Growing healthy communities

The Health and Wellbeing Index

Place Analytics insight, October 2015
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Executive summary

It has long been recognised that the health of a population is strongly linked to the circumstances in which people live. Our health and wellbeing index clearly supports this assertion and highlights the extent to which economic, social and environmental determinants translate to good or bad health outcomes in their broadest sense. It also shows the scale and nature of inequality across the country and reiterates the need for a local, place-based approach to tackling health outcomes.

The wider economic determinants that affect health outcomes are often beyond the control of the NHS. It is becoming increasingly apparent that a number of outcomes can be influenced by other elements of the public sector, predominantly by local authorities, but also other bodies, including – as our Lancashire case study shows in a really positive fashion – the police. It is a factor that gives weight to the focus of providing a joined-up, multi-service approach to addressing public policy challenges at a local level.

The organisational and structural environment in which the public sector can effect these changes has arguably never been stronger. The renewed responsibility for public health given to local government in 2013 as part of the 2012 health and social care reforms, the creation of the Better Care Fund to encourage joint planning, the ambitious, leading-edge messages from the NHS chief executive in ‘The Five Year Forward View’, the creation of 29 vanguards and the developing devolution agenda, all point to the increased opportunity for public sector bodies to work together to answer the challenge of continued austerity and the NHS £30 billion funding gap by tackling prevention, rather than cure.

Given the financial and other pressures on local authorities, there needs to be a clear way to focus on determinants that will make the most difference. Health and well-being is an area where data is not in short supply. However, having a clear understanding of local dynamics can help CEOs and other stakeholders to navigate effectively through the mass of available data and to make decisions based on what it is that needs to be done here and now strategically to make a tangible difference. A correlation assessment of the health determinants measured and the outcomes shows that the determinants that most influence health outcomes are tackling child poverty, deprivation, unemployment, childhood education and social cohesion.

The reality of achieving successful collaboration is never as easy as it may sound. The purpose of this report is to help stakeholders – NHS providers and clinical commissioning groups (CCGs), local authorities, health and social care providers, housing associations, fire authorities and the police – to improve collaboration through a better understanding of the correlation between the economic, social and environmental health determinants and health outcomes within their locality. This includes enabling joint health and wellbeing strategies to be better targeted on actions that will make a difference. Alongside this, our presentation of the data is also designed to provide health organisations with an insight into some of the tools and information available to local authorities that more traditionally and readily have a place-based approach to decision-making. We also provide a set of questions to help facilitate those discussions in the light of joint service needs assessments.
The index, based on league tables that assess 33 key health determinants and outcomes at local authority district level, provides a coherent national story on health and wellbeing for England and also reveals ‘outliers’. These are particular areas that perform better than their health determinants would suggest. Case studies from Barnet, Greenwich and Richmond and Kingston outline some of the lessons that can be learnt from these and where collaboration has been seen to address an area’s determinants to improve health outcomes. That nine of the ten fall within London, where the boundaries of health commissioning are coterminous with those of the local authority may imply more readily facilitated joint-working leading to improved outcomes. These areas also receive the public health grant allocated on a per capita/deprivation basis rather than size of geography and this, coupled with the fact that 32 of the 211 CCGs fall within London, reinforces the point that in London there are many health services that can be easily accessed by residents. It is also worth noting that London has stronger educational attainment and a higher proportion of graduates than other parts of the country.

More specifically, the national data allows segmentation, revealing areas with similar health determinants, but different health outcomes so that learning can take place, and underscores again the need to work in collaboration, if there is an opportunity to learn from ‘others like us’.

The overall message, however, is that while determinants heavily influence outcomes, it is possible for determinants to be influenced and outcomes to be improved by partners working in effective collaboration. Joined-up, place-based approaches can make a significant difference and this is further evidence for the case for radical decentralisation of powers to local areas to enable public services to collaborate and create across organisational boundaries. Significant results could be achieved if Whitehall promoted place-based, outcome-focused approaches – with devolved responsibility for outcomes to local leaders, with no strings attached.

**Top 10 over-achievers**

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Devolving healthcare

Devolution proposals are in the process of being developed by regional partnerships across England in response to a new timetable set out by the Conservative government. One of the most advanced deals is for Cornwall and the Isles of Scilly, for whom new powers and local flexibilities have also been agreed around health and social care.

This stops short of what has been agreed for Greater Manchester, where in February 2015, a signed memorandum for the Greater Manchester area brought £6 billion of combined health and social care budgets under the local government control with a planned implementation date of April 2016. (Further details of the features of this are outlined on page 16.)

