Care Services Improvement Partnership CSIP

Integrated Care
Network

The role of public health in supporting the development of integrated services





May 2007

What is the Integrated Care Network?

The Integrated Care Network (ICN) provides information and support to frontline NHS and Local Government organisations seeking to improve the quality of provision to service users, patients and carers by integrating the planning and delivery of services.

Key to the role of the ICN is the facilitation of communication between frontline organisations and government, so that policy and practice inform each other effectively.

The ICN is part of the Care Services Improvement Partnership (CSIP).

Care Services Improvement Partnership

The Care Services Improvement Partnership (CSIP) was launched on 1 April 2005 after a formal public consultation. Our main goal is to support positive changes in services and the well-being of:

- People with mental health problems
- People with learning disabilities
- People with physical disabilities
- Older people with health and care needs
- Children and families and
- People with health and social care needs in the criminal justice system

The Integrated Care Network offers advice on partnerships and integration that cut across all services in health and social care. It works closely with other networks and programmes across CSIP to ensure synergy in improvements.

About the authors

Matrix team members have worked in the commissioning and public health arenas for many years providing policy, organisational development, leadership, analytical, economic, public health intervention and evaluation support to the Department of Health, NICE, SHAs, Local Authorities, PCTs and NHS Trusts.

Our public health work has explored ways of maximising health and well-being by the development and application of public health evidence, identifying effective levers and incentives for change and engaging the wide range of stakeholders that can make a contribution to health improvement and reducing health inequalities.

As well as our work in the health field, Matrix research and consultancy works with clients in a wide range of other public services including crime reduction, criminal and civil justice, social care, substance misuse, children and young people's services, education, transport and sustainable communities. This helps us to engage the full range of stakeholders to support improved public health.

matrix
research and consultancy

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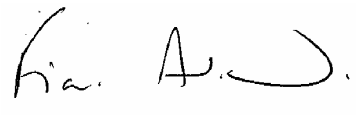
Foreword

It is widely recognised that health inequalities cannot be reduced by the health service alone. Partnership solutions have been at the heart of Government policy for some considerable time driving approaches to improving health, reducing inequalities and improving service access. To create the right environment for these initiatives to succeed, a range of incentives and drivers are available to enable greater collaboration and ensure system reform delivers for committee and individuals. The Commissioning Framework for Health and Well-being consultation document (March 2007), highlighted a number of these opportunities, including the key role which joint strategic needs assessment can play in understanding and planning for local need.

Public health intelligence and expertise offers a unique contribution to local government and health services in taking forward population-based and individual needs assessment, strengthening evidenced based approaches and identifying current priorities and future outcomes.

This publication has been produced to highlight how Public Health can significantly support local government and health professionals to identify need, support prioritisation and develop integrated services to maximise health and well-being.



Fiona Adshead

Director General for Health Improvement
Deputy Chief Medical Officer
Department of Health

David Behan

Director General for Social Care
Department of Health

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1. Introduction

1.1 What this briefing is for

Integrated services are designed to respond more effectively to the needs of service users and carers than services planned and delivered by individual agencies. Having a good understanding of the needs of clients and the impact that different interventions will have is an important part of the planning and delivery of integrated services. Public health as a discipline and public health professionals offer some valuable resources for managers and professionals involved in the development and delivery of integrated services.

This briefing paper is intended for use by managers and professionals who are either involved in the direct management and delivery of integrated services in England, or the commissioning of these services. It is a comprehensive resource, and of relevance both to those who have a detailed knowledge of public health and to readers who are relatively new to the field. The paper provides an overview of the scope of public health practice, outlines some of the tools and techniques that might be used in designing and evaluating integrated services and explains how they might be used as a lever for change and service improvement. The paper includes some case studies showing how public health techniques can be applied and links to further resources and material for those interested in developing a more detailed understanding of public health practice.

1.2 Integrated services and public health – what's the link?

There is a natural synergy between the drive for reducing health inequalities and improving public health on the one hand and integrated services on the other. Both require concerted action across a range of sectors and input of a variety of players working in partnership. Both have a focus on improving health outcomes for service users. But whereas public health tools and resources have been central to health service planning, they have been less fully applied in the planning and delivery of integrated services.

Whilst improving public health and reducing health inequalities have been long standing features of Government policy, they have received even greater attention in recent years. In 2002 the Government set a challenging target in its public service agreement – to reduce inequalities in health outcomes by 10% by the year 2010, as measured by infant mortality and life expectancy at birth. The following year *Tackling Health Inequalities: A Programme for Action* was launched with the support of twelve departments. The Treasury Spending Review in 2004 added further

PSA targets to reduce health inequalities in the areas of cardiovascular disease, cancer, adult smoking, obesity in children under 11 and the conception rate in under 18s.

Derek Wanless's independent review of NHS spending *Securing our Future: Taking a Long Term View* (2002) strengthened the financial and economic arguments for promoting health and well-being and tackling inequalities. In his vision of the future, Wanless indicated that outcomes from health services over the next 20 years (to 2022), could be substantially improved through improved public engagement in their health and well-being. In its 'fully engaged' scenario, the report suggested that £30 billion in NHS expenditure could be saved. The 'fully engaged' scenario is based on the continuous seeking of efficiency and effectiveness improvements on the supply side, and a health literate public nurturing their own health on the demand side. Unless this was achieved, Wanless predicted that the NHS could cost the public a third more.

Although there has been a plethora of national initiatives targeted at reducing health inequalities, it is now recognised that the best way of securing lasting improvements is to place health inequalities within the mainstream of service delivery, ensuring that resources are targeted at disadvantaged areas and groups. It is fair to say that whilst the focus on whole populations and health inequalities (a public health perspective) is an enduring feature of social policy, there is an equally strong emphasis on personal responsibility. Both the Department of Health's 2004 White Paper *Choosing Health: Making Healthy Choices Easier*[1] and the 2006 White Paper *Our health, our care, our say: a new direction for community services*[2] put the emphasis on the individual being supported to make healthier, informed choices about their lifestyles.

It is recognised that health inequalities cannot be addressed by the health sector alone. The Government is encouraging and supporting local authorities to improve the health of their communities and to tackle health inequalities, working in partnership with the NHS, other public sector bodies and the private, voluntary and community sectors.

A variety of tools and incentives are now in place to encourage public bodies to work together and align their goals to improve the health of their communities. Local Strategic Partnerships (LSPs) and Local Area Agreements, for example, provide a focus for agreeing joint objectives for community health and well-being and implementing this vision. Legal devices such as Health Act Flexibilities which enable local authorities and Primary Care Trusts to pool resources, establish joint management arrangement for services, or transfer resources and services to one agency are also designed to improve health and reduce inequalities through effective service delivery.

The latest iteration of health policy changes has turned attention to the commissioning of services.[3] PCTs are being encouraged to focus their attention on improving the effectiveness of the commissioning process, working in partnership with primary care practices and collaboratives who are being given devolved budgets for commissioning for their patients. PCTs will commission integrated health and social care services together with their colleagues in Local Authorities, particularly the directors of adults' services and directors of children's services.

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[1] Department of Health (2004) *Choosing Health: Making Healthy Choices Easier* http://www.dh.gov.uk

[2] Department of Health (2006) *Our health, our care, our say: a new direction for community services* http://www.dh.gov.uk

[3] Department of Health (2005) *Commissioning a Patient-led NHS* http://www.dh.gov.uk/

The role of public health in supporting the development of integrated services

The White Paper *Our Health, Our Care, Our Say*, highlighted the importance of using public health information and intelligence to improve understanding of health inequalities and challenges and the targeting of resources to those who can benefit most. It also stressed the increasing importance of joint commissioning to further the development of integrated services. Health and social care regulators are also gearing up to take a closer look at how effectively local authorities and PCTs discharge their commissioner functions, jointly as well as separately. This suggests that there is increasing need to make the links between public health and integrated services.

The Department of Communities and Local Government (DCLG) 2006 White Paper *Strong and Prosperous Communities* puts even greater emphasis on the role that local authorities plan in promoting the health and well-being of their communities. It signalled action in four areas – enabling patients to voice concerns about health and well-being; identifying a lead member for adult social services who can influence commissioning of health and social care and drive actions to reduce health inequalities; more systematic partnership working on public health issues such as through joint appointment of public health directors and specialists; and joined up performance management and reporting. It announced a single set of national indicators covering social care, public health, health protection, disease prevention, and mental health that will apply to local authorities and their healthcare partners. The new guidance on joint commissioning reinforces this further, making it clear that commissioning of health and social care needs should be led by a partnership between PCT's and Directors of Adult Services and Directors of Children's Services in LA's. It highlights too the importance of strategic needs assessment driving the definition and agreement of local objectives and priorities, with Local Area Agreements being important umbrella plans for improving health and well-being of the local population.

(Further information on the Local Government White Paper is provided in a CSIP networks briefing paper available from the Integrated Care Network's website: http://www.icn.csip.org.uk)

2. An overview of public health and how it is organised

2.1 What is public health?

There is a great deal of confusion in the terminology that is used to describe health improvement and public health. This section aims to explain the different meanings. At the heart of the problem is that the term 'public health' can be used to refer to a profession; a set of skills; desired outcomes; or to the factors that contribute to health and illness.

The Faculty of Public Health defines public health as: *"The science and art of preventing disease, prolonging life and promoting health through organised efforts of society"*[4]. This is a very broad definition that incorporates a range of disciplines and professions and requires the input of different sectors and services.

Public health is a multi-disciplinary profession regulated jointly by the Faculty of Public Health and the UK Public Health Voluntary Register. The discipline focuses on improving the health of the population rather than treating the illnesses or injuries of individual patients. Public health professionals – doctors, nurses, economists, statisticians – work with others to monitor the health status of the community, identify health needs, develop programmes to reduce risk and screen for early disease, control communicable disease, foster policies which promote health, plan and evaluate the provision of healthcare, and manage and implement change. The tools and techniques that public health professionals use are increasingly being applied by people from other backgrounds to support effective planning and commissioning of services or evaluation of services and their effectiveness.

Public health specialists typically define their role and the application of their skills in three domains:

- **Health Protection and Prevention**. This function includes:
  - disease and injury prevention such as screening;
  - communicable disease control including surveillance, contact tracing, immunisation and vaccination and tackling infection outbreaks;
  - environmental health hazards; and
  - emergency planning.

