Public Health England

Protecting and improving the nation's health

Tools to support 'Place-based approaches for reducing health inequalities'

Tool A: Place-based working towards population-level change in health inequalities

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Corporate member of
Plain English Campaign
Committed to clearer
communication
339

SUSTAINABLE
DEVELOPMENT G⚪ALS

Contents

Introduction to 'Place-based approaches for reducing health inequalities' tool set

Chapter 4 of the 'Place-based approaches for reducing health inequalities', describes the Population Intervention Triangle (PIT) as a model for planning action to reduce health inequalities. A series of tools exists to support local areas apply the principles set out in each part of the model.
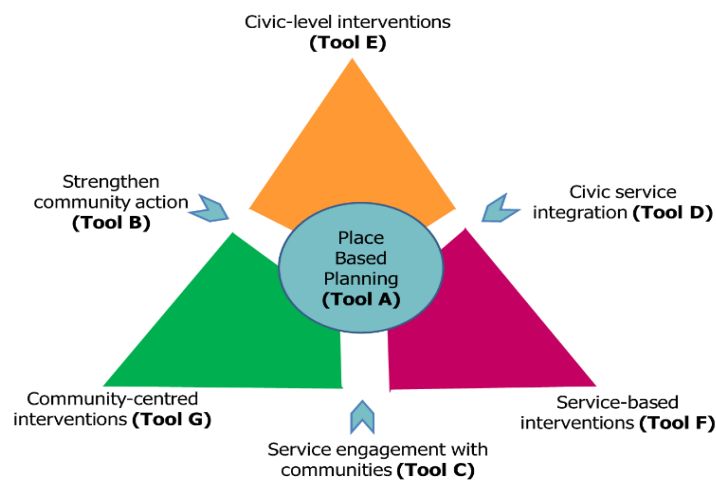

Figure 1 Population Intervention Triangle

How to use the tools

All of these tools have been developed to use either through:

- self-guided means
- a peer-peer support process (for example Sector Led Improvement) or
- facilitated workshops

If you would like further information about potential practical support for the application of these tools then please contact health.equity@phe.gov.uk.

It is important to note that local areas should not work through all tools in one go. It is recommended to start with Tool A on Place-based planning, which examines key elements of place-based working as a whole. Then local areas can pick and choose which section of the model could benefit from further investigation given local circumstaces.

Tools A, B, C and D provide a a checklist of questions based on experience of what makes a difference to that component of the model. Most of these tools start with a series of statements progressively rated from emerging to thriving. This informs what good practice looks like in this area. It also enables users from different parts of the system to individually rate which statement in each of the 10 Steps would best describe the current situation from their perspective. This discussion can then be useful and creative to explore reasons for the different partner perspectives. The colour rating also allows agreed prioritisation amongst the steps of how to move the system towards further improvement. Armed with those priorities, the more detailed diagnostics in the annexes of the tools add more information on what potential action may benefit those priorities. Therefore, users do not need to run through all parts of the detailed diagnostic content, instead they should simply pick out their priority areas to inform potential improvements.

Tools for E, F and G are pre-existing documents which readers can use to inform further action on the apices of the triangle: civic, service and community interventions. The links to these tools are provided in Chapter 4.

Checklist for this tool – Tool A

Scoping

1. Leadership in place: fully committed to HI goals?
2. Joint strategic needs assessment: bottom-up and top-down?
3. Joint priority setting: balanced across partners?
4. Scoping whole system: full range of contributions considered?

Planning

5. Intervention selection: realistic about system and scale?
6. Target setting: locally relevant and meaningful?
7. Business planning: health economic case for change?

Delivery

8. Information governance: systematic intelligence sharing?
9. Programme management: who is accountable?

Evaluation

10. Evaluation: built in from the start?

Screening Tool A: Place-based working towards population-level change in health inequalities

