

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



A resource to promote public health's involvement in  
integrating care, health and wider public services

## Acknowledgements

The report was informed by a discussion paper on public health and integration by Anna Middlemiss, Sue Matthews, Jim McManus and Andrew Furber.

Thanks to all those who provided information for the case studies.

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

# Foreword

Developing integrated services across local government and the NHS is a key government policy imperative. 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 help improve their quality and cost effectiveness, to provide a better experience for those who use them, and, ultimately, to improve the health of the population.

This report is intended to support those goals by showing why public health should be involved in integration, and what expertise public health can bring to planning, commissioning and delivering more integrated services. It was commissioned following recent reviews by LGA and ADPH which found that while in some areas public health has been fully involved in the Better Care Fund (BCF) and wider integration agenda, in others there is significant potential for its role to be more fully utilised.

Our understanding of integration is a broad and inclusive one, including, but going beyond, programmes that are now under way, such as the BCF and new models of care under the NHS Forward View. Following the Comprehensive Spending Review, this paper sets out what public health can contribute to integration to make the greatest impact on health outcomes.

This report draws on information from six case studies of areas in which public health is one of the local leaders of integration and where their contribution is highly valued by local partners.

We hope that this document will be helpful to those involved in integration at a local, regional and national level, including:

- directors of public health in making the case for public health being fully involved in supporting system-wide integration
- leaders in councils, CCGs, health and wellbeing boards (HWBs) and partner organisations, including national stakeholders, by providing comprehensive information about how public health can enhance the integration agenda.



**Councillor Izzi Seccombe**  
Chair, Community Wellbeing Board  
Local Government Association



**Andrew Furber**  
President  
Association of Directors of Public Health

# Contents

Introduction	5
The case for involvement in integration	7
Collaborative system leadership	7
A population approach	9
A focus on prevention	11
Developing outcomes	13
Conclusion	14
Self-assessment tool	15
Glossary	17

# Introduction

“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 partners.”

**Andrew Balchin, Corporate Director,  
Adults, Health and Communities,  
Wakefield Council**

“With the evidence provided by public health, we’ve been able to be bolder in developing new integrated services and more decisive about de-commissioning services.”

**Iain MacBeath, Director of Health and  
Community Services,  
Hertfordshire County Council**

The integration of local government and NHS services and systems is a national priority, which received fresh impetus in the Comprehensive Spending Review. This contained a government commitment for every part of the country to have an integration plan in place by 2017, to be delivered by 2020. NHS England has also produced Delivering the Forward View: NHS shared planning guidance 2016/17 – 2020/21 which requires CCGs to work with partners

to produce sustainability and transformation plans which will include plans for integration.

The integration agenda is moving at pace. The challenges in this are significant. Planning and delivering integration is taking place at a time of persistent health inequalities; when public services are expected to make significant economies as part of a national government austerity programme; when adult social care continues to face severe resource challenges; and when the NHS must tackle provider deficits while delivering major transformation.

However, there are also opportunities. Many acknowledge that funding constraints have brought organisations together to identify joined-up, innovative solutions. The move towards devolution is also encouraging organisations to cooperate across larger footprints, and can be particularly useful for large-scale health and wellbeing initiatives.

This report identifies two overarching reasons for involving public health in integration:

1. The integration agenda presents huge opportunities for public health to influence major service changes so that these promote health and wellbeing and reduce inequalities – it is therefore part of the core role of public health teams, of local government in general and of the NHS.
2. Public health teams have skills and expertise that can help local areas to plan and deliver integration effectively.

For these reasons and because of the importance and current focus on integration, local areas may wish to consider, as a matter of urgency, the role which public health is playing in this work.

LGA and ADPH surveys and case studies have indicated that while in some local economies, public health is fully involved in the integration agenda, this is not the case everywhere. This report makes the case for greater engagement of public health in supporting integration, with a view to promoting comprehensive involvement across the country.

The report is based on information and perspectives from the LGA and ADPH, from six detailed case studies that have been published as a companion to this report, and from further case studies in the latest LGA public health annual report, 'Public health transformation three years on: extending influence to promote health and wellbeing'. The case studies represent areas in which both public health teams and their partners are agreed that public health is central to driving the work on integration. They include local authority areas from across England, covering both rural and urban environments and with varying degrees of deprivation and affluence. The areas are: Doncaster, Hertfordshire, London Borough of Richmond, Somerset, Wakefield and Worcestershire.