[4] Public health professionals are employed throughout the NHS – in trusts, PCTs, health authorities and boards – in government departments and in academic and research institutions. In other countries the organisational settings for the practice of public health vary according to local circumstances.

- **Improving Health and Social Care Services**. This function includes:
  - specifying quality standards;
  - assessing clinical effectiveness;
  - service planning based on epidemiological analysis of health needs;
  - audit and evaluation; and
  - design of clinical governance and quality assurance systems.

- **Health Improvement**. The focus here is on planning and implementing interventions which tackle the root causes of ill health and disability either directly or through influencing other agencies. These include:
  - employment;
  - housing;
  - social cohesion/exclusion;
  - education;
  - lifestyles (food, health risk behaviours such as smoking, drugs and alcohol); and
  - environmental risks.

Supporting all three domains is public health intelligence – research, information and analysis of public health data.

2.2 Who works in public health?

Given the broad definition of public health outlined above it is clear that a wide range of people have a role in health improvement and reducing inequalities. Teachers, local business leaders, managers, social workers, transport engineers, housing officers, other local government staff and the voluntary sector, as well as doctors, nurses and other healthcare professionals, for example.

Professionals who spend a major part, or all of their time, in public health practice however, are a rather smaller group and include public health specialists (the majority of whom are doctors), health promotion specialists, health visitors, environmental health officers and community development workers, and those who use research, information, public health science or health promotion skills in specific public health fields.

Supporting public health practice is public health intelligence – research, information and analysis of public health data carried out by public health analysts. Public health analysts are skilled in data analysis but specifically with reference to population-based datasets, and epidemiological data.

2.3 How is public health organised?

In England there is a range of organisations involved in planning, regulating and delivering interventions to improve public health.

- **The Department of Health**
  - **Cancer Screening Programmes (NHS)** runs the national screening programmes for breast, bowel and cervical cancer.
  - **Regulatory bodies** – *the Commission for Social Care Inspection*, the *Healthcare Commission*, and the *Audit Commission* that regulate the performance of the NHS and local government take an interest in performance in relation to public health outcomes and the effectiveness of commissioning.
  - **Faculty of Public Health** sets and maintains the professional standards for public health medicine and public health specialists.
  - **The Chartered Institute of Environmental Health** sets the professional standards for environmental health specialists and undertakes campaigning work on public health issues such as smoke free work places and protecting people against the risks of skin cancer.
  - **Health Protection Agency** has responsibility for a wide range of functions including disease surveillance and control of infections and emergency planning. They have both regional and local health protection teams to provide advice and support to public bodies on issues such as infectious disease control.
  - **National Institute for Health and Clinical Excellence (NICE)** is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. NICE also publishes effectiveness reviews of public health interventions.
- **The Association of Public Health Observatories** facilitates collaborative working of the Public Health Observatories (PHOs) and their equivalents in England, Wales, Scotland and Ireland. It disseminates good practice and coordinates action.
- **The Association of Directors of Public Health** promotes and protects the interests of directors of public health within NHS structures.
- **UK Voluntary Register for Public Health Specialists** – this Register is for public health specialists from any professional background (including health and local government). All such specialists have a common core of knowledge, skills and experience, and work (or have the ability to work) at a strategic or senior management level, normally with direct access to the employing organisation's Board.

National and regional public health

Below National level there are 10 Regional Directors of Public Health (one per Strategic Health Authority) who have a small team of specialists. They work as part of the Government Offices for the regions[5] and as Strategic Health Authority DsPH, and are joint civil service and NHS appointments. They work closely with the Regional Development Agencies[6]; and London Regional Assembly[7], as well as providing support to local public health teams.

[5] The role of the Government Offices for the regions is to bring together the activities and interests of ten Government Departments at a regional level. They take a cross-departmental approach to provide a coherent view of the operations and interactions of Government programmes at regional level.

[6] The role of the Regional Development Agencies is to coordinate work on regional economic development within their region, particularly around improving productivity, enhancing skills and furthering regeneration.

[7] The London Regional Assembly is the only directly elected regional assembly. It scrutinises the work of the Mayor and undertakes regional planning.

Within each Region there are Public Health Observatories (PHOs) that carry out data analysis, monitoring and surveillance activity on national and regional policies. Each of the nine PHOs in England takes a policy lead in a particular area, as shown in the table below:

Public Health Observatory	Lead Policy Areas
East Midlands Public Health Observatory	Food and Nutrition Renal Disease Teenage Pregnancy
Eastern Region Public Health Observatory	Primary Care Rural Health
London Health Observatory	Black and Ethnic Minorities Tobacco Health Inequalities
North East Public Health Observatory	Mental Health Prisons Europe and International
North West Public Health Observatory	Drug Misuse Alcohol Crime and Violence
South East Public Health Observatory	Physical Activity Obesity Transport Coronary Heart Disease Stroke
South West Public Health Observatory	Sexual Health Injuries Housing
West Midlands Public Health Observatory	Cancer Older People
Yorkshire and Humber Public Health Observatory	Children and Young People Diabetes

See Appendix 1 for links to the website for each PHO.

2.4 Local public health resources

At a local level each Primary Care Trust (PCT) has a Director of Public Health who is accountable for the health of the population in the area that they serve. Most PCTs are now coterminous with unitary or county Local Authorities and increasingly Directors of Public Health are being appointed to joint posts that cover both the PCT and Local Authority. There is a range of organisational arrangements for the management of public health resources. In some places the PCT and Local Authority have a shared public health or health promotion resource. In some locations this team may be called a Healthy Living Team.

Cheshire and Merseyside Partnerships for Health (ChaMPs): Making joint posts for directors of public health work – a toolkit

A toolkit has been developed by ChaMPs to support local NHS organisations and Local Authorities who are considering jointly appointing a Director of Public Health.

Six people in areas with joint Director of Public Health posts met throughout 2005 to share their experiences of joint working and to develop advice for areas considering whether and how to develop joint Director of Public Health roles. These meetings were used to produce a toolkit which has been endorsed by 14 Directors of Public Health in Cheshire and Merseyside and published by the ChaMP public health network.

The toolkit can be found here:
http://www.nwph.net/champs/Publications/Making%20joint%20posts%20for%20Directors%20of%20Public%20Health%20work.pdf

Contact:

Viv Martindale
Tel. 0151 643 5369
champs@bwwpct.nhs.uk

Over the last few years, public health professionals in PCTs have developed public health networks to share specialist expertise and resources. The effectiveness of public health networking does vary from place to place. In some locations, networks are not just for public health professionals working in PCTs, but serve a wider function in connecting professionals working in Local Authorities, education and community organisations.

With the recent reconfiguration of PCTs, the way in which local public health resources are organised will change again so it is difficult to give a very definitive picture. Some PCTs are considering a separation of public health resources for commissioning and corporate advice from those resources which are primarily involved in delivering public health interventions. With greater focus on improving the cost effectiveness of services, public health interventions themselves are likely to be subject to the disciplines of commissioning and contestability.

2.5 Sources of public health data

There are numerous sources of public health data available at national and local level. The DH is encouraging greater use of this information to support the delivery of health improvement plans and to ensure that commissioning really is based on evidence of the health needs of local people.[8]

Appendix 1 contains links to some of the main data sets, including ready-made indicators and data on programme budgets, which may be helpful if you choose to compare levels of spend on particular conditions or care groups in relation to levels of need.

The following table (overleaf) summarises the main public health data sets:

[8] Department of Health (2006). *Informing Healthier Choices: Information and Intelligence for Healthy Populations* http://www.dh.gov.uk/assetRoot/04/13/11/67/04131167.pdf

Dataset	Description
ONS Population statistics	The Office of National Statistics (ONS) hold data on the population, broken down to the level of electoral ward. The data contain information on ethnicity, gender, age and economic status of residents, all of which can be used to derive estimates of prevalence of health conditions, amongst many other indicators. As data are available at electoral ward level, they can be used to pinpoint geographical 'hotspots' for particular issues in the community. Neighbourhood statistics which are available from the ONS website bring together a range of indicators and analyses describing the characteristics of a neighbourhood.
Clinical and Health Outcomes Database	The National Centre for Health Outcomes Development (NCHOD) manages a dataset containing a large number of indicators on health and social status, called the Compendium of Clinical and Health Indicators. The dataset replicates population based indicators from the ONS, as well as data on mortality from, morbidity from, and incidence of given conditions, and other indicators of population health. Programme budgeting data are also held by NCHOD, which enable: • identification of where resources are currently invested, e.g. for the purpose of monitoring expenditure against National Service Frameworks; • evaluation of the efficacy of the current pattern of resource deployment; and • the process for identifying the most effective way of investing in services for the future to be strengthened.
Hospital Episodes Statistics (HES)	HES holds data on all NHS acute hospital activity, including patient characteristics such as gender and age, diagnosis, clinical procedures carried out and outcome. These data can be used to identify particularly high admission rates for specific conditions that may be better managed in a community setting.
Healthcare workforce PCT database	The NHS healthcare workforce portal holds a resource which brings together workforce planning variables and data from the Department of Health, Office of National Statistics and Healthcare Commission. The data are designed to inform workforce planning initiatives and benchmark performance against other organisations. They include data on PCT list size and makeup, prevalence of key conditions, and factors that influence health such as deprivation.

Dataset	Description
Health Profile for England	Summarises the local indicators to do with the six priority areas identified in *Choosing Health*, at a national level, and can be usefully linked with Local Authority Health Profiles to consider important problems with health: • tackling health inequalities; • reducing the number of people who smoke; • reducing obesity and improving diet and nutrition; • improving sexual health; • improving mental health and well-being; and • reducing harm and encouraging sensible drinking.
Health Protection Agency	The Health Protection Agency collects data on incidence of particular communicable diseases in the community and in healthcare settings. They also collect data as part of a quarterly audit of waiting times for genito-urinary medicine waiting times.
The Quality and Outcomes Framework	The Quality and Outcomes Framework is a series of performance indicators for primary care practices. These data are used by PCTs to performance manage primary care and for SHAs to assess PCT performance. The data include information on primary care professionals' practice list-level prevalence of key conditions: coronary heart disease; left ventricular disease; stroke or transient ischaemic attack; hypertension; diabetes; chronic obstructive pulmonary disease; epilepsy; hypothyroidism; cancer; mental health; and asthma.

As well as these data, a wealth of other data on performance against key public health targets in specific areas exists, for example, prevalence of specific conditions such as diabetes, and behaviours such as smoking. These data can be accessed via local public health observatories (see Appendix 1 for a link to your local PHO's website).

