchmarks are available. Small area analyses can usefully be considered.

There is also a need to improve young people's access to services, particularly to emergency contraception, and to make professionals more accessible and sensitive.

Elements of a London-wide strategy

(1) The issue of young people's health and parenthood should be addressed now rather than later.
(2) A wide social exclusion perspective is imperative, building on the synergies between the range of social exclusion issues affecting young people and the interventions developed to address them.
(3) Any programme must start with the distinctive views and experiences of local young people, so as to develop a shared understanding of the issues.
(4) There are several issues on which experience can usefully be shared to minimise duplication and share workload, or to which a specific

London perspective could add especial value.

(5) Evidence of need and best practice should be used explicitly to inform any London-wide strategy, with consistent evaluation and monitoring tools developed and used.

(6) Implementation of tried and tested ideas across mainstream service provision is as important as, or perhaps even more important than, the development of more new ideas.

(7) It is vital to mobilise the wide range of potential existing resources and influencing strategies. Potential community resources, or sources of them, include parents, young people of both sexes who have lived through the experience of parenthood, and magazines. Pharmacists could have a significant role. Among statutory agencies there are local pharmaceutical committees (including a London forum), local medical committees, primary care groups and trusts, NHS Direct, education committees, and youth services (which also have London networks). Churches and voluntary services should not be forgotten. For all these agencies, current activities could be refocussed.

(8) Any London-wide strategy must really make a difference. It aims to avoid duplication and the reinventing of lots of wheels, rather than being a bureaucratic chore.

(9) An effective strategy will need adequate resourcing, with the development of ownership and commitment from across London.

(10) Evidence of need and best practice, where it exists, will be used explicitly to inform any London-wide strategy to address the issue. Useful intelligence has already emerged from a rapid review.

Coordination of support for young people

(1) There will be an overarching focus on young people, rather than an exclusive emphasis on single issues. Explicit links must also be made with other strategic developments, including the Children's Strategy for London, the national sexual health strategy, and *Quality Protects*[5].

(2) Teenage pregnancy coordinators are recommended in the Social Exclusion Unit report, and their establishment has now been announced. Coordinators should not only link with each other, but also with other partners such as the Employment Service, the London Region of the Housing Corporation, regeneration agencies such as the London Development Agency, the London and Middlesex probation services, and the prison service. This would help to ensure effective coordination of support for young parents, and also facilitate the development of cross-cutting prevention and health promotion campaigns. A coordinated response would allow a collective approach, rather than the duplication inherent in a series of interventions for specific single issues.

(3) This sort of approach could have significant implications for the delivery of statutory services to young people, since these have traditionally been more single issue focussed. It fits well with the partnerships developed being in Health Action Zones.

Listening to, and hearing, young people and their parents

(1) This listening process is essential for developing a shared understanding of

[5] Further details can be found in LAC (98)28 *The Quality Protects Programme – Transforming Children's Services*. Can be downloaded from http://www.doh.gov.uk/quality.htm

the issues. This in turn is key across the whole cycle of development, delivery and evaluation of interventions aimed at both prevention and support. Much work has already gone on to elicit young people's concerns. In particular, models of peer-led work need to be supported and effectively evaluated.

(2) The parents and wider communities of young people also have a key role to play. Some work has already been done to learn from and build on their existing skills and experience.

Key opportunities

Common issues on which experience can usefully be shared to minimise duplication and share workload include:

(1) mapping of need and of local initiatives, with especial reference to sharing lessons from high and low need / adverse health outcome areas, and to clearly understanding and prioritising the research agenda. There would also be value in using common data sets to monitor the results of any changes;

(2) promoting coherence and cohesiveness. While this is key for successful implementation of local initiatives, it has not been facilitated by the short term and fragmented nature of many small projects. A London-wide focus could facilitate the involvement of voluntary agencies, who otherwise face issues of their capacity to engage with large numbers of statutory agencies;

(3) creating effective channels of communication to influence regional and national bodies. The roles of the Mayor and of the Greater London Authority in this regard are not yet completely clear;

(4) developing culturally appropriate 'marketing' or media campaigns. These, as already emphasised, must start from the distinctive views and experiences of young people. They need to be appropriately resourced. A London focus would enable the special local needs, for example, of the large black and minority ethnic population to be addressed. Resourcing alternatives, including pooling, could be explored;

(5) further developing partnerships with education services. It will be important to build on established successes like the Healthy Schools Partnership Project, and also not to forget those who have been excluded from, or exclude themselves from, standard services. Relationships with school governors (supported by an information pack), the Department for Education and Employment, and 'educating the educators' are key areas with potential for useful joint working;

(6) shared media handling. Young parenthood is a high profile area, and there would be benefits in developing a shared proactive and reactive media strategy. This could be linked with the national media initiatives announced in the Social Exclusion Unit report.

(7) other specific joint initiatives, including, for example, helplines or helpline support, improvements in accessibility of emergency contraception or supportive advice, and counselling services for young people, as well as the new network of borough-based coordinators.

Targets

The first target will be to reduce inequalities in pregnancy rates among young people. As already highlighted, this will be based on a better understanding of why current rates are as they are. There needs to be further consideration of which age group or groups to target.

Part 5 D: The health of refugees and asylum seekers

Some basic facts

The health of refugees and asylum seekers is an issue of increasing concern. Estimates suggest that there are over 250,000 refugees and asylum seekers in London who have entered the UK over the past fifteen years. They can be among the most vulnerable and excluded groups in our society, suffering not only from problems from the past, but also in having to build a new life in a new country. The health and welfare of refugees is linked with economic and employment opportunities, education, housing and welfare services. Some of these elements are considered in other strands of the strategy and it is important to recognise the overlaps.

In addition, the London boroughs are currently supporting over 50,000 destitute asylum seekers, and another 9,000 asylum seekers have been provided with temporary accommodation under the Housing Acts. Some 71,000 asylum seekers came to the UK during 1999. The Home Office is establishing new support arrangements, which will include dispersal of destitute asylum seekers from London to areas more readily able to provide accommodation.

It is recognised that, given the complex and fluid nature of the refugee and asylum seeker population, it will always be difficult to gain reliable and up to date demographic information along with detailed needs assessment. However, as outlined above, broad indications are available as a start.

Current activity

The provision of services and support to refugees and asylum seekers is considerable, ranging from self-help community groups to more specialist organisations, as well as the work of mainstream statutory services in primary care, social services, education, housing and employment. Within the health service there are some innovative projects, for example the personal medical services pilots, giving new modes of access to the NHS; and the use of NHS Direct, with language support, in multi-ethnic areas. Some pan-London groups involved in work include the Association of London Government, London Borough Grants, and the London Research Centre, as well as a number of voluntary sector groups such as the Refugee Council, the Medical Foundation for the Care of Victims of Torture, and the King's Fund. The Health of Londoners Project recently produced a review of health issues for refugees which gives an overview of the situation in London.

Potential in London and measures of success

Action within the London Health Strategy to improve the health of refugees and asylum seekers will need both to take account of the national policy context, particularly as regards dispersal, and to aim to inform practice elsewhere in the country. To ensure that any programme of action is delivered effectively, there needs to be high level policy commitment.

