

# Public health's role in local government and NHS integration

# Foreword

The case studies described below have been commissioned to support the role of public health in developing integrated services across local government and the NHS. The case studies are linked to a resource document, 'Public health's role in local government and NHS integration: a resource to promote public health's involvement in integrating health, care and wider public services'<sup>1</sup> which discusses the reasons why public health (DsPH) should be involved in integration and the added value that directors of public health and their teams can bring to integration programmes.

The resource document contains key messages from the case studies, a tool for self assessment which local commissioners, health and wellbeing boards (HWBs) and others involved in integration may find helpful, and a glossary which may be useful to those unfamiliar with some of the terms used in current integration programmes.

The Local Government Association (LGA) and the Association of Directors of Public Health (ADPH) are strongly committed to supporting the involvement of public health in integrating services to improve their quality and cost effectiveness, to provide a better experience for those who use them, and, ultimately, to improve the health and wellbeing of the population.

Our understanding of integration is a broad and inclusive one, including, but going beyond, programmes that are now under way, such as the Better Care Fund (BCF) and new models of care under the NHS Five Year Forward View.

<sup>1</sup> [http://www.local.gov.uk/documents/10180/7632544/L16-95+Public+health+roles+report\\_web+main+report.pdf/42e15392-f911-4d10-a699-bbeba12333b2](http://www.local.gov.uk/documents/10180/7632544/L16-95+Public+health+roles+report_web+main+report.pdf/42e15392-f911-4d10-a699-bbeba12333b2)

The six case studies listed below were commissioned following recent reviews by LGA and ADPH which found that, while in some areas public health has been fully involved in the BCF and wider integration agenda, in others there is significant potential for its role to be more fully utilised.

The cases studies are from areas in which public health is one of the local leaders of integration and where its contribution is highly valued by local partners. They include council areas spread across England, covering both rural and urban environments and with varying degrees of deprivation and affluence.

The case study areas were asked how they became involved in integration, and a number of common themes emerged:

- a history of being involved at a senior level in strategic partnership planning while at the Primary Care Trust (PCT) which transferred automatically to the council
- the public health team is strategically placed, through supporting the HWB, other partnership groups, or being a member of the Clinical Commissioning Group (CCG) board
- the director of public health (DPH) operates at a senior level within the council management team, and with politicians
- the public health team saw integration as a huge opportunity and was proactive in pursuing this and demonstrating its own contribution
- while the first theme can only evolve over time, actively adopting the others could be helpful in areas where there have been barriers to involvement.

Key lessons for involvement from case studies:

- It is important to have a clear story to tell about what the public health skill set is and how it can contribute to integration work.
- High profile public health staff with a dedicated role in integration will prove useful.
- Public health specialists should be prepared to find common ground, tune in to partners' agendas, and be open to public accountability and what matters to people, as well as what the evidence says will work. Mutual sharing of expertise and resources is the best way forward.
- A public health contribution is most likely to be welcomed if the team show they understand what the priorities are for their local integration programme and seek to add value with the public health offer, for example by using the Joint Strategic Needs Assessment (JSNA) as a mechanism to identify priorities, shift the focus towards prevention and monitor progress.
- Cabinet and HWB members need to be briefed on the public health offer.
- It is helpful to find some local issues to work on and articulate what the difference could be from applying public health tools.

By showing a variety of ways in which public health can enhance the integration agenda, we hope that these case studies will be helpful to those involved in integration at a local, regional and national level.



**Councillor Izzi Seccombe**

Chair, Community Wellbeing Board  
Local Government Association



**Andrew Furber**

President  
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# The case studies

## Doncaster Metropolitan Borough Council

- A history of collaborative working with the CCG.
- The BCF has enabled local partners to work towards more comprehensive integration.
- Building on approaches such as One Team Working with co-located social care and health teams, work has started on more fundamental reform.
- The aim is to deepen integrative approaches based around locality working and primary care.

## Hertfordshire County Council

- Relationship building with CCGs, providers, districts and clinicians and a structured approach (jointly agreed priorities, agreed leads, agreed workstreams, project management timescales and principles applied) working on jointly agreed priorities, which gave transparency to what was happening.
- Elected member, partner and public health leadership were all important components.
- Dividing the work into workstreams with different leads meant an ability to be flexible, with different tools, leadership approaches and problem-solving approaches for different issues, allowing the context to guide the approach.

## London Borough of Richmond upon Thames

- Council and CCG moving jointly towards an integrated outcomes-based adult social care and community health service.
- Aspiration now includes mental health and early thinking for children's services.
- Accountability to residents and service users and what matters most to them is the explicit driver for integration.
- The concept of place plays an important role for integrated services.
- Localities not always congruent across the health and care sectors, but being able to work with the 'messy reality' is an important part of integration.

## Somerset County Council

- Joined-up care accelerated through initiatives such as joint commissioning, an integrated data system, and the BCF programme.
- A model for ambitious, whole-system reform is being developed, with agreement in principle to work towards outcome-based commissioning with a capitated payment system and pooled budgets.
- A vanguard site for a primary and acute care system (PACS) providing joined-up care in three community hubs.

## Wakefield District Council

- The council and CCG Connecting Care Programme incorporates BCF and children's services, working closely with NHS providers and voluntary and community sectors.
- Integrated care hubs to bring care closer to people's homes through integrated teams based around GP practices.
- An integrated care pioneer and a vanguard site for person centred care in care homes and supported housing, and multi-speciality community provider.

## Worcestershire County Council

- Combined directorate of adult services and health with single DPH and Director of Adult Services.
- Public health contribution of needs analysis, definitions of outcomes and service specifications to a five year integration strategy.
- Key public health role in identifying high-risk population groups whose needs impact significantly on both social care and health services, thereby revealing a mutual interest for integrated prevention and improvement.
- Data analysis by public health has enabled integrated commissioning to specific services for the 19 to 64 age group.

# Doncaster Metropolitan Borough Council

## Overview of integration in Doncaster

- Doncaster Council and CCG have a history of collaborative working, and the BCF has enabled local partners to work towards more comprehensive integration.
- Building on approaches such as One Team Working with its co-located health and social care teams, work has started on more fundamental reform. The aim is to deepen integrative approaches based around locality working and primary care.

## How public health became involved

When based in the PCT, public health was central to both NHS strategic planning and joint planning with the council. This role was maintained when it transferred to the council, with public health taking the lead for several aspects of the BCF and wider integration.

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### What others say – **Councillor Pat Knight**, Cabinet Portfolio Holder for Public Health and Wellbeing

Public health has made a big contribution to integration in Doncaster. It provides a bridge between the NHS and the council which helps both partners work more effectively together.

Public health's experience of working both in the NHS and the council helps both to understand how the other operates, which is very useful in the work towards greater integration.

The BCF was a good piece of joint work which brought partners round the table to look in more depth at activity and costs, and the DPH was fully involved in this work.

Public health provides skills in research, evaluation and data analysis, and has helped the council develop a better understanding of population health both across the city and at ward level. This helps the council to better engage in the integration agenda.

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## Public health contribution to integration

### Strategic leadership

The DPH is an executive director of the council, and the council's director lead for the HWB, which oversees the BCF. The DPH is also the lead within the council for linking with NHS initiatives such as the primary care strategy.

The cabinet member for health and wellbeing is chair of the HWB and responsible for leading on integration, working closely with the portfolio holders for adult social care and children. The chief officer for the CCG is the vice chair.