By using a combination of data on prevalence of key conditions, data on current services provided and other indicators of socioeconomic status or deprivation, it is possible to show where integrated services need to be targeted. However, there are limitations to the use of area based indicators as they give a high level picture and do not necessarily indicate levels of need at an individual or family level. Some issues to be aware of when using public health data are:

- it is sometimes difficult to make comparisons between data relating to different timescales or locations, because geographical boundaries and indicator definitions change over time;
- it is important that denominator data are accurate and consistent – and this is not always possible for specific populations, particularly those that are highly mobile such as refugees, asylum seekers or travellers;

- although the need to share data between organisations is recognised, it is currently difficult to do this effectively because there is a lack of appropriate protocols, and systems may be incompatible;
- there are charges to access some datasets. Your local public health department may already have procured these data sets so it is always worth approaching them for help;
- there is currently limited capacity within the public health information and intelligence workforce. This is recognised nationally and in *Informing Healthier Choices: Information and Intelligence for Healthy Populations*, the DH has set out a strategy for provision of comprehensive and innovative information systems to underpin the delivery of a national health improvement strategy; and
- the quality of underlying data is of fundamental importance to ensure that information derived from the data is robust and useful. Some datasets such as details on ethnicity, for example, are known to be of variable quality due to differences in methods of recording.

Example: Integration of health and non-health data sources

Milton Keynes Observatory is a repository for a range of data about Milton Keynes and tools for analysis of these data.

The Observatory is managed by Milton Keynes Council as a 'one stop shop' for information, on behalf of its partner organisations.

The data held comprise all relevant information about the development of the city and its health, and support and inform decision-making processes.

See: www.mkiobservatory.org.uk

3. Public health principles and concepts

3.1 What factors are important in determining health and well-being?

As the previous section highlighted, the definition of public health is very broad: concerned with the promotion of health and well-being as well as the prevention of disease. Improving health is not simply about providing services. It means tackling the root causes of ill health. These include personal lifestyle issues such as diet, exercise, smoking, and substance misuse as well as wider elements such as environmental quality and housing. A useful framework for thinking about the different types of influence on health is illustrated in the diagram below.

The implications for integrated services are clear. Whilst there may be effective integration across some aspects of these health determinants – such as between health and care services – there are many other factors that affect individual and population health that could benefit from more integrated working.

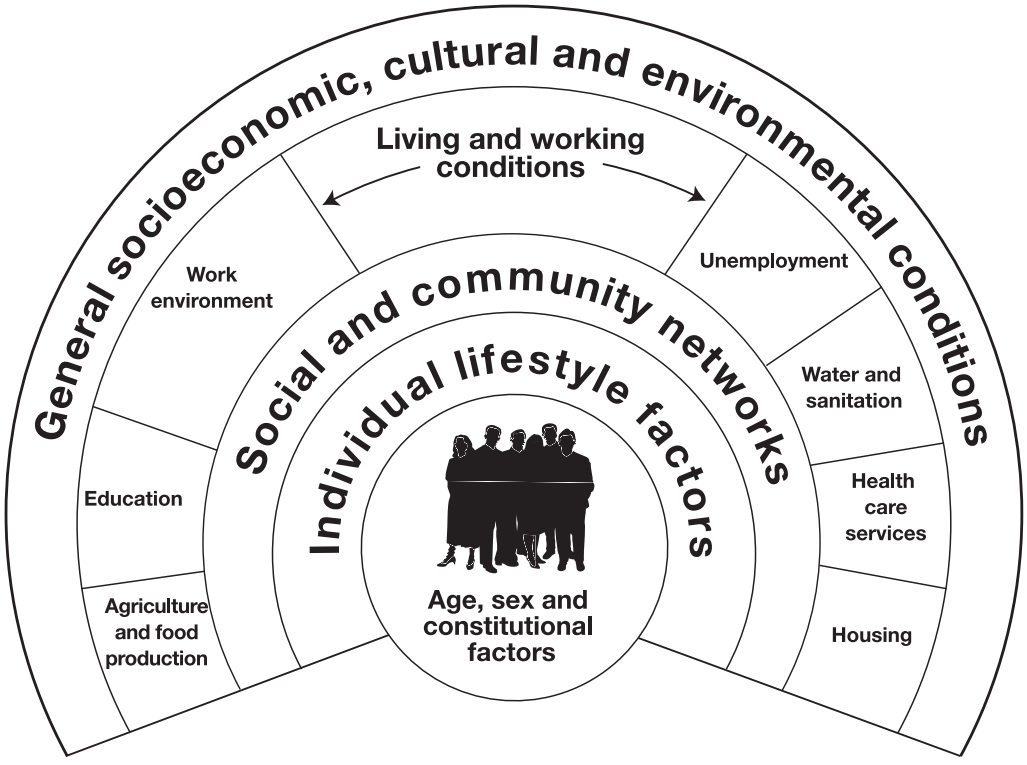

Figure 1: The Dahlgren and Whitehead model of health determinants, 1991

3.2 Investment for health

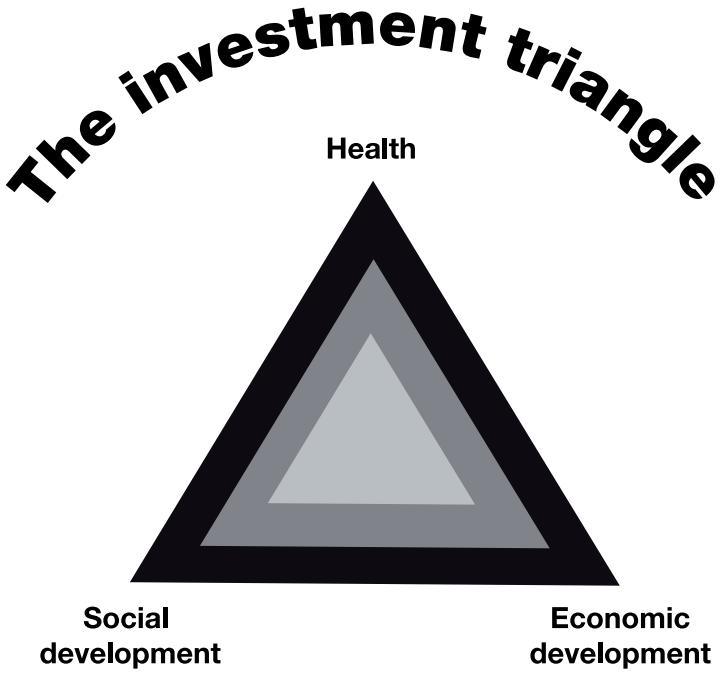

Figure 2: The investment triangle
Erio Ziglio, Director of the WHO European Office for Investment for Health and Development.

The World Health Organisation (WHO) has built on the above framework and talk about health as an investment. The triangle illustrates a balanced approach to public investment in which health improvement contributes to social development and economic prosperity. A healthy workforce is more productive than one that is less healthy.

Not all economic and social developments improve health. For example, a new factory that creates jobs may be contributing to health, as there are close links between unemployment and ill health. However, if it is also a heavy polluter of the local environment then the health impact could potentially be negative. The trick is to find ways in which health, economic and social investment decisions are mutually reinforcing.

For integrated services there are opportunities to use resources in ways that promote health and sustainability beyond the provision of health and social care services – the so-called health dividend.[9] Actions that can help include:

- Recruiting from the local labour market and providing access points to health and social care careers through investment in skill development. There are strong links between unemployment and illhealth. Investing in local jobs for local people will bring positive improvements in the community's health.
- Procuring goods and services locally. Whilst there are some legal and policy restrictions around purchasing and supplies there are some choices that can be made to support local jobs and wealth creation. For example, child care could be procured from national companies and this may give a short term advantage in access to affordable child care. Another option

[9] A. Coote et al. (2002). *Claiming the health dividend: unlocking the benefits of NHS spending*, Kings Fund http://www.kingsfund.org.uk/resources/publications/claiming_the_1.html

that could bring wider long term gains would be to support local small enterprises with social as well as economic goals. Food purchasing is another example where decisions can have a positive impact on the sustainability of the local economy and environment.

- Promoting recycling and reduction of waste;
- Improving efficient use of energy and adaptability. For example, new housing development should meet Lifetime Homes Standards to meet the needs of people with disabilities and, in future, meet the Eco Homes Rating System (www.housingcorp.gov,uk). Further information on affordable warmth is available in the Department of Health's 'Health and Winter Warmth' fact sheet which can be downloaded at http://cat.csip.org.uk/_library/docs/Housing/Housingandhealth/HealthandWinter_Warmth_Factsheet_100107.pdf
- Ensuring any new buildings are constructed in a way that is health enhancing and sustainable as set out in the Department of Communities and Local Government's Decent Homes Standard and Code for Sustainable Development (www.communities.gov.uk). Furthermore, where option appraisals are used to decide on locations and building designs, ensuring that evaluation criteria include health improvement measures as well as service needs and financial issues is a further way of including health considerations in investment decisions.

The example shown in Figure 3 below shows how health determinants have been considered in relation to an assessment of health needs associated with the development of transport services. The determinants of health identified range from those that are fixed and unchangeable – those that must be taken into account but cannot be acted upon – to those that transport services can influence or control. Leaders of integrated services could use a similar diagram to map their own interaction with health determinants and identify ways in which they can build health considerations into planning and decision-making.

