

Health Inequalities National Support Team

A Generic Diagnostic Framework for Addressing Inequalities in Outcome at Population Level from Evidence-based Interventions

*Identifying strengths and effective practice and making tailored
recommendations on how to address gaps in service delivery*



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For Recipient's Use	

Generic Workbook

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Foreword

National Support Teams (NSTs) were established by the Department of Health from 2006 to support local areas – including Local Authorities, Primary Care Trusts (PCTs) and their partners – to tackle complex public health issues more effectively, using the best available evidence. By undertaking intensive, 'diagnostic' visits to local areas, spending time with key leaders (commissioners and providers) including clinicians and front-line staff, the ten NSTs provided intelligence, support and challenge to local areas to assist in their achieving better public health outcomes. The programme finished in March 2011.

The ten subject specific teams (Sexual Health, Tobacco Control, Health Inequalities, Teenage Pregnancy, Childhood Obesity, Alcohol Harm Reduction, Infant Mortality, Response to Sexual Violence, Vaccination and Immunisation and Children and Young People's Emotional Wellbeing and Mental Health) were commissioned and established with a focus on improving health and reducing health inequalities.

The ten teams undertook more than 450 visits to local partnerships during the course of the programme and their findings and successes have been documented in Knowledge Management and Evaluation reports. Each team also produced reports setting out and consolidating the learning from their work. A further report that captures best practice identified by each team is planned to enable local areas to continue using the expertise and lessons learnt from the NST model.

The NST process involved a desk review of key documentation and data-based intelligence, and interviews with key informants, often in combination with a series of workshops or focus groups. Collation and analysis of findings was immediate, and the findings, including strengths and recommendations, were fed back straight away and on site to the key local players and leadership. Recommendations were accompanied by offers of support, either at the time of reporting, or as part of follow-up activity.

The Department is publishing a number of reports which distil the learning from the programme, and exemplify the methodology employed.

Introduction to the Approach

This generic workbook is the overarching guide and template for a diagnostic approach to analysing whether a population level outcome will be achieved from a set of evidence-based interventions. It is the master workbook of a series of diagnostic workbooks developed by the Health Inequalities National Support Team (HINST), while working with the 70 local authorities covering populations in England with the highest levels of disadvantage and poorest health. The programme finished work in March 2011, but the Department of Health is publishing its key outputs for local commissioners and providers to use if they so wish. Any of the areas of work within local partnerships that affect the health of the population could be explored using the generic set of questions in this workbook. The HINST has already developed these generic questions into specific topic based workbooks, each selected for the importance of its potential impact on health and wellbeing, and also on mortality and life expectancy in the short, medium or long term.

HINST topic based diagnostic workbooks

This workbook developed in partnership with the Infant Mortality National Support Team (IMNST), is one of a series developed by the Health Inequalities National Support Team (HINST), in its work with the 70 local authorities covering populations in England with the highest levels of deprivation and poorest health. These workbooks are a summary of local views on good practice. The suggested approaches are not mandatory, and reflect learnings from a snapshot in time. Where there is clear established evidence to support interventions, this has been signposted in the footnote. This is offered as useful resource for commissioners: use is NOT mandatory

Cancer – Systematic Delivery of Interventions to Reduce Cancer Mortality and Increase Cancer Survival
Cardiovascular Disease – Management of CVD Risk and its Cardiac Consequences to Reduce Mortality at Population Level
Stroke - Equitable Access to Best Stroke Prevention and Management
Diabetes - Assessment of Services to Reduce Diabetes-related Mortality
COPD - A Systematic Approach to Delivering Management of Chronic Obstructive Pulmonary Disease (COPD) to have a Population Level Impact
Seasonal Excess Deaths - The Systematic Delivery of Population Interventions to Protect Vulnerable Older People from Preventable Seasonal Excess Deaths (SED)
Infant Mortality - Systematic Management of Programmes to Address High Infant Mortality Rates
Tobacco Control - Tobacco Control Strategies to Reduce Inequalities in Mortality
Alcohol Harm Reduction - A Diagnostic Framework for Addressing Inequalities in Outcome at Population Level from Evidence-based Alcohol Harm Reduction Interventions
Employment Worklessness and Health
Offender Health
Housing and Health
Low Income, Debt and Health

At the core of each workbook is a diagnostic framework – Commissioning for Best Population Level Outcomes (see p12-13). The diagnostic focuses on factors that contribute to a process in which a group of evidence-based interventions produce the best

possible outcomes at population level. Part of the structure addresses delivery of **service** outcomes in the most effective and cost-effective manner. However this is balanced by considerations of how the population uses services, and is supported to do so, to aim for **optimal population level** outcomes that are fairly distributed.

The framework is made up of a set of detailed, topic-based questions. These provide local groups of commissioners and providers with **a systematic approach to deciding what needs to be done** to further improve population health and wellbeing, capitalising on evidence-based interventions. **How** these improvements will best be achieved in a given locality will be for local participants to decide. This generic version provides the bare bones of the diagnostic, which can be used in three ways:

1. With a group of commissioners and providers to develop a systematic approach to commissioning and delivering any set of evidence based interventions - by adapting the generic questions to apply to the area of work being addressed.
2. As a check against the existing topic based workbooks. These workbooks are necessarily complex covering the detail behind commissioning and delivering the interventions, with a range of references and good practice examples included. Use of the generic workbook alongside the detailed workbook may help the group focus on the key diagnostic questions in each section of the framework.
3. For taking stock of a set of commissioned interventions to check their potential for delivering optimal population level outcomes that are fairly distributed.

The first section in the workbook – known intervention efficacy – is not filled out, as this is the section where the evidence base for the topic will be outlined. To make most effective use of this generic workbook in a new topic area (1 above), it will be important to identify evidence of known interventions for the specific topic under consideration and include it in the first workbook section. For guidance on the approach, see other HINST workbooks.