The BCF has three strands: 'vibrant and strong communities,' 'choice of support' and 'healthy and safe.' The DPH is the council's lead on the 'healthy and safe' strand, and is responsible for providing research and evaluation across the BCF programme.

Public health also leads on specific integration areas such as falls and information and advice, and supports performance management, reporting to the HWB.

### **Brokering relationships**

Because of its links with the CCG and the council, public health can be seen as an 'honest broker' with an understanding of the issues and pressures facing both organisations. Public health has been involved in problem solving and finding solutions both at a senior, strategic level and in operational delivery. For example, it was involved in working with the CCG, local medical committee and adult social care to increase GP support for council intermediate care beds.

### **Evidence, outcomes and evaluation**

The public health team provides data analysis and an evidence base which supports the direction of change. Examples from the BCF and other integration work include:

- An information pack analysing Doncaster-specific factors in non-elective admissions covering age, diagnosis, geography, length of stay etc.
- Based on the above, a resource pack providing the evidence base for key interventions that have led to a reduction in emergency hospital admissions in the areas of falls, chronic obstructive pulmonary disease and asthma.

Public health has identified the need to get better at understanding 'big data,' moving beyond basic analysis to being able to make accurate forecasts. It is working to better join up health and social care data and to turn the JSNA into a future-facing resource. It has been involved in commissioning a system which for the first time will allow a view of integrated health and social care information through a series of online dashboards.

Public health was involved in a major study into the housing needs of older people to provide the analysis and evidence base for a strategic plan for housing and accommodation options.

The study covered the range of housing issues, including general stock, extra care, residential care, adaptations, and community support. It involved quantifiable data, a literature review and the views of local older people. Overall, the study found the need to develop specialist housing and intermediate accommodation options to avoid hospital admission or facilitate discharge, and concluded that housing, health and care could work more effectively together. These findings have been fed into the strategy.

Public health is involved in the evidence and evaluation aspects of a review of intermediate care, which aims to shape a new step up, step down model that better reflects the integration of health and social care.

As well as carrying out in-house research, the council has an academic partnership with Sheffield Hallam University and Sheffield University which have been involved in a number of projects to inform the integration agenda.

The council uses an outcomes-based accountability model which has been adopted by the HWB for the BCF. Public health has been involved in developing outcomes for a number of programmes and has also contributed to the Doncaster Outcome Tool, a framework for measuring quality of life and outcomes for people who use services. The tool has been tested with a group of people, three months after they received adult social care support, with interesting findings.

The evaluation found little change in overall quality of life scores, but there were variations on some components such as positive changes in self care, carrying out usual activities and anxiety/depression. On wellbeing there were positive changes on all outcomes, suggesting that service users' perceptions of their health and wellbeing improve after initial engagement with social care. More work will be done to develop the tool, including introducing benchmarking and comparative data to better understand impact.



Results from using the tool will also be fed into the blended value assessment model which is also being developed.

In the blended value model, programmes and activity are evaluated based on their potential for a blend of financial and social value. The academic partners have helped to pilot this approach in the area of assistive technology. The analysis considered the reduction in inpatient admissions, avoided A&E episodes, and delayed admission to residential care, and suggests that use of assistive technology leads to a £2.10 public sector cost benefit on every £1 invested. Public health will be involved in work to test the blended value approach more widely.

The academic partners are conducting a year-long study to understand people's experiences of going through the hospital discharge process and what can be done to make this more positive. Interim findings suggest that many people have very little understanding of what is available to help them post discharge, and what they are entitled to.

An integration programme prior to the BCF established a community funding prospectus for the voluntary and community sectors, focused on developing innovative solutions to support and maintain independence in adults. The programme has been evaluated in relation to factors such as co-production, innovation and cost effectiveness prior to a decision about its future beyond 2016.

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### What others say – Jackie Pederson, Deputy Chief Officer of Doncaster CCG

Public health has been integral to developing the BCF from day one. Responsibility for planning and shaping the BCF is shared across public health, adult social care and the CCG, with each taking the lead for areas which fall within their areas of expertise, interconnecting within an overall programme for integration.

For public health this includes the areas of prevention, such as developing community assets and self help.

As a team based in the council, but closely connected with the NHS, public health has a role in working across the system, making connections, but also providing challenge and a different perspective.

As integration develops, all partners, including public health, will need to work in different ways, such as increased joint commissioning and more detailed data analysis. New models are emerging, with the CCG taking on responsibility for co-commissioning primary care, looking to develop a complex case management approach, and reviewing intermediate care. These developments will need to be joined up, and complemented with social care and preventative approaches.

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## Developing preventative approaches

The public health team views integration as an opportunity to engage with partners to promote health and wellbeing through developing preventative approaches. The 'vibrant and safe communities' strand of the BCF has an emphasis on upstream developments.

Further work needs to be done with the next stage of BCF planning, including establishing a target operating model, in which preventative approaches are embedded. Public health will also look at the potential of pooling elements of the public health grant within the BCF.

As part of the Public Health England Well North programme to reduce health inequalities, the public health team is working with a local community using a '4D' developmental model – discover, dream, design, deliver.

The programme has two main themes:

- finding people who are not known to services, but who are at high risk of needing support as a focus for local integration
- working with communities to develop assets, using the method of 'appreciative inquiry' – a method of changing social systems, such as communities, with a view to developing economic and environmental regeneration using questions.

The CCG is developing a primary care strategy to reflect its full range of commissioning powers, delegated from NHS England. Prevention and self care will be an element of this strategy, and public health will contribute to an integrated approach to this area.

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# Hertfordshire County Council

## Overview of integration in Hertfordshire

- Hertfordshire based its work on topics jointly agreed as priorities rather than just what the public health team thought was important.
- Projects with too many barriers or dependencies were put back while higher priority and more deliverable projects were prioritised.
- Elected member, partner and public health leadership were all important components.
- Work is divided into workstreams with named leads to enable different timescales, a flexible approach with different tools, leadership approaches and problem-solving approaches. These are needed for different issues (eg a project altering clinical systems to enable social prescribing needs a very different approach from clinician training).

## How public health became involved

The JSNA for Hertfordshire sets out 32 indicators comparing outcomes in each district of Hertfordshire with the county and England averages.

The HWB agreed a pooled budget of £230 million for 2015/16 for integrated care services. Based on the needs identified in the JSNA, BCF for the area is allocated to a number of priority areas relating to older people and long-term conditions. This fund was developed largely for adults with some childrens' work. A specific BCF for children is now in development.

The public health team paved the way for its direct involvement in Hertfordshire's work on integration by taking on several pieces of work through which it articulated the public health role and demonstrated its benefits. A number of areas were identified in which joint commissioning could be undertaken with public health.

For adults, these projects included:

- a joint prevention strategy for older people
- applying behavioural science techniques such as motivational interviewing to social care
- a project to reduce section 136 place of safety calls for people with dual diagnosis
- a self-management strategy group which among other products developed self-management tools for people with long term conditions
- a multi-agency and multiple funder project to get more people with existing health and social care needs benefitting from physical activity
- applying health protection insights in social care including uptake of seasonal flu vaccination and working with care homes and commissioners to develop a new approach to infection control
- a review of what pharmacy could do for system resilience
- the DPH leads as sponsor on a multi-agency project for adults with very complex needs who use a great deal of criminal justice, district, county and NHS service time.