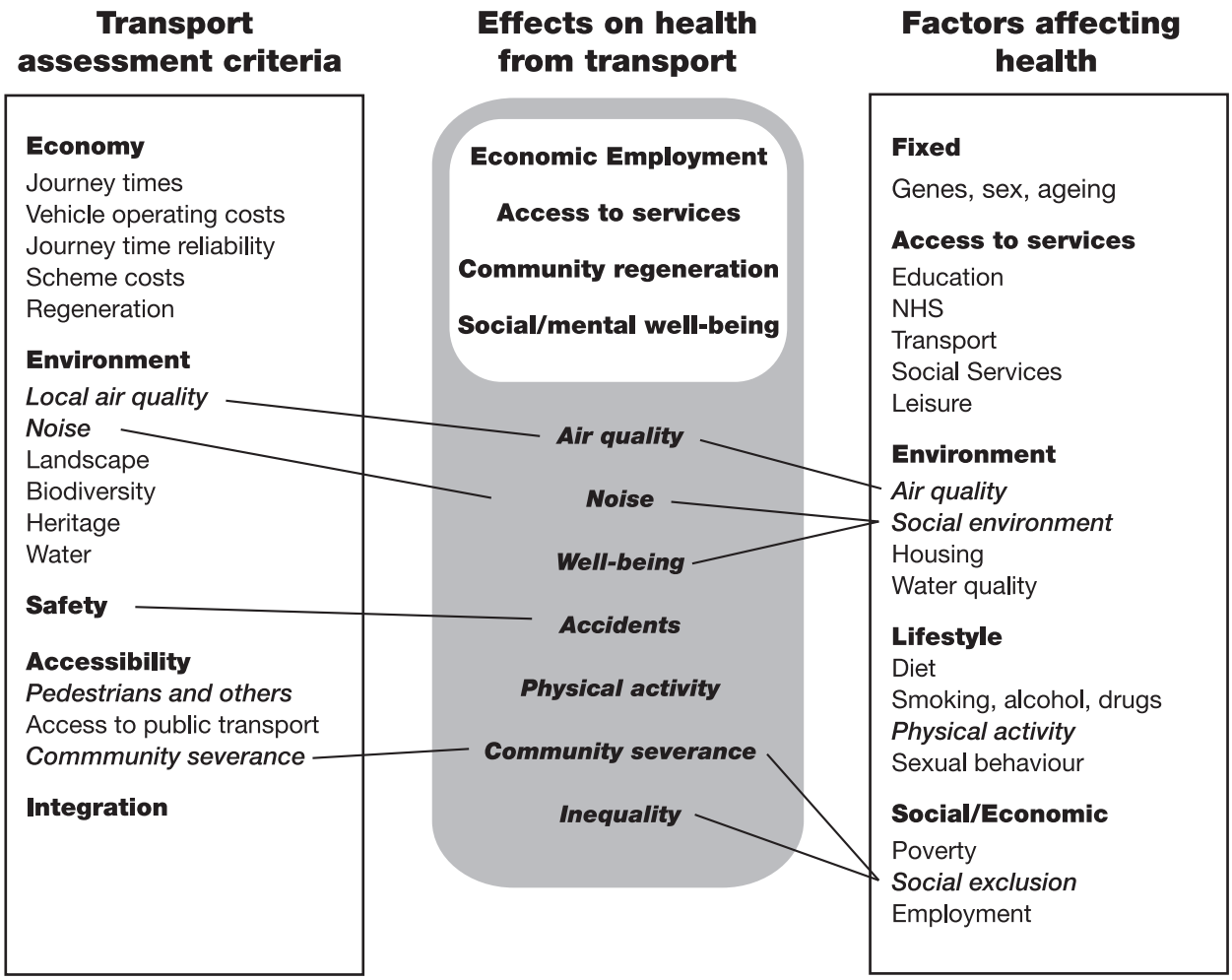

Figure 3: Consideration of health determinants in relation to an assessment of health needs associated with development of transport services

Integrated services: investing in health improvement

Which of the range of health determinants does your service address?

- Which factors will have the greatest impact on the health and well-being of the clients that you serve?
- Where are the greatest opportunities to extend integrated working?
- What other services or organisations have an interest in these factors?
- What partnerships and alliances do you need to develop with these organisations to address the health and well-being of your clients?
- Are your services organised in a way that reflects the different influences on the health of your clients?
- How could you use your assets and resources differently to address the whole needs of your clients?

4. Public health tools and techniques and their application to integrated services

4.1 Health profiling

This is essentially a description of the health characteristics of the population in a given area – this might be a school, a locality, a ward or even a whole local authority. Profiling can also be done for a section of the community (such as children under 11 or ethnic minority groups). A population profile may include some or all of the following:

- age;
- gender;
- ethnicity;
- disability;
- size of population;
- any important sub-groups;
- any major trends in the data;
- resources in the community;
- crime rates;
- health statistics;
- housing conditions; and
- high rates of particular diseases.

A population profile should provide a systematic review of health issues for all the population, not just those who use services. It should also be explicit about what information is used when prioritising services.

4.2 Calculating prevalence and incidence

It is helpful to understand both incidence and prevalence in putting together health profiles and planning future services. Incidence quantifies the number of new problems that develop in a population at risk during a given period of time – the number of people with depression, for example – incidence is quantified as a RATE:

$$\text{incidence} = \frac{\text{number of new problems during a given period of time}}{\text{total population (or person-time) at risk}}$$

Incidence provides an estimate of the probability (or risk) that a patient or client will develop the problem during the given period of time.

Prevalence (the proportion of a population with a problem at a designated time) depends on both the incidence (the rate of new problem during a period of time) and the duration of the problem. Prevalence can be calculated from national norms or averages. The following example shows how to do this:

It has been estimated that 2.3% of the population aged 65–75 have cognitive impairment and that this rises to 7.2% of those 75–85 and to 21.9% of those over 85.

	Locality population (a)	National rate (b)	Local prevalence (c=axb)
65–75	28,244	2.3%	650
75–85	17,348	7.2%	1,249
85+	5,271	21.9%	1,500

The prevalence of people with HIV/AIDS in a locality, for example, may be helpful in planning services to meet their needs, but it is a snapshot of a problem and gives little detail about the level of need in the future. The prevalence of the condition may be increasing due to the longer survival of patients because of the use of modern treatments. A fall in death rates could produce a high prevalence even if the incidence of disease, people who are newly infected with HIV, is falling.

How to use population profiling in integrated services

Population profiling may be helpful in:

- pooling all information about a particular client group across different sectors and services;
- understanding why the number of people with a condition or characteristic in a population is changing;
- raising awareness amongst health professionals of the wider needs and characteristics of the people they are supporting;
- triggering questions about unmet needs; and
- the extent to which resources are being appropriately targeted.

4.3 Health needs assessment

Health needs assessment (HNA) is a systematic method for reviewing the health issues facing a population. It can be used to help inform decisions about priorities and resource allocation, that will improve health and reduce inequalities. In social care services, needs assessment tends to refer to an assessment of individual needs. The *Joint Commissioning Framework for Health and Well-being* refers to the role of strategic health needs assessment. This is a macro level needs assessment which is jointly undertaken for a Local Strategic Partnership and used to inform the setting of local objectives and priorities, including those in the Local Area Agreement. It is a key building block of the commissioning process and for setting local priorities and targets for population health improvement.

There are three common approaches used to assess population healthcare needs – corporate, comparative and epidemiological. The table below summarises these approaches and their strengths and weaknesses:

Approach	Description	Strengths	Weaknesses
Corporate/ participatory	Uses stakeholder views collected in a systematic way, e.g. through workshops, focus groups, interviews or surveys	Encourages ownership of the issues	Based on perceptions rather than fact and liable to focus on demand rather than need
Comparative	Compares different localities or countries in terms of the levels of service provided	Quick and inexpensive	Can be difficult to get accurate comparisons Focuses on services rather than needs
Epidemiology	These approaches are used to analyse the incidence and/or prevalence of a health problem, the effectiveness and cost-effectiveness of current interventions for the problem and the current level of service provision	Robust, systematic and evidence based	Can be time consuming and costly Some health issues and interventions do not have a strong evidence base

4.4 What is need?

One of the differences between individual assessments and population health needs assessments is that the latter can help in identifying people who may not be accessing services and in answering questions on opportunity costs – are the resources being targeted to those whose needs are greatest? In undertaking any health needs assessment it is important to be clear about the problem that the analysis is designed to address and what is meant by need. The box below shows three quite different interpretations:

Type of need	Definition	When to use this definition of need
Felt need	Needs perceived by the individual	• to assess people's satisfaction with service delivery • to identify possible areas for service integration and • to understand the value that different groups place on health and interventions designed to improve it
Expressed need or demand	Felt need that is expressed in terms of demand or service uptake and/or an aspiration	• to explore gaps between demand and service provision
Normative needs	Needs that are defined by a professional	• exploring eligibility criteria for services or resource allocation priorities
Comparative need	Needs implied by an inequitable service to a comparable group or population	• to compare expressed needs between areas or sections of the community and • to explore inequalities in access to services

4.5 Needs, demands and services

A useful tool for assessing the interactions between needs, demand and service supply has been developed by the Eastern Region Public Health Observatory. The ideal alignment at the centre is where there is demand for services that are actually needed and sufficient cost-effective services to meet them. In the outer circles are different combinations where needs, demands and services are not aligned.

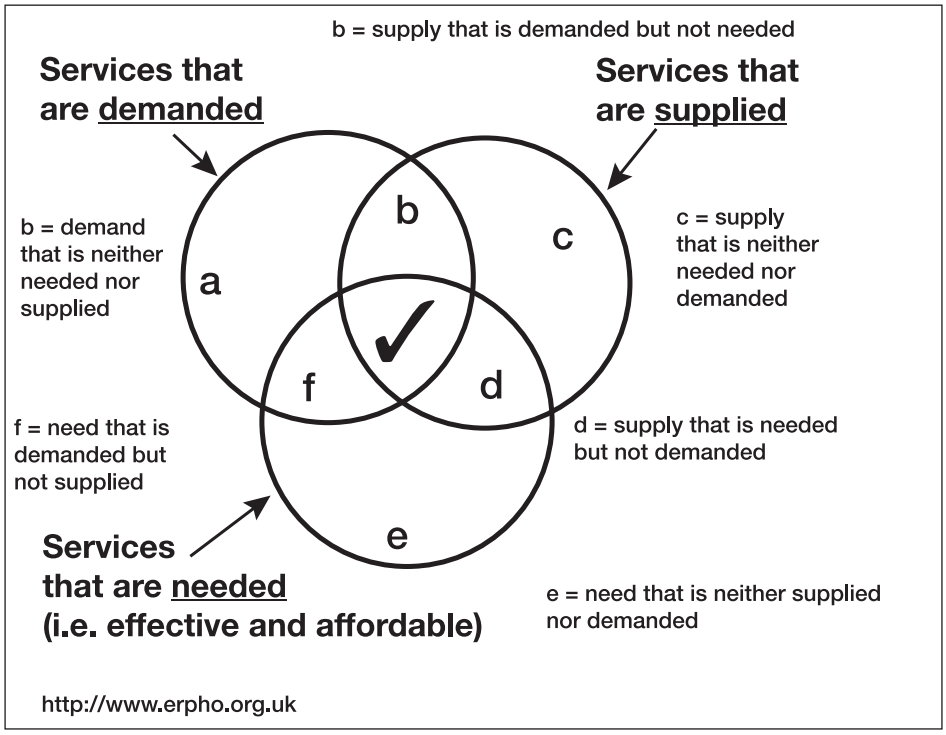

Figure 4: ERPHO tool for assessing needs, demand, and service supply

Public health professionals can help advise on the design of appropriate methodologies for health needs assessment and may have resources to undertake an epidemiological analysis. If you are looking to undertake a simple comparative or participatory analysis, here are some top tips for undertaking this work.