The resource represented by these workbooks can make a significant contribution during a period of transition for the NHS, as responsibility for commissioning of health and health related services transfers to the NHS Commissioning Board, GP Commissioning Consortia and working towards delivery passes to the Health and Wellbeing Boards. Changes are also in progress within local government, social care and the voluntary sector. Current policy in relation to public services highlights the centrality of engaging people – as individual service users and patients, and as whole communities, in their own health and wellbeing and that of the wider community.¹ The workbooks will support the newly emerging organisations and networks as an aid to understanding commissioning processes to aim for population level outcomes. Key processes that should significantly influence local commissioning priorities such as the development of Joint Strategic Needs Assessment and Health and Wellbeing Strategies, will be highlighted through the use of the workbooks. The skills and knowledge embedded within the realigned local Public Health teams will be critical in development and coordination of these key processes.

The workbooks are designed and tested to help areas identify which factors are important in the systematic and equitable delivery of health improvement. They should, therefore, provide a good framework for early identification of local solutions driven by the new perspectives being brought to bear.

¹ See for example NHS Constitution: <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx> and Localism Bill: <http://services.parliament.uk/bills/2010-11/localism.html> And NHS and Social Care Bill: <http://services.parliament.uk/bills/2010-11/healthandsocialcare.html>

The NHS also faces a challenging financial environment during the transition. Through the Spending Review, the government protected the NHS, with cash funding growth of £10.6bn (over 10%) by 2014/15. Nevertheless, by historical standards this remains extremely challenging and the NHS has been developing proposals to meet the Quality, Innovation, Productivity and Prevention (QIPP) challenge of efficiency savings of up to £20bn by 2014/15 for re-investment. This means that considerations of the affordability, and evidence of the cost-effectiveness and cost-benefit of the interventions presented should be of central consideration. Where possible priority should be given to interventions which are likely to lead to cash-releasing savings that can be re-invested in other services, based on a sound evidence base. Some of the relevant evidence has been referenced through the workbooks.

One suggested outcome of the use of the generic or topic specific workbooks, would be to draw together the information needs recognised during the diagnostic workshop. Together with suggestions from the workshop participants as to how to gather the information and insights from different sources, this could make a useful contribution to the area Joint Strategic Needs Assessment (JSNA).

How to Use this Workbook – a guide for facilitators

The objective of the workbook, used in a workshop setting, is to gain a picture of the local strengths and gaps in services in relation to the objective of achieving best outcomes at population level, and to identify and recommend changes that could be introduced.

As noted above, if this guide is to be used in relation to a specific topic that is not part of the HINST set of tools, it is recommended that evidence of known efficacy in relation to that issue is identified and included in section one of the workbook. Thought should be given to adapting the generic questions to apply directly to that topic.

The workbook is best used in a facilitated workshop setting for a minimum of 8 and a maximum of 25 participants. Allow 4 hours for the workshop. The participants in the workshop should include key individuals who are involved in planning, commissioning and delivering services and interventions in relation to the workbook topic through a partnership approach. The make-up of the group will vary according to local situations.

Where there is more than one organisation (for example, hospital trust) providing similar local services, it is advisable to invite senior representatives from each.

Provide a copy of this workbook to each participant at the workshop. It is suggested that the participants do not see the workbook in advance, but are informed that the workshop will be an opportunity to explore their knowledge of approaches to the issue with others who will bring differing perspectives. This will mitigate against any participants over-preparing, becoming defensive or being resistant to discussing and finding solutions for local issues.

The facilitator should be familiar with the workbook questions and the model described below, which encourages a population level perspective to be taken. It is suggested that facilitators introduce the participants to this model and approach. Following the introduction, it is useful to look at section 13 first as this gives an overview of the situation in the area for this topic and provides all participants with an opportunity to contribute at the beginning. Finish by working through each sections 1-12 of the model).

Group discussions about all of the questions in each section allows strengths, best practice and gaps to be identified, and the group to begin to think about where improvements could be made. A separate publication available on the website includes a facilitator's recording book, which can be used during the workshop to record this discussion. This need not be copied for workshop participants.

Key actions and lead stakeholders to take these actions forward can be identified during the workshop. The greatest impact is likely to result if summaries of these key actions and of the recognised strengths and recommendations from the workshop are produced and circulated to attendees and key accountable stakeholders within the partnership, following the workshop.

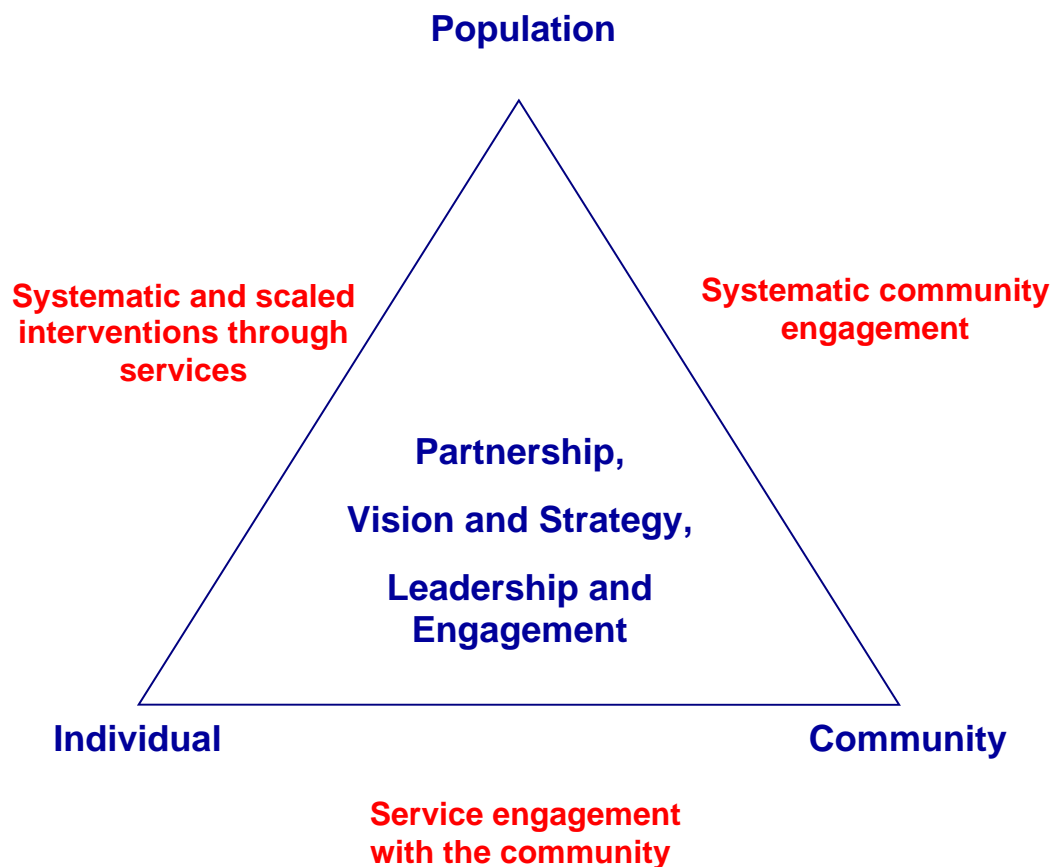
Background to Population Level Interventions