For children:

- a system-wide review, led by the DPH, of child and adolescent mental health services (CAMHS) resilience promotion which has led to a whole system transformation approach for CAMHS
- a review of drug and alcohol services for children and young people
- integration of health visitors with children's centre services to provide a more holistic service model
- supporting the development of an integrated commissioning strategy for children which is now moving to a second iteration and the development of a BCF for children
- funding psychologists to work in the Thriving Families programme
- putting specialist health visitors into the MASH
- a joint early years board which is progressing integration of children's centres and health visitors.

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## What others say – Councillor Colette Wyatt-Lowe, Chair of Health and Wellbeing Board and Cabinet Member for Adult Social Care and Health

In embedding public health into the council, we wanted to see a resurgence of the golden age of public health, one of the original drivers of local government, with a particular emphasis on prevention. Nothing in Hertfordshire happens without some public health involvement. This means that public health needs to be involved in all our integration work. We could not have carried out our major review of CAMHS without the number-crunching and statistical context-setting and trends identified by public health. Similar skills have also been helpful in developing the BCF – the evidence provided by public health has helped persuade people of the rationale for bringing services much closer together. The skills of the public health

team and DPH have also enabled us to take a wider perspective on health determinants, for example in thinking about where we want to go with the next tranche of the BCF and how we will incorporate a wellbeing aspect into our commissioning.

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## Public health contribution to integration

### Strategic leadership

The DPH leads the public health directorate, reporting directly to the chief executive. Public health coordinates and supports public health activities across Hertfordshire through the public health board which has representation from over 30 agencies and feeds into the HWB. Public health staff produce high level CCG locality reports to support health and social care integration: these profiles are aimed at NHS, county and district councils to help identify key issues for joint working.

### Brokering relationships:

- The public health and social care teams are located together and this has proved helpful in developing working relationships at all levels.
- Public health staff have been training NHS and council commissioners on a public health approach to commissioning and discussions on a shared understanding of the commissioning cycle are already leading to implementation of this in a phased approach.
- Public health recently brought together every commissioner in the county including districts and police and crime commissioners to identify areas of shared work and areas of duplication.
- A public health consultant is embedded within each CCG to share access to their specialist skills and knowledge.
- A public health consultant is also embedded in adult social care and children's services.

- The DPH or his deputy is a standing member of the clinical executive in one CCG and the partnership board for the other CCG.
- Joint executive meetings between CCGs, childrens, adult social care and public health now happen regularly.

## Evidence, outcomes and evaluation

The JSNA makes it clear that Hertfordshire faces a number of inter-connected public health challenges where the county is not performing as well as it could. These challenges require the development of integrated services across agencies. The public health team has provided evidence, intelligence and foresight to assist in this development.

### Year of Mental Health

The Hertfordshire HWB has declared the period between its annual conferences, July 2015 and July 2016, the Hertfordshire Year of Mental Health. The DPH is the lead officer and has provided project management support.

The DPH led on a system-wide review of CAMHS. The review culminated in a number of actions which are now being implemented by a CAMHS transformation board of which the DPH is a member.

A similar review, led by the DPH has just been completed on children's drug and alcohol services.

Both programmes feed into the multi-agency integrated commissioning executive for children and young people.

### HomeFirst care at home

HomeFirst is an integrated community support programme developed jointly by Hertfordshire County Council, CCGs and Hertfordshire Community NHS Trust. The programme provides effective care for people at risk of hospital admission or social care placement.

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## What others say – Iain MacBeath, Director of Health and Community Services

The public health team has brought an evidence-based approach. Historically, social care has been less strong in this area than the NHS. With the evidence provided by public health, we've been able to be bolder in developing new integrated services such as HomeFirst, using a risk stratification approach and designing our evaluation criteria up front to iterate our roll-out with GP colleagues – and being more decisive about de-commissioning services.

For example, testing a number of new post-acute social care pathways to get people home and independent and then using public health expertise and evaluation to select the most successful model.

Overall, Hertfordshire is a relatively wealthy county but there are pockets of deprivation and the public health team have helped to identify these 'hotspots' and their specific health problems so that our work on integrating services can be targeted to areas and groups in greatest need.

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### Integrating health visiting and children's centres

A major integration project is taking place on services for children aged under five. This is bringing together a number of services including the Healthy Child Programme, health visitor services and Sure Start children's centres. A joint early years board oversees this, co-chaired by the DPH and director of children's services.

Proposals for a BCF approach for children are now being developed following a number of projects on improving outcomes for children.

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## What others say – Jenny Coles, Director of Children’s Services

At a strategic level, public health is acting as the glue that holds together evidence and practice. Together, we have brought children’s services in a big way into the HWB’s agenda. The transfer of responsibility for nought to five-year-old public health and the opportunity to bring school nurses and health visitors together with children’s centres fits in well with the board’s priority of early childhood. They have helped us on the ground as well as at a strategic level, for example in developing a number of pilot projects around the two-year-old developmental check. The public health team has also played a big part in developing our improvement agenda – they are still involved in the improvement board following the mental health review, led by our DPH.

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### Family safeguarding

In January 2015, Hertfordshire County Council was awarded a grant of £4.86 million by the Department for Education (DfE) to develop new ways of delivering child protection services. The aim was to develop integrated child protection teams with professionals working together to address the parental behaviours that place children at risk of significant harm or impairment of their health and development. The bid was made in conjunction with public health, adult services, Hertfordshire constabulary, CCGs and probation services. Around 85 per cent of child protection cases involve the ‘toxic trio’ of substance misuse, domestic abuse and mental health in some combination. Public health made immediate changes to its commissioning of substance misuse services to shift some of its service delivery to child protection teams, with the grant being deployed to add additional substance misuse capacity to the teams. Having substance misuse workers in the child protection teams has made a significant difference to the assessment of treatment needs, improved identification of risks to children and resulted in more consistent engagement of parents in treatment programmes. It has led to far better information sharing, more positive

working relationships with families and shared decision making that has improved confidence and morale of staff working in this stressful area. The project is being evaluated by Bedfordshire University, overseen by the Rees Centre Oxford University, on behalf of the DfE.

### Beezee Bodies

Beezee Bodies is a 17 week programme, started as a whole family approach to healthier lifestyle and weight, so it needed to join up families and services. The programme works across services, taking referrals from health and social care. Public health has commissioned the service to deliver the programme in Hertfordshire from September 2014 to July 2016. It was specifically conceived as a life adjustment programme for the whole family, rather than just a weight reduction programme. Over the course of the contract Beezee Bodies will deliver four programmes. Each programme will run between eight to 12 different groups in a variety of locations across the county. Specific areas of deprivation and high obesity prevalence are identified.

The service was commissioned to accept referrals from a range of professionals. Referrals have been received through children’s social services where weight has been an issue and families are on a child protection plan. Beezee Bodies have supported these families to continue to attend the programme and have worked closely with social services to provide a holistic care package.

## Developing preventative approaches

The DPH asks stakeholders what they feel should be the focus of the public health annual report and since 2013 it has always been on a topic where integration can bring benefits. In 2014 it was on early deaths. In 2015 it was on district council roles in public health.