For other areas, however, health and social care devolution is not one of the most frequent proposals – with concerns around the size of the challenge and political risk cited as inhibitors by some.

Vanguards

Further to the Five Year Forward View, on 10 March 2015, NHS England announced the creation of 29 vanguard sites. These sites modelled three different types of care:

1. **Primary and acute care systems** – with GP, community hospital and mental health service being directed from a joint budget to wherever patients are judged to need it most
2. **Multispecialty community providers** – where specialist services such as chemotherapy and dialysis are brought out of hospital and closer to people’s homes
3. **Enhanced health in social care** – where the NHS and councils work together on providing better preventive services, and more healthcare in care homes

NHS Five Year Forward View

The NHS Five Year Forward View, published by NHS England in October 2014 sets out a vision for the future of health services. Produced with input from regulators, patient groups, clinicians and other experts, it articulates a landscape for a sustainable and improved NHS and defines the framework for further detailed planning.

It describes a move away from a uniform model and top-down re-organisation, to recommend the development of new models to suit local needs. It presents joint working as being essential, not the exception, and argues that it needs to happen at a larger-level where it is happening already. Among its proposals are the setting up of multispecialty community providers (out of hospital care provided by groups of GPs, nurses, clinicians and other specialists) and primary and acute care systems where GPs and hospitals combine.

It also emphasises the importance of public health, disease prevention, the reduction of avoidable illness through life and environment changes, and advocates stronger public health-related powers for local government and elected mayors. The development of a suite of new models that can be adapted to suit local needs is part of the frontline transformation the document describes as necessary if a net efficiency of 2% or higher is to be achieved, against the backdrop of a predicted £30 billion funding gap for the NHS by 2020 and a continuing decrease in resources for local authorities.
Building the health and wellbeing index

The factors influencing public health are broad ranging. The sector is awash with data and statistical predictions for the future, yet the health sector needs to make changes now if it is to find the required savings, and local authorities need to know the areas which will influence citizen well-being. A clear understanding of local dynamics can help CEOs and other stakeholders to navigate effectively through the mass of available data. To take this into account, our index is based on league tables that assess 33 key health determinants and outcomes for the 324 local authorities to provide a coherent national story on health and wellbeing for England.

Methodology

• The data was analysed by Grant Thornton’s place analytics team and draws on proprietary data including composite measures and scores relating to occupations, unemployment, deprivation, quality of life and natural environment
• As it is local authorities that predominantly take a place-based view, the analysis was carried out at a local authority level, covering district, unitary, metropolitan and London borough councils
• Drawing on 33 indicators, each local authority area has been given an index score in terms of both health determinants and health outcomes
• The data and process used to collate the report is independent and unbiased
• Health outcomes are not linked to the NHS five outcome domains

1 City of London and the Isles of Scilly have been omitted due to lack of data.
Determinants are those factors identified as having a key influence on an individual’s prospects for good health. These fall under three broad areas:

**Economic**
- Unemployment, qualifications, childhood education, occupations and income

**Society**
- Deprivation, child poverty, fuel poverty, crime and social cohesion

**Environment**
- Household occupancy (overcrowding), natural environment, social housing, homelessness and living environment

All of the above factors were combined to create the overall determinants score.

Ranking and mapping the combined scores shows the great range in level of health determinants across the country, with Hart District in Hampshire ranked first at 117 and Newham in London last with 74 (Map 1 and Table 1). In addition, while there is a wide variation between the best and the worst, variation is not necessarily spatially determined, with areas of poor and good health determinants in close proximity. Nottingham City, for example, appears in the bottom 20 (Table 2) while neighbouring Rushcliffe ranks in the top 20.

The national picture shows that the South East has some of the best determinants in the country, with 11 South East local authority areas featuring in the top 20. A band of strong performance surrounds London and spreads into parts of Oxfordshire, Warwickshire and up into Cambridgeshire. Other more rural areas in the East of England and moving south towards London have good determinants, particularly around Hertfordshire.

It is apparent that a number of areas face significant challenges. Less favourable determinants are found in London boroughs as well as in and around major towns and cities in the Midlands (Leicester, Stoke and Birmingham). The map also shows a corridor of low-performing areas stretching from parts of Humberside across to Merseyside, encompassing areas such as Kingston upon Hull, Manchester and Liverpool. However, contradicting this pattern are several local authority areas in the north of England performing particularly well, for example Ribble Valley in Lancashire performs in the top 20 rank of local authorities.