Challenging public health outcomes, such as achieving significant percentage change within a given population by a given date, will require systematic programmes of action to implement interventions that are known to be effective and reaching as many people as possible who could benefit.

Programme characteristics will include being:

- **Evidence based** – concentrating on interventions where research findings and professional consensus are strongest
- **Outcomes orientated** – with measurements locally relevant and locally owned
- **Systematically applied** – not depending on exceptional circumstances and exceptional champions
- **Scaled up appropriately** – 'industrial scale' processes require different thinking to small scale projects or pilots ('bench experiments')
- **Appropriately resourced** – refocusing on core budgets and services rather than short bursts of project funding
- **Persistent** – continuing for the long haul, capitalising on, but not dependant on fads, fashion and changing policy priorities

Interventions can be delivered through three different approaches to drive change at population level, illustrated by the following diagram:



Producing Percentage Change at Population Level

C. Bentley 2007

Population approaches

Direct population level interventions will include developing healthy public policy, legislation, regulation, taxation and public funding strategies. These elements should support making 'healthy choices easy choices' for individuals and communities.

The impacts of such population level interventions, however, will not automatically 'trickle down' to all, often in particular missing those who are socially excluded for various reasons. Strategies for targeted communication and education, service support and even enforcement will be required to achieve full impact.

Individual approaches through services

Some interventions taken up at individual level, such as support for environment and behaviour change, therapies, treatments and rehabilitation, can change individual risk significantly, in some cases by 30-40%. The challenge is to achieve so many of those individual successes that it adds up to percentage change at population level. This will be achieved only if services take into account issues of system and scale to enable this to happen, and work to address population level outcomes as well as those for individual service users.

Improvements in health and wellbeing will require some reorientation of health and other services to take a more holistic view of individual circumstances, with regard to any personal characteristics/sub-population group status or socio-economic status and to focus on development of personal skills of staff and service users, so promoting healthy choices and actions.

Community approaches

Individuals will only choose to use and benefit from certain behaviours and actions if those behaviours fit with the cultural and belief system of their own community. Communities can be based on place (neighbourhood, school, workplace), culture (ethnicity, faith) and others (disability, sexual orientation). Community development is one way of facilitating communities' awareness of the factors and forces that affect their wellbeing, health and quality of life.

Community engagement is often patchy, favouring those communities that already have leadership, organisation and some resources. Instead, it needs to be systematic in bringing top-down and bottom-up priorities together into plans. This will strengthen community action to create more supportive environments and develop knowledge and skills of community members.

Service links into communities can be superficial, of poor quality, unsystematic, and based on low levels of understanding. Connectivity between services can be disorganised and confusing. Use of the voluntary community and faith sector as a bridge between services and community based structures needs to be more systematic and based on need rather than supply. Commissioning is key to this.

Commissioning for Population Level Outcomes

Substantial progress can be achieved in making an impact in the short, medium and long term in relation to inequalities in mortality and life expectancy through a focus on existing services. Because of this, extra attention is given here to extracting maximum benefit from delivery of interventions for which there is strong evidence of effectiveness. In addition there is a deliberate emphasis wherever possible, on improving access to services at a scale that will impact on bringing about a population level improvement in mortality and life expectancy within a two to three year period.

The detail is illustrated in the attached diagram on page 12, entitled 'Commissioning for Best Population Level Outcomes', otherwise known as the 'Christmas Tree' diagnostic, with an accompanying description of its component principles. The framework balances two sets of factors that determine whether optimal outcome can be achieved at population level from a given set of personal health interventions.

The right hand side of the diagram (1 to 5) - a challenge to providers: links the factors that will influence health *service* outcomes, that is, how can we construct the most effective service.

However, optimal outcomes *at population level* will not be obtained without the following:

