



MISSION STATEMENT

THE HEALTH DEVELOPMENT AGENCY is the national authority for England providing information on what works to improve people's health and reduce health inequalities. It gathers evidence and produces guidance for policy makers, professionals and practitioners at national, regional and local level. Working in partnership across the public, private, voluntary and community sectors, the Agency supports informed decision making and the development of effective practice at all levels.

The establishment of the HDA was announced in the white paper, 'Saving Lives, Our Healthier Nation' in the summer of 1999. It opened on 3 April 2000. The Agency has around 120 staff and an annual budget of £12 million.

HEALTH DEVELOPMENT AGENCY

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CHAIR'S INTRODUCTION

This has been a particularly successful year for the Health Development Agency (HDA) – one in which we have begun to move closer to our core audiences, in particular, those working on the frontline to improve people's health and reduce health inequalities.

Gratifyingly, 88% of our key audiences describe the HDA as an important source of information. Indeed, as a result of our evidence and guidance, increasing numbers are improving their practice (see pages 6-23).

Collaborative working

During the past year, we have worked hard to put sound arrangements in place for collaborative working with a range of partners. Four new collaborating centres have been established to further develop evidence and guidance. These will focus on the prevention of drug misuse and accidental injuries and the promotion of physical activity and maternal and child nutrition.

In addition, three practice development centres have been set up. These will be working in tobacco control, maternal and child nutrition and on how to engage communities in health promoting activities.

The establishment of these centres marks a major shift in the HDA's way of working, with a much greater proportion of our resources now being deployed in the regions. Our successful Healthy Communities Collaborative (HCC) with the National Primary Care Development Team (NPDT) has

already demonstrated the benefits of this new style of working – its pilot programme led to a 32% reduction in falls among older people. We have now appointed NPDT as an HDA practice development collaborating centre for the project. We have also extended the scope of this work to cover nutrition. (For HCC highlights, see pages 12-13.)

New chief executive

The Board was pleased to appoint Paul Streets as our new chief executive in October 2003. In a short space of time, he has had a significant impact on both the strategic direction and management of the organisation.

Rising to the challenge

I am grateful to all my colleagues on the Board – executive and non-executive – for their wisdom, insight, loyalty and support. I am also really proud of our staff working in London and in the regions. They all continue to deliver high quality work with great professionalism.

The HDA faces a series of challenges in 2004, from a rapidly changing policy environment and the continuing drive to improve and modernise public services. But I have no doubt the Agency will rise to meet those challenges, without losing sight of its prime purpose – to improve the health of the public and tackle health inequalities.

This has been a particularly successful year for the HDA – one in which we have begun to move closer to our core audiences, in particular, those working on the frontline to improve people's health and reduce health inequalities.



DAME YVE BUCKLAND CHAIR

Achievements



QUALITY & USAGE OF HDA EVIDENCE

UPTAKE OF HDA GUIDANCE & SUPPORT

PRACTICE, POLICY & PLANNING LINKED TO HDA ACTIVITIES



PROMOTING BREASTFEEDING



One of my big issues is changing the way people think – and getting them to talk openly about it, rather than just turning away. I think that’s a big shift, but it is beginning to happen.

DANIELLA THORNTON BREASTFRIENDS DONCASTER

Daniella Thornton was breastfeeding her second child when she ran into difficulties. Her health visitor suggested that she contact Breastfriends Doncaster, a local peer support service. She was so impressed with their work that she went on to train as a peer supporter. She then got involved in a programme in schools and now trains peer supporters herself.

In between, she has talked at national conferences, including the HDA’s 2003 annual event, where she was one of a handful of ‘lay’ people presenting papers.

‘I love it,’ Daniella says of her involvement with the project. Nevertheless, she admits it’s not easy trying to persuade Doncaster women to breastfeed their babies. ‘People here think it’s disgusting,’ she says. ‘One of my big issues is changing the way people think – and getting them to talk openly about it, rather than just turning away. I think that’s a big shift, but it is beginning to happen.’

The government has set targets for PCTs to increase breastfeeding among disadvantaged women by 2% a year. An HDA evidence briefing published in 2003, *The effectiveness of public health interventions to promote the initiation of breastfeeding*, shows that peer support is one of the most effective ways of achieving this.

‘PCTs are crying out for help on this,’ says Caroline Mulvihill, an HDA senior research specialist. ‘The next step for the HDA is to develop practical guidance for health professionals – and to update the evidence on what helps women to continue breastfeeding beyond the first crucial weeks. We’ll be using initiatives like the Doncaster project as examples of good practice that others can draw on.’

In the meantime, thanks to her experience working with Breastfriends Doncaster, Daniella has landed herself a job as teenage breastfeeding support coordinator with a project being set up by Doncaster & Bassetlaw NHS Trust.

■ **Mothers from minority ethnic groups are more likely to breastfeed at birth, compared to white mothers. But they’re also more likely to discontinue exclusive breastfeeding after four months**

■ **New evidence on breastfeeding duration is expected to be published by the Health Development Agency during 2004-05, with practical guidance and support to follow**

■ **Mothers from low income groups are 25% less likely to breastfeed than women in higher income groups. Every woman who breastfeeds lowers their risk of breast and ovarian cancer**

■ **Breastfed babies are at less risk of gastrointestinal and ear infections. They are also less likely to develop juvenile onset diabetes or obesity, and less likely to develop heart disease in later life**

MAKING ROADS SAFER

John Metcalf is a grandfather. He likes to take his two grandchildren (aged two and four) out for a ride on his tricycle. But what with the speed of cars these days, it's a worry. 'I just want safe roads,' he says.

John is also a member of Hertfordshire County Council and in January, tabled a motion calling for 20mph zones in residential areas. 'It met some opposition,' he says. 'But reducing childhood accidents is a national priority – and road safety is a very important element of that.'

John knows that he needs help if the county council is to take up the idea in its forthcoming strategy on speed management – and that's where the work of the Health Development Agency comes in. 'It's very important to have all the evidence about how speed limits can save lives,' he explains, adding: 'It will help counter all the [pro-motorist] propaganda in the tabloid press.'

Val Moore, East of England regional associate director for the Health Development Agency, has already referred John to *Prevention and reduction of accidental injury in children and older people. HDA Evidence Briefing* (2003) This shows how cutting speed limits in residential areas to 20mph could save 13,000 children in England from death and injury every year.

Val is keen to provide him with any other support he needs – whether that means teaming up with other agencies to gather local figures on accidents, or tapping into national networks to find out about the experiences of other councils that have already implemented 20mph zones. As she explains: 'We aim to support people like John, who are making an impact at a level that we, as a national organisation, cannot normally reach.'

In the meantime, HDA evidence has already been used to good effect in Val's patch: the East of England's regional social inclusion strategy has taken up the Agency's 20mph recommendation for residential areas.



Speeding cars and lorries make the streets a dangerous place for John's grandchildren (top & right). That's why he is campaigning for safer roads.

JOHN METCALF A MEMBER OF
HERTFORDSHIRE COUNTY COUNCIL



■ Just under half of all fatal accidents among children and young people aged 0-14 are caused by traffic on the roads

■ Cutting speed limits to 20mph in residential areas could reduce these deaths and injuries by about two-thirds

■ As pedestrians, poorer children are five times more vulnerable to death and injury on our roads than their better off peers

■ In Hull, 20mph zones have helped save 300 lives – and £40 million in injury costs – since their introduction in 1995

QUALITY & USAGE OF HDA EVIDENCE

UPTAKE OF HDA GUIDANCE & SUPPORT

PRACTICE, POLICY & PLANNING LINKED TO HDA ACTIVITIES



HEALTHY SCHOOLS



If children are happy and healthy they will come to school and get better results. The 'healthy' vending machine was very much 'the icing on the cake' in what is a much wider programme. It's been a great success.

ANDREW DOBBERSON ASSISTANT HEAD TEACHER, TRING SCHOOL, HERTFORDSHIRE

There are three vending machines at Tring School in Hertfordshire. One sells fizzy drinks, another sells sweets and snacks and a third sells healthier options – milkshakes, skimmed milk, bottled water and fruit juices (see opposite). All three are turning out a healthy profit.