Refugees and asylum seekers should be seen as a resource rather than a problem. Institutionalised racism remains a significant concern, and there is a need to shift the focus of service provision away from paternalism towards working in partnership with refugees and asylum seekers. This would provide a framework within which they would be able to take a more active role in shaping the development of networks and services

which harness their skills, knowledge and experience.

It is desirable to establish pan-London working, to share experience and reduce duplication of effort, with the involvement of the Home Office, and in particular its new asylum support directorate; and the new Asylum Seekers Consortium. There are a number of issues that can be considered at a London level: for example, more effective dissemination of existing guidelines, good practice and language resources, and the development and delivery of training for frontline primary care staff, who are likely to be the first point of contact.

In addition, the Health of Londoners Project report produced these ten recommendations:

(1) Develop better systems for identifying the numbers and demographic characteristics of refugees.
(2) Promote research into health needs and effectiveness of measures to improve health.
(3) Review the role of new entrant screening, to include the contributions of port health authorities, of local health authorities, and of information exchange.
(4) Improve the accessibility of primary care, and in particular registration with GPs.
(5) Improve understanding of refugees' entitlements to health care and other services.
(6) Improve access to services for interpreting, advocacy and translation.
(7) Ensure that information about health services is accessible through other agencies; use partnerships to address wider determinants of health.
(8) Improve systems for giving information to refugees.
(9) Use local refugee and community organisations in planning and delivering services.
(10) Facilitate better coordination of services at a national, or London level, for example through shared resources for health promotion; facilities for interpreting; improving information for and about refugees; and projects that work with refugee communities.

Tackling all these issues is a major long term task, with significant resource and organisational implications. The following areas are therefore proposed as the immediate priority for joint work within the framework of the London Health Strategy.

Short term action required

(1) Develop effective dissemination processes, using common information and training materials:
    - for NHS staff about refugees' needs and entitlements;
    - for refugees about the NHS and local services. An example of this is work being undertaken by three London health authorities (Enfield & Haringey, Camden & Islington, and Barnet). Discussions with the Home Office asylum support directorate will be important in maximising the effectiveness of dissemination.
(2) Promote research and development programmes to look at basic demographic characteristics of refugee populations, their health needs, and the effectiveness of interventions.
(3) Agree standards and monitoring systems for assessing GP registration and enabling better access to primary care.
(4) Develop collaborative working on translation, advocacy and interpreting services. Consider mechanisms for resource allocation for these services.

(5) Explore ways to make best use of NHS Direct for refugee groups.

It will be necessary to prioritise the most deliverable objectives and to identify resource implications.

Processes required

An intersectoral group, willing to link health agencies with other agencies, and to liaise with the London Asylum Seekers Consortium and the Home Office Asylum Support Directorate.

Key opportunities

The recent legislation on asylum is changing the way that claims are processed. It is important that this changed is used positively, to ensure that the health experience of asylum seekers is recognised and that appropriate local services are in place. The health of refugees is, and is expected in the long term to remain, a London issue. Whilst there is much local work going on, there needs to be pan-London action on a number of points to make progress. Recognition of this within the outline strategic framework is potentially a valuable step forward.

Links to the fundamental principles and priorities of the strategy

The health of refugees and asylum seekers relates to all of the strategic principles and priorities. Refugees and asylum seekers are amongst the most deprived and excluded groups in London. Key steps to improve their health require better research and information; developing refugee community organisations and participation; and elements of workforce training in the NHS and other sectors. This work also links to some issues in relation to health of black and minority ethnic groups. Reducing inequalities in health experienced by refugees and asylum seekers provides the ethical content.

Part 6: Working to promote healthier lifestyles

Part 6 A: Reducing smoking

Some basic facts

London has nearly two million adult smokers. This represents 29% of the adult population with a range of 23% to 36%. However, in some disadvantaged groups and black and minority ethnic groups up to 60% are smokers. The approaches that have reduced smoking among large sections of the population have made no difference to the poorest sections.

Introduction to the issues

The need to reduce tobacco consumption and exposure to tobacco is well recognised. Tobacco control needs concerted action; and for the first time the United Kingdom has a strategy, *Smoking Kills*[6], which takes a comprehensive approach. The strategy prioritises and sets targets to reduce smoking prevalence in the following groups: people who want to give up and in particular the poorest in the population; pregnant women; and children and young people. In it, the roles of the NHS, Government and some enforcement agencies are made clear, and other agencies have important, though less defined, role.

At the London Health Strategy Conference held in December 1999, concern was expressed that a greatly enhanced drive to reduce smoking will form one important focus of the strategy. Although, smoking reduction is not one of the substantive issues during the first stage of this strategy it will receive priority attention in the next stage of development. In the meantime, considerable work on tobacco control will continue at a local level and as part of the *SmokeFree London* programme.

Current activity

(1) London has had two tobacco alliances funded by grants from the former Health Education Authority and by varying small sums from health authorities. These alliances coordinate a number of London-wide activities such as the No Smoking Day campaign as well the dissemination of information to local organisations. The two alliances have now merged into one London Alliance.

(2) Two London seminars brought together representatives of the NHS, local authorities, the voluntary sector and other interested groups. Activities and interventions which require a local input and those which would be best undertaken pan-London were identified. The recommendations from these events could form the basis of a London Tobacco Strategy.

(3) The four Health Action Zones in London received central funds in 1999 to set up and develop specialist smoking cessation services, which are now fully operational. The other London health authorities have been planing their services and they too will receive funds from April 2000 for specialist smoking cessation services.

(4) A multisectoral steering group, now called the SmokeFree London Steering Group, to develop and plan London-wide tobacco control has agreed a work programme. A coordinator to head up the work programme is to be

[6] *Smoking kills: a White Paper on tobacco control.* Department of Health: Stationery Office, 1998.

appointed and London health authorities have all agreed to provide funding for London-wide activities.

(5) A survey of London activity for tobacco control has found varying degrees of smoking prevention and cessation activity. The survey forms a useful baseline to measure progress.

Findings of a rapid review

The findings of a rapid review of evidence for the effectiveness of interventions to control tobacco at a London-wide level are now available. Interventions were considered for review if they show economies of scale; or might be more effective with coordination and consistency across London; or have a natural target population extending across all of London; or fall within the remit of a London-wide authority. City-wide programmes elsewhere have long experience, although no such programme covers an area of London's size or boundary complexity.

London must therefore develop a tailored solution. The main questions to be addressed are:

(1) What interventions to contribute to progress towards the *Smoking Kills* aims are best made at a London-wide level?
(2) What is the evidence for the effectiveness of city-wide tobacco control interventions?

The main findings are:

Changing attitudes

The clearest evidence of effectiveness, and the strongest case for action at a London level is for interventions of all kinds which aim to change attitudes. These include mass media campaigns, unpaid news coverage, and special events.

London-wide facilitation and coordination

This will enhance the impact of some tobacco control actions by health authorities, boroughs and the voluntary sector to help smokers give up, reduce smoking by children and young people, and achieve clean air in public places. In particular, there needs to be a consensus on approaches to illegal sales.

