Health & Wellbeing
Delivering the Outcomes

Carl Bennett

Inclusion, Disability & Health Lead

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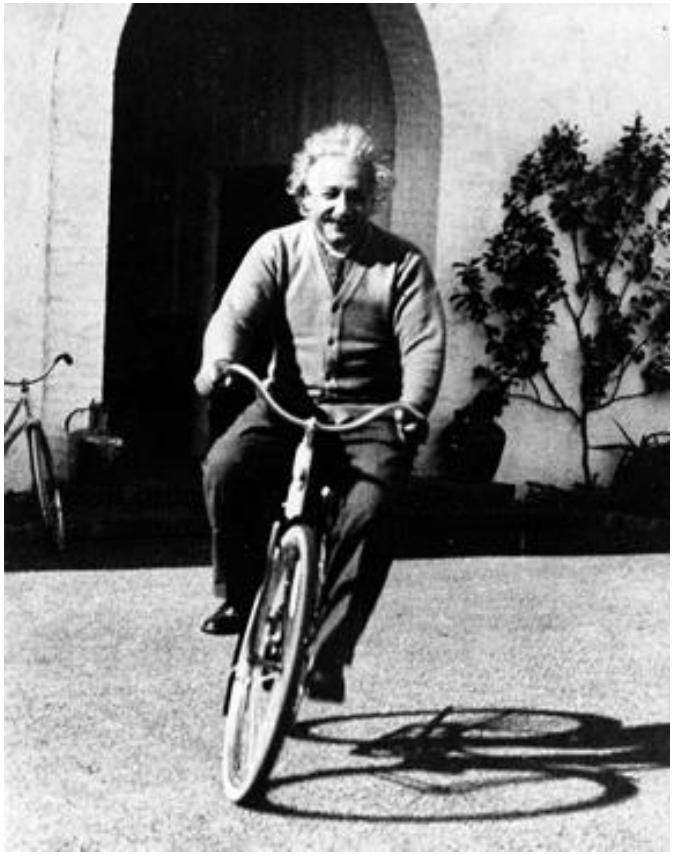
- **What, Why and Where** - Identifying Valid, Reliable & Current ‘Local’ Data, Information & Priorities

  - **Differentiating Impact and Outcomes** - having a consistent view of these two different measures

    - **Examples of Tools** - to help you measure change



“People love chopping wood. In this activity one immediately sees results”

“Insanity: doing the same thing over and over again and expecting different results”

Identifying ‘Local’ Data, Information, Needs & Priorities - The Golden Thread

Brilliant quote:

"Data is the crude oil – it's how you refine it, how you work with it, that makes it valuable"

Jonathan Woodward, Business Lead for BI and Analytics at Microsoft UK

Where do we look?

What should we find?

Key Q's - is it Reliable, Valid & Current?

What Should Be On Your ‘Understanding Priorities & Needs’ Shopping List?

5mins in groups - come up with 4 key documents, strategies, plans that will help you identify the local issues, priorities and needs which your programmes & interventions can address – discuss the differences in your groups before choosing your 4

What Should Be On Your 'Needs' Shopping List?

Joint Strategic Needs Assessment - LA web
Will include a wealth of data and information already filtered and prioritised for you

Health Profile

Director of Public Health Annual Report

Sets the scene for local health issues

Public Health England

Protecting and improving the nation's health

Stoke-on-Trent

Unitary authority

This profile was published on 4th July 2017

Health Profile 2017

Health in summary

The health of people in Stoke-on-Trent is generally worse than the England average. Stoke-on-Trent is one of the 20% most deprived districts/unitary authorities in England and about 28% (14,400) of children live in low income families. Life expectancy for both men and women is lower than the England average.

Health inequalities

Life expectancy is 9.3 years lower for men and 7.1 years lower for women in the most deprived areas of Stoke-on-Trent than in the least deprived areas.

Child health

In Year 6, 22.7% (643) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 is 35*. This represents 19 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding initiation and smoking at time of delivery are worse than the England average.

Adult health

The rate of alcohol-related harm hospital stays is 1,058*, worse than the average for England. This represents 2,494 stays per year. The rate of self-harm hospital stays is 361*, worse than the average for England. This represents 923 stays per year. The rate of smoking related deaths is 405*, worse than the average for England. This represents 511 deaths per year. Estimated levels of adult excess weight, smoking and physical activity are worse than the England average. The rate of hip fractures is worse than average. Rates of sexually transmitted infections and people killed and seriously injured on roads are better than average.