As a result, a number of workstreams were set up, each working with a number of health and council partners towards more integrated services:

- Housing – co-chaired by the DPH and director of adult social care, extensive analysis of housing needs of vulnerable people has been undertaken. Public health also funded the use for every district of the Building Research Establishment housing costs calculator to help districts include health issues in their strategic planning.
- Physical activity – involving public health, leisure services and the CCGs. A multi-agency working group has been tackling key local issues to ensure physical activity promotion is more systematically embedded within the NHS. Progress includes securing £500,000 from Sport England, £300,000 from CCGs and £200,000 from public health for brief interventions in general practices; embedding physical activity into GP care algorithms for long term conditions, training primary care staff and improving the quality of exercise on referral schemes.
- Falls – with social care, the voluntary sector and the local CCG. A falls liaison service was set up by the public health team and is now funded by the CCG. Hospital admissions have been reduced by seven per cent with a net saving of £800,000.

### **Dehydration prevention**

The public health team recently took over some aspects of commissioning, for example a hydration project, part of a preventative strategy for older people. This was jointly commissioned by public health and adult social care and delivered by the major voluntary sector meals provider, Hertfordshire Independent Living Service. Work on commissioning self-management approaches continues.

### **Making Every Contact Count (MECC) with older people**

A collaborative cross-agency project, led by public health, has developed a pilot information package and video to encourage brief conversations with older adults about some key issues. The package is aimed at staff across the public sector and volunteers across Hertfordshire who have contact with older adults in their own homes. The areas covered in the package are:

- preventing falls
- making sure homes are safe
- making sure homes are warm
- preventing loneliness
- ensuring good nutrition
- preventing dehydration
- encouraging physical activity.

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### **What others say – Councillor Teresa Heritage, Portfolio Holder Public Health, Localism and Libraries**

Within the last month, the county council, in implementing one of the scrutiny recommendations, has started a council-wide prevention workstream, led by the public health directorate, the finance department and the fire service. This for us is an important way of recognising most departments have a preventive ethos already and we are contributing to and supporting that, not claiming pre-eminence.

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# London Borough of Richmond upon Thames

## Overview of integration in Richmond upon Thames

- The council and the CCG are moving jointly towards an integrated outcomes-based adult community health and social care service. This aspiration now also includes mental health services and early thinking has started for children's services.
- The accountability to residents and service users is the explicit driver for partners and integration is a means to achieving the outcomes that Richmond people say matter to them most.
- The concept of place plays an important role for integrated services, a significant number of which are based around community localities. These localities are not always congruent across the health and care sectors, but being able to work with the 'messy reality' is an important part of integration.

## How public health became involved

Public health has been treated as a senior partner in the council and the skills that public health specialists bring to the integration agenda are highly valued. The public health team is part of adult community services: DPH reports to the director of adult services but also has a seat at the council's executive table.

It was timely that when public health became a function of the local authority, Richmond upon Thames Council had made a decision to become a more systematic commissioning organisation.

This meant that the intelligence skills of the public health team were immediately useful, assisting in turning a procurement-driven system into one driven more by outcomes; for example a re-tendering exercise for an integrated drugs and alcohol service acted as a learning exercise in moving away from a medical treatment model to a recovery model. This model involves not only the NHS and social services, but is also linked to education and employment and the relevant agencies, with which the council already had links.

## Public health contribution to integration

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### What others say – Councillor David Marlow, Cabinet Lead for Health and Social Care

Richmond residents tell us they want 'joined-up' health and social care services; that is why the council is clear on its priority for health and social care integration. Our public health team has played an important role in supporting our HWB in the development of our borough strategy for health and wellbeing, and in championing integration. Work of our public health team has included: working with older people to better understand and tackle loneliness and isolation; work with carers to inform our needs assessment and increase support for carers across the whole health and care system; and setting up a vibrant Dementia Action Alliance (DAA) which brings together a wide variety of local organisations working together to make Richmond a dementia friendly borough.

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## Strategic leadership

Public health, adult services and Richmond CCG are co-located in the council offices on the same floor. The DPH and her staff are seen as honest brokers between local government and the NHS. Along with the chief officer of the CCG, the director of adult services and the director of children's services, the DPH is a member of the strategic partnership group where potential areas for integrating services are first broached. The local NHS and the council have established a number of other important joint groups that bring together senior officers from each to ensure that integration becomes 'hard wired' into how business is done. The DPH and her team act as a conduit within and between all these groups.

One of the first actions of the public health team was to demonstrate how data and statistics could be turned into intelligence about the whole population of Richmond. The first JSNA and Joint Health and Wellbeing Strategy (JHWS) identified a number of 'cracks' in the system that mattered most to local people, specifically between:

- health and social care – multiple points of access and care assessments, lack of care coordination sometimes leading to increased costs, confusion about social care and NHS funding arrangements and eligibility
- services for mental and physical health – co-morbidity
- children's to adult services transition
- the transition between hospital and home – the need for greater collaboration between the local NHS and the council on managing care for people with long-term conditions in a community setting.

Each of these priorities requires more integrated services. Key outcomes which the partners, including public health, have developed are:

- an integrated health and social care commissioning strategy

- a joint collaborative commissioning team for health and social care
- reconfiguration of services into a local outcomes-based model of care that includes primary care, community care, some social care and links to hospital services.

The JHWS is now being refreshed. Joined up services continue to be one of the major planks, but in addition there is a wider remit that also explicitly adds in prevention. Both are adopted across the life course around the three themes of 'starting well,' 'living well' and 'ageing well,' with integration the golden thread.

Representatives of public health were also key partners round the table in planning and developing Richmond's use of the BCF. In particular, public health provided intelligence about the population and its health and care needs, current performance, metrics and performance management tools and identified high-impact interventions for which the BCF could be used. Public health specialists continue to lead on the metrics and monitoring aspects of the BCF. A review of the BCF has been scheduled and the public health team will be involved in considering how children's services can be included and how the BCF can take account of the wider prevention agenda while freeing up partners from some of the complex administrative demands that attended its first year.

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### What others say – Cathy Kerr, Director of Adult Services

Public health colleagues helped us define the problem and focus on clear definitions and evidence. For example, they helped us look very closely at precisely which hospital admissions are avoidable, why and what can be done to avoid them.

We will also be involving them in Richmond Response and Recovery, our programme for effective discharge from hospital. They will look at the numbers of people who need support on discharge, what is the evidence of effective interventions and what outcomes we should aim for.

They will take a granular look at ‘softer’ outcomes, such as patients’ and service users’ perceptions and how we can capture these and use them to measure our performance.

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## Evidence, outcomes and evaluation

The strategic partners involved in developing integrated services in Richmond are all committed to the idea of integration as ‘a marker of people’s experience’ of services and the extent to which they are perceived as seamless and centred on the way they want to live their lives. The public health team has contributed valuable expertise to developing an outcomes-based approach to integration which focuses closely on community services.

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### What others say – Kathryn Magson, Chief Officer, Richmond CCG

Our DPH provides an overall perspective on outcomes-based commissioning. She has been heavily involved in the design of all our outcomes, in relation to both physical and mental health. She has helped us to focus not just on shifting care into the community, but also on including the prevention agenda – bringing prevention closer to home. Public health colleagues bring more than just content, (ie their specialist knowledge) they also bring discipline and rigour to the planning and commissioning process.

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The outcomes-based approach began with a really intensive piece of community engagement to find out what the outcomes are that people want. This has brought all the partners together and helped develop clear objectives for a new integrated (seven to 10 year) contract for adult out of hospital health and social care services to be let in April 2016. Further work is under way to develop an outcomes framework for mental health community services and it is intended that this will also be in place by April 2017.

The community engagement exercise made it clear that a place-based approach should be taken to services. The council has developed ‘village planning’ as a tool to work with self-defined communities with a common identity. More recently, the public health team has used this tool with the health and wellbeing board. Public health staff sit on the village planning board and steering group and are able to bring their intelligence function to good use in helping identify where services need to be brought more closely together.