The 'healthy' vending machine arrived on site in 2003 as part of a Food Standards Agency pilot scheme to see how popular its products would be compared with the high fat, high sugar alternatives. However, the groundwork for success had already been laid by the National Healthy School Standard (NHSS), which is being implemented by the school for the benefit of both staff and its 1,500 pupils, who are aged from 11 to 18.

NHSS encourages a 'whole school' approach. That means encompassing all possible opportunities for healthy eating throughout the school day. 'We try to link the NHSS with achievement,' explains Andrew Dobberson, assistant head teacher. 'If children are happy and healthy they'll come to

school and get better results. The vending machine was very much "the icing on the cake" in what is a much wider programme. It's been a great success.' The healthier options have also been welcomed by pupils. Tim Whitton (age 17), says: 'Before we had the milkshake vending machine, the only choice was chocolates and Pepsi.'

Schools are seen as crucial in the fight to improve the nation's health (as highlighted in the DH's *Choosing Health? Choosing a Better Diet: A consultation on priorities for a food and health action plan*) and the government has already established the Food in Schools Programme.

Five hundred schools are involved in eight pilots to determine how to encourage healthier eating on their premises. The pilots cover everything from vending machines, tuck shops and lunchboxes to breakfast, cookery and growing clubs, dining rooms and water provision – all areas cited in NHSS guidance on how to adopt a whole school approach to healthy eating.

■ **The National Healthy School Standard (NHSS) team is based at the HDA. NHSS is a partnership between the Department of Health, DfES and HDA**

■ **'The management of obesity & overweight: An analysis of reviews of diet, physical activity and behavioural approaches' (HDA 2003) says 15% of 15 year olds are obese**

■ **Obesity is more prevalent in lower social classes. The proportion of obese or overweight children is higher among Asian groups than other minority ethnic sectors**

■ **British children eat less than half the recommended portions of fruit and veg a day – the majority eat more saturated fat, sugar and salt than recommended for adults**

FALLS PREVENTION

Falls are the leading cause of mortality among people who are aged over 75, yet HDA evidence (*Prevention and reduction of accidental injury in children and older people*) shows that simple changes in and outside the home can help prevent such accidents. It also demonstrates the value of improving people's strength and balance through exercise. So how do we get this evidence of what works into practice to help those people who most need support?

The Healthy Communities Collaborative (HCC), developed and delivered by the National Primary Care Development Team (NPDT) and supported by the HDA, is doing just that. So far it has reduced the number of falls among older people by over 30% since its pilots were set up in 2002.

The three HCC pilots were established in deprived areas covered by Easington, Northampton and Gateshead Primary Care Trusts. They each include five, ward-based teams comprising local residents and representatives from the council, health services and voluntary sector. Each team has used HDA evidence to devise their own activities.

'The HDA evidence briefing set the context,' explains Maggie Woodward, Gateshead project manager. 'It allowed us to move away from the focus on secondary services, look at the research and identify the key things we could do to prevent falls.' The result was a mix of physical activities and changes to the environment. In Easington, for example, low maintenance night lights have been given out to prevent falls in the dark. In Northampton, 'Mr Motivator' teaches chair-based activities to the over 65s.

In Gateshead, where winter often turns the hilly streets to ice, the council now delivers 2kg bags of salt to older residents so they can grit their paths – thanks to HCC pressure. 'It's all about "people power",' says community volunteer Edie Cape (main photograph). Indeed, it was in recognition of its work in 'genuinely engaging' with communities that the HCC won the health inequalities category of the 2003 *Health Service Journal* awards.

■ **In England, over 3,000 people aged 65 plus die each year after experiencing a fall**

■ **Over 50% of deaths from accidental injury and over 60% of serious accidental injuries occur among people who are aged 65 and over**

■ **Standard six of the National Service Framework for Older People focuses on falls prevention**

■ **Simple changes inside and outside the home can help prevent falls among older people, according to 'Prevention and reduction of accidental injury in children and older people' (HDA 2003)**





The HDA evidence briefing set the context. It allowed us to move away from the focus on secondary services, look at the research and identify the key things we could do to prevent falls.

MAGGIE WOODWARD HCC PROJECT MANAGER FOR GATESHEAD

SMOKING CESSATION



Standards in training are absolutely vital. I'd very much hope that in future it won't be possible to run a course that isn't compliant with the Health Development Agency's standard.

JENNIFER PERCIVAL DIRECTOR, RCN TOBACCO EDUCATION PROJECT

Primary care trusts are facing tough new smoking cessation targets, healthcare professionals are crying out for quality training to help achieve them – and the Health Development Agency's standard for smoking cessation training is proving invaluable. Take Carmel O'Gorman, smoking cessation midwife at Good Hope Hospital in Sutton Coldfield (see photograph, opposite).

She recently gave a talk as part of a two-day training course on smoking and pregnancy developed by the Royal College of Nursing's (RCN) Tobacco Education Project to meet the new HDA standard. 'I was there to talk. But I attended the whole course and came away feeling I could have done with that when I started my job two years ago... It was very, very good,' she says.

The standard, published in June 2003, aims to ensure everyone has equal access to the best advice – wherever they live. Jennifer Percival, director of the RCN's Tobacco Education Project and a member of the HDA steering group that developed it, says: 'Standards in training are absolutely vital. I'd very much hope that in future it will become the national standard and that it won't be possible to run a course that isn't compliant with it.'

Lesley Owen, HDA public health adviser on smoking, says it has already been used to inform development of a pilot GP training programme. 'More recently, we used it to help inform the content of a guide for dental teams. A "first" for us is that the guide includes a multiple choice questionnaire that dentists can complete and submit to the British Dental Association. This will count as up to three hours of continuing professional development.'

Development of the standard is 'just the first step', she adds. 'We're now looking at how we roll it out. We are planning, for example, to pilot an accreditation system for the standard, on behalf of the Department of Health. Accreditation is something Lisa Fendell, a specialist smoking cessation midwife for Central Doncaster Primary Care Trust, believes is vital. As she points out: 'National standards are really important. But unless something is accredited and deemed to be appropriate, people might not be getting the skills they need.'

The HDA is also working with the Royal Pharmaceutical Society to see how the standard can be built into the continuing education of pharmacists – as well as developing a standard for the trainers themselves.



■ Smoking is the principal reason for inequalities in death rates between rich and poor in the UK. 'Smoking and public health: a review of reviews' HDA (April 2004)

■ The HDA's cessation training standard has been endorsed by the Society for the Study of Addiction and the Society for Research on Nicotine and Tobacco

■ New NHS targets expect the 'average' primary care trust in England to produce 900 successful quitters a year – an increase of 170% on previous targets

■ The national targets are: to reduce smoking in manual groups to 26% by 2010, and to get 800,000 smokers from all groups to quit at the four week stage by 2006

PHYSICAL ACTIVITY



Coverage of Mobilise! in *Health Development Today*, the Health Development Agency's magazine, 'was instrumental' in it winning £880,000 in new funding – and this money is now being invested in three new cycling and walking trails.

LINDLEY OWEN MOBILISE! DIRECTOR

Had you been in South West England this spring, you might have happened upon the *Way to Go* television series which was broadcast early on Sunday evenings. The programme was all about getting out and enjoying the countryside. It was accompanied by an advert telling interested viewers to call NHS Direct for a factsheet on the availability of local sport and leisure activities.

The programme and advert were the result of a sponsorship deal involving a group of regional and local public sector organisations, including HDA South West. 'The aim was to encourage local people to build regular physical activity into their everyday lives,' explains the HDA's South West regional associate director, Maggie Rae.

The television programme is just one of the outcomes from Mobilise!, a Cornwall-wide programme which is encouraging local people to go walking and cycling, mainly through the creation of trails – and by organising groups of people to use them. 'The strength of this project is that it provides easy ways to become active – and literally take a step towards a healthier life,' Rae adds.