London-wide services

These might include smoking cessation facilities in central London for commuters or for dispersed minority populations; pilot projects; and training of professionals. This type of activity depends on organisational development, and on the support of London's commissioners and providers of services, to ensure that London-wide added value is achieved.

Local responsibilities

Some interventions are clearly the responsibility of particular local agencies, and there is no added value in London-wide provision, coordination or facilitation.

Innovation

This is needed to reduce smoking prevalence among the *Smoking Kills* priority groups – children, pregnant women, and disadvantaged groups. Thus allowance must be made for innovations which go beyond the existing evidence base, and for resources to be invested in further research. In particular, research should be commissioned on effective methods of working with disadvantaged groups, and on how to involve communities.

London-wide action required

(1) Concentrate on actions and interventions which could not be undertaken locally, based on current evidence of effectiveness where available.

(2) Establish a London-wide media campaign including press, television, posters, unpaid press coverage and events such as No Smoking Day and Ramadan.
(3) Develop a communication and advertising strategy for SmokeFree London which is innovative and creative in its approach.
(4) Work with pan London organisations, such as the London Tourist Board, leisure groups, and business and retailers to encourage and promote clean air policies. For example, the London Tourist Board can encourage service providers in the hospitality industry to make changes which increase customer choice for smoke free surroundings.
(5) Collate data on no smoking facilities. Produce an information booklet and web site on SmokeFree London for shops, recreational areas, hotels and restaurants, with a view to increasing customer demand for such facilities; and monitor trends in their provision.
(6) Facilitate cooperation and sharing of good practice between agencies and across London.
(7) Coordinate London-wide research, training and education where appropriate.
(8) Build on pooling of resources for joint service provision for special groups and commuters.
(9) Begin pilot projects for service provision for London-wide target groups.
(10) Explore international collaboration, to share evaluation of local and city-wide interventions.

Links to the fundamental principles and priorities of the London Health Strategy

Work on smoking prevention and cessation promotes all of the strategic principles and priorities. Since smoking contributes to inequalities in healthy life expectancy, disadvantaged groups will be targeted for smoking prevention and cessation activities. However, this needs to be done alongside the commitment to tackle other related issues, such as poverty, and regeneration to renew the capital's infrastructure and deprived localities.

Although no reviews have been found of the added value of working in partnership, expert consensus has repeatedly emphasised the benefits of a concerted approach.

Experience in other countries, particularly concerning clean air, demonstrates greater success in implementing smoking control measures in public places where there is community support.

Part 6 B: Reducing substance misuse: drugs and alcohol

Some basic facts

According to the results of a rapid review commissioned to support the London Health Strategy, there is evidence of increased drug use and misuse nationally among young people. In London, reports of drug use by young people under 20 increased by 35% between 1995 and 1998. Alcohol use amongst the young is also a matter for concern. When considering harm to society and health need, it is thought that alcohol and heroin probably cause the most harm, although the impact of stimulants such as cocaine has yet to be assessed. Service capacity across London is low in relation to all substances misused.

Recent progress

There has been considerable progress over recent years in the development of joint approaches to substance misuse work at both strategic and operational levels. Drug action teams, commissioning groups, community safety and education initiatives, as well as ongoing work on key strategies for action, have all contributed to the process. However, the agenda related to substance misuse remains challenging, and several organisations have highlighted the importance of ensuring that work related to misuse of alcohol receives the attention it requires, to counterbalance the increased focus on drugs work. In addition, further action is needed to disseminate knowledge and to promote best practice across London on all aspects of substance misuse work, from education and prevention to treatment and rehabilitation.

Current activity

Development of London-wide commissioning

A Greater London drug and alcohol purchasers group has for several years been leading joint work between social services departments involved in commissioning services for alcohol and drug misuse, and has also facilitated joint work across key agencies during this time. This group has recently commissioned the Consultancy Partnership further to develop work on needs analysis, outcomes, quality measures and London-wide commissioning of specialist services funded through the drug and alcohol specific grants. This work will include mapping the need for services, current service provision, and shortfalls between supply and demand; followed by analysis by key budget holders, and development of a plan for investment and commissioning, to be implemented over the following two years.

Pan-London drug treatment strategy

This is being led by the UK Anti Drugs Coordination Unit, with active involvement from health, social care, police, probation, and prison services representatives. It includes consideration of the treatment demands likely to emerge from the further development of criminal justice initiatives, such as arrest referral schemes, drug treatment and testing orders, and 'counselling, assessment, referral, advice and throughcare'. The aim is to develop a treatment strategy which ensures that there are sufficient resources available to meet projected needs; this work will be linked with other commissioning initiatives as appropriate.

Alcohol strategy for England

This is currently being developed by the Department of Health policy branch, building on consultation work undertaken by Alcohol Concern. The strategy will include consideration of a full range of issues, from education and prevention to treatment and rehabilitation; and will

identify recommendations for action at national government, local and individual levels.

Other strategies

The Mental Health Strategy for London (please see annexe D to this document) includes a specific focus on people with needs related to both substance misuse and mental health issues. Other strategies being developed include local police strategies, based on the Government's priorities; and the Inner London Probation Service drugs strategy, which includes a focus on drug-related offending, community safety and harm minimisation issues. In addition, the development of joint work related to education of young people is progressing, for example through the drugs education strategy group, facilitated by the police. The police service has also established senior strategy groups to focus on education and young people, partnerships, and enforcement.

Drug action teams

These have completed and submitted their plans for local inter-agency action on substance misuse; the Drugs Prevention Advisory Service is involved in considering these, with a view to identifying emerging themes and making recommendations based on its assessment of the plans. Alcohol and drug issues have also received varying degrees of attention in other local strategic and development initiatives – including health improvement programmes, community safety initiatives, and regeneration projects. The extent to which this has happened has largely been determined at local level, depending on needs assessments and agreed priorities for joint work. There may be scope for further development of the integration of substance misuse issues into relevant planning and initiatives.

Findings of a rapid review

This has been undertaken with a focus on identifying the needs of people in London with problems related to substance misuse, outlining the health issues that need to be addressed concerning this area of work. The review includes identification of gaps in services; areas where further research is required to understand needs; the effectiveness of interventions to meet needs; and policy issues requiring London-wide attention.

Making a difference in London

The following have been identified as important areas, some of which could benefit from further work on a London-wide basis:

Issues related to both drugs and alcohol

(1) Primary care: general practitioners and primary care groups need to be involved in strategic planning on such matters as the mobility of drug users, prevention of problems in pregnancy, alleviation of workloads, and primary prevention.
(2) Common human resource issues: those arising out of current and proposed work in this area need to be identified, with a view to working jointly to develop staffing capacity and expertise. Education and training need to be provided to frontline staff such as social workers and primary care teams.
(3) Joint commissioning: development will continue, with a focus on ensuring that sufficient resources are available to meet the increased needs in this area, including those arising from initiatives in the criminal justice system.
(4) Equity of access: where necessary, for example, in relation to services for young people aged under 16, further work is needed to improve access to services across London, including

access to educational, preventive, and early intervention services.