For example, the DPH chairs the DAA, which consists of a wide variety of local organisations working together to make Richmond a dementia friendly borough. Recently the DAA has embraced the concept of dementia-friendly villages, identifying important local community assets, including not only dementia specific care services but local pharmacies, shops, schools, faith groups, heritage sites etc that define a locality and engaging them in the dementia friendly work.

The public health team recognises that the reality of a place-based approach is not as neat as the village concept might suggest. For example, in addition to the village model, there has been a long history of four locality based health and social care teams, the voluntary sector-run independent living service is organised around four community locations and the Richmond GP alliance has recently established four locality based multidisciplinary primary care hubs, using the money they have won from the Prime Minister’s Challenge Fund to offer extended access. These geographical units are not all completely congruent. The public health team, colleagues and partners in the NHS acknowledge that it is important to work with this ‘messy reality’ rather than pursue an ideal of co-terminosity that is unreachable, and jeopardises success. Being honest and recognising this reality is seen as part of Richmond’s success in its integration work.

The cross-council prevention strategy developed jointly with the CCG in response to the Care Act 2014, was led by public health.

It provided an opportunity to define prevention around the idea of place and connected, resilient communities and to embed the concept of prevention in a wide range of council and NHS activities. For example, the MECC programme was used in relation to topics across the life course that are specific to Richmond, such as loneliness and isolation among older people; winter warmth; active travel and accessing new technologies. A 45 minute web-based training programme has been developed for staff to help them to understand why certain issues are specific to Richmond. This programme, along with other web-based training is also available to staff in other agencies including voluntary sector staff. Further initiatives include the development of dementia friendly parks, ensuring the accessibility of parks and open spaces and training frontline staff, such as the safer cycling team (who train people in schools, workplaces and other settings on safe cycling) to champion and support the wider community inclusivity. Integrated transport is an important component of our approach, making explicit links between strategies and programmes such as the cycling, air quality and healthy workplaces programme (community intervention) as well as road infrastructure and cycle routes (place-level intervention).

Public health skills have also been helpful in commissioning a community independent living service from the voluntary sector. The public health team has assisted in identifying people at risk of loneliness and of hospital admission, understanding the burden of morbidity and level of need in each of the four Richmond health hubs and helped in developing a service specification and performance management framework.

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### What others say – **Cathy Kerr**, Director of Adult Services

Public health has been predominantly involved in providing us with intelligence, helping us to shape strategies and take an outcomes-based approach to commissioning.

They have also done some very helpful work around risk stratification, working very successfully with CCG and GP colleagues, identifying high risk population groups and what interventions are most likely to be effective in meeting their needs. They bring rigour, discipline and the sort of evidence that takes clinicians along with us. They can talk clinicians' language and act as a bridge to them.

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Integration is often just thought about in the context of adult health and social care. However, in Richmond the refreshed HWB strategy theme 'starting well' explicitly looks at prevention and joined-up services at the beginning of life, focusing on joint working in areas of high impact. For example, health visiting (commissioned by public health) and children's centres are working to achieve the internationally recognised standards (developed by UNICEF) that mean services are 'baby friendly'. For women suffering from mental health problems during and after pregnancy, a joined-up pathway is being developed which will involve local authority health visitors as well as specialist NHS mental health services.

A new transformation plan is the start of a five year emotional wellbeing and mental health programme for children and young people. This plan is focused on improving outcomes through a whole-system approach, involving families, communities, schools and services. It centres on promoting resilience and early help, particularly through schools and community settings, and improving access to specialist mental health support. The school nursing service (commissioned by public health) will develop its role in promoting emotional wellbeing and mental health. Outreach school and community-based clinics will be piloted by the emotional health service to provide timely access to psychological therapies.

Achieving for Children, the social enterprise company providing children's services for the London Boroughs of Richmond and the Royal Borough of Kingston upon Thames, is taking forward Phase 2 of its Strengthening Families programme – a five year programme begun in 2015/16.

This involves a multi-agency approach to ensure families are identified as early as possible and that there is a comprehensive response to their needs. A form of risk stratification developed by the public health team will support the process.

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## What others say – Robert Henderson, Deputy Chief Executive, Achieving for Children

Our public health team has a very coherent and clear understanding of prevention, integration and of how commissioning can be used to move them forward. The team has a strong understanding of our locality model of working with teams, built around the school and the community. In drawing up the specification for our school nursing service, public health has captured exactly what we want to achieve and is doing the same for health visiting.

They have done significant work around services to mitigate risky behaviour of children and young people, making it very clear that separate services will not be helpful. They have also gathered some good analysis and produced evidence on suicide and self harm which means that we have put more resources into supporting emotional health.

We are very excited about having a fully-integrated health and social care service for children aged nought to five and their parents. In designing this service, our public health colleagues have embraced what matters to us and given us a clear steer on what is likely to help us meet our objective of delivering for children.

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In general, the public health team is seen as a facilitator that can bring partners together around need, outcomes and evaluation. The team recognises the importance of understanding partners' agendas to find common ground and of being open to what matters to residents. In return, partners trust and use public health expertise to play an important role in the joint endeavour of integration.

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# Somerset County Council

## Overview of integration in Somerset

- Somerset County Council and Somerset CCG have been developing joined-up care for several years, and this has accelerated through initiatives such as joint commissioning, an integrated data system, and the BCF programme.
- A model for ambitious, whole-system reform is now being developed, with agreement in principle to work towards outcome-based commissioning with a capitated payment system and pooled budgets.
- Somerset is a PACS vanguard site providing joined-up care in three community hubs.

## How public health became involved

When the public health team moved to the council, it developed an operating model for how it could best promote health and wellbeing. One strand of the model was focused on influencing across organisational boundaries and providing specialist public health support to the whole health and wellbeing system, as well as to the CCG through the public health core offer. This approach means that public health has been involved at an executive level in planning and shaping the plans for integration.

## Public health contribution to integration

### **Strategic leadership and vision**

Public health strongly supports Somerset's vision for joined-up care as the best way of promoting health and wellbeing, and tackling health inequalities. The current organisation of health and social care has many disadvantages. Fundamentally the system is too disjointed, largely with a focus on treating ill health and fostering dependence. Not only is this detrimental to promoting health and wellbeing, it is costly and unsustainable.

The proposed new model aims to 'flip the system' by introducing levers and drivers to shift from being demand driven to prevention led, and from provider-focused to person-centred.

Rather than paying NHS providers for the activity they do, the new model will pay providers for achieving health outcomes which are geared to promoting good health and independence and which are valued by service users.

The supporting mechanism will be a payment system based on delivering care for individuals (year of care) which is aligned with financial incentives that encourage providers to prevent or reduce the need for clinical intervention. For example, providers could help people with long-term conditions learn to manage their illness, or provide health and wellbeing support to keep people active in their communities.

Providers will be encouraged to come together as a coordinating body which will hold the contracts with commissioners. They will be able to be innovative and flexible, redesigning services and switching resources to best meet contract outcomes.

Somerset has consulted on the proposals, and is developing a business case with a view to establishing an outcomes-based approach in April 2017. Public health has influenced the details of the business case. It supports the view that to make the biggest impact on public health, the new model should eventually include the widest range of services and people, for both adults and children. This would avoid the need to double run different systems, which would be costly and could also lead to health inequalities.