The HDA has also helped the project gain additional funding: Mobilise! director Lindley Owen explains that coverage of the project in its magazine, *Health Development Today*, 'was instrumental' in it winning £880,000 in new funding. This money is now being

invested in three more cycling and walking trails. The aim is to tackle regeneration, sustainable development and health inequalities – all regional priorities – in one hit, he adds, by linking areas of high deprivation with Cornwall's innovative biodiversity centre, the Eden Project (pictured behind the cyclists below and opposite).

Mobilise! began life in 2003 as a joint initiative between Cornwall and Isles of Scilly Health Action Zone (HAZ) and the sustainable transport charity, Sustrans.





■ A sedentary lifestyle is one of ten main causes of death in developed countries. Physically active adults are 20-30% less likely to die prematurely and 50% less

likely to develop major chronic diseases like CHD and stroke. Six in ten men and seven in ten women in the UK are not active enough to benefit their health

■ 'The effectiveness of public health interventions for increasing physical activity among adults: a review of reviews', HDA (Feb 2004) was summarised as an annex

in the CMO's report, 'At Least Five a Week' (April 2004). The CMO recommends that adults should be active for at least 30 minutes, five or more days a week

IMPACT REPORT

During 2003-04 the Health Development Agency has worked in collaboration with the Department of Health on delivery of the Health Inequalities Programme for Action. This 'Impact Report' demonstrates significant and solid progress, based on quantitative evidence drawn from external evaluation and supported by qualitative evidence and real life examples.

Our progress is measured against recommendations made to the Agency by the Minister of Public Health at its 2003 accountability review. We also demonstrate progress against measures laid out in the Health Development Agency's delivery plan for 2003-06.

Progress is measured in relation to:

- Quality and usage of the HDA Evidence Base
- Penetration and uptake of HDA guidance and support
- Changes in practice, policy and planning linked to HDA activities.

A full version of this report is available at : www.hda.nhs.uk/documents/Impact_report2003-4.pdf

Quality and usage of the Health Development Agency's Evidence Base

During 2003-04 the Health Development Agency continued to support public health professionals in developing their evidence-based work.

As one means of assessing the Agency's impact, we commissioned research with directors of public health in primary care trusts (PCTs), health promotion managers and specialists in primary care trusts and health leads in local authorities.¹

88% of our core audience perceived the HDA as an important source of evidence-based information – compared with 84% in 2003.

77% are satisfied with the HDA website – we are working towards a target of 80%. The proportion of 'very satisfied' customers increased from 16% to 29%.

In addition, there has been a 15% increase in new visitors to the site since January 2003.

Gaps in the evidence identified by the Agency are being filled by reviews and primary research:

- The Department of Health (DH) is commissioning a number of major research consortia to work on health inequalities, young people's risk taking and health, and incentives and regulation for health improvement – all gaps identified by HDA briefings.
- The DH tender and commissioning process for a new accidental injury prevention programme reflects recommendations that were made in the HDA's *Evidence Briefing: Prevention and reduction of accidental injury in children and older people*.

¹One hundred and fifty people (50 primary care trust directors of public health, 50 health promotion specialists, 50 health development leads in local authorities) were interviewed in January and February 2004. This was followed by 19 indepth interviews. The survey was carried out by independent research agency, Jigsaw. The results form the basis of charts used on pages 18-23 – except where indicated. More details of the survey are at: www.hda.nhs.uk

As agreed at last year's accountability review:

- The HDA is working on a national database of effective practice with the Department of Health Inequalities Unit. A national steering group has been formed and three 'effective practice' guides will be produced in 2004.

- The Agency is working on a new version (version 1.1) of the Public Health electronic Library (PHeL), the virtual public health branch of the National electronic Library for Health (NeLH). This will be launched in July.

- Press launches of several of the HDA's key evidence briefings – on obesity, physical activity and accident prevention – ensured that they received widespread media coverage at national, regional and local level.

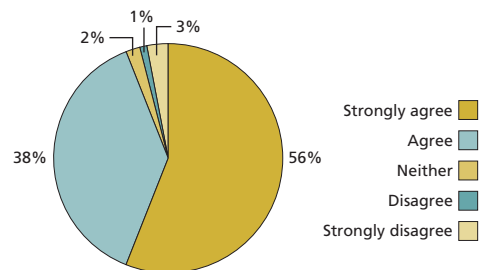
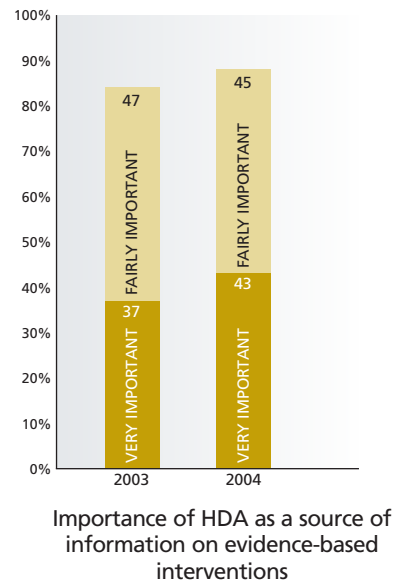
As a result of the widespread publicity generated at the launch of the HDA briefing, *Prevention and reduction of accidental injuries in children and older people*, Hertfordshire County Council is investigating the possibility of introducing a 20 mph speed limit on residential roads. A Lancaster City councillor is pushing for a similar approach. (For more on the councillor behind the Herts proposals, see pages 8-9.)

In both incidences, evidence published by the HDA has been used to show that speed limits can help reduce fatal road accidents among children and young people.

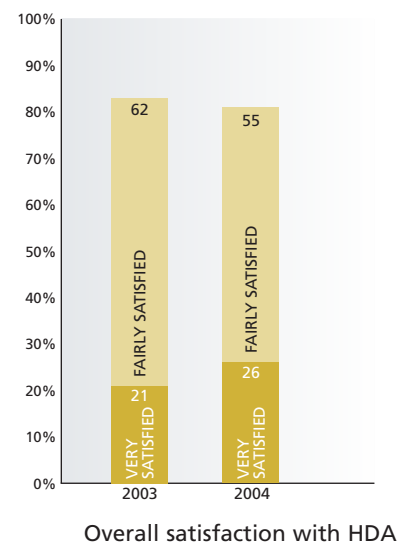
During the past year, a number of national and regional reports have cited evidence published by the Health Development Agency. For example:

- The Agency's evidence briefing on the prevention of sexually transmitted infections (STIs) was referred to in a sexual health report by the House of Commons Health Committee. (*Sexual Health. Third Report of Session 2002-03. Volume I. Report, together with formal minutes.* June (2003) The Stationery Office.)

- Health Development Agency evidence on effective ways of promoting physical activity (*The effectiveness of public health interventions for increasing physical activity among adults: a review of reviews*, published in 2004) was referenced in an appendix to the Chief Medical Officer's report on the subject, *At least five a week: evidence on the impact of physical activity and its relationship to health*, published April 2004.



HDA as a credible source of information



Penetration and uptake of HDA guidance and support

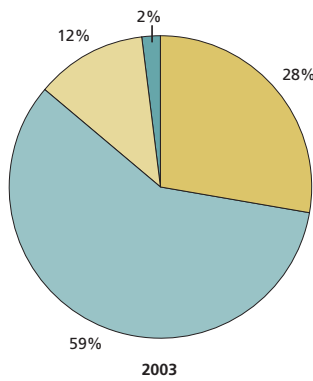
46% of our core audience cited evidence to improve health as a reason for approaching the HDA – up from 38% in 2003.

22% are aware that the Agency helps translate evidence into practice – up from 19% in 2003.

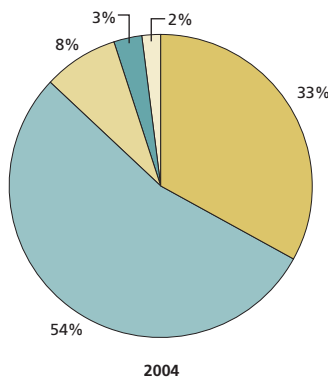
87% were satisfied with HDA publications – the same as last year (we are working towards a 90% target).