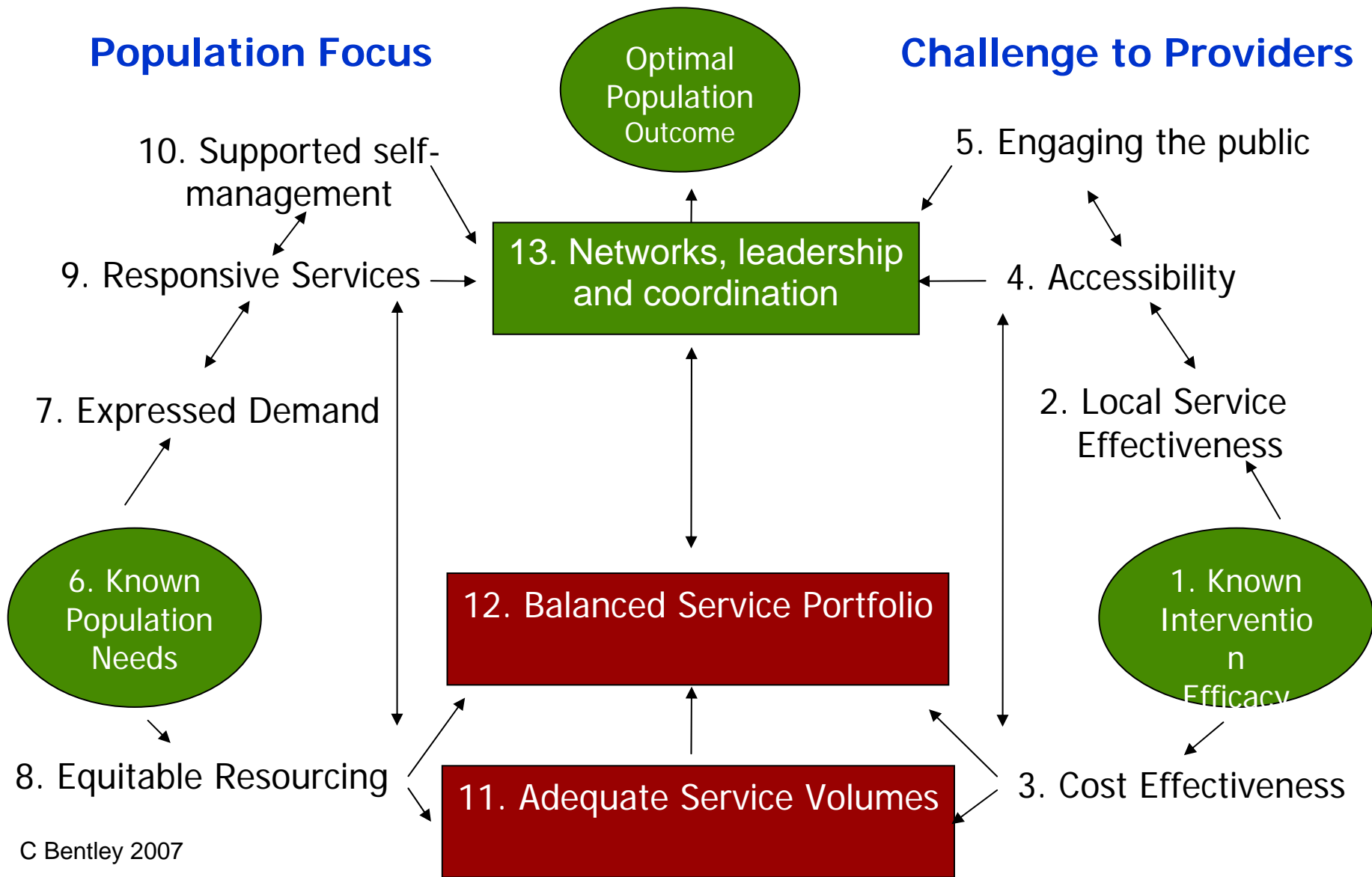
The left hand side of the diagram (6 to 10) - a population focus: identifies those factors that determine whether a community makes best use of the service provided – for example, whether the benefits of personalised improvements to services are having a systematic impact on reducing health inequalities at the population level.

The balance between the two sides of the diagram - the commissioning challenge:

Aiming for equality of outcome, not just equality of access to service provision and support, is a significant and crucial challenge for commissioners. The 'Christmas Tree' diagnostic, is a tool to help achieve this. The right side of the diagram enables commissioners to identify the best services available for their population. The left side allows commissioners to consider that what is commissioned and delivered best meets the needs of all people in the local population. Attention to both sides of the diagram will help to make sure that all services are effective **and** engaged with and used by all of the diverse communities in the area they serve.

The central elements of the diagram are concerned with aiming for that when the most effective services/interventions are identified that are fully acceptable, accessible and effective in terms of take-up and compliance, there is adequate capacity to meet the need. Effective leadership and networks are needed to work towards all of these elements are being kept under review to encourage continuous improvement and equality of morbidity and mortality outcomes.

Commissioning for Best Population Level Outcomes



© Bentley 2007

Commissioning for Best Population Level Outcomes

A CHALLENGE TO PROVIDERS

1. **Known Intervention Efficacy:** Looks for life saving interventions, for which there is strong evidence, to be implemented equitably and made available to as many people who could benefit as possible.
2. **Local Service Effectiveness:** Aim for service providers maintaining high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit.
3. **Cost Effectiveness:** Aim for programme elements that are as affordable as possible at population level.
4. **Accessibility:** Aim for services to be designed with the minimum barriers to access, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of that service.
5. **Engaging the Public:** Working with service users and communities to aim for needs and requirements to be placed at the centre of service provision and for quality assurance systems in place that makes the services acceptable to service users.
 11. **Adequate Service Volumes:** Commissioning adequate service volumes to aim for acceptable access times.
 12. **Balanced Service Portfolio:** Aim for balance of services within pathways to avoid bottlenecks and delays.
 13. **Networks, Leadership and Co-ordination:** Designating leadership and co-ordination to aim for services that are commissioned and networked to meet population need and the population is supported to use services and interventions appropriately.

B POPULATION FOCUS

6. **Known Population Health Needs:** Aim for a realistic assessment of the size of the problem locally, its distribution geographically and demographically and the level and type of service being based upon this assessment.
7. **Expressed Demand:** Aim for as many people as possible who are suffering from the problem or its precursors, to present to services in a timely and appropriate fashion, through informing, educating and supporting the population.
8. **Equitable Resourcing:** Aim for the distribution of finance and other resources to support equitable outcomes according to need.
9. **Responsive Services:** When people present to services, aim to make sure they are afforded equal access to timely beneficial interventions according to need.
10. **Supported Self Management:** Where appropriate, help service users to be empowered to make choices about their circumstances and service offer on the basis of good information, and to be supported to utilise the service offer to best effect.