The report identifies several key areas in which public health has been found to make the greatest impact:

- as a collaborative system leader
- bringing a population approach to integration planning
- supporting the focus on prevention
- supporting an outcomes-based approach to performance and evaluation.

It explores each of these areas, making the case for public health involvement and describing the offer that it can make. The areas are illustrated by examples and key messages from the case studies.

The report identifies the situations which have led case study areas to make good progress in involving public health in integration programmes, and includes a short self-assessment tool which can be used for areas to check out their public health involvement.

The final section includes a glossary of some of the technical terms used in the report. This report takes a broad approach to integration, reflecting the fact that, across the country, areas are at different stages and are taking different approaches. Some areas have made significant advances on specific programmes such as multi-agency locality teams, others have ambitions for whole system reform, such as creating an accountable care organisation, or tackling the wider determinants of health. Some have subsumed their BCF in wider plans for integration: others are still focused on the BCF, which itself varies in scope from area to area. Some are including children's services in a system wide programme, others are focused on older people and people with long term conditions. Some are integration pioneers and vanguard sites.

While it is acknowledged that areas have different starting points, and that integration will be an iterative process, elected members, senior local government and NHS officers in case study areas were of the view that working towards a wide approach to integration was where the greatest public health gains could be made. Some spoke of 'changing conversations' to include 'a public health approach to integration'. Most importantly, areas need to be clear about what they mean by integration at any particular time, and public health has a role in helping achieve this clarity.

# The case for involvement in integration

This section explores the key reasons why public health should be involved in taking forward the integration agenda, and what it can offer to this. These include the skills, capacity, expertise and resources that public health can bring, and also the potential of integration for improving health and wellbeing. Points are illustrated by key messages and examples from case studies.

## Collaborative system leadership

### Why involve public health

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

**Councillor Pat Knight, Cabinet Portfolio Holder for Public Health and Wellbeing, Doncaster**

“In our integration planning, the public health team acts as a guardian and champion of a broad approach to health and wellbeing.”

**Frances Martin, Integrated Care Director, Worcestershire**

Public health has a long-standing role as a system leader, both at a national and local level. The type of leadership that public health specialists bring has a number of key elements. It is collaborative, aiming to work in partnership with others to support and influence their work so that this has a positive impact on health and wellbeing. Directors from case study areas spoke about the crucial importance of influencing others, but were also clear that this must go alongside active involvement – ‘getting stuck in’ – to show that public health was not an arms-length advisor but a full partner. Contributing resources to

integration work programmes or services was seen as a way of demonstrating commitment.

Public health also involves a role as an independent advocate for health and wellbeing, which means that public health leaders should be objective, standing back from organisation-specific interests and concerns to look at the bigger picture, with a focus on the needs of groups and individuals as well as on positive health and wellbeing outcomes. 'Thinking big' was a theme within some case study areas, which advised that it was important for public health to look beyond its traditional programmes, using the potential of integration to shift the whole system towards prevention and promoting health and wellbeing.

Public health are often seen as 'boundary spanners', with a history of working in both health and local authorities, and a responsibility for reaching across organisations to build relationships, partnerships and joint ventures with a range of stakeholders. They are also experienced in working in regional networks, which, in areas such as Greater Manchester, is proving very useful for the public health dimension of devolution (see Tameside case study in 'Public health transformation three years on: extending influence to promote health and wellbeing').

All of the case study areas emphasised the importance of relationships rather than structures for achieving service improvements. Directors of public health (DsPH) and partners pointed to public health often being regarded as an 'honest broker', trusted by both the councils and NHS and with an understanding of both cultures. The broker role is used to enhance communication and resolve problems across organisations.

In all the case study areas, DsPH were recognised system leaders for integration, with a place at top level discussion and decision making.

### Examples from case studies

The director of public health (DPH) in Somerset is a member of the senior group developing a model for ambitious, whole-system reform, with agreement in principle to work towards outcome-based commissioning with a capitated payment system and pooled budgets. The DPH chairs the workstream responsible for delivering the commissioning outcomes framework.

In Doncaster the public health team was involved in problem-solving with adult social care, the CCG and the local medical committee to increase GP support for council intermediate care beds.