33% were ‘very satisfied’ – up from 28% in 2003.

81% were satisfied with *Health Development Today* magazine.



Very satisfied
Fairly satisfied
Neither
Not satisfied
Don't know



Overall satisfaction with HDA publications

Regional directors of public health also endorse the HDA's work:

'It's a very positive partnership. The HDA RAD [regional associate director] is part of the public health top team. He made a big contribution to the RDPH report and the regional strategic framework for health and is integral to regional public health group development. The HDA is also a key player in the government office and regional assembly.' **Paul Johnstone, Yorkshire & Humber**

'The regional public health team have an excellent working relationship with the HDA. The HDA's evidence and guidance is a key resource for supporting public health delivery within the region.' **Dr Gina Radford, East of England**

'Very happy' with what the HDA region delivered last year and proposes for next year. **Janet Baker, West Midlands**

'The HDA is an integral part of the delivery of public health at the regional, sub-regional and local level across the North West. The contribution of the Agency is vitally important and much valued.' **Professor John Ashton, North West**

The document put together for the PCT local delivery plans was useful. The HDA RAD has raised the profile of community involvement and development in the wider public health workforce. He has been asked to lead on the HLC network and coordinate next year's regional public health conference. **Dr Mike Gill, SE**

'The work of the regional public health group in the South West would be much poorer without the enormous contribution of the HDA as part of the group. The development of public health structures and functioning in the region is heavily dependent on the commitment of the HDA staff. They all make a visible and valued contribution.' **Dr Gabriel Scally, South West**

'The HDA team are doing an excellent job here in the East Midlands. I would definitely give them a mark of "10 out of 10". They are integrated closely with the regional public health group, playing a major role in many of our "corporate" issues.'

Professor Lindsey Davies, East Midlands

'We decided to utilise the HDA regional resource to support the London Health Commission as the strategic partnership for health across London. This model has been successful in getting health and inequalities on a much wider set of agendas than just the NHS.'

Professor Sue Atkinson, London

'The HDA regional team continues to deliver a vital contribution to the development of policy across sectors and to the work of frontline practitioners.'

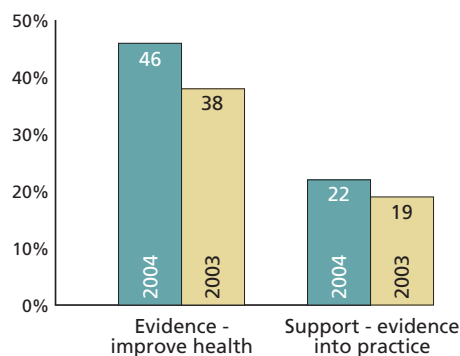
Dr Bill Kirkup, North East

The HDA has achieved a 93% satisfaction rating for its contribution to regional public health networks:

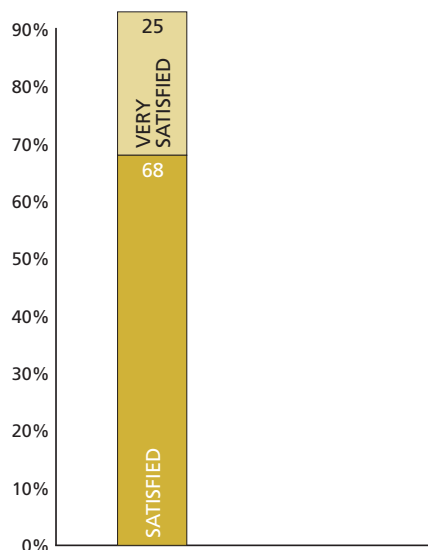
- Our Yorkshire and Humber office is coordinating a network for standard eight leads to support the *National Service Framework for Older People* and the inequalities delivery plan. This has led to a document of local good practice and influenced NSF development. *Judy Stewart, Calderdale PCT*, said: 'The regional HDA has been supportive of the network from the start, organising and funding the meetings. They have responded to issues that have arisen. For example, the development of the website as a way of facilitating communication and commissioning work to map good practice.'

- The message that community development is an important means of reducing social exclusion and tackling health inequalities is being spread via the Health and Community Development Forum, chaired by the HDA's South East RAD. Via the Forum's networks, community development workers are disseminating their work to NHS audiences. NHS staff have also input into the curricula of local community development degrees.

- East Midlands HDA is helping to capture and disseminate learning from HAZs, using NatPaCT funding. This has led to the appointment of two health inequalities facilitators. *Dena Adamson, NatPaCT East Midlands*, said: 'NatPaCT's strong working relationship with the HDA in the East Midlands has ensured that this financial resource has been targeted appropriately to achieve our dual goals of improving health inequalities and developing primary care. The expert advice, leadership and coordination... has been invaluable.'



Spontaneous reasons why the HDA would be approached (only respondents expressing opinion)



Support for regional public health networks

Changes in practice, policy and planning linked to HDA activities

The Healthy Communities Collaborative (HCC) has achieved a 32% reduction in falls among older people and is being spread to 10 more sites. (For highlights, see pages 12-13.)

In agreement with the ministerial accountability review, the collaborative's profile has been raised considerably:

- The project received national recognition by winning the health inequalities category of the 2003 *Health Service Journal* annual awards, for engaging with communities.
- HCC has been cited in numerous press releases produced by the HDA, as well as featuring in an article in *Health Development Today* magazine, published by the HDA.

During the past year, many government policy and planning statements have reflected HDA evidence and guidance:

- The Agency's view that NHS and local government performance management systems should link together and promote action on health inequalities was echoed in the Wanless report, *Securing Good Health for the Whole Population*. This report also reflects HDA calls for research on the cost effectiveness of public health interventions.
- The HDA report *Planning with a purpose: local authorities and the NHS* helped to foster closer partnerships between PCTs and local authorities. Minister for Public Health Melanie Johnson described it as, 'a very helpful resource for anyone working at the local level; those involved in local partnership and those managing the delivery of mainstream services.'
- The HDA's self-assessment tool is being used by local authorities involved in testing out ways local government can reduce health inequalities, as part of the Department of Health/Local Government Association Shared Priority Project. The project will help LAs as they prepare for their next comprehensive performance assessment, when their performance on health inequalities will be judged.
- The HDA's evidence briefing, *Teenage pregnancy and parenthood: a review of reviews* helped inform the CMO's *Update 35* and reinforced the importance of sex and relationships education among ministers.

The Agency continues to support smoking cessation services in line with The NHS Cancer Plan, the National Service Framework for Coronary Heart Disease and the Health Inequalities Programme for Action:

- Ten months after HDA guidelines were disseminated, most PCTs had complied with the main recommendations. In the South West, over 90% of PCTs are using HDA evidence and guidance to support smoking cessation work.
- In June 2003, the first ever smoking cessation training standard was launched to support PCTs in their endeavours to help 900 people a year quit the habit. It will ensure everyone has equal access to the best advice – wherever they live. In a recent audit of 72 cessation courses, 43% were 'totally compliant' and 47% were 'mostly compliant'. (For comments on the standard see pages 14-15.)
- HDA London helped organise the London Health Commission's Big Smoke Debate to assess support for public restrictions on smoking. Nearly 40,000 people took part – and most were in favour of more restrictions. Local, regional and national media coverage also highlighted the issue. The debate prompted London SHA chief executives to lobby DH to make NHS premises smoke-free. It also led the Mayor of London to lobby for powers to ban smoking in taxis. Seven other regions are now rolling out this approach using materials from the campaign.

89% of our audience are satisfied with HDA events:

- In 2003, the HDA worked with the Health Inequalities Unit to develop its first national conference on tackling health inequalities. The event attracted 300 delegates from a range of sectors. 95% rated it as 'good' or 'very good'.
- Translating HDA cancer prevention guidance into concrete action was the driver behind a conference organised by HDA East of England, in conjunction with the region's five cancer networks. The event resulted in a commitment to make prevention activities a priority. As part of this commitment, cancer networks in the Anglia television region have agreed to help lever the funds needed to continue running a public awareness campaign.