1 City of London and the Isles of Scilly have been omitted due to lack of data.
### Table 1 Top 20 by health determinants score

<table>
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<th>Rank</th>
<th>Local authority</th>
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### Table 2 Bottom 20 by health determinants score

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**Chart 1 Health determinants score by region**

- Very high score
- High score
- Low score
- Very low score

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**East Midlands**

- Rushcliffe
- S Northants
- South Cambs

**East of England**

- St Albans
- Richmond upon Thames

**London**

- Northumberland
- N Tyneside
- S Tyneside

**North East**

- Great Yarmouth
- Luton

**North West**

- Middlesbrough
- Liverpool
- Manchester
- Blackpool

**South East**

- Portsmouth
- Thanet

**South West**

- Torbay
- Plymouth

**West Midlands**

- Stratford-upon-Avon
- Bromsgrove
- Harrogate
- Stratford

**Yorkshire and Humber**

- Bradford
- Kingston upon Hull
- Sandwell
- Birmingham
The indicators used to assess health outcomes sit within two broad categories: healthy lifestyles and health conditions. The lifestyles data indicates the propensity of healthy behaviours (differing from the determinants by involving personal choices about how one lives, as opposed to the wider economic/social/environmental context in which one is living). Health conditions groups indicators reflecting what are often the consequences of certain lifestyle choices.

**Healthy lifestyles**
- Adult obesity, child obesity, sports participation, smoking, drug misuse, binge drinking, under-age pregnancy and low birth weight

**Health conditions**
- Life expectancy, infant mortality, cancer mortality, suicide mortality, circulatory mortality, alcohol mortality, excess winter deaths, hip fractures, diabetes, self-reported well-being

The combined score for each area creates a similar pattern to the determinants map, with the South East having some of the best health outcomes overall, as reflected in the top 20 table. However, good performance on health outcomes can also be seen spreading further afield from the Home Counties into parts of the South West. Many East of England local authorities perform similarly well on health outcomes, with five featuring in the top 20 table. Also notable is Richmond upon Thames, ranking third overall and the only London borough to feature in the top 20. Further north there are small pockets of strong performance in parts of Cumbria and Lancashire.

Poor health outcomes are predominant in the North West, particularly in large urban towns and cities, with 11 of the bottom 20 ranking local authorities from this region. Compared to the determinants score, the bottom 20 list contains far fewer London boroughs, with only Barking and Dagenham featuring.
### Table 3 Top 20 by health outcome score

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### Table 4 Bottom 20 by health outcome score

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### Chart 2 Health outcomes score by region

- **Very high score**
- **High score**
- **Low score**
- **Very low score**

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Growing healthy communities – The Health and Wellbeing Index
Comparing the ranking of health determinants and outcomes

Comparing the performance of local authority district areas using percentile values shows a strong positive overall correlation between health determinants and outcomes scores (Chart 3). In broad terms, it reinforces the view that the ability to influence these determinants will have a strong impact on public health.

The overall aim for public health would be to move all areas represented on the chart to the top right hand quadrant, with both good determinants and outcomes.

Within this overall picture, there are areas which ‘buck the trend’ by having better or worse outcomes than would be expected based on their determinants score. The top ten out-performing areas are all in London with the exception of Babergh. The bottom ten under-performing areas cover a wide geographical reach, falling across The Midlands, North and South East. Understanding how and why those that have out-performed may offer valuable insights for other places facing similar challenges.

A fuller understanding of the factors leading to the poor score could form part of a joint strategic needs assessment, particularly for those areas that are performing poorly compared to more favourable determinants.
London and urban areas

Of the top 20 local authority areas whose outcome rank outperforms their determinants rank, 17 are London councils, including some with comparatively low determinant scores. Most other urban areas, such as Liverpool and Manchester, face similar challenges and generally have both poor determinants and outcomes scores, with all of the core cities in the bottom left-hand quadrant of the graph.

Typically, urban areas are more diverse in ethnicity and have a tendency towards more transient populations, which can raise significant problems for health bodies in meeting the healthcare needs of their populations. Unlike the more remote rural areas, barriers to services are not physical, but can be linked to problems with communication and timing (eg language barriers and inflexible working conditions affecting availability to attend appointments).