Wakefield has established a public health consultant post specifically to drive and support a public health approach to integration in both adult and children's services.

Hertfordshire's public health team led a system-wide review of child and adolescent mental health services (CAMHS) emotional wellbeing and resilience promotion which has led to a whole system transformation approach for CAMHS.

### What public health brings to the table

When public health is involved as a system leader it will:

- provide a public health, population perspective to top level discussions and decision making
- lead on partnerships and work programmes within the integration agenda
- help clarify concepts such as integration and prevention, so that areas are working to the same definitions and goals
- provide a link to academic institutions, public health training programmes, centres of excellence in the UK and internationally
- provide a link to regional public health activity, including that carried out in devolving areas

- have its own links with the voluntary, community, faith and business sectors
- act as a system facilitator, brokering relationships and finding solutions across boundaries
- act as an objective ‘critical friend’ and advisor in assessing approaches to integration
- where relevant, have a strategic plan for allocating public health funding to integrated services which meet health and wellbeing outcomes.

### **Key messages from case studies**

Integration needs new styles of leadership and communication based on networking, rather than vertical management. This is precisely the kind of leadership that public health is used to providing in working across and between organisations.

Integration offers the opportunity to make public health gains at scale, and to incentivise health and wellbeing by refocusing incentives in the system.

Plans that are developed too quickly don't change behaviour. Difficult conversations will need to take place – for example, to be effective all parts of the system need to be working to the same values of promoting independence and person-centred care, but this is unlikely to be embedded across all organisations without significant preparation.

The public health team can help ensure that partners have a clear, common understanding of what they mean by integration and what they are trying to achieve at every stage.

## **A population approach**

### **Why involve public health**

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

### **Dr Matthew Dolman, Chair Somerset CCG**

An understanding of populations is crucial to successful integration, which must include a detailed analysis of local health and wellbeing needs, priorities and assets. Population approaches are fundamental to public health, which has specialists with the expertise to undertake this work, often working alongside colleagues in the council or from the CCG. A public health approach reinforces the need to consider the whole population, as well as service users, including an emphasis on inequality and vulnerable groups.

DsPH take the lead on developing and updating Joint Strategic Needs Assessments (JSNAs) of their local population. These are the starting point for understanding how the social determinants of health are impacting locally and for understanding areas of greatest need and where need is and is not being met – all vital information in planning for effective integrated services. JSNAs are increasingly mapping local assets and should be fundamental to developing integration, rather than seen as a separate process.

In many areas, public health is seeking to improve the quality of the information it presents, to be better able to make future forecasts, and to make it clearer and more meaningful for partners.

### Examples from case studies

Wakefield public health team designed and commissioned an evaluation of the local integrated care hubs, funded by the CCG and carried out in real time so that results are fed into service changes, including measures to tackle social isolation and increasing access to step-up support in the reablement service.

Doncaster public health team developed an information pack analysing Doncaster-specific factors in non-elective admissions, and based on this, 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.

### What public health brings to the table

When public health is promoting a population approach to integration, it will:

- bring skills in research, data analysis, health profiling and evidence evaluation providing the local system with meaningful information to support in-depth understanding of local data, both qualitative and quantitative, to underpin the direction for strategic planning
- use tools such as risk stratification, health needs assessment, and health impact assessment to inform planning for integration
- provide an analysis of the evidence base for interventions, to help local areas prioritise what is likely to work best in tackling integration, and to identify the best way forward
- bring expertise in public health economics which can contribute to delivering cost-effective interventions.

### Key messages from case studies

Strategic planning is often 'data rich but knowledge poor'; case study areas have found it helpful to ensure that data is predictive and meaningful to commissioners, providers, lay people and the public.

It is vital for an integration strategy to be informed by well-researched and robust evidence about what is most likely to work with the specific population and groups within it. Case study areas have found that it pays dividends to take every opportunity to present evidence briefings to council, CCG and other HWB colleagues, to demonstrate the usefulness of evidence in developing commissioning strategies.

Finding out which groups are and are not using services and why is one of the strengths of public health – this information is vital in designing integrated services that can be accessed by the whole of the population.

## A focus on prevention

### Why involve public health

“To really make a difference public health needs to think big – to consider how it can influence the whole system, contributing to integration with a public health perspective. We need to strive towards a prevention-led health and social care system, rather than one which is demand-led.”