Tips for effective health needs assessment

1. Be clear about the problem that health needs assessment is designed to address (from general to specific).
2. Define which sections of your client population you are going to look at – if possible divide them into smaller categories (e.g. people with specific characteristics or at high risk).
3. Decide what facets of need you are going to look at (e.g. expressed need, comparative need, perceived need).
4. Estimate what time resource and commitment you will need to undertake this task – who is going to lead or collaborate? How will decisions be made when this has been completed?
5. Given the problem and resources available, establish appropriate measures of the problem (how much exists/occurs?).
6. Identify all possible services that might be available to address this problem.
7. Assess how effective, affordable and wanted **all** possible services are that might address this problem.
8. Decide on the service models or care pathways that would be most appropriate in meeting this need.
9. Clarify your goals, targets and success criteria.
10. Decide how the actions from this exercise will fit into your planning/decision-making cycle.

How to use needs assessment in planning integrated services

- What evidence would you need to collect to assess how well your services are meeting the needs of your clients?
- How much need is not being met at present?
- What services are being provided that are needed, but not explicitly demanded, by those who are using them?
- Look at the numbers in each of the categories above – what does this tell you about how well these services are meeting your clients' needs?
- Look at each stage of the care pathway and try to identify the level and magnitude of need for each stage.

Example: Health Needs Assessment at Huntercombe Prison

A health needs assessment was undertaken at Huntercombe prison for young offenders aged 15–19 between 2005 and mid 2006. Four different facets of need were considered: normative (in relation to national best practice); epidemiological; comparative; and corporate. On the basis of this, a draft list of needs was developed. For each need, a range of options was identified that would reduce or eliminate this need. The analysis showed that not all prisoners were getting basic health screening on entry to the prison. The needs assessment helped to identify where current policies were not working effectively, as well as highlighting wider options for improving prison health.

4.6 Health Impact Assessment

Health Impact Assessment (HIA) is an approach that enables evaluation of how proposals for changes and developments to services will impact on people's health. The approach results in recommendations that can inform decision-makers.

The approach is underpinned by the following principles:

- democracy;
- equity;
- sustainable development;
- scientific and robust practice; and
- holistic approach to health.

Of course, in assessing the development of new initiatives, health may not be the only impact that local authorities will want to consider. HIA therefore needs to connect with other evaluative methods such as:

- **Strategic environmental assessment**

  Strategic environmental assessment (SEA) is a process to ensure that significant environmental effects arising from policies, plans and programmes are identified, assessed, mitigated, communicated to decision-makers, monitored and that opportunities for public involvement are provided.

- **Environmental impact assessment**

  Environmental impact assessment (EIA) is an important procedure for ensuring that the likely effects of a new development on the environment and local infrastructure are fully understood and taken into account, before the development is allowed to go ahead.

- **Social impact assessment**

  Social impact assessment is the process that is followed in order to assess the social impacts of planned interventions or events, and to develop strategies for the ongoing monitoring and management of those impacts.

- **Integrated impact assessment**

  In the context of sustainable development, the social, economic and environmental impacts of an intervention are all interlinked. The various types of impact assessment may therefore need to be combined in an integrated impact assessment, whose nature will vary according to the type of intervention.

How to undertake a health impact assessment

1. Decide whether to undertake an HIA.
2. Decide how to undertake an HIA.
3. Identify and consider a range of evidence for potential impacts on health and equity.
4. Decide on and prioritise specific recommendations.
5. Engagement with decision-makers to help reinforce the value of the evidence-based recommendations.
6. Ongoing monitoring and evaluation to assess if adoption of specific HIA recommendations did occur.

A range of methods and approaches is used to help identify and consider the health and equity impacts of a proposal on a given population, for example:

- policy analysis (where appropriate);
- profiling the areas and communities affected;
- involving stakeholders and key informants in predicting potential health impacts using a predefined model of health;
- evaluating the importance, scale and likelihood of predicted impacts; and
- considering alternative options and making recommendations for action to enhance or mitigate impacts.[10]

Example: A Rapid Health Impact Assessment

A Health Impact Assessment was undertaken to ascertain the potential health effects of a local public health policy Active St Helens. This is an integrated sport, physical activity and physical education strategy. The HIA was used to make recommendations about how the strategy could be tailored to maximise positive and minimise negative health effects.

Stakeholder participants took part in a focus group, and completed a postal questionnaire. The participants followed the stages of the Devon Health Forum 'Health and Well-being screening checklist' a rapid HIA process (Devon Health Forum, 2003). Results revealed that the main potential health impacts of the strategy as identified through a thematic framework were:

- **Positive:**
  - healthy lifestyles; and
  - healthy beginnings for children.
- **Negative:**
  - affordability; and
  - individually targeted and not population.

The main action points arising from the thematic framework were:

- **partnerships, collaboration and co-ordination;**
- **information and education; and**
- **community involvement.**

A further HIA was recommended, with a wider brief that addressed equity and health inequality dimensions.

[10] Scott-Samuel, A., Birley, M., Ardern, K. (2001). *The Merseyside Guidelines for Health Impact Assessment*. http://ihia.org.uk/document/merseyguide3.pdf

4.7 Health equity audit

Health equity audit is a process by which partners systematically review inequalities in the causes of ill health and access to effective services and their outcomes for a defined population and ensure that further action is agreed and incorporated into policy, plans and practice. Its focus is on how fairly resources are distributed in relation to the health needs of different groups and may include a wide range of services and determinants of health, e.g. employment and education.

The process is dynamic and involves defining an inequitable pattern of healthcare, a review of the current local position and measures for securing resources to address the inequities which have been identified. Health equity audits are similar to clinical audits and Best Value reviews in that the purpose is to find ways of using local planning, partnerships and resources to make the necessary changes in service provision and delivery.

There are several ways in which a health equity audit can assess equity in service delivery in the NHS, local government and beyond. These include reviewing:

- equal access for equal need: such as greater availability of free fruit in schools in the most deprived areas;
- equal use for equal need: such as greater use of smoking cessation services among low income smokers;
- equal quality of care for all: such as culturally appropriate and relevant maternity services for black and minority communities;
- equal outcomes for equal need: such as greater reductions in coronary disease mortality among lower socio-economic groups.

Further examples of health equity audits are provided in the DH/Association of Public Health Observatories/Health Development Agency publication ‘Health Equity Audit Made Simple: A briefing for Primary Care Trusts and Local Strategic Partnerships’ (2003).

4.8 Clinical audit

Clinical audit is a process that aims to improve patient/client experience and outcomes through systematic review of evidence against explicit criteria and evidence of implementation. It answers the questions 'are we following best practice?' and 'are we following the standards set for this service?'. The term 'clinical' is perhaps a little misleading as the approach is equally applicable to reviewing the effectiveness of social care or integrated services. The word 'clinical' refers to those who are meant to own and undertake the audit. Not all audits are undertaken by people with a public health background but public health professionals are trained in evaluation methods and have many of the skills used in defining effective audit programmes. The key stages are shown below:

How to use public health expertise to support effective clinical audit

- identifying the topic;
- agreeing specific standards for the service;
- collecting data on how things are done now;
- comparing the results with the standards/criteria;
- identifying the reasons for any differences and agreeing what needs to be changed to align practice with standards;
- implementing any changes; and
- re-auditing to check that the changes have been made and to assess progress made.

Example: Auditing learning disability services

Ali et al.[11] undertook annual audits of the enhanced care programme approach (CPA) over a four year period in two inner-London community learning disability services. The notes of all patients on enhanced CPA were analysed, using a structured data collection form.

The audits showed a gradual improvement in the attainment of national targets in both services. The audits helped to identify the factors that contributed to improved plan compliance, such as allocating a date for the next CPA review, crisis plans and documentation of service users' comments. The audits also highlighted areas that needed to be improved such as completion and review of risk assessments and the availability of a care plan for the previous six months. The researchers showed that completing the audit cycle and re-auditing improved the attainment of targets and encouraged service development.

[11] Ali, A. and Hall, I. and Taylor, C. and Attard, S. and Hassiotis, A. (2006) Auditing the care programme approach for people with learning disability: a four year audit cycle, *Psychiatric Bulletin*, 30 (11). pp. 415-418.

4.9 Evidence based practice and evaluation – the difference between outputs and outcomes

Evidence based medicine is the 'conscientious, explicit and judicious use of best evidence in making decisions about the care of individual patients[12]. It attempts to answer the question 'What is the evidence we have to justify the treatments used in clinical practice?'. This is as important for commissioners as it is for those involved in service delivery. Public health professionals bring a range of methods and tools that can help address this question. They include:

- **Critical appraisal.** This is the process of deciding the relevance and strength of evidence from existing research in answering whether or not a service is effective in improving health/care outcomes. It is based around considerations of whether the evidence is valid, important and applicable to the patient/client group in question.
- **Evaluating programme outcomes**. One of the key issues to consider in any evaluation is the purpose of the evaluation. For example, reducing teenage pregnancy is the stated goal of a number of national PSAs and has therefore been included in many local LAAs. Assessing whether teenage pregnancies have been reduced requires an analysis of four different types of data:
  - the size of the population, so that the denominator – the number of teenage girls – can be determined;
  - the number of abortions or terminations – this is part of the data needed to assess teenage pregnancies;
  - the number of live births – this will tell you how many teenage girls actually give birth – the other side of the teenage pregnancy equation; and
  - the level of sexual activity – this will help you to determine whether the proportion of teenage pregnancies is due to increased levels of sexual activity or other factors such as poor use of contraceptives.

  However, deciding what you are evaluating is of crucial importance to designing an appropriate research programme. Aside from factors such as the reliability of data, in the above example there are several possible options which could be the objective of the outcome evaluation. All of these are equally relevant and important, but the way that services are targeted to deliver the outcome of reducing teenage pregnancies would be very different:

  a) to delay the timing of sexual activity;

  b) to reduce levels of sexual activity or number of partners in the sexually active population;

  c) to increase levels of contraception;

  d) to improve the reliability/effectiveness of sexual health services; and

  e) to increase the self esteem and awareness of young people so they take greater responsibility for their sexual health.