■ HDA North East's health needs assessment seminars, undertaken with the NE Change Centre, made a positive contribution to strengthening public health capacity. *Wendy Francis, Middlesborough PCT, said: 'I am about to lead health needs assessments across eight localities in the North East. Following the seminar, I have been inspired to use – and cascade to the teams undertaking these assessments – the principles and steps set out by the HDA.'*

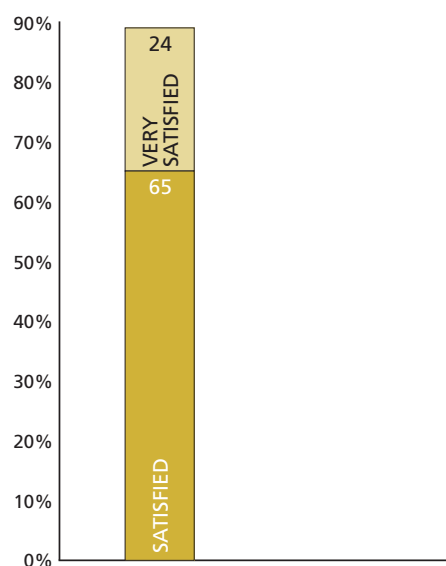
■ HDA West Midlands, in conjunction with the Local Government Association, helped to enhance both PCT and local government understanding of the role that local authorities can play in improving people's health, by running four multi-agency regional workshops on health scrutiny and overview. *Delegate comments included: 'Enabled me to appreciate where councillors are coming from...'* 'The workshops provided knowledge and information which I took back to my organisation to use to help build the health overview and scrutiny infrastructure'.

HDA regional offices played a leading role in influencing regional plans and strategies:

■ HDA North West is working with its public health observatory to develop a regional obesity plan which links new regional data to HDA evidence. As part of the process, it helped organise a conference attended by Chief Medical Officer Sir Liam Donaldson and leading regional figures, to ensure the regional public health system (inside and outside the NHS) was involved. The resulting data has already been used to inform Preston PCT's local obesity strategy.

■ HDA South West helped its three strategic health authorities (SHAs) develop their health inequalities strategies. It also helped Avon, Gloucestershire and Wiltshire SHA organise a conference to launch its strategy. *Philip Milner, strategic health authority director of policy and partnership, said: 'The South West HDA made a significant contribution...This is a superb example of multi-agency public health partnership at its best.'*

Former SHA chief executive, the late Geoff Scaife, said: 'HDA South West helped deliver an excellent conference. It was a springboard for local action and provided us with practical steps to improve the health of the local population'.



% of people attending HDA seminars, workshops and events who were 'very satisfied' or 'satisfied'

National Healthy School Standard (NHSS)

The NHSS's capacity to promote social inclusion and raise pupil achievement is increasingly recognised at policy level. In March 2004, Schools Minister Stephen Twigg provided a resounding endorsement of the programme's achievements, describing it as a central part of the DfES's work.

During the past year:

- 3,575 schools with 20% or more Free School Meal Eligibility have achieved healthy school status (making a total of 9,584 healthy schools in England)
- 95% of a random sample of 586 secondary and primary schools in England were aware of NHSS. Two thirds were already participating (March 2004)
- 630 teachers are on track to achieve the PSHE certificate
- More than 40 community nurses are on track to achieve the community nurse PSHE certificate
- 150 local teenage pregnancy plans and young people's substance misuse plans reference NHSS
- The NHSS re-accreditation process was suspended until the national evaluation was completed.

HIGHLIGHTS OF HDA WORK DURING 2003-04

	Underlying determinants of health	The big killers – coronary heart disease and cancer	Children and young people	Adults
Evidence	<p>Housing and health*</p> <p>Employment and health summary*</p> <p>Transport and health*</p> <p>Health inequalities case studies</p> <p>Contributed to the Neighbourhood Renewal Unit website</p>	<p>Smoking evidence briefing</p> <p>Physical activity evidence briefing</p> <p>Obesity evidence briefing</p> <p>Collaborating centre on physical activity*</p>	<p>Child health evidence review</p> <p>Sexually transmitted infections evidence briefing</p> <p>Teenage pregnancy evidence briefing</p> <p>Social support in pregnancy evidence briefing</p> <p>Breastfeeding evidence briefing</p> <p>Low birth weight evidence briefing</p> <p>Collaborating centre on maternal and child nutrition, including breastfeeding*</p> <p>Health Behaviours of School-aged Children Survey</p> <p>Collaborating centre on accidental injury (children)*</p> <p>Collaborating centre on drugs*</p> <p>Accidental injury evidence briefing (children)</p>	<p>Men's health scoping papers</p> <p>Accidental injury evidence briefing (older people)</p>
Guidance	<p>Health impact assessment</p> <p>Health equity audit</p> <p>Supporting primary care trusts (PCTs) to tackle health inequalities</p> <p>Policy implications of HDA evidence reviews</p> <p>Transport and health*</p>	<p>Regional smoking guidance</p> <p>Update of smoking prevalence statistics and associated health implications</p> <p>Smoking cessation among hard-to-reach groups</p>	<p>National Healthy School Standard</p> <p>HIV prevention</p> <p>Sexual health promotion</p> <p>Drug prevention</p> <p>Teenage pregnancy</p>	<p>Wellbeing in later life</p> <p>Work on the preventive aspects of the National Service Framework for Older People (standard 8)</p> <p>National evaluation report on pre-retirement services</p>

Cross-cutting activities and products

Regional and local support, Public Health electronic Library (PHeL), HDA website, training, toolkits, advisory services, *Health Development Today* magazine, conferences, methodologies to develop evidence and to translate evidence into practice

Practice development

Partnership toolkit
Healthy living centre and NGO PHorum support
Social Action Research Project (SARP) roll out
First HDA national conference: 'Health inequalities and delivery'
Healthy communities training
Collaborating centre on community engagement*
Support for regional assemblies
Support for local authority scrutiny of inequalities
Health impact assessment, health needs assessment and health equity audit

5 A Day coordinators' support
Smoking cessation standard
Collaborating centre on tobacco control*
Scoping current capacity for tobacco control
Physical activity

National Healthy School Standard
Teenage pregnancy
National HIV Prevention Information Service
Collaborating centre on drugs*
Collaborating centre on maternal and child nutrition, including breastfeeding*
Current awareness bulletins

Pre-retirement learning
Healthy Communities Collaborative

* *Project ongoing*



CHIEF EXECUTIVE'S UPDATE

These are exciting times. The public health white paper will undoubtedly have a huge impact on our work. Allied with the Wanless reviews, which have made the case for a less disease oriented, more health focused NHS, the time is ripe for public health.



PAUL STREETS CHIEF EXECUTIVE

These are exciting times. The new public health white paper, which is due to be published this summer, will undoubtedly have a huge impact on our work. Allied with the Wanless reviews – which made a strong case for the NHS becoming less disease oriented and more health focused – it looks like the time is ripe for all those working to improve the public's health.

Indeed, the environment for investment in effective, evidence based public health interventions is probably stronger than it has ever been since the Health Development Agency was first formed in April 2000.

The HDA will play a crucial role in ensuring that all those who work to improve health and reduce health inequalities can capitalise on these opportunities.

Policy context

Following publication of the public health white paper, health inequalities and other public health issues are likely to feature more strongly in the government's national health priorities and plans.

In particular, tackling health inequalities is likely to form an important part of the 2005 to 2008 priorities and planning framework for the NHS. It is also likely to feature in cross-government expenditure plans.

In addition, it will become one of the major drivers behind local government in the next 12 months: local authority efforts to promote healthier communities and

Looking forward



reduce health inequalities will be included in their next comprehensive performance assessment.

In the meantime, the government's delivery plan, *Tackling Health Inequalities: A programme for action* (2003) is giving momentum to a cross-government approach to tackling health inequalities.