**Trudi Grant, Director of Public Health, Somerset County Council**

“Being involved in integration is essential to public health – reduced budgets mean that in future the role will increasingly be about influencing others and shaping programmes to include a health and wellbeing element.”

**Dr Rupert Suckling, Director of Public Health, Doncaster Council**

DsPH in case study areas generally felt that, until recently, the focus of integration programmes had been on preventing hospital admission amongst high risk patients. However, they were optimistic that a change was taking place, and partners were increasingly interested in what they could do both as individual organisations and together to make an impact across all the levels of prevention, including tackling upstream the environmental and social risks of poor health and health inequalities.

As specialists whose concern is the overall health of the population, public health staff have a detailed understanding of all stages of prevention, from conception and throughout the life course. They are also

experienced in encouraging behaviour change that leads to better health, working both with individuals and with communities. Both elements can make a major contribution to effective integration. Like ‘integration’, ‘prevention’ is a term which means different things to different people. Public health is well placed to explain and clarify this, so that partners are clear about what they are trying to achieve and whether this is realistic.

Case study areas talked about how they were helping to shift systems to focus on prevention, which was where the real health and wellbeing gains could be made. Public health often led on developing system-wide prevention strategies, commissioned integrated prevention services, led on developing self-care initiatives and had a major role in working with local people and organisations to develop community assets.

### Examples from case studies

In Richmond the cross-council prevention strategy developed jointly with the CCG was led by public health, and was based around the idea of place. It enabled prevention to be embedded in a wide range of council and NHS activities.

As part of the development of new models of care, public health in Somerset was asked to identify a suite of evidence-based preventative activities that could be taken forward by partners, including the provider trusts, in the coming years.

Worcestershire has an asset-based prevention policy for children and young people, and a number of services in the integration programme are commissioned by public health.

Hertfordshire’s DPH led a self-management strategy group which among other products developed self-management tools for people with long-term conditions.

## **What public health brings to the table**

When public health is involved in promoting prevention it will:

- help partners to develop an understanding of the theory, practice and application of all levels of prevention (primordial to tertiary)
- help to develop a comprehensive local prevention strategy which covers all levels of prevention
- lead on workstreams within the prevention agenda, such as self care or falls
- ensure that public health activity is not just focused on tackling the behavioural causes of ill health, such as smoking, but on the wider social determinants such as debt, isolation or poor housing, through, for example, integrated healthy living services or integrated housing support services
- work with others to develop community asset-based approaches with the voluntary and community sectors
- work to ensure that partners, including the business sector, promote health and wellbeing in their activities, such as developing workplace health standards
- understand the full range of local government functions that impact on health and draw these into integration planning where appropriate
- commission services that support integration, and support wider commissioning through helping others to develop outcome-based service specifications.

## **Key messages from case studies**

Case study areas aim to flip the system so that the starting point for all partners is how to prevent illness and loss of independence from taking hold.

It is useful to encourage lead councillors and chief executives to sign up to a 'whole council' approach to prevention, and ensure they understand how this can contribute both to the BCF and to commissioning a range of services with integration as a priority.

The concept of place plays an important role for integrated services, a significant number of which are based around community localities. Localities are not always co-terminous across the health and care sectors, so it is important for public health teams to show that they can work with the 'messy reality'.

## Developing outcomes

### Why involve public health

“Our DPH provides an overall perspective on outcomes-based commissioning. She has been heavily involved in the design of all our outcomes, both in relation to physical and to mental health.”

**Kathryn Magson, Chief Officer,  
Richmond CCG**

“A key feature of public health is the way we use evidence and tools such as decision analysis and prioritisation to improve the outcomes of services. Integrated care pathways are an example of this.”

**Professor Jim McManus,  
Director of Public Health,  
Hertfordshire County Council**

Working to improve, and measure, long-term health and quality of life outcomes for populations is fundamental to the public health role. This focus on outcomes has meant that public health can make a valuable contribution to the outcome-based commissioning approaches being adopted in local authorities and the NHS. In many of the case study areas, public health teams had a lead role in developing the metrics and outcomes by which integration programmes are evaluated; in doing this they emphasised the importance of qualitative outcomes based on user experience, as well as quantitative outcomes. A system-wide consensus on outcomes and the importance of evaluating progress makes it much more likely that successful integration programmes will be delivered.