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### What others say – Dr Matthew Dolman, Chair Somerset CCG

The public health team has been fundamental in driving forward a bold and ambitious approach to population health. Their expertise has been critical in supporting the development of joined-up care at general practice, community and system-wide levels.

Somerset is working to ensure that services are joined up around the needs of individuals, and the public health team has made an important contribution to the model we are developing. In particular, public health provides a focus on population health, tackling health inequalities and developing preventative support.

Public health intelligence makes a link between people and places, which is central to our model. One of the strengths of public health in Somerset is that it presents information, such as community profiles, in a way that it is clear, understandable and meaningful. This helps us to see where the challenges lie, and to identify ways of tackling these.

It also allows us to look to the future, and how our priorities may need to change. Information is provided at the levels of GP practices

and wider communities, and in system-wide approaches, developing the outcomes and metrics for integration.

As the model is rolled out, providers will need to develop their understanding of population health and promoting health and wellbeing so they can continue ‘flipping the system’ – the shift towards prevention. Public health will continue to have a crucial role in supporting this.

Overall, public health’s move to local authorities has been helpful; it provides a useful bridge between the council and the NHS, bringing together the potential of both to improve health and reduce health inequalities. As organisations work ever more closely together, a new type of leadership will be needed to combine understanding of systems and communities, and public health is well placed to provide this leadership.

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### Evidence, outcomes and evaluation

The demographic and geographical issues facing Somerset are a key driver for pursuing integration. It faces challenges in sustaining services across such a large geographical area as well as additional challenges in the health and care workforce. In 2014, public health refreshed the JSNA to provide detail about the current situation to establish a clear analysis of the case for change.

Another significant step forward for integration has been learning from the integrated data system in South Somerset, which has now developed into the vanguard PACS programme. This programme involved a partnership between several organisations, focusing on providing a very different model of care for an initial group of approximately 1,500 residents with long-term conditions. The project developed an innovative integrated dataset providing invaluable information about health and social care usage for people with long-term conditions.

The DPH chairs the workstream responsible for delivering the commissioning outcomes framework for the new model of care. It is envisaged that contracts in the future would be over a longer period of time, thereby enabling much more potential for achievement against public health outcomes, which tend to have a longer gestation. Outcomes are currently being devised within three domains:

- population health and wellbeing eg healthy life expectancy
- quality and value eg safeguarding, patient safety
- transformational metrics – outcomes used to support the system as it goes through the transition stage.

Outcomes and metrics are being informed by National Voices 'I' statements, local consultation, the local JSNA and the annual public health report, as well as the work of the vanguard and other integration programmes.

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### What others say – **Steven Foster, Director of System Transformation Programmes, Somerset Council and Somerset CCG**

The DPH is a key member of the leadership group involved in developing the Somerset Together programme, contributing a focus on population health and health inequalities which has been very influential in shaping the programme.

Rather than focusing on specific public health activity, such as drugs and alcohol, a strategic approach has been taken, providing the evidence base and intelligence for preventative approaches such as self care, and helping to put wellbeing at the heart of the system.

The DPH is responsible for supporting the work of the HWB. As a two tier authority, the five district councils in Somerset are represented on the county HWB as well as some operating their own local boards.

This has ensured that district councils, which make an important contribution to public health, are included in strategic planning. Districts are involved in several initiatives that support integration, including collecting information about housing adaptations in a study to see the extent to which they prevent or delay emergency hospital admissions.

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## Developing preventative approaches

The topic of prevention has an increasingly high profile across partners in Somerset. As part of the development of new models of care, and to help increase preventative activity in the health and social care system, public health was asked to identify a suite of evidence-based preventative activities that could be taken forward by partners in the next year or two.

These include delivering brief lifestyle interventions and MECC, increasing staff take-up of flu vaccination and working towards healthy workplace awards. Organisations in the system have each nominated a representative to join a working group to progress this work, and have undertaken a self assessment against the top tips, with action plans expected in the new year.

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# Wakefield Metropolitan District Council

## Overview of integration in Wakefield

- Wakefield Connecting Care programme, which incorporates the BCF, is a partnership between the CCG and the council, working closely with NHS providers and the voluntary and community sectors.
- A key element of the programme is establishing integrated care hubs – care closer to people’s homes through integrated teams based around GP practices.
- The Connecting Care programme also covers children’s services.
- Wakefield is an integrated care pioneer and a vanguard site with involvement in three programmes: person centred care in care homes and supported housing, establishing a multi-speciality community provider, and part of the West Yorkshire urgent care vanguard.

## How public health became involved

Public health was involved in system-wide strategic development while in the PCT, and maintained this role when it transferred to the council, particularly through involvement in the health and wellbeing board. The public health team saw integration as an important opportunity for promoting health and wellbeing. It established a locum consultant post to support integration, initially on a short term basis. That role has now been absorbed into a permanent consultant post within the public health team.

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## What others say – Dr Phil Earnshaw, Chair of Wakefield CCG

Public health has had a great deal of involvement in integration. The starting point for this is that the DPH, as well as the director of adult services, is strategically placed as a member of the CCG board, which means that they are fully involved from the start of major service developments.

It has been very helpful to have the input of public health on matters such as population health and other specialist advice which provides a different perspective to the board. Public health is also a fully signed up and active partner, responsible for leading several important integration workstreams, including evaluation, prevention, and engaging with the voluntary and community sectors.

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## Public health contribution to integration

### Strategic leadership

The DPH is a member of the Connecting Care Executive Board – the commissioner group responsible for overseeing the Connecting Care programme. Public health leads the workstream on research and evaluation, and the work on developing a prevention strategy. An important role has been to bring local, and sometimes national, partners together to discuss and plan for integration.



## Evidence, outcomes and evaluation

### Establishing the evidence base

Public health has a central role in providing the evidence base for integration. In 2013, a mid-Yorkshire, CCG-led integration programme 'Meeting the Challenge' produced an independently commissioned business case which estimated the number of admissions that could be reduced by increasing community capacity. Public health examined this research, then conducted a systematic review of the evidence for integration. The report, 'What does the evidence say on how to reduce non-elective admissions, readmissions and length of stay?' concluded that it is hard to reduce non-elective admissions, but that reducing length of stays is easier. Subsequent public health analysis indicated that a more realistic way to reduce emergency bed days would be to maximise resources for supported discharge and maintain realistic targets around admission reduction.

The public health team has also carried out a number of other evidence reviews, including a telehealth and telecare evidence review, summarising available research and identifying the need to conduct a systematic assessment to ensure the factors that result in successful services are in place.

### Developing outcomes

Public health led on developing the outcome-based assurance framework which is used to monitor progress on integration. As well as considering hard data on hospital admissions and lengths of stay, metrics based on the views of service users are included. This is to ensure that putting people who use services at the heart of service improvement 'goes beyond the rhetoric and becomes reality.'

### Evaluating programmes

The model of integration was initially rolled out as a 'proof of concept' in one locality in 2014. Following the success of this, two further hubs were established in 2015.

Public health promoted the view that a far reaching programme of integration should clearly demonstrate the outcomes that it is designed to deliver, and Wakefield CCG agreed to fund a comprehensive independent evaluation of the integration programme. Public health designed and commissioned the evaluation, which covers quantitative data metrics such as reductions in hospital admissions and the experience of both staff and service users. The evaluation has adopted an iterative process, with six-monthly formative reports presented to commissioners and providers so that findings can shape service delivery on an ongoing basis.