Its message – that we need to tackle the underlying determinants of health – has been reinforced by the second Wanless review, *Securing Good Health for the Whole Population. Final Report* (February 2004).

This stresses that the responsibilities, roles and incentives for the public health 'delivery chain' need to be improved. In addition, it emphasises the need for more evidence on the best ways to reduce health inequalities – in particular, what is most cost effective.

All these developments are set against a backdrop of government moves to reduce 'top down' direction and encourage local organisations and partnerships to tailor their activities to meet local needs.

HDA focus for 2004-05

As we await the forthcoming public health white paper, our new delivery plan concentrates primarily on the 2004-05 financial year. During this time we will focus on four programme areas:

- The 'big killers' – coronary heart disease and cancer
- Children and young people
- Adults – in particular, older people and the most vulnerable groups
- The underlying determinants of health and health inequalities.

Once we have a clear idea of the kind of opportunities that have arisen as a result of the new white paper, we will develop our strategic plan for 2005-2008/9.

In the meantime, we aim to meet our customers' need for support to translate evidence of what works into practice – whether it's to reduce inequalities in health or generally to improve people's health.

It's a need that was clearly spelt out in the HDA's *Impact report* for 2003-04 – 45% of the Agency's core audience said they would like more of this kind of help (for highlights of the report, see pages 18-23).

Highlights of our delivery plan for 2004-05 can be found on pages 32-33. Our emphasis will be on adding value to the evidence and building on work undertaken during 2003/04.

Evidence gathering to fill the gaps in public health knowledge will still be an important part of our work. However, we will concentrate more on solutions to what could be described primarily as 'NHS problems' – but which may involve other government departments.

We will also focus on a narrower range of topics, dealt with in greater depth, using the kind of settings approach adopted by the National Healthy School Standard. One of the important results of this work will be clear, targeted guidance to help practitioners focus on activities that are proven to be effective.

We plan to implement a number of strategies to underpin this new approach. These include:

- Developing a stronger customer focus and a marketing orientation, targeting both the wider public health workforce and those who influence investment decisions
- Bringing more practitioners into the agency and sending our staff out into the field to ensure we better understand and meet our customers' needs
- Increasing our capacity to respond more rapidly, and in a timely manner, to opportunities arising to influence policy practice

Agency's new approach involves two streams of work

■ In the short to medium term, the HDA will focus on influencing and changing practice within an NHS-driven agenda. We will concentrate on topics that have a resonance nationally, regionally and locally – while recognising that the NHS will need to work in partnership with local authorities and other government departments on health inequalities.

■ In parallel, we will develop our capacity as an influencing agency. Equipped with the evidence on how to improve people's health, we will work 'behind the scenes' to influence future government policy to ensure it has a positive impact on health and health inequalities. These activities will be directed at both the NHS and the wider, cross-government public health agenda.

- Building the business case for investment in public health – including evaluation of what works
- Increasing our sub-regional presence through strategic health authorities to provide more direct, hands-on support to public health networks.

Collaborative working

To ensure success, we need to become a more networked, externally focused organisation. A network of regional and central practice development officers has been set up.

We are also establishing collaborating centres. These will support partnership working with academics and practitioners to deliver evidence and advice informed by (and highly relevant to) policy makers, planners and practitioners. They will lead to further support for change on the ground and help build the evidence base.

Our first evidence and guidance collaborating centres have been established to tackle: accidental injury among children, maternal and child nutrition, prevention of drug misuse and the promotion of physical activity. They will:

- Develop and maintain evidence reviews
- Produce guidance based on the evidence
- Provide an inquiry service for both public health practitioners and researchers (in many cases)
- Input to the Public Health electronic Library (PheL).

During 2004-05 we will also collaborate with NICE to produce guidelines on how to prevent and tackle obesity.

Our first practice development collaborating centres will focus on: tobacco control, community engagement and partnership development, maternal and child nutrition and the prevention of falls in older people. They will:

- Help to develop professional practice and lead work to find the best ways to reduce health inequalities and improve health in these areas
- Produce a range of resources for training and distance learning, curriculum development and organisational development (in particular, for primary care trusts and public health networks).

The effectiveness of collaborative working will be assessed over the next year. If successful, framework agreements with 15 other institutions mean we could quickly roll out this approach to other areas of our work.

At the time of writing, the Agency's future as a separate entity was under review, as a result of the Department of Health's review of all 42 'arm's length' health bodies. Irrespective of the outcome, we remain committed to our current delivery plan (for highlights, see p32-33) and future efforts to put public health evidence into practice, address health inequalities and improve the general health of the population.

HOW WE WILL MEASURE OUR IMPACT DURING 2004-05

Initiatives to improve health and reduce health inequalities are notoriously difficult to measure in the shorter term. Nevertheless, we have devised a number of targets to give a realistic indication of how useful and effective people find our products and services

Our targets will demonstrate:

- The quality of HDA evidence and guidance and how it is used
- Practice development.

We will measure our progress using:

- A comprehensive, annual stakeholder survey
- Evaluation of specific aspects of HDA work
- Information and case studies gathered from the regions
- Recording the uptake of the Agency's evidence, guidance and advice in government policy
- Regular communication with our core audiences and stakeholders.

Much of the practice development and guidance work that is included in the Health Development Agency's delivery plan for 2004-05 builds on projects completed in previous years. In this respect, our work is cumulative: building year on year into a body of expert knowledge backed by practical support. (For a summary of the products and services we will deliver in 2004-05, see pages 32-33.)

As just one of many examples of this, the Agency's cancer prevention work and our recent report on obesity management in children were both cited in Department of Health documents, as part of the consultation for the forthcoming public health white paper. (The reports were referenced in *Choosing Health? Choosing a Better Diet* and *Choosing Health? Choosing Activity* respectively at: www.dh.gov.uk)

The results from our annual stakeholder survey, which we have undertaken for the past two years, is perhaps the best demonstration of the cumulative impact of our evidence-based work, however. For highlights of the 2003-04 survey – and other measures of our impact during the past year – please turn to pages 18-23.

Indicators of success

For 2004-05, as in previous years, we have set a number of targets to measure the broad impact of the HDA's publications and other activities. This year these targets are grouped under two main headings:

- The quality of the Agency's evidence and guidance and how it is used by our core audiences
- Our support for practice development.

We will demonstrate the quality and uses made of HDA evidence and guidance by meeting the following targets:

- At least 90% of the HDA's core audience will rate the Agency as an important source of information.
- We will achieve at least a 90% satisfaction rating for HDA products among our core audience.
- We will achieve a 5% increase in awareness of HDA core functions year on year – to a maximum of 95%.
- We will achieve at least an 80% satisfaction rating for HDA contributions to the development of effective, regional public health networks.
- At least 80% of directors of public health will routinely use HDA material to guide their work.

Similarly, we will demonstrate HDA support for practice development by meeting the targets below:

- At least 70% of primary care trust (PCT) delivery plans will reference or use HDA evidence/guidance
- At least 70% of local strategic partnerships will reference or use HDA products in their plans.

How we will measure progress

We will assess our progress towards these targets by using the following methods:

- A comprehensive, annual stakeholder survey
- Evaluation of specific aspects of HDA work
- Information and case studies gathered externally
- Recording how HDA evidence, guidance and advice has been used to inform the public health white paper and any ensuing policy initiatives
- Regular communication with our core audiences.

Our annual stakeholder survey aims to assess the HDA's overall impact on its key customer groups. During 2004-05 we will also undertake focused surveys on particular aspects of our work. In future years, we may alternate between a broad stakeholder survey and surveys of different audiences to ensure we are reaching non-specialist public health audiences, in particular, senior people with a direct influence on resource allocation.

We will also measure specific aspects of our programme delivery. This is a pragmatic solution to the substantial costs and methodological difficulties involved in establishing a conclusive link between a particular health outcome and HDA activities. At present we plan to include our work on obesity, falls and Chlamydia in this assessment. We will also draw on evaluation undertaken for the National Healthy School Standard (NHSS).