London presents something of a paradox. It has many challenged areas, with nine London boroughs listed in the bottom 20 performers on the determinant index. Yet, all of these areas appear to be achieving better health outcomes than would be expected, based on their determinants scores. This may be due to the effect of many years of significant investment and the status of many NHS providers as centres of excellence (notwithstanding that there are many others throughout the country). Another factor may be that London has a dense concentration of health commissioning bodies coterminous with local authority boundaries – of the 221 CCGs in the country, 32 are in London. Having this many bodies dedicated to commissioning healthcare with the potential for close working relationships with London boroughs sharing the same boundaries could be resulting in an improved level of outcomes compared to areas where commissioning bodies may be more stretched geographically. A further contributor could be the public health grant which London borough councils receive. Aside from the size of the grant available, its allocation on per capita/deprivation basis rather than size of area, reinforces the point that in London there are many health services that can be easily accessed by residents.

### Table 5 Top 10 ‘over-achievers’ and public health allocation

<table>
<thead>
<tr>
<th>Rank</th>
<th>Determinants rank</th>
<th>Outcomes rank</th>
<th>Rank difference</th>
<th>Total 2015/16 public health allocation (pre-revision)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Kensington and Chelsea</td>
<td>236</td>
<td>30</td>
<td>206</td>
</tr>
<tr>
<td>2</td>
<td>Westminster</td>
<td>301</td>
<td>97</td>
<td>204</td>
</tr>
<tr>
<td>3</td>
<td>Camden</td>
<td>285</td>
<td>90</td>
<td>195</td>
</tr>
<tr>
<td>4</td>
<td>Brent</td>
<td>312</td>
<td>121</td>
<td>191</td>
</tr>
<tr>
<td>5</td>
<td>Barnet</td>
<td>195</td>
<td>32</td>
<td>163</td>
</tr>
<tr>
<td>6</td>
<td>Haringey</td>
<td>308</td>
<td>166</td>
<td>142</td>
</tr>
<tr>
<td>7</td>
<td>Waltham Forest</td>
<td>311</td>
<td>177</td>
<td>134</td>
</tr>
<tr>
<td>8</td>
<td>Lambeth</td>
<td>304</td>
<td>182</td>
<td>122</td>
</tr>
<tr>
<td>9</td>
<td>Babergh (Suffolk)</td>
<td>130</td>
<td>11</td>
<td>119</td>
</tr>
<tr>
<td>10</td>
<td>Enfield</td>
<td>290</td>
<td>172</td>
<td>118</td>
</tr>
</tbody>
</table>

North-South divide

There is a clear North-South divide in outcomes and determinants, which may almost certainly reflect variations in economic prosperity across England. The upper quadrant of Chart 1 (good determinants, good health outcomes) is dominated by local authorities from the home counties. Interestingly, the south west has healthier outcomes in overall terms compared to its determinants. A number of northern local authority areas are bucking the North-South trend; comparing determinant and outcome rankings, there is a ‘corridor’ with a number of relatively high performing local authorities in parts of North Yorkshire, Lancashire and Cumbria.

Areas performing poorly, both in terms of determinants and outcomes, can be side-by-side with areas with much more favourable indicators (eg Nottingham City and Rushcliffe). CCGs, local authorities and health and wellbeing boards overseeing arrangements for the Better Care Fund (BCF) need to investigate these differences where they are occurring, with a view to the potential for learning lessons from better performing neighbours and addressing the needs of their population within the joint health and wellbeing strategy.

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1 Local authority public health allocations 2015/16: in-year savings. A consultation. 31 July 2015
Case study

London Borough of Barnet, an ‘over-achiever’

Barnet Council is ranked as the fifth best ‘over-achiever’ in terms of health outcomes outperforming determinants. Joint working between the CCG and the local authority is helped by London borough boundaries being coterminous with the CCGs. Beyond this, the council and CCG also work closely with the Haringey and Enfield councils and CCGs, which also appear sixth and tenth on the overachiever list respectively.

Barnet faces challenges as London’s most populous borough and its fastest growing age group is the 5-14 year olds. A lower than average number of pupils spend less than three hours a week on sport and physical activities and 18% of year 6 pupils are obese.

To tackle this, initiatives such as the ‘Choose Well’ campaign was undertaken with Haringey and Enfield, with the aim of providing people with information on how to choose the right NHS service – GP, pharmacist, NHS 111 or A&E – to enable them to get access to the right services quickly and to reduce pressure on health services, particularly over the winter period. It included leaflets, wallet-sized ‘z-cards’ and posters, which were widely distributed to libraries, GP practices, health centres, dentists, pharmacies and voluntary and community organisations in the three boroughs. It also included local advertising, on-line information and a Choose Well app which is free to download on Apple and Android devices and available in English, Turkish, Polish and Somali.