### Examples from case studies

Richmond’s outcomes-based approach began with intensive community engagement to identify what outcomes people wanted. The public health team also carried out analysis of suicide and self harm among children and young people which has led to additional resources being allocated to emotional health, involving a number of agencies.

Data analysis by Worcestershire’s public health team has enabled integrated commissioning for ages zero to 19 to specify how services are to be delivered as well as defining outcomes.

### What public health brings to the table

When public health contributes to developing integration outcomes it will:

- develop metrics, monitoring tools and outcomes, including outcomes focused on user experience, as a basis for commissioning and performance management
- undertake or commission research to evaluate local programmes to identify what has worked, what could be improved and whether the impact on outcomes has been achieved
- contribute a public health perspective to service specifications.

### Key messages from case studies

Integration is big, complicated and hard to explain and understand. It is helpful to keep repeating and reinforcing the clear message that integration is about improving outcomes for the population, centring services around the people using them and enabling people to have responsibility and control over their health and wellbeing.

In developing a programme of integration, real-time monitoring and evaluation should be built in from the beginning, so that lessons can be learned and changes made, where necessary, in a timely and effective way. Any major change involving multi-agency working will face initial problems that need to be tackled. A real-time evaluation will help new services to establish themselves more quickly and effectively.

# Conclusion

There is no doubt that developing integration programmes that make a real difference to health and wellbeing outcomes and to how citizens experience services is a huge challenge. The discussion above indicates a number of reasons why it is important to bring a public health perspective to address this challenge, and outlines the skills and experience which public health can contribute to making a difference.

The next section provides questions for public health and strategic partners to consider if they wish to assess the extent of public health involvement in integration in their own area. The questions indicate areas in which public health teams on the one hand and local government in general and NHS partners on the other may wish to take action.

# Self-assessment tool

Public health teams may find it helpful to discuss the first set of questions below, while members of HWBs and others involved in developing and delivering integration programmes and the BCF may wish to use the second set of questions as a way of assessing whether they could add value through greater involvement of public health.

## For public health

Have you reviewed your involvement in integration to see whether you are making the most of this opportunity for system-wide influence?

- Have you sought the views of partners on whether the information and data you provide is as clear and relevant as they would like? For example, could you do more to help partners understand the implications of the needs and assets described in your JSNA for integrated care pathways?
- Do your partners know, for example through your presentations of evidence reviews and development of service specifications, the extent of the contribution you could make to integration?
- Have you shown that you understand the priorities of partners in relation to integration and that you are willing to commit resources eg through dedicated officer support or contributing to pooled budgets?
- Could you do more to ensure that integration planning in your area is part of a broad approach to prevention, for example, through explicit links to a prevention strategy?

## For partners

- How is public health represented on your integration and BCF executive boards/ planning groups/implementation groups?
- How clear is your collective understanding of what you mean by integration and what purpose you wish to achieve by it?
- How are you developing a deep understanding of the population groups for whom you wish to offer integrated services and what outcomes these groups want?
- Are you making the best use of your JSNA to determine priorities? Could your DPH do more to help you understand the implications of the JSNA?
- How well does your approach to integration shift the focus towards prevention – for example, do you have a prevention strategy?
- Does your approach to integration involve the whole system – not just services for older people and those with long term conditions, but all service areas including mental health and children's services?
- Does your approach to integration draw on other council functions such as housing, planning, education, leisure services? Do all partners involved in the integration agenda understand the potential for involving a wide range of council and other public sector functions?
- Are you taking an outcomes-based approach to integration and prevention?
- How do you gather and assess the evidence base for the different components of the integration programme you are proposing?

- Have you built in an evaluation process from the beginning of your programme?  
How will you know if you have been successful in achieving your desired outcomes?

# Glossary of terms used in this report and in the integration agenda

**Accountable care organisation** – a care provider that takes responsibility for providing all the care for a given population for a specified period of time.

**Asset-based approaches** – approaches which mobilise the skills and knowledge of individuals and the connections and resources within communities rather than focusing on problems and deficits.

**Better Care Fund** – a £3.8 billion fund announced by the Government in the June 2013 spending round, to bring about more integrated social care and health. It creates a local single pooled budget to incentivise the local government and NHS to work more closely together. Councils and CCGs may add to the pooled budget from their own budgets to align with their health and care priorities.