(5) Children's services: a high proportion of children and families have substance misuse and alcohol needs; the interface between service providers and families needs to be improved.

(6) Complex needs: the current separation of drug, mental health and alcohol services makes it very difficult for vulnerable people to gain access to more appropriate, 'joined up' services. A more integrated approach that recognises combined mental health, drug and alcohol needs is required.

(7) Community safety: there is a need to recognise the wider links between drug and alcohol use, crime and community safety.

(8) Hepatitis C: the push to reduce hepatitis B rates having been effective, drug action teams now need to develop prevention strategies and interventions for hepatitis C. Harm minimisation schemes could be threatened unless hepatitis C strategies are in place.

(9) HIV/AIDS: with an increased focus on sexual transmission, there is concern that the prevention and care needs of drug users with HIV could be omitted from future planning of substance misuse services.

(10) Prevention and health promotion: work in this area needs to include wider issues, including the well-being of young people, education and employment opportunities, housing, financial and community safety concerns.

(11) Specific needs: coordinated approaches are required in relation to young people, stimulant users, and people from black and minority ethnic communities.

(12) The workplace: the development and implementation of substance misuse policies will be encouraged, making use of existing expertise.

(13) Sharing of information: this needs to be made to work better, especially as regards best practice, and the effectiveness of implementation across London.

Additional issues related to alcohol

(1) An increased focus is required, involving analysis of needs, services and gaps, collation of existing research about best practice, and identification of common commissioning issues between agencies.

(2) Awareness needs to be raised via messages about alcohol in workplace settings and with young people.

(3) Alcohol issues will be built into other strategies and plans, for example in relation to accident and injury prevention.

(4) Inter-agency work is needed to develop health promotion interventions with and for young people, covering alcohol issues and links with other issues such as that of sexual health.

(5) Work across organisational boundaries to improves access and share resources will be promoted.

(6) The Greater London Authority could be invited to consider reviewing licensing hours, and how alcohol has an impact on other strategies, such as transport strategy.

General issues

In general, there are concerns that there are too many priorities, and therefore none; that added resources are needed for effective implementation; and that the profile of substance misuse work needs to be raised, with a view to increasing the consideration it receives in relevant planning processes and funding decisions.

There is a need to recognise the range of factors that might contribute to substance misuse, including housing, employment

and financial concerns; and to consider provision of appropriate support on these issues – both housing/legal/financial support within substance misuse services for those already requiring them, and support on substance misuse issues in initiatives to tackle unemployment, poverty etc.

Action needed to make progress with London-wide initiatives

Further work is required to ensure that good use is made of current activity and expertise in substance misuse work. This will include:

(1) identifying common themes and priorities from existing and emerging strategies, and from London-wide analyses of drug action team templates, community safety plans etc;
(2) identifying gaps in existing knowledge of needs related to drugs and alcohol, and of the effectiveness of different approaches to prevention, intervention and rehabilitation;
(3) building on current joint approaches to commissioning, developing and evaluating services to meet specific needs related to substance misuse;
(4) building on existing educational, preventive and early intervention initiatives, identifying where London-wide dissemination of good practice may be required;
(5) raising the awareness of those working with children and families and with people experiencing mental health problems about issues relating to substance misuse, and about where to gain access to further advice and support;
(6) increasing knowledge of substance misuse in primary care and other settings where people may present with other health, financial, or practical problems so that early intervention in problems related to alcohol or drugs can be offered as appropriate;
(7) developing a multi-agency training strategy for both generic and specialist workers, aimed at sharing expertise and training resources to increase the knowledge and skills required in this area of work.

Part 6 C: Reducing accidental deaths and injuries

Some basic facts

Accidents are a leading cause of death and acquired disability among Londoners, particularly in the deprived inner London boroughs. The main killers are road accidents, fires, falls, and poisoning.

Rapid review

A rapid review of accident and injury prevention in London was commissioned, with the aims of describing the size of the problem in London; reviewing the effectiveness of available interventions to prevent accidents and injuries; and to make recommendations as to which interventions would have the greatest impact, and what action should be taken across London.

Summary of health issues

(1) Ensuring the safety of pedestrians is a particularly important public health issue for London. Unless greater efforts are directed towards ensuring the safety of pedestrians, it is unlikely that the trend towards increased car use will be reversed.

(2) Falls are the leading cause of death from injury among people aged 75 or over, and are a leading cause of nonfatal injuries. They are also a leading cause of injury to children.

(3) Fires are an important cause of injury in London. There is a steep social class gradient in the risk of accidental death in childhood, and this is particularly true of accidental deaths resulting from fires.

(4) Poisoning by opiates and related narcotics accounts for nearly half of all unintentional injury deaths among adults aged 25 to 64 in the inner London boroughs.

Action to reduce accidental deaths and injuries

There are many interventions of proven effectiveness for reducing the impact of accidental injuries, including education programmes, legislative and environmental measures, as well as the provision of effective emergency and trauma services. A review of the evidence of the effectiveness of these interventions suggests that the greatest impact in terms of improving the health of Londoners would result from the following actions:

Promoting safe walking and cycling

The interests of pedestrians and cyclists will be put forward when transport and planning decisions are taken; every local authority in London should consider making ‘safe routes to school’ a priority. London health authorities should take a lead in promoting healthy travel patterns for NHS staff.

Traffic calming initiatives should be introduced to improve the safety of pedestrians and cyclists, and consideration should be given to the implementation on residential streets of the concept of the ‘home zone’ – where people come before cars.

Promoting physical activity among older people

The promotion of safe walking and cycling, and other forms of physical activity, would also have a major impact on the health of older people in London. The decline in walking is considered to be one of the main reasons for the doubling in hip fracture rates since the 1960s.

Increasing the prevalence of functioning smoke alarms in inner city housing

This policy is the cornerstone of the Government's strategy for preventing deaths and injuries resulting from fires; smoke alarm use is substantially greater in England since this policy was introduced. However, the prevalence of functioning smoke alarms in deprived inner city housing in London is very low – this inevitably contributes to the steep social class gradients in fire deaths. A coordinated pan-London strategy is required, particularly in relation to social housing and private rented accommodation.

Reducing deaths from narcotic overdose in inner London

Narcotic overdose is a leading cause of unintentional death among young adults in the inner London boroughs; coordinated action is required to reduce such deaths. This will include action to reduce opiate abuse itself, and action to reduce the risk of death in the event of an opiate overdose.

Providing an integrated trauma care system for London

The efficient and effective management of injured people will have an important impact on the number of accidental deaths and the levels of disability resulting from injuries. The provision of effective trauma care systems within London would thus potentially make a substantial contribution to reducing the burden of injury. Work is under way to develop a strategy for serious injury.

Relevance of other strategy areas

Many of the other issues included in the London Health Strategy are relevant to reducing accidental deaths and injuries. For example, transport, land use, housing, and social and economic policies can all have a major impact on accidental injury rates. Policies for alcohol and drug use (risk factors for a wide range of injuries); tobacco use (smoking is a major risk factor for house fires); and mental health (maternal depression may be a risk factor for childhood injury) are also relevant. Effective action in these areas would therefore be expected to have an impact on rates of accidental death and injury in London.