In integrated services where there are different stakeholders and interests and different statutory responsibilities, this degree of clarity is important in maintaining the relationships and contributions to integrated care.

[12] Sackett, D. L. et al. (1996). Evidence Based Medicine: what it is and what it isn't. *BMJ*; 312: 71–2

Evaluation methods

The three methods most typically used in service evaluations are:

- cost benefit analysis;
- cost effectiveness analysis; and
- cost utility analysis.

Cost benefit analysis

This is often considered to be the gold standard of evaluation. At its simplest, this method lists all the costs and benefits that might occur as a result of a service intervention within a specified timescale. These costs and benefits are calculated from a starting point (time zero). If the total benefits are greater than the total costs, the intervention is said to have a positive net present value. All costs and benefits have to be expressed in monetary terms and this can be difficult if you are assessing the value of lives lost or saved.

Cost benefit analysis is best used when a choice has to be made between two or more options. The option that gives the most positive net present value score would be the one that typically would be selected. Cost benefit analysis is a useful tool because it can take into account costs or benefits that are wider than the direct health outcomes. For example, the costs associated with the amount of time spent by informal carers could be taken into account in evaluating a jointly run service to support older people at home.

Example: Cost benefit analysis

The Rotherham IT2Eat project is a multi-agency partnership addressing healthy eating issues by providing information and support for people over 55 in Rotherham. It is an innovative, pilot project aiming to enable older people to obtain information about healthy eating and dietary advice using the Internet in a range of community settings and in people's own homes.

IT2Eat is based on a broad partnership between statutory and voluntary agencies involving older people as key stakeholders. Age Concern Rotherham, RMBC Social Services Department, Library and Information Services, and Rotherham Primary Care Trust Health Promotion Department are the main constituent partners.

Forty-one IT2Eat clients completed questionnaires that were used to identify the impact of the project in terms of, for example, visits to GPs, changed attitudes towards food, and morbidity. The impact analysis indicated that the innovations initiated by IT2Eat would lead to clear cost savings in the medium to long term rather than the short term. The qualitative component of the study revealed that IT2Eat had transformed clients' sense of well-being and general attitude to life.

Cost effectiveness analysis

This approach expresses the net direct and indirect costs and savings in terms of a unit of health outcome. This could be measured in cases of illness avoided or severity of disability reduced. One of the difficulties in cost effectiveness analysis is that there is no numerical valuation of the health outcome. For example, it can only provide an estimate of the net costs of reducing the number of suicides or cases of disability. It does not provide any information on the relative value that society might place on each averted case. So cost effectiveness is best used to compare two or more strategies that have the same health outcome. For example: 'would counselling be a better way of reducing suicides than a befriending scheme or crisis intervention?' Cost effectiveness analysis can be used to define the cost of a single intervention per single health outcome and so can be useful in making decisions about the implementation of an intervention.

Cost utility analysis

This is a special form of cost effectiveness analysis where the outcome is measured or valued in terms of utility for the quality of life that is derived from a health outcome. Examples of these units of value include QALY – quality adjusted life years and DALY – disability adjusted life years. The calculation of both of these requires an assessment of the valuation of life or disability.

How to undertake evaluations of integrated services

Public health professionals can help in evaluation of integrated services by:

- helping you to clarify the objectives of your study;
- providing advice on research design and methodology;
- providing statistical analysis;
- supporting you in finding appropriate external bodies such as universities or independent researchers who could undertake this analysis on your behalf; and
- using their critical appraisal skills to help you find examples of similar evaluations to learn from.

5. Levers and incentives for improving integrated services: how public health can help

In this section we look at some of the current levers for change in improving integrated services and how public health tools and approaches can enhance their effectiveness.

5.1 Commissioning integrated services

The art and practice of commissioning and joint commissioning is a rapidly changing field and further national guidance is expected later this year. There is a growing emphasis on public health evidence both at a strategic level to inform joint plans and strategies between health, local government and other partners (strategic health needs assessment), and to inform efficient, value-based commissioning by individual organisations and in joint commissioning arrangements. More guidance and advice on commissioning for effective outcomes, and the role of needs assessment in strategic planning and commissioning is available from CSIP's Better Commissioning Learning and Improvement Network: www.icn.csip.org.uk/commissioning and www.cat.csip.org.uk/commissioningebook

Commissioning

Strategic Needs Assessment starts with a needs assessment of the population, which will include a health needs assessment, to help inform statutory organisations in setting priorities and in allocating resources. This in turn should provide the framework within which specific public services are commissioned. The combination of health needs data on the one hand and the views of patients and the public on the other, provide the main evidence for commissioners in deciding how resources available could be better spent or where further investment made to improve services and outcomes.

The new NHS commissioning framework places an emphasis on commissioning according to population need, as identified through data analysis.

Public health professionals can support commissioning and joint commissioning in a variety of ways which include:

- undertaking analysis of needs;
- advising on research design for public and patient engagement;
- translation of national targets into local targets that are based on the population of the local area;
- designing prioritisation frameworks based on evidence of cost effectiveness and public opinion;
- advising on service impact and effectiveness;
- specifying relevant outcome targets;
- evaluating the health impact of alternative service investments; and
- brokering relationships between primary, secondary and tertiary clinicians and local commissioners.

Example: The Diabetes Commissioning Toolkit

A toolkit has been developed to support commissioning of diabetes services for communities. Although the toolkit is aimed predominantly at NHS commissioners, it describes the steps required for successful commissioning for all organisations and disease groups. The toolkit is structured around four questions:

1. **Where are we now?**

   The toolkit provides advice on carrying out a healthcare needs assessment for diabetes, focusing on a number of domains including prevalence, trends etc.

2. **Where do we want to be?**

   The toolkit signposts best practice quality markers that all services need to strive towards, such as NSF Standards, NICE guidelines, national targets etc.

3. **How do we get there?**

   The toolkit provides a framework for services to enable them to think about service redesign. A supporting guide aims to help local commissioners and providers design and cost the workforce component of possible local options for services.

4. **How will we know when we are there?**

   The toolkit includes a number of suggested indicators that can be used by local services as measures of effective practice.

See: http://www.dh.gov.uk/assetRoot/04/14/02/85/04140285.pdf

Joint commissioning

"….a joint approach with health, housing and other agencies, based on a shared vision for older people is paying dividends in many parts of the country. An increasing number of councils are engaging with their partners to carry out 'whole systems' Best Value reviews of older people's services, looking at the broad shape of current service provision and exploring how best use can be made of all agencies' resources in the future." [13]

In many instances, meeting identified needs for a population will require contributions from two or more agencies across the health, local authority and third sectors. In these cases, the development of a joint commissioning framework should be considered. Joint commissioning has various benefits such as:

- enabling the use of new, more cost-effective solutions and services;
- avoiding duplication and overlap in service delivery and use of resources;
- achieving economies of scale; and
- providing greater capacity, flexibility, and influence on the market borne out of a larger joint budget.

Where joint commissioning takes place, analyses of need and prevalence should be used to influence joint commissioning decisions and set priorities for the partner organisations. It is also important in any framework for joint commissioning that partner organisations agree the definition of commissioning that they are working with – historically health and local government have had slightly different approaches to this process despite using the same term. Overall accountability for commissioning across the organisations needs to be defined and roles in the commissioning process allocated according to individual specialist knowledge.

Practice based commissioning and integrated services

Primary care practices are being encouraged to take on budgets for commissioning services for their practice populations. In most places, practices have decided (or are being encouraged by their PCTs) to work collaboratively either in a geographical area/locality or as a group of like minded organisations. Practices/collaboratives are able to keep a proportion of any savings they make from commissioning to reinvest in further patient care initiatives. This provides an incentive to achieve greater value for money from commissioning. It is still early days and not all practices are taking on integrated budgets for health and social care. Whilst practices often have a natural awareness of the importance of integrated services to meet patient needs they may have had little direct experience of working with local authority services.

Public health can help practices and collaboratives become more involved in the planning and commissioning of integrated services by:

- providing practices/collaboratives with a profile of social care services available in their areas. Practices do not always have a well informed picture of the range of services available to their patients;
- ensuring that locality profiles include details of health determinants as well as summaries of health needs – mapping tools can be a helpful way of communicating this information;

[13] *Tracking the Changes*. Joint Review Team Sixth Annual Report 2001/02

- raising awareness of the extent to which integrated services are effective in meeting client needs compared to more traditional models of care;
- developing (or signposting) databases that hold details of health improvement interventions or services that could have a positive impact on patient needs;
- engaging practices in social care/leisure/education referral systems 'on prescription'. There are many examples around the country of 'information or exercise on prescription' or similar schemes focused around healthy eating. These enable patients to access information about their health or actual health improvement initiatives which are funded not by the NHS but by other agencies free or at a reduced rate. The significance of a GP referral is that people are more likely to take up this option than if this were suggested in a leaflet or through lay advice. For example, these types of initiatives may be suitable for:
  - people with mild to moderate mental health problems;
  - older people at risk of falls or nutritional problems;
  - children with health risks or behavioural difficulties; and
  - rehabilitation of people with drug and alcohol problems; and
- training and development for staff in organisations involved in integrated service commissioning and provision, to develop a shared understanding of the drivers for public health and the public health tools and methods that can be used to develop integrated services.

5.2 Local strategic partnerships and joint targets

Each Local Government Area has a Local Strategic Partnership (LSP) with a view to identifying shared priorities for improving the health, social and economic well-being of the local population.

An LSP is a single body that brings together, at a local level, the different parts of the public sector as well as the private, business, community and voluntary sectors, so that different initiatives and services support each other and work together.

There is no blueprint for how LSPs should co-ordinate their approach, as this will depend on local needs and priorities. All LSPs have sub-groups or thematic partnerships (often referred to as the 'LSP family' of partnerships) which are responsible for effective targeting of resources to the neediest communities.

LSPs are expected to set local targets and priorities for their communities as well as contributing to the national targets in the Public Service Agreement. The Health Poverty Index (HPI) provides key information on differences in health and health outcomes between various geographical areas and groups, allowing differences to be monitored over time. The HPI tool can be accessed from the HPI website (www.hpi.org.uk), enabling information to be presented in an easily accessible format. The tool can be used to support local priority- and target-setting for local health communities and their partners.