Local priorities

Priorities in Stoke-on-Trent include tobacco control, healthy weight and reducing under 18 conceptions. For more information see www.stoke.gov.uk/health and http://webapps.stoke.gov.uk/uploadedfiles/Public-Health-Annual-Report-2015.pdf

* rate per 100,000 population

This profile gives a picture of people's health in Stoke-on-Trent. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info for more profiles, more information and interactive maps and tools.

Follow @PHE_uk on Twitter

Health summary for Stoke-on-Trent

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared

Regional average£ | England average | England worst | 25th percentile | 75th percentile | England best

Domain	Indicator	Period	Local count	Local value	Eng value	Eng worst	England range	Eng best
Our communities	1 Deprivation score (IMD 2015)	2015	n/a	34.4	21.8	42.0		5.0
	2 Children in low income families (under 16s)	2014	14,350	27.9	20.1	39.2		6.6
	3 Statutory homelessness	2015/16	130	1.2	0.9			
	4 GCSEs achieved	2015/16	1,211	48.4	57.8	44.8		78.7
	5 Violent crime (violence offences)	2015/16	8,556	34.1	17.2	36.7		4.5
	6 Long term unemployment	2016	788	5.0 ^a20	3.7 ^a20	13.8		0.4
Children's and young people's health	7 Smoking status at time of delivery	[illegible]	[illegible]	[illegible]	[illegible]	26.0		1.8
	8 Breastfeeding initiation	2014/15	1,734	48.4	74.3	47.2		92.9
	9 Obese children (Year 6)	2015/16	643	22.7	19.8	28.5		9.4
	10 Admission episodes for alcohol-specific conditions (under 18s)†	2013/14 - 15/16	58	34.7	37.4	121.3		10.5
	11 Under 18 conceptions	2015	111	26.9	20.8	43.8		5.4
Adults' health and lifestyle	12 Smoking prevalence in adults	2016	n/a	20.3	15.5	25.7		4.9
	13 Percentage of physically active adults	2015	n/a	48.2	57.0	44.8		69.8
	14 Excess weight in adults	2013 - 15	n/a	68.5	64.8	76.2		46.2
Disease and poor health	15 Cancer diagnosed at early stage	2015	499	48.6	52.4	39.0		63.1
	16 Hospital stays for self-harm†	2015/16	923	361.2	196.5	635.3		55.7
	17 Hospital stays for alcohol-related [illegible]	2015/16	2,494	1058.3	647	1,163		374
	18 Recorded diabetes	2014/15	16,987	7.6	6.4	9.2		3.3
	19 Incidence of TB	2013 - 15	91	12.1	12.0	85.6		0.0
	20 New sexually transmitted infections (STI)	2016	1,008	623.6	795	3,288		223
	21 Hip fractures in people aged 65 and over†	2015/16	281	708.2	589	820		312
Life expectancy and causes of death	22 Life expectancy at birth (Male)	2013 - 15	n/a	76.4	79.5	74.3		83.4
	23 Life expectancy at birth (Female)	2013 - 15	n/a	81.0	83.1	79.4		86.7
	24 Infant mortality	2013 - 15	84	7.9	3.9	8.2		0.8
	25 Killed and seriously injured on roads	2013 - 15	137	18.2	38.5	103.7		10.4
	26 Suicide rate	2013 - 15	67	10.5	10.1	17.4		5.6
	27 Smoking related deaths	2013 - 15	1,532	404.6	283.5			
	28 Under 75 mortality rate: cardiovascular	2013 - 15	530	87.1	74.6	137.6		43.1
	29 Under 75 mortality rate: cancer	2013 - 15	1,084	178.3	138.8	194.8		98.6
	30 Excess winter deaths	Aug 2012 - Jul 2015	403	17.5	19.6	36.0		6.9