	Emerging	Developing	Maturing	Thriving
Leadership (1)	Health Inequalities (HI) described as a principle, with little practical integrated action, commitment of resource, programme support or top-table monitoring.	Organisation level HI priorities accommodated in partnership discussions. Ambitions incorporated into overarching vision, but missing or weak co-ordinated practical action.	Organisational HI champions recognised and used. Some co-ordinated action accommodated in system plans. Need for systematic application and appropriate scale acknowledged in business plans.	System leadership is fully committed to and owns HI as a local priority, and integrates vision, strategy and action plans into other priorities as a matter of course in place-based approach.
Needs Assessment (2)	JSNA continues to be updated and driven by HWB as a statutory function, but STP/ICS and CCG related action based on unlinked NHS sources (NHS Digital; RightCare).	Partnership analysts combine to draw on main sources and data products to produce a comprehensive integrated statistical foundation for joint planning.	Qualitative information from communities combined with 'top-down' data to create a recognised 'picture of place'. Profile extends to localities; neighbourhoods; GP clusters. Implications from analysis considered.	Community assets as well as needs mapped, and constructively considered as part of planning. Audits assess how priorities agreed link back to intelligence base, and systems adjusted.
Prioritisation (3)	HI agenda crowded out by other priorities. Aggregation of fragmented agendas of different partners. No clear appreciation of HI impact with limited consultation.	Partners propose jointly agreed vision and ambition for change, based on shared analysis, benchmarking and interpretation. Covers short, medium, long-term change.	Joint priorities acknowledge how action on HIs integral to other main agendas. Graded action proposed based on need. Organisation- based public consultation.	Joint consultation with communities on a place / community of identity basis. Joint HI priorities track forward as 'golden thread' to constituent organisational plans.
Scoping Whole System (4)	HI strategies and plans add together interventions making up existing actions of partners which might contribute to agreed priorities.	A 'desk-based' review of evidence by a technical team (eg NICE; PHE; LGA) provide a catalogue of possible interventions to address agreed joint priorities for consideration and proposal.	Partners representing expertise from the three 'segments' of the Population Intervention Triangle contribute possible interventions within their functions as part of a long-list for joint consideration.	Joint considerations include how interventions might combine more effectively (and efficiently) across the segment interfaces ('seams'), so the whole can be greater than the sum of the parts.

	Emerging	Developing	Maturing	Thriving
Intervention Selection (5)	Aggregation of some possibly relevant interventions collated, but unclear if consideration given to systematic application; scale; or sustainability of approach.	Clear criteria for change at population level used to select options. Modelling used to assess whether desired dimensions of change possible.	Assumptions on possible options for change clearly laid out, separately and in combination. Gestation for delivery of outcomes realistic.	Widespread, transparent consultation on portfolio of suggested interventions. Clear contributions needed by partners stated and agreed.
Target Setting (6)	Ambitions stated for addressing HIs, but without setting realistic targets based on firm plans.	Targets based on appropriate benchmarking, and match agreed joint priorities. Built on analysis of trends and modelling.	Interventions deliverable at scale with credible timescales. Resourcing realistic. Measurable local indicators of progress.	Clearly stated equitable distribution of benefit being monitored. Measures translated to be meaningful to a wider audience.
Business Planning (7)	No business planning in place or those that do have unreaslitic assumptions and outcomes .	Financial case made based on outcomes not just savings. Costs and impacts counted across the partners, not just single organisations.	Credible assumptions made about funding necessary scale, capacity and consistent delivery of standards. Sustainable funding over target period.	Plans provide graduated resourcing according to need. Cost of *not* investing also considered.
Information Governance (8)	Data sharing between partners negotiated on a case by case basis. Quality of Information Governance patchy across systems.	Data sharing policies and protocols agreed amongst key partners in principle. Some barriers remain in practice.	Confidence in consistent standards of governance amongst partners. Working to remove IT barriers. Joint Communication strategy.	Connectivity of IT effective in reducing barriers to integrated work. Sharing supports useful monitoring and evaluation.
Programme Management (9)	Contributory actions to agreed priorities reported separately by organisation or sub-group on intermittent basis. Health inequalities addressed separately.	Health inequalities addressed across mainstream priority programmes. Organisation based actions with some cross-cutting themes.	Combined infrastructure to deliver joint programmes. Pooling of resources. Clear dissemination of updates and reports, decisions taken, and who has authority for what.	Joint funding. Dedicated, cross organisation programme manager responsible for reporting to Board, and empowered to mitigate problems with progress.
Evaluation (10)	No planned evaluation at outset.	Monitoring with planned review and reporting periods. Detailed 'deep dive' scrutiny at high level committee or Board during/end of plan period.	Plan; Do; Study; Act approach drives progress with reflective, disseminated learning to adjust structures, processes and intermediate outcomes behind plan.	Plan for independent evaluation during and at end of programme period. Investigators appointed from start with baselines established.

Detailed diagnostic for place-based planning:

Is the system leadership fully engaged in the problem?

Has the case for addressing local inequalities in health and wellbeing been made, and been accepted as a strategic priority at the highest organisational levels? eg:

- Devolved Authority
- Sustainable Transformation Partnership (STP)/ Integrated Care System (ICS)
- Health and Wellbeing Board

Do sub-structures working under the auspices of these System arrangements also take on accountable responsibilities for addressing health inequalities in their work? Such as:

- Integrated Care Providers/Provider Alliances
- Professional Executive Committees/Clinical Senates
- Thematic Transformation Working Groups

Have the major partner organisations also accepted the priority, and that they will have a contribution through their individual organisations and through joint action? For example:

- Local Authority(s)
- CCGs
- Healthcare Trusts
- other critical sectoral partner organisations (name) for example housing; welfare; employment; policing

Does the relevant overarching System Board/Committee build in regular quality time to engage key partners in continually refreshing/evaluating health inequalities policies and programmes?