Part 7: Underpinning the strategy

Part 7 A: Developing indicators of progress

The need for indicators, and their desirable features

A set of high level indicators will be used to measure progress in improving the health of Londoners and narrowing inequalities in health. They embrace how well we are doing as regards tackling the wider determining factors for health; are supported by the partners to this strategy; and will, the strategy partners believe, enjoy wide public acceptance and understanding.’

Ideally, these indicators should have these features:

(1) be well established;
(2) form part of a high level agenda;
(3) embrace the widest determinants of health;
(4) belong equally to all partners;
(5) have public acceptance and understanding.

A basic set of indicators

At an early stage in developing the London Health Strategy, it was proposed that seven ‘quality of life’ indicators, selected from the fifteen detailed in *A Better Quality of Life*[7] – the Government’s sustainable development strategy – should form the basis of the London Health Strategy high level indicators. These seven indicators satisfied criteria (ii)-(iv) above, although some were not well established, and others might have less public acceptance. However, they were consulted upon, with a different London response to that obtained nationally, and most are readily understandable.

The seven already available indicators proposed for incorporation into the London Health Strategy set were:

(1) proportion of people of working age who are in work;
(2) qualifications obtained by the age of 19;
(3) expected years of healthy life;
(4) proportion of homes judged unfit to live in;
(5) levels of crime;
(6) proportion of days when air pollution is moderate or high;
(7) levels of road traffic.

These embrace one health dimension [(3)], and six determinants of health: employment [(1)], education [(2)], housing [(4)], crime and security [(5)], the environment [(6)], and transport [(7)].

Additional indicators for London

Further dimensions needing to be covered in any consideration of Londoners’ health are those of ethnicity; inequalities and social exclusion; and the health of children. Some of the proposed seven basic indicators are particularly relevant to these dimensions. However, for greater sensitivity, the following two additional indicators were proposed:

[7] *A better quality of life: a strategy for sustainable development for the United Kingdom.* Department of the Environment, Transport and the Regions: Stationery Office, 1999.

(8) unemployment among black and minority ethnic people;

This is a 'core' indicator from *A Better Quality of Life*, and is also included in the draft Economic Development Strategy for London.

(9) infant mortality rate.

This is a high level NHS indicator.

Finally, a general health indicator was also proposed. This could be the indicator arising from the relevant question featuring in the 2001 census; or the one arising from the Health Survey for England; or be based on the results of a specific London population survey, using a general health questionnaire such as SF36 or Euroqual:

(10) general health indicator (to be determined)

The full set of ten proposed indicators is shown in table 1, with indicators (1), (2), and (4) through to (8) regrouped as *Determinants of Londoners' health*, with (3), (9) and (10) regrouped as *Health effects / consequences*.

Table 1 London Health Strategy indicators: originally proposed set

Item	Indicator
	Determinants of Londoners' health
(1)	Proportion of people of working age who are in work
(2)	Qualifications obtained by the age of 19
(4)	Proportion of homes judged unfit to live in
(5)	Levels of crime
(6)	Proportion of days when air pollution is moderate or high
(7)	Levels of road traffic
(8)	Unemployment among black and minority ethnic people
	Health effects / consequences
(3)	Expected years of healthy life
(9)	Infant deaths
(10)	General health indicator (to be determined)

Development of the indicators

The originally proposed indicators have been revised in the light of further research and comments received from partners. For example, a few needed further definition (eg those relating to crime); or were unavailable at lower geographic levels than nationally (eg expected years of healthy life); or were not available routinely, and would need to be specially commissioned.

More fully defined or alternative indicators are presented here, and mapped at various geographic levels in the statistical supplement. It is hoped that this will aid further consultation on the indicators, which are not 'set in stone' and will develop over time.

Inevitably some of the indicators, whilst the best available, are flawed, and are not always those one would wish to have. As examples, the education and road traffic accident indicators relate to education authority area and place of accident respectively, rather than to place of residence, so that the educational

achievement or road traffic accident rate for a local population is not routinely available from current data sources.

London Directors of Public Health are discussing further work relating to a quality of life or lifestyle indicator for London. This may result in the suggested 'general health indicator', or in the commissioning from the Office for National Statistics of work needed to produce the 'expected years of healthy life' indicator. Alternatively, indicators being used or developed in local government could be adopted.

Limitations

With a restricted set of indicators such as the one now proposed, it is inevitable that some important dimensions of the health of Londoners will be underplayed. This could be remedied by further adjusting the proposed set, or by adding dimensions of particular relevance to subgroups of the population. Missing dimensions include lifestyle, and disability.

The main indicators are intended to be supported by other lower level indicators, such as the 'core' indicators of *A Better Quality of Life*, or the NHS indicators. These could include, for example, ones for other population or age groups and geographical areas, thus adding an inequalities dimension. Whilst some could be used at electoral ward level, for others only borough level data would be possible.

Targets

Once an indicator set has been agreed upon, it will be necessary to agree upon reasonable targets for each indicator, and who should take responsibility for addressing them.

Table 2 below shows the revised indicators alongside the originally proposed set. London baseline values, and maps or tables relating to each indicator, can be found in the statistical supplement.

Table 2 London Health Strategy indicators: originally proposed set and revised set

Item	Originally proposed indicator	Revised indicator
	Determinants of Londoners' health	
(1)	Proportion of people of working age who are in work	International Labour Organisation (ILO) unemployment rate
(2)	Qualifications obtained by the age of 19	Percentage of pupils achieving GCSE grades A-C
(3)	Proportion of homes judged unfit to live in	Proportion of homes judged unfit to live in (ie same as originally proposed)
(4)	Levels of crime	Burglary rate
(5)	Proportion of days when air pollution is moderate or high	Number of exceedences of $N^{2}0$ air quality standard
(6)	Levels of road traffic	Road traffic accident rate per 1,000 resident population
(7)	Unemployment among black and minority ethnic people	Unemployment among black and minority ethnic people (ie same as originally proposed)
	Health effects / consequences	
(8)	Expected years of healthy life	Life expectancy at birth
(9)	Infant death rate	Infant death rate (ie as originally proposed)
(10)	General health indicator (undetermined)	Proportion of people with self-assessed fair, poor or bad health

Part 7 B: Developing health impact and health inequalities impact assessments

The London Health Strategy is promoting the use of health impact and health inequalities impact assessments. These will help ensure that all organisations consider the impact of their policies on health and health inequalities. Such tools are being stressed by central Government; their use forms a key recommendation of the Independent Inquiry into Inequalities in Health (the Acheson Report), and is endorsed in *Saving Lives: Our Healthier Nation*. Partners in the development of the London Health Strategy are committed to using these tools in developing their own policies and strategies.