The survey of service users is designed to capture people's experience of the integrated health and social care teams, and is based on National Voices 'I' statements. A representative sample of 1,000 people is being surveyed over a two year period. Wakefield Healthwatch was commissioned to recruit and train volunteers, mostly older people, to carry out confidential peer to peer interviews in people's homes. This approach overcomes barriers to engagement, allowing people who are housebound, or have dementia or communication problems, to be involved.

Since the evaluation started in summer 2015, around 500 people have been interviewed. Take-up has been excellent, and people reported that they valued being involved. Initial findings that are shaping service delivery include:

- work to improve service users' understanding of who coordinates their care, as only 10 per cent of respondents knew who their care coordinator was
- positive findings on the quality of care provided by the integrated care teams
- social isolation was identified as a problem – this is being fed into work around community anchors (see below).

The views of staff involved in delivering integration are collected every six months through surveys and face to face events. Issues raised so far include the following:

- overall, staff are very positive about integrated working
- staff identified a gap, in that the evaluation did not include carers – further funding was found to interview 50 carers
- staff were concerned at the lack of step-up support to prevent people needing hospital admission. The reablement service has now been transformed to include this.

Other responses to concerns include increasing administrative support to teams and establishing better joint working with mental health services.

Public health also carried out the initial evaluation of the ‘integrated personal care in care homes pilot’ which found several important benefits, including reductions in A&E attendances and admissions, and cost savings. The pilot has now been extended into the vanguard programme, and public health is supporting this by:

- developing an assurance framework for care homes
- leading an ambitious evaluation programme to measure outcomes for care home residents.

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### What others say – **Andrew Balchin**, Wakefield Council’s Corporate Director for Adults’ Health and Communities

Involvement in integration has raised the profile of public health in a very positive way. The team has taken the time to be actively engaged, to build relationships and offer solutions, and this is appreciated by their partners.

They have undoubtedly made a very helpful contribution to integration in Wakefield, particularly in four areas.

### **Prevention**

All partners are keen to develop a preventative approach, but public health led this process, bringing people together, facilitating discussion and providing clear, critical thinking to identify the best way forward. This has led to a prevention strategy being developed, and has also helped to bring the voluntary and community sectors to the heart of integration.

### **Evaluation**

Public health has successfully championed the value of assessing the evidence base for new interventions, and making sure that the impact of major change is evaluated. The real-time evaluation of integrated care teams is already paying dividends in shaping how the teams operate, to the benefit of people using the service.

### **Business intelligence**

Public health has provided skills in data analysis and, most importantly, making this meaningful to others. This has been very helpful in analysing complex issues such as non-elective admissions.

### **Investment**

Public health pooled part of the public health grant with the BCF, showing its commitment to joint commissioning.

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## Developing preventative approaches

Public health has promoted preventative approaches throughout the Connecting Care programme. Prevention is now seen as having gained in importance – whereas once it seemed to be mentioned as an afterthought, now it is discussed regularly as a matter of course. The public health team led on work to establish a prevention strategy, and set up an event to explore what needed to be done. The event had excellent representation from all sectors, and identified principles, enablers and priority areas.

Enablers to prevention included increasing voluntary and community capacity to create resilient communities, developing self care and individual responsibility for health, and embedding shared health records. Older people were the first target group for prevention, and four priority areas were identified – mapping services, addressing avoidable sight loss, working with the fire and rescue service on safety and wellbeing, and digital inclusion.

Public health has established a time limited task and finish group to work on these issues. For example, currently a survey is taking place in lunch clubs and related venues about older people's access to the internet.

In addition, a major piece of work to develop community assets is taking place. 'Community anchors' are independent multi-purpose community organisations based in geographically defined neighbourhoods. Historically, Wakefield has had fewer such organisations than many comparable areas, so public health worked with the voluntary and community sectors, council community development workers and the national charity, Locality, to develop a community anchor approach.

Public health has allocated £250,000 over three years to support this development. In time it is envisaged that community anchors will form part of a comprehensive network of support, linked with the integrated community hubs and public health's lifestyles service, which is to be commissioned in early 2016.

## Children's services integration

### Connecting Care for children and young people

Connecting Care is a whole-system integration programme, which covers children and young people as well as adults. Established in April 2015, seven early help hubs provide a focus for locality based support for children and families.

The peripatetic integrated workforce use a designated building in the heart of the community, children's centres, schools and other community buildings alongside outreach support to reach the most vulnerable.

Public health has been involved in supporting integration through data analysis and evaluation, and providing a link between the council and the NHS. Two recent pieces of work are:

- The public health team helped facilitate planning for the Future in Mind programme, including developing an emotional health and wellbeing element in the school survey. The Future in Mind Transformation Plan was identified nationally as good practice.
- The commissioning of nought to five services has been established in the children and young people directorate in order to better integrate with other children's services. A universal service is being maintained, and public health is supporting the process through analysis of population and staff skill needs, and ensuring that GPs and other healthcare professionals are informed and involved.

The ultimate aim is to work towards seamless, integrated services for children and young people which help communities to achieve the best possible outcomes, facilitated by coordinated services provided as close to home as possible.

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# Worcestershire County Council

## Overview of integration in Worcestershire

- A combined directorate of adult services and health puts the director (who is also the DPH) in a strong position to ensure a public health input to integration.
- The public health team has contributed with population needs analysis, definitions of outcomes and service specifications to a five year integration strategy bringing together a wide range of adult health and care services.
- An important public health role is to identify high-risk population groups whose needs impact significantly on both health and social care services, thereby revealing a mutual interest for both NHS and county council to develop integrated improvement and prevention services.
- Data analysis by public health has enabled integrated commissioning for ages nought to 19 to specify how services are to be delivered as well as defining outcomes.

## How public health became involved

The joint director of adult social care and health (DASH) role has provided a way in to close involvement with the full range of council services. Among other duties, the post is directly responsible for managing the integrated commissioning unit which puts the post holder in an excellent position to bring a public health approach to integration, including the BCF proposals for the county.

## Public health contribution to integration

### Strategic leadership

The DASH is a member of the council's strategic leadership team. The public health team acts as a bridge with the local NHS, brokering mutual understanding between the council, the CCG and providers of NHS services. Public health staff believe that 'the relationships are more important than the structures' in building trust and joint working practices between the council and the NHS.

The Well Connected initiative is the integrated care initiative led by the HWB in Worcestershire. It aims to achieve a progressive integrated health and care system ranging from acute services to prevention and early intervention programmes across the county and across the lifecourse. The DASH is a member of the leadership group which has developed the five year strategy for implementing Well Connected and the various work strands that sit under it.

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### What others say – Frances Martin, Integrated Care Director

The combined role of DASH and DPH is a very powerful one. The public health aspect of the role gives us a long-term look at the population's needs, the ability to access longitudinal studies, a scientific, evidence-based approach and academic rigour. Richard Harling (DASH) has given strategic leadership to our work on integration, including the BCF which we have used as an enabler, not as an end in itself.

A significant number of the services that we are bringing together through our integration programme are commissioned by public health. This brings public health staff into our joint planning and decision making in addition to the strategic role of the senior public health team. It was a big risk when public health moved over from the NHS to the council, but we still succeed in talking closely and in making joint decisions. In our integration planning, the public health team acts as a guardian and champion of a broad approach to health and wellbeing.