Whilst the service design elements are an immediate concern to providers, all sections of the 'Christmas Tree' diagnostic are of direct relevance to commissioners

Equality

Equalities perspectives need to be built into all whole population approaches. The Equality Act 2010 set out the public sector equality duty:

(1) A public authority must, in the exercise of its functions, have due regard to the need to:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The Act identifies a number of 'protected' population groups/characteristics where specific elements of the legislation apply. These groups/characteristics are:

age; disability; sex reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Although socioeconomic inequalities are not specifically included in the Equality Act, there are a range of duties in relation to tackling inequalities included at different levels in new health and social care legislation, and for all key structures and partners involved in the commissioning and delivery of this legislation.

The Health and Social Care Bill 2010 proposes new legal duties on health inequalities for the Secretary of State and the NHS. Subject to Parliamentary approval:

- The Secretary of State for Health must have regard to the need to reduce health inequalities relating to the NHS and public health.
- The NHS Commissioning Board and GP consortia must have regard to reducing inequalities in access to, and outcomes of, healthcare.

In order to carry out these duties effectively an emphasis on socioeconomic disadvantage will be essential as it is recognised as a major driver in relation to inequalities of access to, and outcomes of, health and wellbeing services.²

Useful Materials³

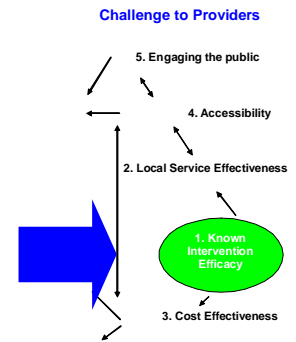
² The Marmot Review (2010) *Fair Society, Healthy Lives - Strategic Review of Health Inequalities in England post 2010*
<http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf>

³ Department of Health (2008) *Making the difference – The Pacesetters beginner's guide to service improvement for equality and diversity in the NHS*

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086039

The Workbook

A Generic Diagnostic Framework for Addressing Inequalities in Population Level Outcome from Evidence-based Interventions

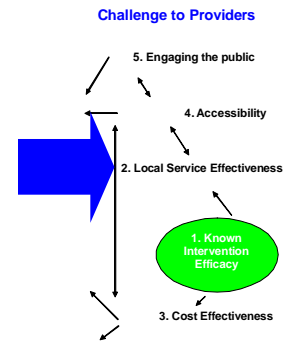


1. Known intervention efficacy

Looks for life saving interventions, for which there is strong evidence, to be implemented equitably and made available to as many people who could benefit as possible.

In the topic-based workbooks in this series, this section is used to list the interventions for which there is strong evidence that, when used effectively at the level of the individual, can result in significant benefit, either through reduction of risk or improved wellbeing.

The rest of this workbook will encourage consideration of how such interventions can be brought efficiently and effectively to as many people as possible who could benefit. This will partly be achieved by addressing current, or potential, inequalities in access and effective use. In this way, it will support attempts to achieve the optimal outcome at population level from the interventions available.



2. Local Service Effectiveness

Aim for service providers maintaining high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit.

1. Information

- What routine information is collected to measure the quality of the impact and outcome of the intervention as delivered locally by:
 - the delivering organisation
 - particular delivery unit or division
 - multi-disciplinary team
 - individual practitioner?
- Is the data systematically collated, analysed and interpreted?
- To whom is it reported?
- Who is responsible for responding and working towards the necessary action being taken?
- Is the information reported routinely, or on an exceptions basis, to a) Senior Management Team and/or b) the Board?

2. Audits

- If routine data is not available, what attempts have there been to carry out special studies or audits to assess impact or outcome?
- Do all relevant teams and individuals participate in such audits?
- Are there examples of action taken to respond to the findings of such audits?
- Was the 'audit cycle' completed by repetition of the studies?
- What did they show?

3. Audits across whole pathways

- Where outcomes depend on a group of related interventions, do mechanisms for performance monitoring or audit take place across a delivery pathway, crossing organisational boundaries?
- How are data flows managed so that individual contributions and the composite picture can be systematically appraised?
- How is subsequent action coordinated?

4. External quality assurance

- Has there been any form of external quality assurance or review of the local delivery system? What did it show?

- Has there been an action plan implemented to respond to the recommendations of the quality assurance or review?

5. **Communication of information**

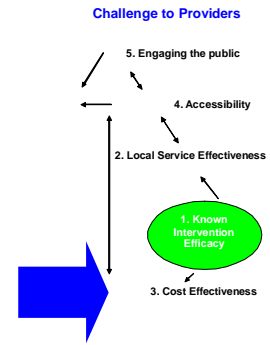
- How is information on individual professionals, practitioners and delivery units fed back?
- Does it allow benchmarking with a peer group?
- Is it anonymised or attributable?
- What techniques are used when aiming for the presentation of information to be user friendly?
- What support is available to help interpret the information, and identify potential consequential action?

6. **Local Service Improvement**

- Where identified outliers are not able to self-improve, what resources are available for development support? How effective have these been?
- What mechanisms have been embraced locally to drive service improvement (e.g. Lean Methodology)? Are there examples of significant resulting change?
- What mechanisms are in place to drive Continuous Personal/Professional Development (CPD)?
 - How systematic are the systems driving this, and do they work towards poor performers being identified and prioritised for extra attention and support?
- Are there mechanisms for teams to receive education, training and development together?
 - Have they been harnessed to drive up quality in the area of interest covered by this workbook?

7. **Management Barriers**

- What management barriers are currently perceived to be holding back service effectiveness?
 - Resources?
 - Facilities?
 - processes?



3. Cost effectiveness

Aim for programme elements that are as affordable as possible at population level .

1. Cost analysis and modelling

- What evidence of cost effectiveness/cost benefit/cost utility have been explored for the interventions under review?
- Have the costs of implementing the programme so as to achieve desired population outcomes been modelled?
 - Has this been used in a business case for implementation?
 - How has Return on Investment (RoI) been described?
- Has modelling incorporated an estimate for Numbers Needed to Treat (NNT)? If so, have assumptions been made for costs of unsuccessful treatment, and service intervention to reduce this figure?