The Barnet, Haringey and Enfield clinical strategy is to re-organise healthcare services to deliver modern standards of clinical care to patients. This has involved changing and restructuring facilities at Barnet, North Middlesex and Chase Farm hospitals.

Barnet CCG also introduced 11 peer review groups. This includes one looking at management – a subsequent study suggests that this was successful in reducing waiting times and increasing referrals.
Collaborating to achieve better health outcomes

The health and wellbeing index indicates that positive improvements in an area’s determinants performance can be expected to have a beneficial impact on health outcomes. It also highlights the regional diversity of determinants and outcomes, underlining the need for a local approach.

Local government activity
While the NHS has traditionally focused on how to respond to the outcomes, there is increasing acknowledgement of the need to focus on preventative measures and actions. Local authorities, as the recipients of the public health grant and having taken on public health responsibilities from primary care trusts, have a vital role to play in reducing health inequalities, by making a wider strategic contribution to improving health determinants. Although improvements in many of the economic, social and environmental determinants are contingent on the success of the various policies and initiatives being pursued by national government, much can be done locally and this mostly falls within the wider remit and day-to-day work of local authorities. This includes:

- driving regeneration and inward investment to improve the local economy and opportunities to work
- ensuring the quality of and improving the access to affordable housing
- ensuring the standard of local education and training
- providing access to green spaces and leisure facilities for improved mental and physical well-being
- labour conditions
- levels of welfare provision
- greater societal cohesion to reduce crime or pervasive antisocial behaviour complaints
- reductions in smoking and levels of alcohol and drug misuse.

What is perhaps less clear is the extent to which the key determinants of good health have an influence on actual health outcomes. As the Marmot Review\(^2\) of 2010 highlighted, there is a need for an evidence-based strategy for reducing health inequalities.

An assessment of the correlation between the health determinants and the health outcomes (where anything over 0.5 is deemed significant) shows a high correlation for child poverty, deprivation, unemployment, childhood education and social cohesion (Table 6) influencing health outcomes.

<table>
<thead>
<tr>
<th>Determinant link to health outcome</th>
<th>Correlation coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child poverty</td>
<td>0.80</td>
</tr>
<tr>
<td>Deprivation</td>
<td>0.79</td>
</tr>
<tr>
<td>Unemployment</td>
<td>0.79</td>
</tr>
<tr>
<td>Childhood education</td>
<td>0.76</td>
</tr>
<tr>
<td>Social cohesion</td>
<td>0.70</td>
</tr>
<tr>
<td>Occupations</td>
<td>0.66</td>
</tr>
<tr>
<td>Crime</td>
<td>0.64</td>
</tr>
<tr>
<td>Qualifications</td>
<td>0.64</td>
</tr>
<tr>
<td>Social housing</td>
<td>0.57</td>
</tr>
<tr>
<td>Income</td>
<td>0.55</td>
</tr>
<tr>
<td>Fuel poverty</td>
<td>0.48</td>
</tr>
<tr>
<td>Living environment</td>
<td>0.44</td>
</tr>
<tr>
<td>Household overcrowding</td>
<td>0.41</td>
</tr>
<tr>
<td>Natural environment</td>
<td>0.39</td>
</tr>
<tr>
<td>Homelessness</td>
<td>0.23</td>
</tr>
</tbody>
</table>

To reduce inequalities it therefore follows that other public sector stakeholders need to be engaged with local authorities when considering local needs services assessments. Although CCGs and local authorities are already working together following authorities’ increased remit in public health and the introduction of the BCF and HWBs, increased efforts are still needed to further the collaborative work to develop a clear focus on improving health determinant levels. This is essential if substantial and permanent progress is to be made on addressing health inequalities, the prevention of ill health and reducing unnecessary visits to A&E.

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\(^2\) Marmot Review of health inequalities in England post 2010 Fair Society, Healthy Lives, which was published on 12th February 2010 (www.marmotreview.org)
Although local authorities were given greater responsibility for public health in 2013 and have the statutory responsibility as directors of public health for promoting improved outcomes, there is still more work to be done, as the benefits of this have yet to fully feed through. Indeed, 42% of local government respondents to our governance survey said that they could not see any real difference resulting from this change.

Other public sector partners
Adopting this holistic approach means that local public sector stakeholders can arguably include more than just local authorities and NHS bodies. Charities have been an established partner for the health sector for some time now and health and wellbeing boards may find it beneficial, in seeking to address health determinants, such as housing, to consider encouraging joint working with local housing groups and charities such as Shelter.