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## Evidence, outcomes and evaluation

The public health team plays a crucial role in developing plans for integration when evidence of effective interventions, population analysis and intelligence, cost effectiveness and appropriately-designed outcomes are required. The DPH sees the role of public health as providing information that enables the NHS and the local authority to decide whether bringing services and budgets together will produce improved outcomes and be the most effective use of their combined resources. Following a decision to integrate services, public health can contribute to the development of a commissioning procedure that reflects the interests of both sectors.

### **South Worcestershire Integrated Recovery programme**

An example of this is the public health contribution to the Worcestershire older people's recovery service. This is a series of commissioning projects that together will achieve greater integration of health and social care for older people who need support to regain their independence following a crisis at home or admission to hospital. As elsewhere, the local NHS has an interest in effective and timely hospital discharge and reduced readmissions; the local authority has an interest in reducing admissions to social care.

The vision for the programme is to achieve:

- a service in which people and their families will feel safe, supported, and be at the centre of planning for recovery in their own homes
- a seamless, person-centred health and social care recovery pathway for frail older people in South Worcestershire, delivered by providers who work across organisational boundaries
- a service that has a single point of access, which makes it easier for people and their carers, as well as professionals to navigate.

The public health team is represented on the project board and has contributed by assisting in the definition of outcomes, analysing the characteristics and needs of the relevant population, modelling care pathways and developing a service specification which draws on relevant evidence.

The programme has considered options for the number of community hospital and social care rehabilitation beds, completed a tender for a nursing and rehabilitation facility, and is progressively integrating community based NHS and social care rehabilitation services.

### **Social impact bond to tackle loneliness and isolation**

Worcestershire County Council and Worcestershire's three CCGs have awarded the country's first social impact bond to help 3,000 older people overcome loneliness in the county. The Reconnections Social Impact Bond service is delivered by Age UK Herefordshire and Worcestershire, together with local voluntary and community organisations.

The county council is contributing £540,000 and the CCGs £480,000 collectively towards the payment-by-results programme based on delivery of agreed outcomes.

The public health team was involved in the analysis of evidence about the life changes, such as retirement, death of a partner and loss of mobility which can lead to a deterioration in emotional wellbeing and contribute to someone needing increased levels of health and social care support. They were also involved in establishing an output based currency for the service based on a reduction in social isolation on a measurable scale. This is based on evidence linking improvements on this scale to better outcomes, including a reduction in hospital admissions and entrants to long-term care.

## Developing preventative approaches

A JHWS for 2016 to 2019 is currently in development, led by the public health team. The strategy details five approaches to prevention:

- creating a health promoting environment
- encouraging and enabling people to take responsibility for themselves, their families and their communities
- providing clear information and advice
- commissioning prevention services based on evidence of effectiveness
- gate-keeping services based on need.

### Prevention work with older people

The public health team has been able to analyse the prevalence and distribution within the population of the four key risk factors for older people of entering long term care. These are:

- stroke
- falls
- dementia
- urinary tract infections.

Analysis by the public health team has revealed that these factors are common to both the NHS and social care and that it is therefore in the interests of each service to develop a joint prevention strategy that would improve and extend the quality of life for older people. The analysis has also shown how these are clustered within the county.

Public health specialists have carried out some risk stratification which has revealed that two per cent of patients/service users account for 37 per cent of the budget. The vision of the HWB is to focus prevention work on this high risk group.

### Prevention work with young people

The prevention policy for children and young people aged nought to 19 has been developed in anticipation of the transfer of responsibility for public health of nought to fives. It is based on the JHWS, the Children and Young People Plan and the council's All Age Prevention Policy.

Following an early help needs assessment of nought to 19s, joint social care and public health have produced recommendations for a fully integrated prevention/early help system and workforce across all agencies. The objective is to consider the needs of children as part of a coherent joined-up approach to the needs and contribution of the whole family group.

The work is designed to create a culture that is asset rather than deficit-focused, stop duplication between the support families are receiving from different agencies, ensure that interventions are evidence based, and enable resources and skills to be shared to fill the gaps and coordinate support better.

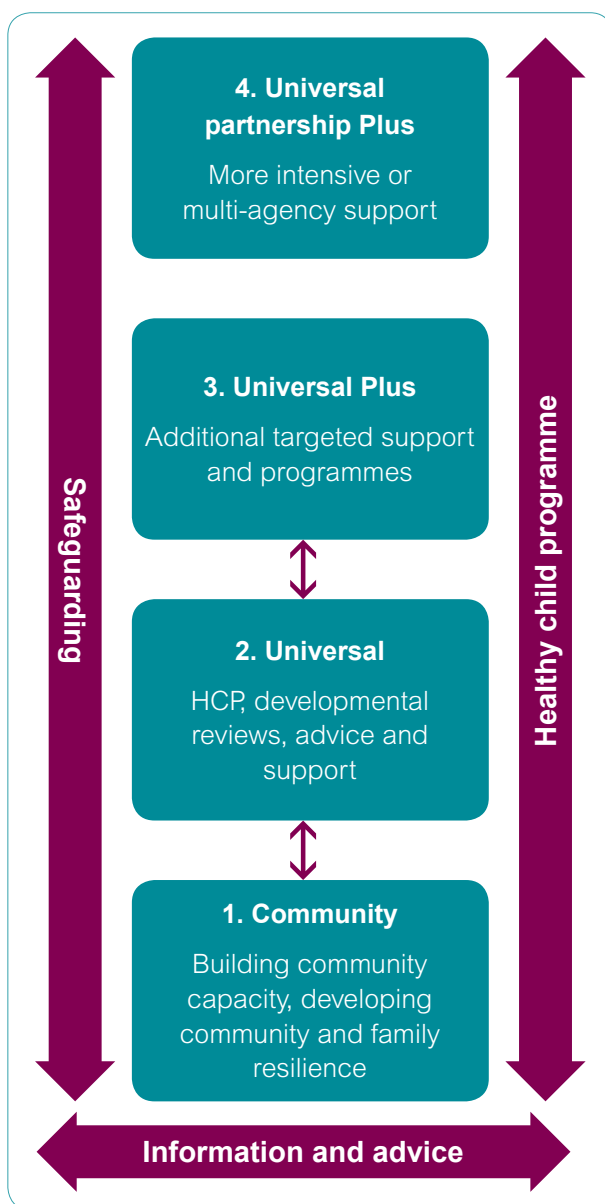
The workforce will be developed to work in an integrated way to support a ‘whole family’ approach and enable parenting. The integrated prevention service will bring together, with a budget of approximately £9.5 million:

- nought to five public health services (health visiting and family nurse partnership)
- five to 19 public health services (school nursing)
- aspects of the current nought to 19 early help services.

Integrated pathways are being developed, with the involvement of public health, in the following areas:

- parent infant attachment
- maternal mental health
- breastfeeding and weaning
- communication and language
- social and emotional
- drugs and alcohol
- domestic abuse
- young parents
- nutrition and physical activity.

### 0-19 Prevention model



### What others say – Simon White, Director of Children’s Services

Public health has brought us access to evidence-based interventions. We are now in a much better position to specify how we want services delivered rather than just outlining the outcomes. We already had integrated commissioning for children’s services, but we are now re-commissioning the school nurse and health visitors services with children’s centres. Public health is represented on the steering group for this work. Their number crunching and use of data to stratify the population has brought an extra dimension to the way we analyse need. We now have a fantastic opportunity to recruit the most disadvantaged families into wider integrated services.

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The detail of this document reflects roles and detail as at the time of its preparation – January to March 2016.



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