2. QIPP

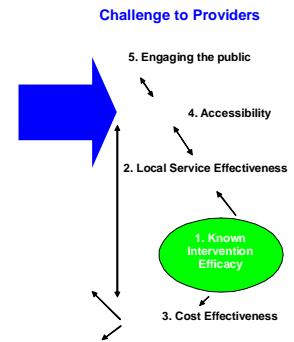
- How have considerations of quality, innovation and productivity been taken into account in designing the programme to maximise cost effectiveness?

3. Costs and outcomes

- In implementing the intervention, have costs and outcomes been analysed together?
- Has this information been fed back to providers allowing them to benchmark their performance against others?
- Are mechanisms in place to support systematic approaches to improved cost effectiveness?

4. Programme Budgeting and Marginal Analysis

- Have Programme Budgeting and Marginal Analysis been applied to this area of work?
- Does interpretation make comparison with peer groups as opposed to an average figure (because of disproportionate cost of delivering average outcomes in disadvantaged areas)?



4. Accessibility

Aim for services to be designed with the minimum barriers to access, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of that service.

1. Balancing costs against effectiveness and usage

- What evidence is there that attempts have been made to bring delivery of interventions within convenient reach of focal points of population need, balancing access with effectiveness and cost effectiveness of sustained delivery?
- What analysis is available that might highlight situations where poor access might be compromising appropriate service use?
- What action has been taken, or is planned, as a result?

2. Needs analysis

- Has analysis of appropriate and proportionate provision according to need been carried out in relation to groups of equity and interest?
 - age
 - sex and sexual orientation
 - disability:
 1. physical disability
 2. learning disability
 3. enduring mental health problems
 - gender reassignment
 - pregnancy and maternity
 - race
 - religion or belief

What action has been taken as a result?

3. Is there appropriate access to:

- interpreter services, including signing
- specialist intermediaries (e.g. for learning disabled) and service advocates?

4. Facilities and estates

- Is there an estates/facilities strategy based on need?
- Does this explore appropriate shared use of facilities with other providers?
- Is use being made of community venues, where appropriate?

5. Different ways of accessing services

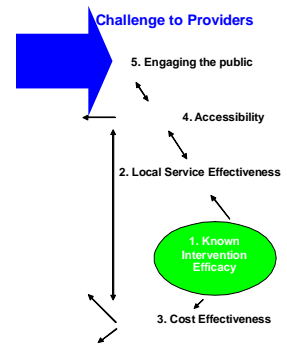
- To what extent have a) cultural, and b) socio-demographic segment preferences, been considered in the way services are offered?
- Is there a customer access strategy offering a menu of options for accessing services (rather than a 'one-size-fits-all' approach)?
- Do appropriate facilities for unscheduled contact or advice exist to optimise access:
 - walk-in facilities
 - telephone helpline
 - on-line access

6. Ease of access to a range of related services

- Have opportunities been fully explored for 'one-stop' provision of an array of related inputs or services, optimising the efficiency of contact, and opportunity cost for patient and service provider?
- Where this is not possible, does 'passporting' occur within and between sectors, facilitating user access to related services, based on perceived needs?

7. Raising awareness of services

- How well advertised or marketed are the variety of arrangements for access, and are messages targeted to priority need groups?



5. Engaging the public

Working with service users and communities to aim for needs and requirements to be placed at the centre of service provision and for quality assurance systems in place that makes the services acceptable to service users.

1. Involvement of communities in service development

- Have the priorities in the service or programme action plan been developed through the involvement of the community?
- Is this involvement part of a wider community engagement programme?
- Are population segmentation tools used to define and engage appropriately with the communities of interest?

2. Voluntary and community sector involvement

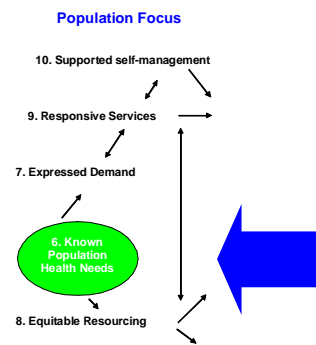
- Are there local Voluntary and Community Sector (VCS) networks in existence locally to coordinate and/or advocate for all the major communities of interest (e.g. a multi-faith forum, a disability forum etc)?
- If not, what role can statutory organisations and partnerships and the individuals working in them, play in trying to strengthen the VCS infrastructures?
- How effective are working arrangements with the Local Involvement Network (LINK)?
- How wide is their reach in relation to the engagement of equalities communities?

3. Mechanisms to involve service users and the public

- Which of the following mechanisms have been utilised to involve service users and the public in design, modification and improvement of services:
 - patient/user satisfaction surveys
 - systematic involvement of user and carer representatives in the networks
 - audit of 'did not attend' episodes in (by ethnicity, sex, age, social segment, etc.)
 - discovery interviews
 - focus and reference groups
 - local support and interest groups
- If these mechanisms have not been used, what plans are in place to make better use of them?

4. Use of Frontline Staff

- How systematic is engagement with, and empowerment of, frontline staff in organisations, to draw in intelligence and ideas to improve the accessibility and appropriateness of service provision?



6. Known population health needs

Aim for a realistic assessment of the size of the problem locally, its distribution geographically and demographically and the level and type of service being based upon this assessment.

1. Needs Assessment

- Has a comprehensive local needs assessment been carried out in relation to the subject under review?
 - What are the main conclusions?
 - What are the important trends?

- Has consideration been given, as appropriate, to distribution of the problem and its predisposing factors, by population sub-group:
 - age
 - early years
 - children and young people
 - adults of working age
 - older people
 - sex and sexual orientation
 - disability:
 - physical disability
 - learning disability
 - enduring mental health problems
 - gender reassignment
 - pregnancy and maternity
 - race
 - religion or belief
 - patients in residential and nursing homes and housebound
 - geography
 - segmentation group
 - other relevant vulnerable groups (e.g. prisons and Travellers)?