The police may also provide a fruitful area for collaboration. The Home Office has an innovation fund (£70 million awarded for the 2015/16 year) awarded for projects to enable the police to implement schemes which they believe will deliver long-term benefit.

Richmond and Kingston CCGs
In common with all London boroughs and CCGs, Richmond and Kingston are outperforming their determinants.

The two CCGs are part of the South West London Collaborative Commissioning Group, six CCGs that are working together with NHS England to improve the quality of care in the NHS for south west London. They published a five year plan in June 2014 outlining their ambitions, which included working together with local authorities and providers, re-aligning health estates and addressing the fact that they are one of England’s 11 ‘challenged health economies’. They are currently modernising the mental health services and investing in new inpatient facilities financed by sale of surplus land.

Richmond serves an area that is not as ethnically diverse as some London boroughs, but still more diverse than the national average. Almost 9% of people in the borough experience above average levels of deprivation. Around 75% of community health services and 68% of social care services are currently used by people aged 65+. The CCG is set to achieve its required financial surplus and on track to complete 75% of its quality, innovation, productivity and prevention (QIPP) programme.

As well as working with the health and wellbeing board, the CCG has set up a joint commissioning collaborative team (JCC) together with Richmond Council. Strategies such as ‘Better care closer to home’ and ‘Mental health strategy implementation plan’ have already been drawn up and feed into the plan for the BCF. Proactive engagement with patient groups helped drive these and they have also held events such as the ‘Big Event’ in Jan 2015 where both the CCG and the council held an open forum to give users of learning disability support services the opportunity to meet organisations from the local health economy and have their say on the future shape of services.

Kingston CCG are also engaging widely with their populace. They were mentioned as a best practice example in the ‘London: A call to Action’ report for April 2014. They are also working with Kingston Council on a similar Care at Home scheme.

Lancashire Police
Just over £2 million (the third largest grant from the Home Office) was awarded to Lancashire Police Force for the Public Service Lancashire project. The project partners include Blackburn with Darwen CCG, Blackburn Council and the North West Ambulance Service. The types of scheme it has put in place include: having a mental health professional in the custody suites from 8am to 4pm to assist with assessments and advise on appropriate sentencing options to reduce re-offending; and a high intensity user review to identify the needs of individuals who make multiple calls across agencies, so that those needs can be met and the inappropriate calls reduced.

Collaborative commissioning

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Growing healthy communities – The Health and Wellbeing Index

Collaborative working

Royal Borough of Greenwich and NHS Greenwich CCG

Greenwich council has a history of working closely with local NHS health partners which placed it in a strong position to respond to the introduction of the BCF, the Government’s initiative to promote closer integration between health and social care. It is also one of the 14 pioneer sites selected by the NHS to lead the way in delivering better joined-up care.

The council and CCG established multidisciplinary teams to deal with emergencies arising within the community which require a response within 24 hours. The Joint Emergency Team (JET) has been successful in reducing hospital admissions and delayed discharges for patients over 65, with significant savings from the social care budget as a result.

Challenges to collaboration

There are inevitably challenges in collaborating to design a local strategy and new healthcare model with partners from the local health economy.

Collaboration faces systemic challenges. Thinking across organisational boundaries has historically been difficult for the NHS and much of the public sector. Placing trust in your collaborative partner and allowing the free flow of information is critical to the success of any venture.

Local authorities and NHS bodies have regulatory, procedural and cultural differences in their financial approaches that need to be recognised and addressed when collaborating. Local authorities have multiple sources of funding and manage a disparate set of departments, often directly providing many local services, while there is the provider/commissioner split in the NHS with the vast majority of the money ultimately coming from the Department of Health. Mutual understanding of the perspectives of the different organisations and an open-mindedness about what can be achieved are vital – for example, for the BCF, we found that differences were compounded by a lack of trust and a perception among NHS bodies that the pooled funds benefited local authorities and adult social services the most. Collaborative schemes should focus on improved outcomes for the end user, not on which body got the biggest share of a fund.

Another key issue to consider for collaboration between different areas of the public sector is that of funding. A major drive in the NHS Five Year Forward View, via the BCF, is for health and social care to integrate. However, almost all health services are free at the point of access (excluding some dental and optical services) while a number of social care streams are means tested, particular those focused on personal and elderly care. Merging these to produce a seamless service to the end user will be challenging. Elderly care is a particular concern as a large percentage of avoidable hospital admissions come from this demographic and all involved in the health sector are aware that England has a steadily ageing population. Further, the NHS has a more centralised structure than local government and this, combined with the extreme financial pressures it faces, creates a more inward-looking focus that may be less conducive to joint working.