Indicator notes

1 Index of Multiple Deprivation (IMD) 2015 2 % children (under 16) in low income families 3 Eligible homeless people not in priority need, crude rate per 1,000 households 4 5 A*-C including English & Maths, % pupils at end of key stage 4 resident in local authority 5 Recorded violence against the person crimes, crude rate per 1,000 population 6 Crude rate per 1,000 population aged 16-64 7 % of women who smoke at time of delivery 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery 9 % school children in Year 6 (age 10-11) 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population 11 Under-18 conception rate per 1,000 females aged 15 to 17 (crude rate) 12 Current smokers (aged 18 and over), Annual Population Survey 13 % adults (aged 16 and over) achieving at least 150 mins physical activity per week, Active People Survey 14 % adults (aged 16 and over) classified as overweight or obese, Active People Survey 15 Experimental statistics - % of cancers diagnosed at stage 1 or 2 16 Directly age sex standardised rate per 100,000 population 17 Admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (narrow definition), directly age standardised rate per 100,000 population 18 % people (aged 17 and over) on GP registers with a recorded diagnosis of diabetes 19 Crude rate per 100,000 population 20 All new diagnoses (excluding chlamydia under age 25), crude rate per 100,000 population aged 15 to 64 21 Directly age-sex standardised rate of emergency admissions, per 100,000 population aged 65 and over 22, 23 The average number of years a person would expect to live based on contemporary mortality rates 24 Rate of deaths in infants aged under 1 year per 1,000 live births 25 Rate per 100,000 population 26 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aged 10 and over) 27 Directly age standardised rate per 100,000 population aged 35 and over 28 Directly age standardised rate per 100,000 population aged under 75 29 Directly age standardised rate per 100,000 population aged under 75 30 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths (three years)

† Indicator has had methodological changes so is not directly comparable with previously released values. £ "Regional" refers to the former government regions.
^a20 Value based on an average of monthly counts $ There is a data quality issue with this value

If 25% or more of areas have no data then the England range is not displayed.

Please send any enquiries to healthprofiles@phe.gov.uk

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webapps.stoke.gov.uk/jsna/reports.aspx

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Joint Strategic Needs Assessment

understanding the health and wellbeing needs of Stoke-on-Trent

Home | About | Contact | Reports | Key Strategies

- Population and demography
- People
- Place
- Deprivation
- JSNA Protocol and other reports

Reports

Health and Wellbeing Board JSNA Outcomes Report 2015

This document has been produced to support strategic planning for the Health and Wellbeing Board from 2016. It is based on the Public Health Outcomes Framework and other key health and wellbeing indicators. The report provides a short summary of individual outcomes, including comparison to national rates, trends and a brief commentary. Please click here to view.

Director of Public Health Reports

The Director of Public Health (DPH) has a duty to produce an independent annual report on the health of the local

The annual report of the Director of Public Health

for Stoke-on-Trent, 2014

city of stoke on trent

I was thrilled during 2014 to come to Stoke-on-Trent and join such a committed Public Health Team. The public's health is a vital part of the future success of our city and I am pleased to report that progress is being made in a number of areas – rates of sexually transmitted infections are lower than the average level for England, a focus on Healthy Urban Planning is reaping benefits and we hosted an excellent series of 'Big Debates' which attracted large numbers of local residents to discuss key issues such as obesity and alcohol. There is still much to do, however. In the coming year there needs to be an increased focus on tackling smoking, more work to reduce the number of young women under the age of 18 who get pregnant, a focus on promoting walking and cycling, more opportunities for young people and even better spreading of messages on how to stay healthy.

Dr Lesley Mountford, Director of Public Health

Health in context

Stoke-on-Trent is steeped in history and tradition and its legacy of the pottery, coal and steel industries can still be seen across the six towns which make up this great city. During 2014 the Wedgwood collection – one of the most important industrial archives in the world and a unique record of 250 years of British art – was saved for future generations of local people. The modern ceramics industry is thriving and Stoke-on-Trent has been reported as 4th out of 64 UK cities for job creation over the last year, with a 3.1% increase in jobs since 2012.

The improving economic and social environment of the Potteries is very encouraging, but deep health inequalities still exist locally. Male life expectancy, at birth, is 76.5 years which is significantly below the national average of 79.4 years, and the gap is increasing. For women, average life expectancy at birth is 80.6 years which is significantly below the average of 83.1 years in England.

Working together

To improve the health and wellbeing of the 250,000 people who call Stoke-on-Trent their home, and the thousands of people who commute to work in the city everyday, requires the cooperation and commitment of many individuals and organisations. Stoke-on-Trent's Health and Wellbeing Board is now well established with its membership drawn from the council, Stoke-on-Trent Clinical Commissioning Group, the voluntary sector and our three large local NHS providers: The Royal Stoke University Hospital, North Staffordshire Combined Healthcare (which provides services for mental health issues) and the Staffordshire and Stoke-on-Trent Partnership NHS Trust, which provides community services.