Feeding back to improve our services

The results from these activities will be used to enhance our services and products by helping us to:

- Understand what difference HDA support makes to practitioners – and which elements of our practice development work is most valued
- Assess our direct impact on practice and, where possible, any resulting health outcomes
- Learn how evidence is effectively translated into practice – and use that knowledge to underpin our future approach and support
- Establish proof of principle, where appropriate, to support further investment and the integration of a particular approach into mainstream services.

SUMMARY OF KEY HDA OUTPUTS: 2004-05

**EVIDENCE
& GUIDANCE**



**PRACTICE
DEVELOPMENT**

Policy advice

Cross cutting activities



EVIDENCE & GUIDANCE

ADULTS

- Evidence reviews
 - Management of chronic illness in mid-life and beyond
 - Blocking pathways or building resilience to vulnerability.

UNDERLYING DETERMINANTS

- Evidence review on impact of childhood disadvantage on health and health inequalities
- Making the case briefings/How to guides
 - Investment for health (including 'NHS as a corporate citizen')
 - Mainstream action to tackle inequalities and develop healthy communities
- Making the connection briefings for LAs on housing and transport.

CHILDREN AND YOUNG PEOPLE

- Guidance on effective smoking cessation among pregnant women in Sure Start and Sure Start Plus areas

- Evidence review of effectiveness on Chlamydia reduction

- Collaborating centres on: maternal and child nutrition, drugs misuse and accidental injury.

BIG KILLERS

- Guidance
 - A smoke-free NHS
 - Prevention and management of overweight and obesity (in development with NICE – ready for 2006/07)

- Physical activity collaborating centre.

PRACTICE DEVELOPMENT

ADULTS

- Report on the impact of the Healthy Community Collaborative (HCC) methodology and Wave II activities
- Health in mid-life training course and peer mentoring.

CHILDREN AND YOUNG PEOPLE

- Establish maternal and child nutrition collaborating centre
- National Healthy School Standard.

BIG KILLERS

- Help for key audiences on obesity, smoking cessation and tobacco control
- *Effective action* briefings on physical activity (for 2005-06)

- Establish a tobacco control collaborating centre.

UNDERLYING DETERMINANTS

- Synthesise learning and practice on health equity audit, health impact assessment and health needs assessment

- Roll out learning from partnership and community development work

- Establish a collaborating centre on community engagement and partnerships.

POLICY ADVICE AND CROSS CUTTING ACTIVITIES

Policy advice Support to implement the public health white paper and for national, regional and local policy making – including help with evidence-based performance management and target setting.

Cross cutting Evidence Base (EB), the Public Health electronic Library (PheL), Health Action website and other electronic information services.

The Learning from Effective Practice (LEP) system will be set up and integrated with EB, the HDA website will be revamped and PHeL will be relaunched. Nine regional support and dissemination programmes will be set up.



BOARD STEWARDSHIP REPORT

During 2003-04 the HDA Board focused on three key issues: business planning, maximising the impact of the Agency's products and services, and restructuring. It met on six occasions – three times in the regions and three times at the Agency's London headquarters in High Holborn. In addition, members attended two informal 'away days'

Overseeing the business planning process was a key strategic priority for the Board. It approved the HDA delivery plan for 2003/04 in May. This was endorsed by officials and by the Public Health Minister, with progress monitored throughout the year.

The Board also provided strategic guidance and advice during the formative stages of the Agency's 2004-05 delivery plan. This was developed by the new chief executive, Paul Streets, and positions the HDA's four main work programmes within a clear policy context, focused on government priorities and targets.

The continuing development of techniques and measures to gauge the Agency's impact on public health practice in general – and on health inequalities, in particular – has been another priority. The Impact Evaluation Committee provided a critical assessment of this work – and we were pleased to see effective measures integrated into the Health Development Agency's 2004-05 delivery plan.

In addition, the Board guided the executive team's response to the HDA's 2003-04 customer evaluation. It also guided development of a comprehensive knowledge management strategy, in accordance with the organisation's strategic responsibilities in this area.

Evidence into practice

The process which began in 2002/03 to refocus the organisation on the systematic translation of evidence and guidance into practice came to fruition this year. The Board advised the Agency's executive on a redefinition of the Health Development Agency's role and the subsequent restructuring necessary to fulfil it.

Organisational development

The new chief executive's *Public and Practitioner First* strategy was approved by the Board in March – and we are confident the Agency has a 'fit for purpose' structure, with clear objectives and a flexible approach to support change in practice on the ground.

Establishment of a number of collaborating centres has been a major Board concern. Detailed approval of the complex contractual arrangements involved was delegated to the Resources Committee. These centres will enhance partnership working and lead to major changes in the way HDA services are delivered.

HDA role in public health delivery

During the year, public health has become an increasingly important part of the government's overall health agenda. We welcomed the announcement of the Treasury's review, *Securing Good Health for the Whole Population* in the autumn – and the secondment of a member of HDA staff to the review team. The Board provided the HDA's executive team with advice and guidance on the Agency's contributions to this process – and on the implications of the final report.

In addition, the Board welcomed the March 2004 announcement of a wide ranging consultation process that will lead to a public health white paper. This gave the organisation an important strategic opportunity to influence the future of public health activities nationally.

Scrutiny and governance

The Board has a key role in ensuring major business risks are identified and managed. In addition to the detailed work carried out by the Audit Committee, it monitored risk management using a board assurance framework. Working with the new chief executive, the Board also reviewed its own operation, agreeing a revised format for its meetings which includes a presentation on work in progress by the executive.

Acknowledgement and thanks

This has been another active and challenging year. We are grateful to all our staff for their hard work and continuing commitment to health development and to reducing health inequalities, during what has been a period of rapid change.

In September, the Board bade farewell to Colin Browne, thanking him for his long and valuable service on the Boards of the HDA and the HEA, since 1996.



DAME YVE BUCKLAND CHAIR OF THE BOARD

COMMITTEE REPORTS

Audit

The Audit Committee met on four occasions, working with the organisation's auditors to ensure compliance and regularity. Business focused on improving the effectiveness of – and compliance with – the Agency's procurement processes. The committee also steered development of a risk management strategy and culture within the organisation.

Resources

The Resources Committee had five meetings. It kept the Agency's performance towards the financial targets set by the Department of Health under close review. The committee also advised on the organisation's major internal policies and monitored its performance against key human resource indicators. The committee took particular responsibility for the contractual process involved in establishing the Agency's collaborating centres.

Remuneration

This committee, which involves all non-executive Board members, met on three occasions. It approved the executive directors' objectives and salary increases. It also reviewed remuneration for the chair and executive directors, pending the appointment of the new chief executive. In addition, the committee advised the chair on the new chief executive's objectives, which were set following his arrival in post in October 2003.

Impact Evaluation

This committee met twice during the year. Its primary focus was to ensure that the evaluation methodology and impact measurements underlying the Agency's 'evidence into practice' processes are clearly defined. In addition, the committee provided guidance on project-level impact evaluation.

BOARD BIOGRAPHIES



Dame Yve Buckland

Paul Streets

Dame Yve Buckland CHAIR

Dame Yve was appointed HDA chair in 2000, prior to which she was chair of the Health Education Authority. She is also vice chair of South Warwickshire PCT, a trustee of the Community Education and Development Centre, an honorary member of the Faculty of Public Health and a fellow of the Warwick Business School Institute of Public Governance. She was part of the Modernisation Action Team on Health Inequalities set up by the Secretary of State for Health to feed into *The NHS Plan (2000)*. In January 2003 she was appointed to the Implementation Group of the Curry Commission on Food and Farming. Dame Yve works periodically as director of the Health Partnership at Warwick University. She became a Dame of the British Empire (DBE) in Her Majesty the Queen's Birthday Honours List in June 2003.

Board attendance: 5 out of 6 meetings

Paul Streets OBE CHIEF EXECUTIVE

Paul became HDA chief executive in October 2003. His long career in the voluntary sector has included Sight Savers, Amnesty International and, most recently, Diabetes UK where he was chief executive. Between 2000-03, Paul served as a founding member of the NHS Modernisation Board, advising on the transition to the new NHS patient and public involvement structures. In 2003 he was awarded an OBE for services to people with diabetes. Paul is also a lay representative and deputy chair of the Healthcare Commission.