- As a result has there been any prioritisation or stratification of the extent of need? Have particular outcome 'black-spots' been identified?

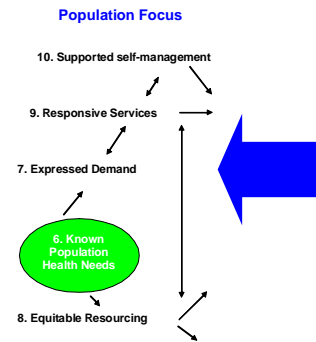
2. Cross organisational data sharing

- Has information from the range of multi-sectoral sources:
 - been shared?
 - been pooled?
 - been jointly analysed?
 - formed part of a joint strategic needs assessment?

- used to develop profiles by – for example - locality, neighbourhood, GP practice)?

3. Information for a range of audiences

- Has the information been collated, analysed and interpreted for a range of audiences? Which ones?
- How has the intelligence been disseminated/communicated, and to whom?
- Has it been received by all relevant parties who might use it to support decision-making and action?
- Who has been missed out?
- Has any 'market' research been carried out to establish how the information may have been made more accessible?



7. Expressed demand

Aim for as many people as possible who are suffering from the problem or its precursors, to present to services in a timely and appropriate fashion, through informing, educating and supporting the population.

1. Actual versus expected

- Is it possible to compare the actual numbers contacting service about an issue with an estimate of need within the population?
- What picture emerges about gaps in demand?
- Can these gaps be further characterised as relating to particular geography or population subgroup?

2. Barriers to presenting to service

- Have any forms of survey or insight work been carried out to establish what barriers may be holding back segments or sub-groups of the population from presenting appropriately to service?
- Have these explored:
 - perceived practical problems with delivery of the service
 - cultural issues of community knowledge and expectation
 - problems of individuals (e.g. self esteem, knowledge, low expectations of life, low expectations of service)?
- How has this knowledge been translated into actions to address barriers:
 - in access and the way services are delivered
 - in engaging with communities to work on cultural barriers
 - in reaching out to individuals/families to support them to appropriately engage in services?

3. Equality

- What ethnic monitoring is possible across the range information sources?
 - How is the validity of the data being improved?
 - Have estimates been used where appropriate (e.g. Nam Pechand software for identification of South Asian names)?
- How far advanced is your organisation/other key public sector organisations regarding the use of Equality Impact Assessments (EqIAs)?
 - Do you focus on all 'protected' population groups in these or just race, gender and disability?
 - Are EqIAs undertaken for policies and services?
 - What training is offered to staff in completing EqIAs?

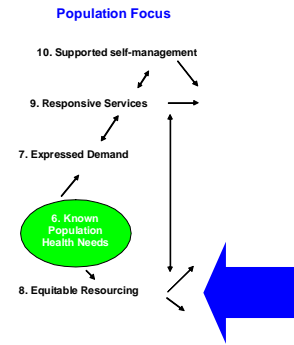
- Are the outcomes of the assessment acted upon?
- How is implementation monitored?

4. Use of frontline staff to engage service users

- To what extent have frontline staff across the partnership been harnessed to help address the problem under review?

Has this included:

- prioritisation by commissioners
- systematic initial and ongoing training for staff to engage them in problem identification
- training for selected staff in brief interventions
- referral pathways into specialist services
- monitoring referrals numbers from different parts of the system?



8. Equitable resourcing

Aim for the distribution of finance and other resources to support equitable outcomes according to need.

1. Outcome based resourcing

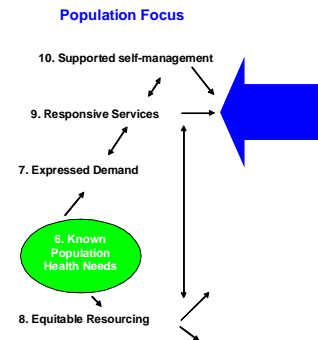
- Do Quality, Innovation, Productivity and Prevention (QIPP) programmes focussing on prevention and management of the problem take into account the inequitable outcomes in subpopulations across the district?
- Do budgets reflect disproportionate costs of achieving equitable outcomes in disadvantaged groups?

2. Shared resource allocation

- Is resource allocation for the costs of service provision decided on an agency-by-agency basis, or is it coordinated across the partnership?

3. Needs based provision

- Have there been exercises to adjust provision of:
 - facilities
 - specialised staffing
 - outreach and community engagement staff
 against mapped levels of need for, uptake and use of services?



9. Responsive services

When people present to services, aim to make sure they are afforded equal access to timely beneficial interventions according to need.

1. Do not attend (DNAs)

- When patients/clients do not attend (DNA) for appointments, how is this handled?
 - no further action
 - patient sent replacement appointment
 - patient contacted to discuss any problem
- Is there a 'failsafe' strategy to consider adequate further opportunity is given before closing file?
- What further forms of contact are used?

2. Choice

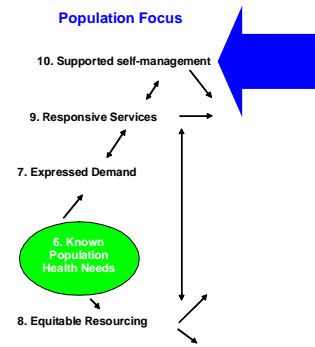
- When patients/clients present to services, to what extent are they offered choices in how to proceed with service options?
- Is there a 'care plan' approach to coordinate inputs where service needs are complex?

3. Support to move between related services

- Do services provide linkages/passporting to other relevant supports from other sectors/organisations?
- Are there supports for patients to be assisted in negotiating complex service pathways (e.g. patient 'navigators', liaison staff, advocates)
- Are service pathways well defined and clearly described in support materials for service users?