For major partnership organisations, are there designated high level champions at member/non-executive and officer level?

Are there clear structures, channels and processes for appropriate level engagement of community representation at all levels?

Does a good quality ongoing process of Strategic Needs Assessment underlie plans?

- what is the capacity and capability for strategic analytical work across the system
- are there good formal and informal links amongst partners? Which are missing
- is there evidence of joint analysis rather than just data pooling/sharing

- are there system wide multi-disciplinary analytical teams, supplemented by specialist skills
- is use being made of advanced analytical tools and software

Does the (statutory) Joint Strategic Needs Assessment (JSNA), or associated reporting combine data and analysis:

- demographic, socio-economic and health and wellbeing
- data on health and social care process/outcomes with benchmarking and trends
- make good use of outside sources, for example PHE Fingertips; NHSE/RightCare; NHS Digital outputs
- other health related service information, for example schools; housing; employment
- systematically collected qualitative input from communities and frontline staff
- assessment of assets as well as needs
- available analysis on protected equity groups
- results of Health Equity Audits/Impact Analysis to ensure actions can benefit all groups

Does the output:

- provide a good 'picture of place' recognisable to partners
- distil out key consequences and recommended issues for possible action
- through various methods of segmentation and stratification identify relative risks, and identification of target populations
- provide baseline information from which to monitor change
- include a breakdown to profile recognisable localities/neighbourhoods forming building blocks for place-based arrangements and organisational boundaries
- lend itself to other working arrangements, for example primary care practice profiles

Does the JSNA form the basis of intelligence for other working groupings, for example STP/ICS/Devolved Authority?

- if not what forms the basis of their intelligence for strategies and plans
- how and why have they needed to be augmented? How might they be consolidated or modified to make more fit-for-purpose

In capitalising on the Needs Assessment(s) to support decision making:

- are relevant important findings and potential consequences interpreted for a variety of partners and audiences including the public
- which part of the workforce takes on this role
- how are the findings disseminated and made accessible? Is there a shared partnership communication plan and process

Is there an audit trail tracking back strategies and plans to address inequalities in health and wellbeing to the Strategic Needs Assessment? If not, from where were they derived?

What were the processes of agreeing health inequalities priorities across the system?

What elements of inequalities in health and wellbeing outcomes have been identified as significant outliers:

- on a national basis
- against a credible benchmark group, for example Similar 10 CCGs; Office of National Statistics LA Cluster
- internally within the Place setting, for exampleby quintile if deprivation; locality profile
- by equity group, for example ethnicity; religion; disability; sexual preference

What are the likely contributory components to the outlier outcomes, including:

- contributory risk/condition
- lifestyle/behaviour
- wider determinants

Based on the shared analysis and interpretation, is there a jointly agreed vision and ambition for change? Does the vision cover ambitions for short, medium and long term change?

How are the identified issues reflected in the agendas of key partners? How would action be likely to impact on goals and objectives of each, positively or negatively?

On this basis, has it been possible to identify a portfolio of objectives which will contribute in a balanced way to partner's organisational aims, addressing elements of population health and wellbeing?

Do the proposals take into account mapping of existing or developing policies, strategies and transformation plans, including those of other sectors and bodies, for example housing; work and skills; spatial planning; Local Enterprise Partnership?

Is it clear by what mechanisms of communication and discussion the visions, aims and objectives can be shared, and where appropriate aligned? policies, strategies

To what extent have the vision and priorities been consulted upon, and with whom? Is there evidence of wider ownership?

Has a whole system approach been taken to consider population level change?

Have considerations of potential ways to intervene to address priority inequality objectives engaged a full range of expertise to establish the range of possibilities:

- external agencies, for example PHE; NHS England; Local Government Association; Association of Directors of Public Health; NICE; Roundtree Foundation
- local partnership organisations, for example Local Authority; CCGs; NHS Trusts and Clinical Senate; Council for Voluntary Services
- academic sector, locally and regionally

Have possible contributory interventions been explored from across the segments of the Population Intervention Triangle to establish a menu of possibilities:

- civic level, considering the full range of Local Authority functions (for example local legislative, regulatory and fiscal measures; healthy public policies) and those of public sector partners
- community level, considering how the 'family' of community-centred approaches can contribute to the health and wellbeing of individuals, families and the community itself
- through a variety of health, social care and allied services (public, Voluntary Community Social Enterprise (VCSE) and other independent), delivering consistent quality and outcomes with system and scale

Was a 'long list' established of possible interventions with the potential to deliver measurable change at population level, ready for a rigorous options appraisal?