Both types of assessment seek to identify the health consequences of actions in other public and private sector activities. There is a range of approaches, from qualitative approaches aimed at eliciting people's perceptions, through to those based on a wider spread of research findings. A toolkit, which will help in undertaking such assessments, is being developed for London. This is currently being piloted and will be available shortly. Work is also under way to look at the relationship between health and transport, and to apply the techniques of health and inequalities impact assessment in this area.

With the Greater London Authority (GLA) having responsibility for areas key to improving the health of Londoners, partners in the London Health Strategy will want to discuss how health impact and health inequalities impact assessments can be used in developing the GLA's eight strategic areas, as set out in part 2 (page 14) of this framework document.

The Mayor and the GLA will have a duty to promote improvements in the health of Londoners, and to consider the implications of all their policies for Londoners' health. There is much existing activity across London to develop and apply assessment techniques.

The London public health observatory, and wider networking across London, will help to develop methods and their application, review work being done, share learning, disseminate good practice, and advise on the focus of pan-London activity.

Part 7 C: Developing the wider research and evidence base

Introduction

The London Health Strategy calls for a sound base of evidence on which to develop. The NHS Executive London Regional Office has a focus on research and development relevant to Londoners, through a specific programme which has already provided some of the evidence on which the strategy is founded.

Rapid reviews

Following the May 1999 conference to launch the idea of a London Health Strategy, rapid reviews were commissioned from the research community on these specific topics, many of which have subsequently been agreed as forming part of the strategy:

(1) housing and the built environment;
(2) homelessness;
(3) crime and disorder;
(4) environmental pollution and health;
(5) transport and health;
(6) the health of young mothers;
(7) reducing drug and alcohol misuse:
(8) reducing smoking;
(9) reducing accidents and injuries;
(10) health services for older people;
(11) services for prison health.

The findings of these reviews have been placed on the London Health Strategy

website, at the address given on the inside front cover of this document; feedback is invited, as a form of peer review.

Research on priority areas

The following research has already been commissioned in relation to two of the four top strategic priorities presented in part 3 of this framework document:

The health of black and minority ethnic people

(1) a systematic review of differences in access and uptake of health services by minority ethnic groups in London;
(2) a systematic review of access to and uptake of health services by black and minority ethnic groups: mental health and cardiovascular services in London;
(3) preparation and maintenance of systematic reviews of randomised controlled trials of treatments for haemoglobin (blood cell protein) disorders.

Transport and health

Development of a health impact assessment framework, by mapping out the relationships between transport and health, for application to London.

Other research projects

Public health and public values

This is an inquiry into the values underpinning public health policy and practice, involving:

(1) development and implementation of a strategy to engage Londoners in discussions about their values;
(2) analysis of the implications of these values for health policy in London.

The economic impact of the NHS in London

As highlighted in part 3A of this document, the NHS is a major employer in London, and has large capital and procurement budgets. Research is being undertaken to underpin assessment of how these major operational functions can best be developed to support the London Health Strategy.

Part 7 D: Developing the knowledge and skills of practitioners in all partner organisations

At the present time, with the renewed emphasis on improving health and well-being, and on partnership working, the agenda for public health practitioners has grown. There are expectations of input from public health practitioners to many areas of work, especially within the NHS. These include, for example, initiatives to address the wider determinants of health; and partnership initiatives such as Sure Start, Single Regeneration Budget activities, drug action teams, initiatives relating to crime and disorder, initiatives to address inequalities, the development of primary care groups and primary care trusts, clinical quality work within national service frameworks, clinical governance work, and specialist commissioning; as well as many initiatives in other sectors which require a public health contribution.

These pressures need to be quantified, and appropriate public health workforce planning for the future undertaken. An initial study in the former NHS South Thames Region highlighted the issues in more detail.

Work is under way across London to identify the range of public health professionals and practitioners, both currently existing and needed for the future, not only in the NHS but also in other organisations. There are many people in other sectors who work to improve the public health, whilst not having hitherto been recognised as public health practitioners.

Further work will identify how functions and roles may change over time, and how joint training can help to provide an appropriate workforce with appropriate skills for the future.

Part 7 E: Developing the London Health Observatory

Saving Lives: Our Healthier Nation proposed that a Health Observatory be set up in each NHS region, with the main tasks of supporting their respective local bodies by:

(1) monitoring health and disease trends, and highlighting areas for action;
(2) identifying gaps in health information;
(3) advising on methods for health and health inequality impact assessments;
(4) drawing together information from different sources in new ways to improve health;
(5) carrying out projects to highlight particular health issues;
(6) evaluating progress by local agencies in improving health and reducing inequalities;
(7) looking ahead to give early warning of future public health problems.

Each of the regional observatories was launched in February 2000. Work has been undertaken to ascertain how such an organisation, in London, can best build on the extensive expertise and academic resource currently in the capital. The intention is to create a small core unit as the centre of a 'virtual' observatory, with links to the existing sources of expertise. It will work closely with the Health of Londoners Project and with the London Research Centre.

The aim is to develop the observatory on a multisectoral basis, potentially providing information, intelligence and analysis to support and monitor the various interrelated strategies which are being developed for London; and to monitor progress in achieving the overall objective of the London Health Strategy: to improve the health of Londoners, and their quality of life as they perceive it, paying special attention to health inequalities between different population groups and between different parts of London.

Annexes: Working to support health services across London

These annexes provide a snapshot of the current state of play in London in the development of health service strategies concerned with priority disease categories or population groups. It is envisaged that the London Health Strategy will help create the most favourable context for such development.

Annexe A: Services for coronary heart disease

Introduction

The coronary heart disease strategy for London will be developed in the context of the national service framework for this disease, which was published in March 2000. The aims of the London strategy will be the same as those of the national strategy, which in summary are to reduce death and ill health from coronary heart disease in London by:

(1) improving the cardiac health and general well-being of the population, particularly those of the worst off;
(2) improving detection of those at risk of developing coronary heart disease, and a reduction in that risk, through advice and treatment;
(3) improving detection of those with established coronary heart disease, and ensuring timely, effective treatment by general practitioners and their teams, and hospitals, working closely together;
(4) improving the immediate response to, and care of, those who suffer a heart attack;
(5) providing high quality, effective rehabilitation services available to all who would benefit;
(6) providing high quality palliative care for those with heart failure.

In London, the specific needs of black and minority ethnic groups with a higher prevalence of coronary heart disease, many of whom live in the most deprived communities, must be addressed.

Current activity

In terms of health improvement, coronary heart disease has for some years been a priority within *Health of the Nation*[8], and now within *Saving Lives*: *Our Healthier Nation*. There are numerous examples of projects established at community level, many in partnership, to address the underlying causes of coronary heart disease; for example, schemes to promote access to exercise, and better nutrition. This work will continue to develop, in the process of implementing both *Saving Lives*: *Our Healthier Nation* and the national service framework.

Early work has also begun locally, led by health authorities and facilitated by the NHS Executive London Regional Office, to address important service areas that are immediate priorities in the national service framework, such as:

(1) rapid thrombolysis (dissolving blood clots) following a heart attack – health authorities have been working with trusts and other local stakeholders to

[8] *The health of the nation: a strategy for health in England*. Department of Health: HMSO, 1992.

assess whether they meet the 60 minute target;
(2) building local implementation groups of key stakeholders to develop an action plan in response to the national service framework.