The Dudson Centre in Hanley, home of Voluntary Action Stoke-on-Trent (VAST) a charity providing services and support to voluntary and community groups, charities and social enterprises in Staffordshire

The strength of local partnership working was evident during the Local Government Association's peer challenge process into childhood obesity. This was an opportunity to look in detail at this important issue in an open, honest and innovative way. Locally, one in ten 4-5 year olds are obese by the time they reach primary school and by the time they are 10-11 years old this figure has doubled to one in five. Obesity can lead to serious medical conditions, including diabetes, and also increases the risk of heart disease, stroke and cancer. The Lifestyle Service, co-ordinated by the voluntary sector, supports individuals to make sustainable healthy choices around weight, diet and exercise. Nearly 3,000 residents took advantage of this service during 2014.

stoke.gov.uk

Other places to find Needs & Priorities

LA Corporate Plan – CCG Local Delivery Plan – Regeneration Plan
Employability Action Plan – Police & Crime Commissioner Plan - Public Health Outcome Framework - Troubled Families Action Plan
Health & Wellbeing Board Plan & Annual Report

Providers of activities / interventions must respond to Local Needs and demonstrate Why and How they are doing things

Need must be established & addressed at the development stage of interventions/services

Do Not Retro-Fit!

If you are 'bolting on' make sure you understand the reasons why and expectations are evidence based

Useful Definitions

What is Public Health?

The science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society

UK Faculty of Public Health; 2010

What do we mean by Evidenced Based?

Evidence[1] - In the broadest sense, evidence can be defined as “facts or testimony in support of a conclusion, statement or belief” and “something serving as proof”

Evidence Based Public Health[2] **-** A public health endeavour in which there is an informed, explicit, and judicious use of evidence that has been derived from any of a variety of science and social science research and evaluation methods

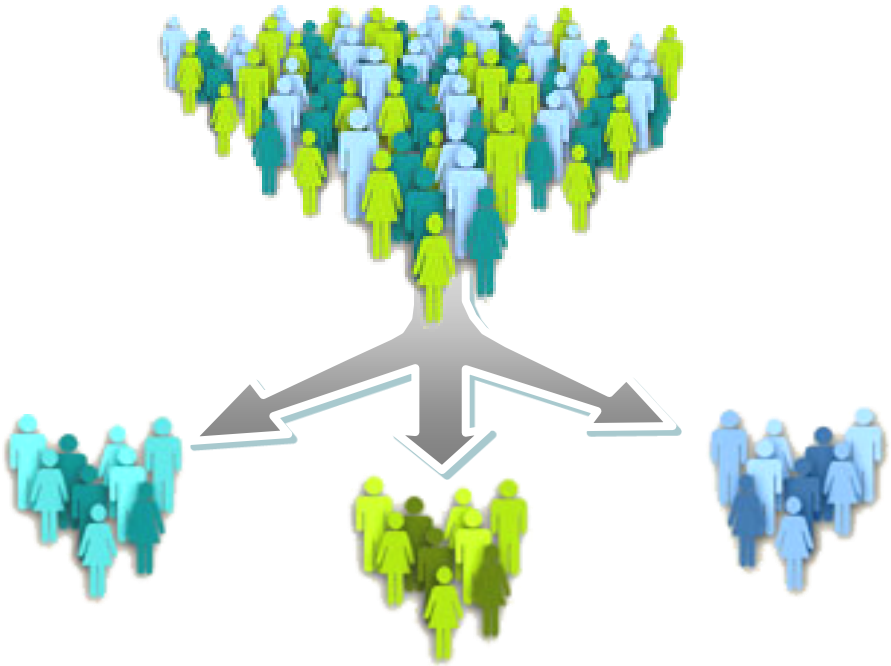
1. Trumble WR, Stevenson A, eds. Shorter Oxford English dictionary on historical principles; 2002
2. Detels R , Breslow. Current scope and concerns in public health. In: Detels R, McEwen J, Beaglehole R, et al, eds. Oxford textbook of public health; 2002

An **Evidence Check** is more crucial now than ever before - Learning from what works, and what hasn't

The really good stuff will be based on Local, Regional, National and International Evidence & Best Practice:

- National Institute for Health and Care Excellence (NICE)
- Sport England Research
- National Obesity Forum
- British Heart Foundation National Centre for Physical Activity
- UKActive Research Institute
- SPORTA 'Make Your Move' & SPORTAPurple
- World Health Organization
- Centres for Disease Control (USA)

Segmentation



“The process of defining and sub-dividing a large homogenous market into clearly identifiable segments having similar needs, wants or demand characteristics”

www.businessdictionary.com

Critical Appraisal

Critical Appraisal is the process of carefully and systematically examining research to judge its trustworthiness, and its value and relevance in a particular context (*Burls 2009*)

Why CA is important

Ensure Data/Information is:

Valid, Current, Reliable, Topic Appropriate and Un-biased

Important

Do not base decisions on Feelings, Beliefs, Preferences, or, the Status Quo (we've always done it that way…)

Key Traits: Objectivity, Inquisitiveness, Sound Practical Research Techniques & Question Everything!