Leaders of integrated services can raise the profile and priority of their services through LSPs by:

- working with public health to highlight health inequalities for the client group that they serve;
- ensuring that the health and care needs of their client groups are included in the health profiles that LSPs use to set local priorities and targets.

5.3 Local Area Agreements

A Local Area Agreement (LAA) is a three year agreement that sets out the objectives and priorities for a local area as agreed between central government (the Department of Communities and Local Government), and a local area (represented by the local authority and Local Strategic Partnership (LSP), and other key partners, including the primary care trusts, police and other partnership bodies.[14] LAAs are designed to:

- improve central and local government relations;
- improve efficiency in public services;
- strengthen partnership working; and
- enhance leadership by local authorities on a range of public service outcomes.

The agreement is made up of outcomes, indicators and targets aimed at delivering a better quality of life and reducing inequalities for people through improving performance on a range of national and local priorities. There are financial rewards for local partners who can achieve the outcomes and targets specified. These priorities are grouped around four blocks:

- Children and Young People;
- Safer and Stronger Communities;
- Healthier Communities and Older People; and
- Economic Development and Enterprise.

Priorities, outcomes and targets are expected to be evidence based and set in the context of goals around health improvement. LAAs are a helpful tool for gaining multi-agency support to common outcomes and integrated services as a means of delivering those outcomes.

LAAs can assist the progression of integrated services by:

- providing a focus on the health outcome measures that local agencies should aim to achieve; and
- identifying freedoms and flexibilities that could be gained from the achievement of the agreed targets. These in turn might be areas that could further the development of integrated care for service users and carers.

Some examples of the agreements that some London boroughs have made for older people are shown below. The targets they have specified could be achieved in a variety of ways and offer the opportunity for local negotiation between the statutory bodies about the ways in which they could contribute to the achievement of the targets individually or through the delivery of more integrated care.

The Improvement and Development Agency (IDeA) have also produced an LAA 'toolkit' which provides ideas and suggestions drawn from practice for anyone involved in the development of LAAs. The toolkit also outlines some of the challenges that may arise as LAAs develop.[15]

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[14] ODPM (2005). *Local Area Agreements Guidance*

[15] ODPM (2005). *The Local Area Agreements toolkit*

	Outcomes	Targets
Redbridge (LPSA)	Reduce number of emergency unscheduled acute hospital bed days as measured by improved health outcomes for older people with high blood pressure, cholesterol and diabetes.	A 1.5% reduction in emergency hospital admissions, as 2,393 less bed days.
Westminster	Improve support to carers of vulnerable adults in the City of Westminster, as measured by number of carers supported.	210 more carers supported
	The extent of social isolation people feel.	Increase the rate of older people in receipt of preventative services as measured in the 'Survey of older people residents using QuiLL inventory' (still under negotiation).
	How people feel about their own health & well-being.	Same as above
	Perceptions of control and influence that people have over their own life.	Same as above
	How people feel about their personal safety.	Same as above

5.4 Extended schools

An extended school is one that provides a range of activities and services often beyond the school day, 'to help meet the needs of its pupils, their families and the wider community'.

Encouraging schools to open for longer hours and during holidays for use as a community resource, and co-locating other public services such as advice centres or libraries on school premises are some of the ways in which their role can be broadened. As such, schools offer valuable facilities for the delivery of integrated services and for signposting.

The box below shows the range of potential health related services that could be offered within an extended school setting.

Health and community services in extended schools

Health screening	Dental services
Family planning	Individual counselling
Substance abuse treatment	Mental Health services
Nutrition/weight management	Referral with follow-up
Housing and benefit advice	Recreation, sports, culture
Mentoring	Family welfare services
Parent education, literacy	Child care
Employment training/jobs	Case management
Crisis intervention	Health education/promotion

How to use public health to increase the value and impact of extended schools

- provide advice on effective health promotion and other interventions that would be suitable for inclusion in the school;
- demonstrate the health impact that an extended school may have as part of the early stages of planning;
- identify appropriate health outcomes that could be built into an extended school's objectives and performance measures; and
- provide professional leadership in local debates about the role of health improvement within extended schools.

5.5 Housing issues

The association between housing conditions and both physical and mental health, has long been recognised and is now generally accepted. Whilst there is a range of specific housing factors which affect health outcomes, the relationship between housing quality and health is complex, not least because the links between different dimensions of housing and health operate at a number of inter-related levels. Housing does not simply operate in isolation to influence health, rather the interplay between structural forces, the broader policy environment, employment opportunities, educational achievement, neighbourhood conditions, social relationships, and housing conditions (as well as individual factors like lifestyle) essentially determine health and health inequalities in society.

The Government's White Paper *Choosing Health* sets out a programme of action that prioritises communities with the worst health and deprivation. The delivery plan requires PCTs, local councils and other partners to work together to achieve cross-cutting targets to narrow health inequalities and improve the conditions that lead to ill health. It identifies housing's contribution to its delivery targets as bringing all social housing up to the new 'decent homes' standard by 2010, reducing the amount of non-decent housing in the private sector, eliminating fuel poverty among vulnerable households by 2010, and improving neighbourhood liveability.

The significance of housing in pathways to better health is recognised in the National Service Frameworks, the NHS strategies for improving specific areas of care and the Department of Health's White Paper, *Our health, our care, our say: a new direction for community services*. Health and other services need to be joined up with housing to achieve integrated care and rehabilitation for people with severe and enduring mental health problems and older people with care needs. In particular, the adult care Green Paper *Independence, Well-being and Choice* identified a key role for housing in future developments, including single assessments of need, smart homes and extra care housing. Housing and homelessness services are also integral to the partnership approach set out in the NSF for children and young people.

The Department of Communities and Local Government policy frameworks for Supporting People and Older People's Strategies also encompass a range of service user groups that require supported housing to be jointly planned and delivered across the boundaries that separate the NHS, local government, housing providers and other partners. As well as older people with support needs and vulnerable young people such as care leavers and teenage parents, these groups include people with mental health problems, people with disabilities, women at risk of domestic violence, homeless households, people with alcohol or drug problems, people with HIV/Aids, offenders or people at risk of offending, refugees, and black and minority ethnic people with particular cultural, language or family needs, or who face harassment.

These groups are at a higher risk of experiencing hazardous housing conditions or homelessness without either short-term or long-term support with obtaining a decent home and living as independently as possible. Failing to provide this support can cause or exacerbate health problems that become more difficult and costly to treat downstream. Housing is an upstream intervention, not just for particular vulnerable groups but across the whole population.

For further information and resource materials on the links between housing and public health, partnership working and examples of good practice, visit the Care Service Improvement Partnership's Housing Learning and Improvement Network at the Department of Health. www.icn.csip.org.uk/housing

6 Next steps for public health and integrated services

In this briefing we have set out some examples of how public health professionals can help improve the planning and evaluation of integrated services. Over the coming months PCTs and LAs will be undertaking further thinking about where public health sits in their organisations and the extent to which public health objectives will guide their joint work. Those that have opted for a joint director of public health have made a first step towards an integrated approach but there are further questions to be asked about how public health can be placed at the heart of health improvement and service development and how best to get the most from this important resource. Here are some questions that PCTs and local authorities may want to consider:

- Joint directors of public health will need to spend considerable time in corporate activities supporting the PCT and LA. What are the resource implications for public health?
- Where will Overview and Scrutiny Committees get independent public health advice from in their scrutiny of health service organisations. If they share a joint DPH, are there risks of potential conflicts of interest?
- What aspects of public health are needed to support commissioning and joint commissioning? How do some of these skills fit with the roles of finance and information analysis?
- How can in-house PCT and LA services access the skills and support of public health colleagues?
- Looking at the full spectrum of health improvement interventions needed locally, what aspects have to be delivered in house and where might there be opportunities to test the market for alternative providers?
- How important is it for commissioning and PH delivery to have a critical mass of health improvement specialists or could the PCT/LA gain more from procuring individual services?
- How can managers and front line clinical and health and social care professionals be supported to develop wider skills in public health?
- With an increasing focus on strategic health needs assessment driving commissioning, the gap between what is currently procured and what is needed is likely to become more transparent. How can the analytical skills of public health professionals be married with the change management expertise to help integrated services move from the current profile to more needs informed approaches.

Appendix 1 – Resources

National organisations

Faculty of Public Health: http://www.fph.org.uk/

UK Public Health Association: http://www.ukpha.org.uk/

Public health observatories

Association of Public Health Observatories: www.apho.org.uk

Eastern Region Public Health Observatory: www.erpho.org.uk

East Midlands Public Health Observatory: www.empho.org.uk

North West Public Health Observatory: www.nwpho.org.uk

North East Public Health Observatory: www.nepho.org.uk

South East Public Health Observatory: www.sepho.org.uk

London Health Observatory: www.lho.org.uk

South West Public Health Observatory: www.swpho.org.uk

West Midlands Public Health Observatory: www.wmpho.org.uk

Yorkshire and Humber Public Health Observatory: www.yhpho.org.uk

Datasets: needs

Health Protection Agency: www.hpa.org.uk

Clinical and Health Outcomes Knowledge Base: www.nchod.nhs.uk

Office of National Statistics: www.ons.gov.uk

Healthcare workforce PCT database:
http://www.healthcareworkforce.nhs.uk/index.php?option=com_content&task=view&id=41/

Quality and Outcomes Framework: http://www.ic.nhs.uk/services/qof

Datasets: performance

Healthcare Commission tobacco control improvement review:
http://www.healthcarecommission.org.uk/_db/_documents/Tobacco_Control_improvement_review_scores_for_public_by_local_area__All_England_-_SD.pdf

PSA targets: http://www.communities.gov.uk/index.asp?id=1503442

HPA GUM clinic waiting times audit:
http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/epidemiology/wtimes.htm

HPA sexually transmitted infection prevalence data:
http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/epidemiology/sti_data.htm

Toolkits

Statistical sampling calculator:
http://www.psychnetuk.com/experimental_design/statistical_sample_size_calculator.htm

Lifestyle survey toolkit: http://www.lifestylesurvey.org.uk/

NHS Health Impact Assessment gateway resources:
http://www.hiagateway.org.uk/page.aspx?o=hia.resources

Health Poverty Index: www.hpi.org.uk

ChaMPs toolkit for creating joint DPH appointments:
http://www.nwph.net/champs/Publications/Making%20joint%20posts%20for%20Directors%20of%20Public%20Health%20work.pdf

Other resources

Public Health Electronic Library: www.phel.gov.uk

Kings Fund public health reading list: http://www.kingsfund.org.uk/document.rm?id=5428

CSIP Networks: http://www.csip.org.uk/our-initiatives/csip-networks.html

We have to stop meeting like this: the governance of inter-agency partnerships (Nov 06)
http://icn.csip.org.uk/index.cfm?pid=10&catalogueContentID=842

Whole Systems Working: A Guide and Discussion Paper (Oct 06)
http://icn.csip.org.uk/index.cfm?pid=10&catalogueContentID=828

Advisory Note 6: Local Strategic Partnerships Local Area Agreements (Nov 05)
http://www.integratedcarenetwork.gov.uk/index.cfm?pid=10&catalogueContentID=203

Local Government White Paper Briefing: Strong and Prosperous Communities (January 2007)
http://www.icn.csip.org.uk/index.cfm?pid=10&catalogueContentID=887

Appendix 2 – Case studies

Tower Hamlets: joint commissioning of children's services

Tower Hamlets Council, Tower Hamlets PCT, and the third sector are working together as a Children's Trust Pathfinder, to rationalise commissioning of children's services.