**Capitated-payment system** – capitated payment or capitation means paying a provider or group of providers to cover the majority (or all) of the care provided to a target population, such as citizens with multiple long term conditions, across different care settings. Payments are generally calculated as a lump sum per patient.

**Health impact assessment (HIA)** – evaluates how proposals for changes and developments to services will (or could) potentially affect people's health.

**Health needs assessment (HNA)** – a method for reviewing the health issues facing a population, leading to a set of agreed priorities and the allocation of resources to improve health and tackle inequalities.

**Integration pioneers** – a number of sites chosen to showcase innovative ways of integrating social care and health services to provide better, more person-centred support at home and earlier treatment in the community to prevent people losing their independence or needing unplanned hospital care.

**Joint Health and Wellbeing Strategy (JHWS)** – each HWB is required to produce a JHWS for the local area, based on the needs identified by the JSNA (see below).

**Joint Strategic Needs Assessment (JSNA)** – the process and document(s) through which local authorities, the NHS, service users and the community and voluntary sector research and agree a comprehensive local picture of health and wellbeing needs. The development of JSNAs is the responsibility of HWBs and is led by public health teams.

**New models of care** – the NHS Five Year Forward View published in 2014 proposed a number of new models of care that would bring together existing services over the following five years. The models being piloted by the vanguard areas (see below) include integrated primary and acute care systems; enhanced health in care homes; multispecialty community providers; urgent and emergency providers and acute care collaborations.

**Outcomes-based commissioning (OBC)** – a relatively new approach to commissioning social care and health services in the UK. It rewards both value for money and delivery of better outcomes that are important to citizens. ‘Outcomes’ refer to the impacts or end results of services on a citizen’s life.

**Person-centred care** – care which is designed around the needs of an individual, rather than the needs of an organisation; intended to promote the independence of those who need care.

**Population approach** – a population approach looks at the health of an entire group of individuals, including the distribution of health and wellbeing within the group, health inequalities between different groups and the impact of social determinants on the health of groups, both those groups which are using services and those which are not.

**Prevention** – one important component of a public health programme, involving action to reduce the incidence and/or impact of disease and health problems in the population:

- **Primordial prevention** aims to address the risks to health of the wider social, economic and environmental determinants of health (see below), for example by improving housing or reducing traffic pollutants.
- **Primary prevention** aims to prevent disease or injury before it occurs, for example by facilitating and supporting breastfeeding of newborns or physical activity among a whole population.
- **Secondary prevention** aims to reduce the impact of a disease or injury that has already occurred, for example through a healthy eating programme for people with diabetes, or an exercise programme for people who have had a heart attack.
- **Tertiary prevention** aims to soften the impact of an ongoing illness or injury that has lasting effects by helping people manage long-term, often complex health problems, for example by enabling support groups for people to share strategies for healthy living and wellbeing.

**Population segmentation** – grouping the local population by the kind of care they need as well as how often they might need it.

**Public Health England (PHE)** – the national public health service, an expert body providing advice and services across the range of public health.

**Risk stratification** – understanding which group of people within each segment of the population has the greatest risk of needing intense care such as a hospital admission.

**Vanguard sites** – organisations and partnerships chosen by NHS England to pilot the new models of care (see above) proposed under the NHS Five Year Forward View.

**Wider (or social) determinants of health** – the social, economic and environmental conditions that influence the health of individuals and populations. There is a clear link between the social determinants of health and health inequalities defined by the World Health Organisation as ‘the unfair and avoidable differences in health status seen within and between countries’.

**Whole-system reform** – the programme of change currently being carried out across social care and health, following the Health and Social Care Act 2012. The concept of whole-system reform involves seeing the social care and health systems as part of one whole system whose component parts interact with each other. Integration is therefore closely bound up with whole-system reform.





**Local Government Association**

Local Government House  
Smith Square  
London SW1P 3HZ

Telephone 020 7664 3000

Fax 020 7664 3030

Email [info@local.gov.uk](mailto:info@local.gov.uk)

[www.local.gov.uk](http://www.local.gov.uk)

© Local Government Association, April 2016

For a copy in Braille, larger print or audio,  
please contact us on 020 7664 3000.  
We consider requests on an individual basis.