Short term action required, and measures of success

Now that the national service framework has been published, local implementation groups are expected to carry out a detailed scoping exercise, to identify levels of performance against the framework standards, and models of good practice; and to develop an action plan to address gaps and shortfalls in performance. This action plan will be developed as part of Health Improvement Programmes.

The national service framework contains both process milestones and outcome measures. A key issue will be to agree how these will be monitored, and performance managed at regional and local level.

Processes required

The development of local action plans is the key process in taking work forward. However, it is important that in developing their action plans in relation to reducing coronary heart disease in the population, local stakeholders:

(1) develop effective policies for reducing smoking, promoting healthy eating and promoting physical activity;
(2) carry out health and health inequalities impact assessments of policy decisions on the cardiac health of the population;
(3) ensure that the work on coronary heart disease is integrated with other action being developed through *Saving Lives: Our Healthier Nation*, work on smoking, and other underpinning policies such as 'Information for Health';
(4) make reducing inequalities in health, and ensuring access to services by the most deprived, a guiding principle.

This work will link with the London Health Strategy by:

(1) using coronary heart disease as an exemplar in work on health impact and health inequalities impact assessments;
(2) sharing examples of good practice, particularly in relation to coronary heart disease and black and minority ethnic health;
(3) tackling the wider determinants of health which will have knock-on benefits for reducing coronary heart disease;
(4) tackling issues in a way which adds value at London level, for example through campaigns aimed at reducing smoking.

Annexe B: Services for cancer

Calman-Hine national service change agenda

The 1995 Calman-Hine report established a national framework for development of cancer services, to improve access to quality care and improve outcomes. The key elements of the Calman-Hine service model are:

(1) a 'hub and spoke' configuration of services – centres, units, primary care;
(2) the concept of 'cancer networks' – cancer centres, their associated units, and commissioners –as the key to further development;
(3) specialist teams – with the necessary expertise, critical mass, and infrastructure;
(4) integrated patient care pathways and protocols agreed across disciplines and networks;
(5) supplementation by national evidence-based guidance on structure, process and audit for specific tumours – breast, lower bowel, lung, gynaecological.

The ten year implementation strategy set out in the Calman-Hine report and subsequent national guidance called for:

(1) local implementation, coordinated by NHS Executive Regional Offices and health authorities, with the respective responsibilities of each left to regional determination;
(2) a process of 'designation' of cancer centres and units assessed as meeting the national service model criteria, with the specifics of the designation process left to regional determination.

Implementation progress in London: phase 1, 1995-1999

Different approaches were adopted in North Thames and South Thames:

Cancer centres

Conditional designation in 1997 of five centres in London, reconfirmed by recent analysis as viable under the Calman-Hine criterion of serving a population of one million.

Cancer units

South London: a regional framework for designation of units based on host health authority assessment against standards, and formal Regional Office concurrence, leading to designation of units for breast, lower bowel and lung cancers.

North London: pace of designation determined by individual health authorities, leading to variation across this part of the region.

National context for phase 2, 1999-2002

There is agreement that there should be movement toward greater consistency in the Calman-Hine implementation process across the country, with a national stocktake by NHS Executive Regional Offices of designated cancer centres and units against key Calman-Hine criteria, and a timetable for catching up with designations where necessary.

London modernisation plan: six month progress report

The key London forum for continuing implementation of the Calman-Hine framework has been the London Health Authorities Cancer Leads Group. This group, in turn, consults with Trust clinicians and managers in each of their

local cancer networks. Its most recent progress report stated that the London-wide strategy is proceeding on schedule; and that each of the five London cancer networks is to develop strategic plans for 2000-2002.

London-wide core standards for common cancers

Core standards have been agreed, in consultation with NHS partners, for breast, lower bowel and lung cancers. These will used to complete all initial designations by April 2000.

National guidance on gynaecological cancers recommends moving most surgery from units to centres. The process of developing London-wide core standards will be initiated by a stocktake of existing patterns of provision in each of the five London networks.

Other elements

The following are in hand:

(1) development of agreed standards and configuration of services for specialist childhood cancer centres and shared care units;

(2) plans to evaluate current service provision and recommend future commissioning arrangements for a target list of rare cancers;

(3) development of a framework for improving palliative care across London.

Opportunities in the London Health Strategy

The mainstream cancer services strategy does not currently address social exclusion, although the London framework for improving palliative care will address this issue specifically. By including cancer as a topic priority, the London Health Strategy could exert influence to ensure that attention to social exclusion is specifically built into the cancer work programme.

In addition, the Cancer Leads Group will take the opportunity of asking the five London networks to develop community based approaches in their strategic plans.

Annexe C: Services for children and for older people

Introduction

There is a commitment within *The Modernisation Plan for the NHS in London 1999-2002*[9] to developing strategic frameworks for services for children and for older people during 2000/2001. Work will be carried out jointly with the London Social Care Region, and will take a broad based, whole system approach. Preliminary work is under way in relation to strategic frameworks for both age groups.

Process

A similar process is being adopted to develop project plans for the two frameworks, to include the following elements:

(1) a scoping exercise to identify existing initiatives, networks and key players in London;
(2) a research review, to identify issues for London and effective interventions available;
(3) stakeholder workshops to consider the results of the above and to agree the scope, focus and development process for the frameworks;
(4) production of project plans for discussion with the NHS Executive London Regional Office.

Structures and groupings to take the work forward will be in place by the end of March 2000. The process will draw on the experience of developing strategic frameworks for mental health and for learning disabilities, as well as the London Health Strategy. In addition, strategic development in London will be closely aligned with national initiatives, including the national service framework for older people, due to appear in the spring of 2000, and the policy review of children's health services.

[9] *The modernisation plan for the NHS in London 1999-2002*. Department of Health, NHS Executive London Regional Office: Department of Health, 1999.

Annexe D: Services for mental health

Introduction

In *Modernising Mental Health Services*[10], the Government announced its intention to make mental health services safe, sound and supportive. In cooperation with a wide range of people, a new national service framework is being created. Its aims are to:

(1) establish consistent services across the country;
(2) ensure equity of access to services for everyone, everywhere.

It will also set standards and define service models. It will be supported by significant new investment.

The situation in London

The Turnberg Report in 1997 had also recommended the development of a mental health strategy for London. The capital faces many challenges in improving mental health services. However, the creation of a London health region, aligned with a social care region, is thought to provide an opportunity for strategic planning and sharing of best practice.

London strategic framework for action

This aims to:

(1) begin the process of wider engagement of key groups and individuals in creating a shared vision and priorities;
(2) apply the national service framework to London's particular circumstances, and facilitate its implementation;
(3) identify good practice and models;
(4) identify critical service issues;
(5) set priorities for action;
(6) underpin investment decisions.

[10] *Modernising mental health services: safe, sound, supportive*. Department of Health, 1998.