4. Urgent care

- Are there mechanisms for service users to get unscheduled advice (e.g. urgent appointments, telephone helpline, online support)?



10. Supported self-management

Where appropriate, help service users to be empowered to make choices about their circumstances and service offer on the basis of good information, and to be supported to utilise the service offer to best effect

1. Support Materials

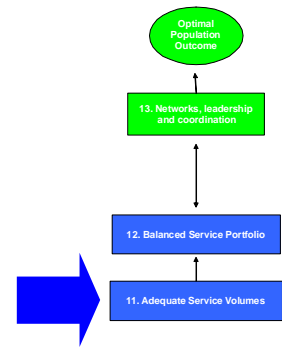
- Are there locally produced or 'kite marked' materials and support programmes available for patients/clients on self-managing their intervention programme?
- Are good quality materials available in local 'minority' languages and adapted to 'minority' cultures?
- Are there support materials available for people with:
 - poor literacy
 - low IQ
 - low vision?
- Has there been any 'segmentation' of education and support materials to reflect social marketing groups?

2. Disabled and Housebound

- Are special arrangements systematically made to support physically disabled and housebound patients/clients?
- To what extent are these successful in overcoming barriers to self-management?

3. Supporting and monitoring self-management

- Are there graded follow-up supports available recognising variability in user's ability to self-manage (e.g. available telephone helpline, telephone or text contact, intermittent face-to-face contact, frequent [domiciliary] contact)?
- Are there local support groups for people with problems in common?
 - Do these cater for a variety of user preferences? Are they accessible from where need is greatest?
- Is there a strong local presence from specialist Voluntary Sector providers?
 - How do they integrate locally with public sector services?
- How are approaches which enable patients to best self-manage their condition being systematised?
- What mechanisms are in place to check progress and maintain use of support by patients/clients?

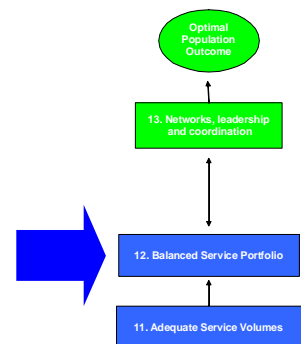


11. Adequate service volumes

Commissioning adequate service volumes to aim for acceptable access times.

1. Planning for changes in service volumes

- Are service volumes sufficient to keep waiting times for access down to an acceptable maximum?
- Does the service capacity and management flexibility enable surges in demand to be accommodated?
- Are predictable fluctuations (e.g. seasonal variation) effectively planned for?

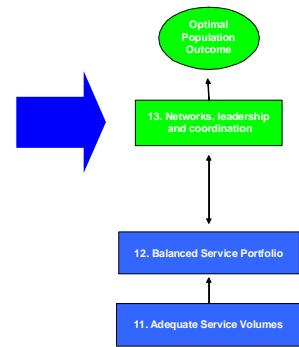


12. Balanced service portfolio

Aim for balance of services within pathways to avoid bottlenecks and delays.

1. Preventing bottlenecks and delays

- Is there sufficient capacity and efficient service management across the pathway of service to eliminate significant bottlenecks in the system?
- Are there routine, timely, information systems that allow detection of pressures in the system, and initiation of effective corrective action?
- Do these systems include data sharing where appropriate across organisational divisions within a pathway?
- Are responsibilities for delivery of outputs and outcomes clear?
- Do these responsibilities extend across whole pathways?



13. Networks, Leadership and Coordination

Designating leadership and co-ordination to aim for services that are commissioned and networked to meet population need and the population is supported to use services and interventions appropriately.

1. Commissioning Plan

- Is there evidence that there is a commissioning plan for services that is:
 - comprehensive
 - needs based
 - geared to population rather than service outcomes
 - actually addressing differential need/ health inequalities
- How are provider networks performance managed by commissioners?

2. Local providers

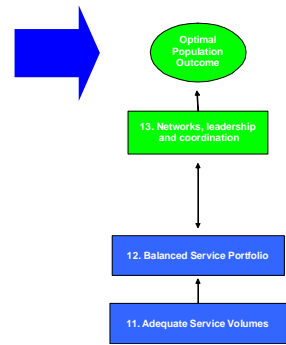
- Is there a network/ Local Implementation Team in place to co-ordinate activity within the city/borough
- What is the level of leadership of the network?
- Is there a specialist lead with dedicated time?
- Is there a coordinator with dedicated time?
- Is there appropriate public health specialist input?
- Is there a recent network strategy/action plan?
- Has the network been subject to external/peer review? If so, what was the outcome?
- Who are the main partners and what is their level of representation and attendance?

3. Supra-district providers

- Is there a supra-district network?
- Has it been subject to a recent peer review? If so, what were the main findings?
- How does it reconcile the needs of commissioners, clinicians, general managers and patients/carers?
- What are the governance arrangements between the network and the Trusts?

4. Partners

- How are the needs of joint commissioning and joint provision partners accommodated in these arrangements?



Optimal Population Outcome

Aim for service outcomes that are meaningful locally, and drive the programme.

1. Outcome Measures

- What goals and outcomes will be used to measure the impacts of the interventions chosen on the issue of concern?
- Are baseline measures available?
- Will it be possible to measure trends?
- Are the outcome measures meaningful at a local level?
- Do they allow measurement of inequalities in outcomes between different population subgroups?
- Is it possible to reflect measured outcomes as simple numbers as well as rates or trajectories, for communication purposes

2. Monitoring outcomes

- How will the outcomes be monitored, and by whom?

3. Communicating outcomes

- How will the progress be communicated to a wider audience?

Acronyms and abbreviations

CPD	Continuous Professional/personal Development
DNA	Do/Did Not Attend
EqIA	Equality Impact Assessment
HINST	Health Inequalities National Support Team
JSNA	Joint Strategic Needs Assessment
LINK	Local Involvement Network
NNT	Numbers Needed to Treat
VCS	Voluntary and Community Sector