Board attendance: 3 out of 3 meetings

Tahera Aanchawan NON-EXECUTIVE DIRECTOR



Tahera is a consultant on inequalities, human rights and organisational development. She is a trustee of the Pastoral and Environmental Network for the Horn of Africa, the Afiya Trust and the Diana, Princess of Wales Memorial Trust.

Tahera chairs Naz, an organisation for BME and migrant communities living with HIV/AIDS, and Transform Africa, which works with NGOs in Africa. She joined the Audit & Resources Committees in November 2003.

Board attendance: 4 out of 6 meetings. Audit & Resources Committees: 2 of 3 meetings

Professor Michael Adler CBE NON-EXECUTIVE DIRECTOR



Michael is professor of genito-urinary medicine/sexually transmitted diseases at the Royal Free and University College Medical School. He is an adviser to WHO,

the British government, DFID and UNAIDS. Michael was National AIDS Trust chair from 1991-2000. In 1999 he was elected to the Royal College of Physicians council. He is seconded to DH to coordinate a sexual health and HIV/AIDS strategy. Michael was awarded the CBE in 1999 for services to HIV/AIDS.

Board attendance: 4 out of 6 meetings

Denise Campbell NON-EXECUTIVE DIRECTOR



Denise specialises in public health at Huddersfield Central PCT. She is also a Sure Start programme manager. Her background is nursing, midwifery, health visiting and community

practice teaching. She was Community Practitioners & Health Visitors Association chair from 1998-2000 and is an honorary NSPCC council member. Denise sat on the Audit and Resources Committees to July 2003.

Board attendance: 5 of 6 meetings. Audit and Resources Committees: 2 out of 2 meetings

Ken Crossland NON-EXECUTIVE DIRECTOR



Ken is a management consultant, writer and broadcaster. He holds a part-time position with IBM Business Consulting Services, plus non-executive directorships at Staffordshire

University and IPF, a specialist public sector consultancy. Ken is one of three deputy chairs of the Board and chair of the Audit and Resources Committees. **Board attendance: 5 out of 6 meetings. Audit & Resources Committees: 5 out of 5 meetings**

Dr Jeff French EXECUTIVE DIRECTOR Jeff joined the HDA in June 2000 after 20 years as an NHS public health specialist and general manager. He is director of marketing and communications. Jeff is also a visiting lecturer at four universities and a visiting fellow at King's College, University of London. **Board attendance: 5 out of 6 meetings**



Professor Christine Godfrey NON-EXECUTIVE DIRECTOR Christine is professor of health economics at the University of York. She has led development of ways to evaluate the cost effectiveness of health promotion, and has contributed greatly to the development of HDA impact evaluation strategies. Christine is chair of the Impact Evaluation Committee and a deputy chair of the Board. **Board attendance: 6 out of 6 meetings. Impact Evaluation Committee: 2 out of 2 meetings**



Carolyn Hughes EXECUTIVE DIRECTOR Carolyn is director of corporate services. She joined the HDA in October 2000, after working in a similar role in Lincolnshire, and as deputy CE of the Healthcare Trust. Carolyn is a qualified accountant. **Board attendance: 6 out of 6 meetings**



Liam Hughes NON-EXECUTIVE DIRECTOR Liam is chief executive of Leeds East PCT. Previously he was strategic director of social services at Bradford Metropolitan District Council, with responsibility for health. Liam was involved in the implementation of health improvement programmes and health action zones, and with the development of PCTs and preventive services for children and young people. **Board attendance: 5.5 out of 6 meetings**



Professor Mike Kelly EXECUTIVE DIRECTOR Mike joined the HDA in December 2000 and is now director of evidence and guidance. Prior to that he was social sciences professor and head of the school of social sciences at the University of Greenwich. **Board attendance: 6 of 6 meetings**



Michael Peters NON-EXECUTIVE DIRECTOR Michael is consultant director of educational services with Tribal Group plc. Previously he was director of education for Lambeth in London, and director of Educational Services in York. He chaired the National Commission for Black Staff in Further Education from 1999-2002 and has been a member of the Joseph Rowntree Foundation's Young People and Families Committee. Michael is on the Audit and Resources Committees. **Board attendance: 2 out of 6 meetings. Audit and Resources Committees: 2 out of 5 meetings**



Dr Viv Speller EXECUTIVE DIRECTOR Viv became director of public health development at the HDA in June 2000. Previously, she was senior lecturer in health promotion at the University of Southampton and Wessex health promotion manager. Viv is a trustee of the Help for Health Trust and the NHF. **Board attendance: 6 of 6 meetings**



Dr Michael Varnam NON-EXECUTIVE DIRECTOR Michael worked as a GP for 35 years. He has been involved in a range of educational issues related to primary care. He is now vice chair of Nottingham City Primary Care Trust's professional executive committee, with special responsibility for health inequalities, homelessness and substance misuse. Recognition of his broader public health role resulted in a Doctor of Medicine award from Nottingham University, and membership of the Faculty of Public Health by Distinction. He is also a director and trustee of Pharmacy Health Link. Michael is a deputy chair of the Board. **Board attendance: 6 out of 6 meetings**



CORPORATE INFORMATION

Appointment of new chief executive

Paul Streets, OBE, became the Health Development Agency's new chief executive in October 2003.

Equal opportunities policy

The Health Development Agency aims to:

- Provide equal opportunities for employment and advancement on the basis of ability, qualifications and aptitude for the work and regardless of any disabilities
- Create an organisation which recognises the contribution of all staff and which is supportive, fair, just and free from discrimination
- Challenge discrimination, by taking decisive action whenever it occurs and by working to redress any past acts
- Promote equality when carrying out all of our functions.

Employee consultation

The HDA continues to inform and consult staff on a range of issues, in accordance with good practice in the NHS. Specifically, an open and transparent consultation was carried out with staff during the restructuring of the organisation, when they had the opportunity to participate in open discussions with both management and their trade union, Unison.

Restructuring

Most of the new organisational structure was successfully implemented in November 2003. Restructuring of the executive management team followed in the spring and top tier appointments are in hand. The new structure provides a sound basis for the Agency's core business.

Organisational structure 2003-04



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WEBSITES

The HDA website – www.hda.nhs.uk – is the first point of call for information about who we are, what we do and the resources we produce. It acts as a distribution vehicle for our publications via its database of over 700 titles available online. It also serves as an umbrella for the HDA's other websites. These include:

PHeL The Public Health electronic Library (PHeL) is a national 'one stop shop' for information on public health. It aims to provide the know-how to promote health and reduce health inequalities: www.phel.gov.uk

HDA EVIDENCE BASE provides access to the best available information on what works to improve health and reduce health inequalities. It has recently merged with the national database, HealthPromis (see below): www.hda.nhs.uk/evidence

HEALTHPROMIS This health promotion database for the UK contains references and links to official publications, surveys, reports, books, research, journal articles and resources: <http://healthpromis.hda.nhs.uk>

HEALTH ACTION gathers and shares information with primary care trusts (PCTs) and their local partners on improving health and addressing health inequalities: www.healthaction.nhs.uk

HIA GATEWAY provides people working in health impact assessment (HIA) with a single source of HIA-related information. It also facilitates the sharing of learning, concepts and experience: www.hiagateway.org.uk

WIRED FOR HEALTH This series of websites provides young people and their teachers with access to relevant and appropriate health information. The sites were developed as a joint initiative between the Department of Health and the Department for Education and Skills. They are managed by the HDA:

www.wiredforhealth.gov.uk (teachers)

www.welltown.gov.uk (key stage 1)

www.galaxy-h.gov.uk (key stage 2)

www.lifebytes.gov.uk (key stage 3)

www.mindbodysoul.gov.uk (key stage 4)

For a complete listing of websites run by the Health Development Agency go to:

www.hda.nhs.uk/html/resources/websites.html

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