Are combinations of interventions identified that can provide the desired impact?

Does each intervention meet the criteria for potential to deliver population level change:

- evidence based – concentrate on interventions where research findings and professional/technical consensus are strongest, and/or where there is authoritative guidance
- outcomes orientated – with measurements and change indicators 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 " bench experiments"
- appropriately resourced – refocus on use of core budgets and services rather than short bursts of project funding (include consideration of double running costs and space to create, test, fail, learn)

- sustainable – continue for the longterm, capitalising on, but not dependant on fads, fashion and policy priorities

Is it possible to model or estimate the potential impact and dimension of change of each intervention, to establish credible impact and contribution to the overall target? Are the assumptions in arriving at the estimates clearly laid out?

Is it clear with each potential intervention what the contributions would need to be from each system partner?

Have there been realistic estimates of timescales necessary for the desired scale of outcome to be achieved?

Has there been widespread, meaningful and transparent consultation on the resulting preferred portfolio of interventions?

Then, are targets for change set which match the vision and objectives?

Are endpoints established:

- by realistic benchmarking with comparator systems/organisations
- on the basis of analysis of trends and modelling
- ambitious but credible

Do they match priorities agreed with key stakeholders:

- do endpoints match local concensus of What Good Looks Like (WGLL)
- are targets developed to be pragmatic
- are credible interventions available
- are they deliverable at scale
- are they achievable within resources likely to be available
- are they measurable, with locally meaningful indicators of progress towards endpoints
- are realistic timescales stated

Is desired equitable distribution of benefit clearly stated and to be monitored?

Can technical targets be translated into measures meaningful to a wider audience (for example mortality rates expressed as numbers of deaths deferred)?

Is there a business plan, making a clear, compelling economic case for change?

Do projected costs of implementing interventions:

- make credible assumptions about the necessary scale and capacity?
- build in any necessary system changes for consistent, delivery?
- plan for sustainable funding over the target period (and beyond)?
- accommodate necessary workforce development: upskilling; realigning; new roles?

Are the potential costs, financial risks and potential impacts and mitigations estimated across system partnerships, rather than for single organisations or sectors? Which part of the system carries each element of the cost burden, and which part benefits?How benefits profile over short/medium/long term?

Is the financial case based on economic returns, not just cost savings? Can these be represented in a range of measures to meet preferences of different partners (for example cost benefit; cost utility; Return on Investment; Cost Consequence Analysis).

Do investment plans allow for graduated resourcing necessary to achieve equitable outcomes according to need, including sometimes exponential extra costs for those with most complex disadvantage?

Do investment plans align contractual levers and incentives to desired outcomes?

Is there robust information governance to support systematic intelligence sharing?

Have data sharing policies and protocols been agreed amongst key partners?

Are these adequate to remove barriers to effective:

- assessment of needs and assets
- management of joint and integrated programmes
- monitoring of milestones and outcomes for jointly agreed targets
- shared processes of evaluation

Is connectivity of information technology and management systems a barrier to integrated working? Are there strategies working towards 'integrated data architecture'?

Is there a joint Communication Strategy agreed for the System partnership? Does this provide mechanisms to systematically disseminate 'a single version of the truth' on partnership decisions and progress to a variety of 'internal' and external audiences, including the public?

Are there clear systems of integrated programme management for system priorities?

For each of the priority programmes to address the health and wellbeing inequality targets are systems of programme management and performance indicators clear?

Are there dedicated programme management resources with agreed contributions from involved partners?

Is there a clear programme manager, empowered by all involved organisations, who is responsible for accounting to the appropriate System Board or Committee?

Where there are complex delivery pathways involving a number of organisations, is it clearly laid out that where action is required to improve impact,

- where and at what level decisions can be taken?
- who has authority to intervene?
- how is information relevant to programme management disseminated?

Are key system partners brought together regularly to continually refresh/evaluate the programme plan

Are processes of evaluation built in to strategies and programmes from the start?

Is there an evaluation plan for the health inequalities strategy and/or its key components agreed from the start, as part of planning, including:

- consideration of potential providers
- financing
- scope
- establishing necessary baselines
- timing of interim and final study and reporting

Within programme management, are mechanisms agreed for evaluation as part of Plan; Do; Study; Act (PDSA) cycles to drive improvements to structures, process and outcomes?