If communication channels are not robust, the information held by strategic decision makers may not be fully shared among the local health economy partners.

There also remain significant governance challenges. As detailed in our September 2014 report, ‘Pulling together the Better Care Fund’, the delegation of authority and accountability remains unclear for a significant number of trusts (59%) and a third of CCGs (30%). Uncertainty leads to delay which at a minimum adds extra cost, but potentially risks service delivery as issues are not dealt with by the correct role. Clearly communicated structures and processes should eliminate these problems.
The Better Care Fund
The BCF does not provide additional funds and requires health and social care organisations to work together in innovative ways to provide integrated care. Although the principle on which the BCF was based and developed was supported by all parties, the fund was introduced over a short period of time and its requirements were changed during this period. As a result the Public Accounts Committee reported in February 2014 their concerns that the BCF may not deliver the savings that were hoped for. The BCF has now been operational for a number of months, so it is too early for health and wellbeing boards to report meaningfully on performance. Greater focus and interest will be on those areas that decided to pool additional funds within their BCF to understand if this does make a difference.

Greater Manchester
Shortly after the Greater Manchester Combined Authority gained new powers and responsibilities (over transport, housing, planning and policing), and a directly elected Mayor in November 2014, a groundbreaking memorandum of understanding (MOU) was signed by the GMCA and its 10 constituent local authorities, NHS England, 12 CCGs and 15 health care providers in February 2015. Its purpose was to devolve a £6 billion health and social care budget to the Mayor by April 2016.

Stated objectives from the memorandum of understanding
- To improve the health and wellbeing of all of the residents of Greater Manchester (GM) from early age to the elderly, recognising that this will only be achieved with a focus on prevention of ill health and the promotion of wellbeing. We want to move from having some of the worst health outcomes to having some of the best
- To close the health inequalities gap within GM and between GM and the rest of the UK faster
- To deliver effective integrated health and social care across GM
- To continue to redress the balance of care to move it closer to home where possible
- To strengthen the focus on wellbeing, including greater focus on prevention and public health
- To contribute to growth and to connect people to growth, for example supporting employment and early years services
- To forge a partnership between the NHS, social care, universities and science and knowledge industries for the benefit of the population

Key features are:
- establishment of the Greater Manchester Strategic Health & Social Care Partnership:
  - involving 12 CCGs, 15 NHS providers, 10 councils, NHS England, regulators, Healthwatch and Greater Manchester Centre for Voluntary Organisation
  - covering acute care, community services, mental health services and social care for a population of 2.8 million
- expected to extend to large elements of specialised services and public health budgets
- currently excludes pharmacy, ophthalmology and dentistry services
- provides an opportunity to move away from existing tariff payment mechanisms
- preventative work in the community such as treating heart conditions by community specialists in a bid to ease pressure on hospitals
- development of strategies around governance, regulation, finances and health education to run the devolved health service.

The Greater Manchester area has a population of approximately three million and has both poor health determinants and correspondingly poor health outcomes. The MOU includes plans for NHS bodies to work together with organisations that can have a significant impact on key health determinants. It is a positive step forward towards a model of healthcare focused on keeping a population healthy, rather than treating an individual when they are sick, along with the savings that this should entail.
Greater Manchester had previously already identified that they had some of the worst health outcomes in the country. The Healthier Together programme was meant to address the structural issues within the health economy and deliver better care, and thus better outcomes. New models of care were proposed for primary and acute care including re-organising hospital sites more efficiently and more joined-up care to allow people to be treated at home. However, a lack of trust with collaborative partners, among other issues, has led to a succession of delays and the focus of the Healthier Together programme was on NHS bodies, so missing opportunities to effect determinants such as housing and education. Merging the aims of the Healthier Together programme with the devolution scheme should yield faster results as there is a clearer framework in place for decision-making and there are clearer lines of accountability for collaborative partners to follow. The upfront investment costs are estimated at £300 million. Current estimations (as at March 2015) are of £165 million increase in primary sector spend, coupled with the corresponding reduction in the acute sector of about £225 million to £235 million. This would realise an annual saving of £60 million to £70 million. Together with the saving from preventing 60,000 avoidable hospital admissions per annum, a total of £250 million per annum is planned. This will half Greater Manchester’s currently projected £500 million deficit.