Priorities for action

Several possible priorities emerged:

(1) Find new ways of ensuring that users and carers are actively engaged and meaningfully consulted, both about their own use of services and about how services are commissioned and delivered.
(2) End stigma and misinformation about mental illness among the public and the media, by achieving real improvements in services across the capital.
(3) Integrate different organisations and pool budgets, moving towards a single managed service for mental health in the long term. Meanwhile, forge better links with primary care by way of prevention and care for vulnerable individuals.
(4) Remap mental health need across London, paying particular attention to the need for housing and employment support for people with mental health problems.

A number of reference and advisory groups have been established to set out the future direction for the short, medium and long term. Their initial findings have been drawn together in a draft outline strategic framework, as a basis for further consultation.

Annexe E: Services for people with learning disabilities

Introduction

A project outline for a London learning disability strategy was presented to the NHS Executive London Regional Office in May 1999. The strategy has three phases:

(1) gathering evidence and information from a broad range of people;
(2) designing a service framework;
(3) implementation.

The first phase was completed by the end of November 1999. There follows a summary of its findings. The second phase is being taken forward through a reference group, which has commissioned further work in a number of areas.

Generic health services

This is the top strategic priority. The issues are applicable across the acute, primary and community health care sectors. The problems are: poor identification of illness; lack of awareness of specific health risks; very poor uptake of health promotion and screening; discrimination; problems with access to services; lack of understanding of special needs; and a greater impact when there is poor practice or poor quality service. All this relates to people who have very high health needs; who use hospital health services to at least the same level as the elderly population; and who, although their life expectancy is improving, die on average in their mid 50s.

Medical and other health care staff receive very little training in meeting the additional needs of people with a learning disability, and usually do not see enough such people to develop expertise in this area.

Residential services

London authorities are responsible for supporting about 9,300 people away from their families. London has only two thirds of the accommodation required for the population of those with a learning disability. This means that significant numbers of people have to live at considerable distances away from their local communities. This problem also has a significant impact on the health economies of the counties surrounding London. The effect of this squeeze is most strongly felt by those people with multiple needs, who are most likely to be sent further afield. Almost all children who do not live with their families are not accommodated within their own borough.

Demographic changes

The learning disabled population has a high proportion of people with very complex disabilities. This will lead to an increase in the numbers of those with ‘continuing care needs’. Members of the learning disabled population are living longer, leading to a small increase in the overall population; but there are also some specific vulnerabilities in ageing which affect this population. The ethnic composition of the learning disabled population is undergoing a major change, with a very rapid rise in numbers of second generation immigrants.

Workforce

There are major issues in relation to the workforce in caring services. Unqualified staff now comprise most of the residential workforce, but this change in skill mix has not been supported by systematic and comprehensive training. There are recruitment difficulties in London, and high turnover rates. This significantly contributes to the lack of competence in

London based residential services for people with complex needs, and increases the number of non-local services for this group. There are also significant shortages of professional staff, particularly speech and language therapists; and a projected shortage of qualified social workers.

Empowerment

Empowerment of people with learning disabilities is one of the major concerns running through all the findings to date. This is an area where there is significant momentum in services, but the development is at an early stage. In particular, direct payments as a vehicle for empowering people who receive services is very under developed.

Ethnicity

Despite the identified rise in numbers of learning disabled people from black and minority ethnic communities, services are ill prepared and lack a strategic approach. There are very few specialist services in London.

Employment

The learning disabled population has an unemployment rate of about 96%. Although most services have employment projects, these are marginal to mainstream services. Over half the services do not know how many of the learning disabled people in their care are employed.

Transition

The transition from children's to adult services has consistently been identified as a problem, and as poorly managed.

Community teams

Learning disability community teams are extremely variable in function, size, staffing and in who provides which service. There is no overall agreement about the roles of the teams. Very few are joint health and social services teams.

Joint working

Although there is in general a significant amount of joint working between health and social services in London, when looked at in more detail it emerges that very few have joint working at all three levels: strategic, operational and individual. There is still a significant amount of disputes between authorities over funding. Frequently, joint working fails to achieve the breadth required to take a whole system approach.

Information

Throughout the strategy development process, the evident lack of information about services, finances or outcomes has been stark. Very little information is collected, considering that about £450m of public funds are being deployed. There are significant and major gaps in definitions, and little consensus in usage. For example, from statutory information it is not possible to identify how many people the statutory authorities fund to live separately from their families. There is no agreed definition of supported living, which now accounts for about a quarter of all residential services.

Leadership

With the shift from hospitals into the community, much of the provision has moved from NHS trusts and local authorities into the independent sector.

One of the impacts of this is that there are often no senior people with designated responsibility in the public sector. Achieving strategic change without local leadership will be a significant barrier in many places.

Annexe F: Services for prison health

Introduction

Following publication of the Prison Service / NHS Executive report *The Future Organisation of Prison Health Care*[11] in March 1999, the Government gave a commitment to taking forward a range of proposals to improve prison health care:

(1) ensure that prisoners have access to the same quality and range of health services that the general public receives from the NHS;
(2) facilitate efficient use of NHS and Prison Service resources when delivering health care for prisoners.

There is a five year programme of change, based on partnership between the Prison Service and the NHS at all levels. The Prison Service remains responsible for primary care in prisons, while the NHS remains responsible for secondary and specialist services. Health authorities and prisons will work together to assess the health needs of prisoners, and to develop health improvement programmes in line with those for the wider community.

A London-wide approach

Ministers agreed this action plan for prison health in London in October 1999:

(1) a London regional steering group, to ensure a London-wide perspective;
(2) local steering groups for each health authority and the prison(s) in their area, to oversee the health needs assessment process and agree specific prison health improvement plans;
(3) a project team for each prison, to carry out rapid appraisals of health care and begin needs assessment.

[11] *The future organisation of prison health care*. The Joint Prison Service and National Health Service Executive working group. Department of Health, 1999.

Current issues

(1) There are ten prisons in London, with seven in three health authority areas.
(2) Drug misuse, mental health problems, and the need to work more closely in line with community mental health strategies.
(3) Primary care in prisons is currently provided in diverse and often inefficient ways. Training is ad hoc.
(4) Use of secondary care is inefficient.
(5) Links between health authorities and probation services need strengthening.

Priorities for action

(1) Undertake a needs assessment analysis of prisons, from which to plan.
(2) Improve the reception screening and discharge planning processes, perhaps on the basis of a national standard.
(3) Agree more appropriate ways of working between prisons and primary, secondary and mental health services.
(4) Build quality measures into service delivery, in line with the clinical governance initiative.
(5) Ensure that all health care delivery is under medical direction.
(6) Develop training initiatives, linked to those of health authorities.
(7) Develop workforce plans.
(8) Strengthen management and organisation.
(9) Improve information systems.
(10) Develop research programmes, linked to those of the NHS.

The London Health Strategy Steering Group

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Virginia Beardshaw	NHS Executive London Regional Office
Jane Belman	London Voluntary Service Council
Mark Blake	Blackliners
Jonathan Bland	Social Enterprise London
Mark Brangwyn	Association of London Government
Christopher Bull	London Borough of Southwark
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Bill Griffiths	Metropolitan Police Service
Professor Andrew Haines	University College London
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