A definition of commissioning has been agreed for all agencies and partnerships, and an agreed model for commissioning has been set out.

The commissioning structure has two levels: strategic and operational.

The strategic level links with the PCT and local authority planning frameworks. Public health professionals have supported improved commissioning through an analysis of needs across the community including calculation of prevalence of need, and development of indicators to measure how well needs are met.

At the operational level, a Children's Specialist Commissioning Unit is to be established in order to lead operational commissioning for specific groups of vulnerable children. Within this unit, officers will have lead commissioning roles reflecting their existing specialist knowledge.

Derbyshire Joint Planning and Commissioning Unit

Derbyshire's Joint Planning and Commissioning Unit has been developed in order to apply the Government's Joint Planning and Commissioning Framework.

A Children and Young People's plan has been developed for Derbyshire, which needs to set the direction of travel for the next four years for the children's trust. It is based around needs assessment to identify key priorities; and integration of information currently held in partner organisations to be used in planning; resource allocation; and identification and measurement of outcomes.

The Joint Planning and Commissioning Unit will have an initial focus around the Local Area Agreement priorities. It will have the authority to direct individual organisations in their own commissioning plans; ensure that plans are matched to outcomes and resources; and ensure that contracts and monitoring are based on outcomes. It will initially be a 'virtual' unit, bringing together colleagues with the appropriate experiences and skills in planning and commissioning services, having responsibility for the development of one-year rolling business plans within a three-year cycle. The unit will agree the annual planning framework.

Parents, service users and carers are involved at every level.

Contact:

Dr Carol D Singleton, Director of Health Improvement and Partnerships,
Derbyshire County Council
Deputy Director of Public Health, Derbyshire County PCT
Carol.singleton@derbyshire.gov.uk

Healthy Lansbury Healthy Communities: involving local people in assessing needs

Poplar Housing and Regeneration Community Association (HARCA) established a project to promote healthier lifestyles through a series of initiatives around healthy eating, physical exercise and health education. The initiative began with a survey of tenants, and continued to involve local residents throughout the process in playing active roles in managing and evaluating the project. The very local and informal feel of the Healthy Lansbury Project achieved engagement from residents for whom existing services are hard to access.

A survey of tenants living on the Lansbury Estate was undertaken in 1999 to identify their needs, which uncovered concerns regarding health, and, in particular, access to health services and access to healthy, affordable and fresh food. In response, Poplar HARCA secured 'Opportunities for Volunteering' funding for a health co-ordinator who was able to supplement statistical data held by the PCT with anecdotal evidence on the issues residents were facing, as well as what they wanted to change.

Based on these findings, the Healthy Lansbury Healthy Communities Project was developed, shaped and led by local residents to encourage the local community to take responsibility for their own health and to promote healthier lifestyles through a number of initiatives. These included healthy eating workshops, cook and eat clubs to support the elderly and parents in the purchasing, preparing and cooking of healthy meals on low budgets, community health and fitness programmes, training residents as volunteer health promoters and educators, supporting the establishment of a healthy food co-operative to deliver healthy affordable food, introducing healthy living into the school curriculum and the development of a Healthy Lansbury website.

The project worked closely with the Health Promotion Unit at the PCT to develop training programmes and to identify nutritionists, diabetes specialists and public health consultants.

Contact:
Tracey Fletcher, Neighbourhood Director
tracey.fletcher@poplarharca.co.uk

Huddersfield Older People's Event (HOPE): improving awareness of health improvement services

The event was run by the three healthy living projects in Huddersfield that were funded by the Big Lottery. These are:

- Newsome Next Generation
- South Asian Healthy Living Partnership and
- Paddock Pathways.

There were five months of planning, involving staff from the three healthy living projects and volunteers. The cost for the event was £1,856.93 for 114 community participants.

The event was well attended by over 100 local residents and over 60 representatives from organisations that provide services for older people. Several services have reported an increased referral rate as a result of the event, following up enquiries and supporting participants.

The Expert Patient Programme is a Neighbourhood Renewal-funded pilot scheme, run by Huddersfield Central Primary Care Trust, targeting people with long-term health conditions. It recruited participants as a result of the event and related outreach. The Falls Prevention Strategy for older people provided valuable support and information on the day.

Participants enjoyed the event and found it useful. A large number of people were introduced to the healthy living projects as a result and subsequently joined in with other activities, particularly in the Newsome area where an older people's group has been established. The involvement of volunteers to help locate isolated people, offering support with transport and encouraging them to take part, contributed to the success of the event. Transport has been crucial to this success and that of subsequent neighbourhood-based healthy living activities.

Contact:

Kath Stewart, Healthy Living Development Worker,
Newsome Next Generation Healthy Living Programme
01484 842698
Kath.stewart@huddersfieldcentral-pct.nhs.uk

Diabetic and Weight Management project: Manchester Joint Health Unit

This project provided a structured programme of healthcare specifically aimed at a group of overweight individuals with type one or two diabetes.

The programme included dietary analysis, advice on healthy eating, food plans, cooking methods and shopping tips, two types of physical activity and one group motivational/behavioural session per week, over a period of 12 weeks. This was delivered by a truly multi-agency team including the strategic health manager; diabetes dietician; exercise instructor; health and fitness assessor; park wardens; leisure centre staff and management support at a cost of £11,000.

The results of the initial 12-week programme showed improvements in diet, physiological fitness, and a greater awareness of the psychology behind patients' behaviour, such as their motivation, reasoning, and thought processes. This created a positive behavioural change. The project also yielded valuable lessons for the council, such as information on what puts people off using leisure facilities.

The group are still together and encouraging new members to join to experience and enjoy the benefits of physical activity, group support, social outings and events.

Contact:
Julia Herring, Strategic Health Manager, Manchester Leisure,
Sports Development Manchester City Council
0161 232 3108

Developing a Whole Prison Approach to health promotion

HMP Risley has developed a three-year health promotion strategy, using a whole systems approach to health improvement/health promotion and focusing on:

- smoking cessation
- dads and families/Quality Family Visits
- healthcare induction
- diet and nutrition
- hygiene
- mental health
- sexual health and communicable disease and
- evening activities.

A disability audit is also being undertaken. This will establish a baseline against which improvements can be made for the whole population of the prison.

The project has been developed by a multi-disciplinary team of staff and prisoners, who monitor the effectiveness of projects and identify new initiatives.

Contact:
Michelle Baybutt, Health Promotion Co-ordinator, HMP Risley

Brighton and Hove PCT public health department: mapping health needs to inform planning of health and social care services

Brighton and Hove PCT produced maps showing the geographical distribution of patients registered with Brighton and Hove GPs that South Downs Health NHS Trust district nurses are attached to.

The maps were put to various uses including in discussions with Social Care to create 'virtual teams' to effectively organise social workers and create common understandings of shared geographical areas and virtual relationships between locality social workers and locality district nursing teams.

Contact:

Andrea Jones, Project Manager Community Nursing, Southdowns Health NHST

andrea.jones@southdowns.nhs.uk

Joint working on smoke free in Berkshire

Various joint projects have been carried out in Berkshire around creating a smoke free environment. These include:

- Smoke Free Slough coalition between Slough Borough Council and Slough PCT, which has established a joint post to commit to working towards a smoke free town and co-ordinate local work. The coalition is a multi-agency partnership which meets quarterly to review and take action on smoke free environments
- Smoke Free Berkshire East Event, an event jointly organised by Berkshire East PCT and all three Berkshire East Unitary Authorities, to support local work towards the smoking ban in summer 2007. It is anticipated that the work will result in an action plan with local ownership for each of the two remaining unitary authorities in Berkshire East
- Local Public Service Agreement project on smoking. A two-year project that commenced in June 2006, aimed at delivering 280 quitters across Slough with a focus on deprived communities. The project is quality controlled and performance managed by Berkshire East PCT for Slough Borough Council
- Slough Children and Young People Plan has a health target on smoking for 2006–07, to establish the baseline smoking rate in 11–19 year olds in Slough. This is being delivered through the SFSC in partnership with Slough Children's Trust Board and led by Berkshire East PCT and
- Children and Young People target on smoking. Berkshire East PCT leads are working with the Royal Borough and Bracknell Forest Council to explore the possibility of establishing the baseline smoking rate in 11–19 year olds.

Contact:

Sadhana Bose, Public Health Consultant, Slough PCT

L20zone – improving access to health improvement services

A group of voluntary health, community, and other statutory service providers in Bootle, Merseyside, has worked in partnership to redesign the way that local people access and engage with health and community services.

Marketing skills and joint working have created a new image for public health in the area, moving away from its previously 'dour' image and raising the profile of providers.

Through the 'Family Fit' initiative, those at risk of coronary heart disease were identified and targeted to take part in a 14-week programme to improve their health. Media skills were employed to communicate with at-risk groups through a quarterly publication. The publication was jointly produced by staff from the various partners.

The publication was used to 'signpost' those in the community to the services provided by the partner organisations, that could help to improve their health, and the constituent organisations reported a subsequent increase in the uptake of services.

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Integrated Care Network

304 Wellington House
133–155 Waterloo Road
London SE1 8UG

www.icn.csip.org.uk

Tel 0207 972 4095
Fax 0207 972 4349

Email mbicn@dh.gsi.gov.uk

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