The pioneer programme
In 2013, 14 pioneer sites were selected to develop integrated ways to co-ordinate care around an individual’s needs. In January 2015, a further 11 pioneer sites were selected, including Greater Manchester. The Pioneer Programme has published its 2014 annual report and full evaluations will be undertaken by the Department of Health later in the year. The indications are that each pioneer has experienced some successes. However, these schemes are not yet at a significant scale and have yet to show if similar results can be achieved on a large scale.Rather, they present a case that person-centred, coordinated care should deliver financial and personal benefits across the health economy.

Cornwall has shown that its approach in Penwith has reduced the number of people admitted to hospital by 50%, building on a 40% reduction experienced in Newquay. Similarly Kent has had success with its first 134 patients reducing non-elective admissions by 55%, with savings estimated to be £200,000. South Devon and Torbay has reduced the number of people living in residential care. In addition many pioneer sites have seen an increase in patient experience.

There are major financial pressures. Nineteen CCGs are in deficit for the financial year 2014/15, and many will only have made their required surplus through non-recurrent funding. This clearly places significant pressure on commissioning services for 2015/16 and beyond. CCGs will need to closely examine the cost improvement programmes (CIPs) of their partner trusts to validate how realistic their QIPP schemes are, given how crucial these will be to delivering the planned budgets. Some areas have seen significant QIPP scheme slippages this year, with resultant pressure on the schemes to achieve even greater savings in the coming years. Worryingly, our 2015 NHS Governance review has shown a downwards trend in CCGs performing a comprehensive assessment of the trusts’ CIPs (going from 60% to 36%) despite this.

The vanguards
The 29 vanguards created on 10 March 2015 which model joined-up working for three different types of care, covering: primary and acute care systems; multispecialty community providers; and social care.
Key questions to support improved collaborative outcomes in your local health economy

1. What do you currently know about the determinants of good health, and the health outcomes in your health area? Is the information being shared across all partners and used effectively to plan integrated services?

2. Are these consistent with the Joint Strategic Needs Assessment and are resources being targeted to improve the determinates and outcomes and are they effective in making a difference?

3. Does your joint health and wellbeing strategy clearly set out how health determinants and outcomes will be improved?

4. What resources are being devoted to preventative measures within the health economy? Is the right balance being struck about the short-term versus long-term benefits of spending decisions?

5. Where does your geographic influence really extend to?
   It is necessary to consider not just the impact of factors within your organisation’s statutory boundaries, but those within your partner organisations as well. These will influence outcomes in any plans you implement together.

6. Who is in your health economy and what assets do they already hold? Where are they?
   With looming deficits a concern it will be important to utilise existing infrastructure to its full potential. Preventive measures often don’t require state of the art technology and brand new facilities, but they do require co-ordinated effort and smooth logistics.

7. When agreeing new care models with partners in the local health economy are you communicating honestly? Are you thinking in the short-term or for the long-term?
About us

**Place Analytics**
Grant Thornton’s place analytics team provides a range of offerings, from on-line research and intelligence services to consultancy services, which inform local area analysis and place-based strategies and decisions.

The team helps clients across the public and private sectors to understand better the places, economies and markets in which they operate, and the people that they serve.

Proprietary data includes composite measures and scores relating to the knowledge economy, creative places, local amenities, quality of life, natural environment and sustainability.

Through a combination of sophisticated business intelligence tools and national coverage of over 4,000 indicators, from 130 different sources, Place Analytics enables:
- comparison between different areas and places across a range of spatial scales
- data sets to be tracked over time and an assessment of the impact of policies
- the correlation of data to undertake multivariate analysis and unpack the drivers of particular patterns
- place optimisation through the identification of particular locations based on a range of criteria
- analysis of people by where they live, to identify common characteristics and behaviours within catchment areas, communities and neighbourhoods.

We provide analytics services to some of the largest local authorities in the UK, as well as leading developers, local enterprise partnerships, central government departments, dynamic high growth businesses and not for profit organisations.

In order to inform local decisions, we can provide in-depth reports for individual local authorities showing how they perform on the health and wellbeing measures used in this report. In addition, the suite of Place Analytics tools can allow for individual health economy assets to be mapped against socio-economic indicators and infrastructure to understand provision of services at the local level. Please contact us to find out more.

**Business intelligence tools to help you understand places, people, economies and markets**

**Place Insight** – achieve a better understanding of places in terms of the economy, society and environment. Based on the latest data, at different spatial levels and linked to an easy-to-use toolkit, it provides a powerful online research & intelligence tool.

**Customer Insight** – achieve a better understanding of customers, citizens and communities. Drawing on the ONS OAC geodemographic classification, together with local data estimates, you can generate a profile of people by where they live and draw general conclusions about their characteristics and behaviours.

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