Result = Making Informed Decisions

IMPACT & OUTCOMES

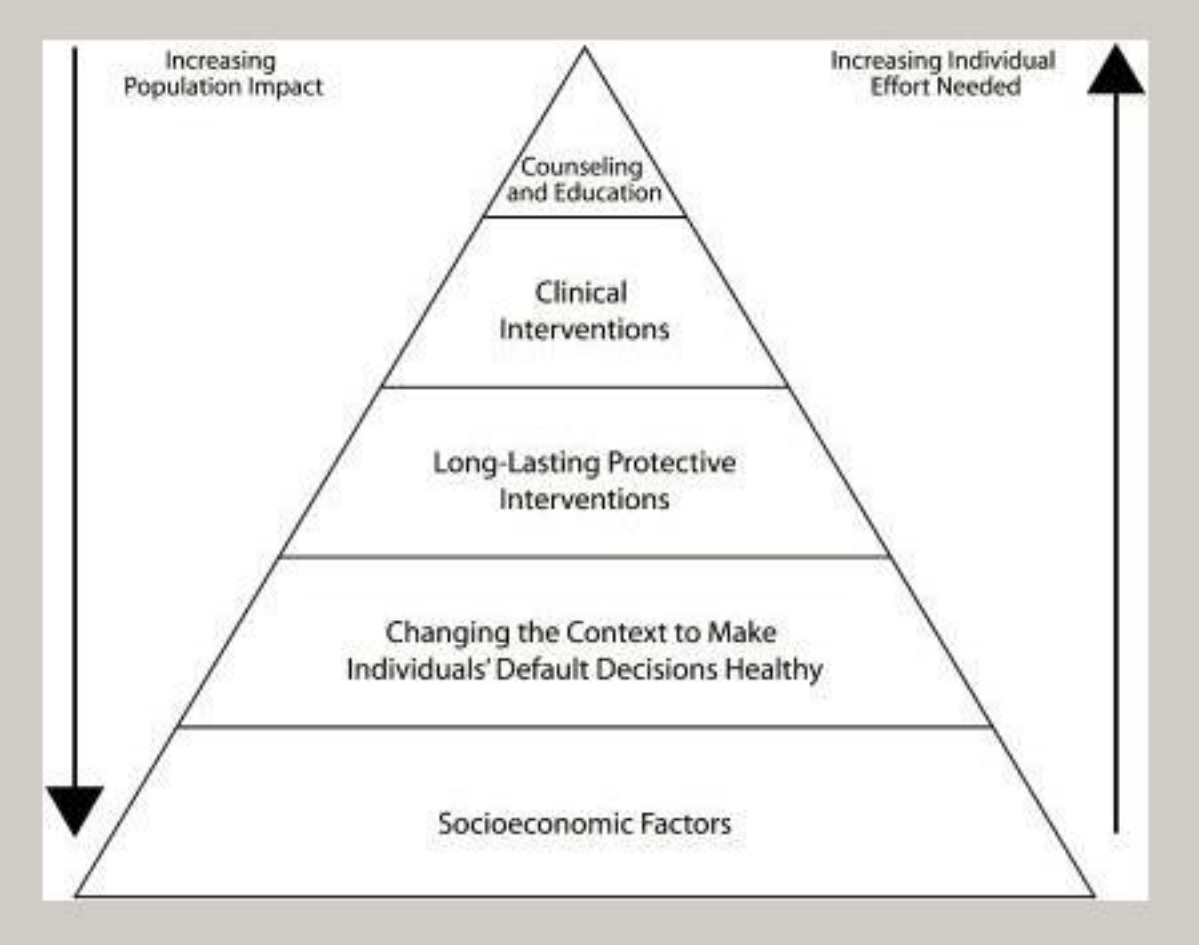
- **Health Impact** (Assessment) is a practical approach used to judge the potential health effects of a policy, programme or project on a population, particularly on vulnerable or disadvantaged groups. Recommendations are produced for decision-makers and stakeholders, with the aim of maximising the proposal's positive health effects and minimising its negative health effects

- **Health Outcomes** are a change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status

Health Impact Assessment http://www.who.int/hia/about/en/

Health Impact

£ = Less Expensive More People



£ = Less People More Expensive

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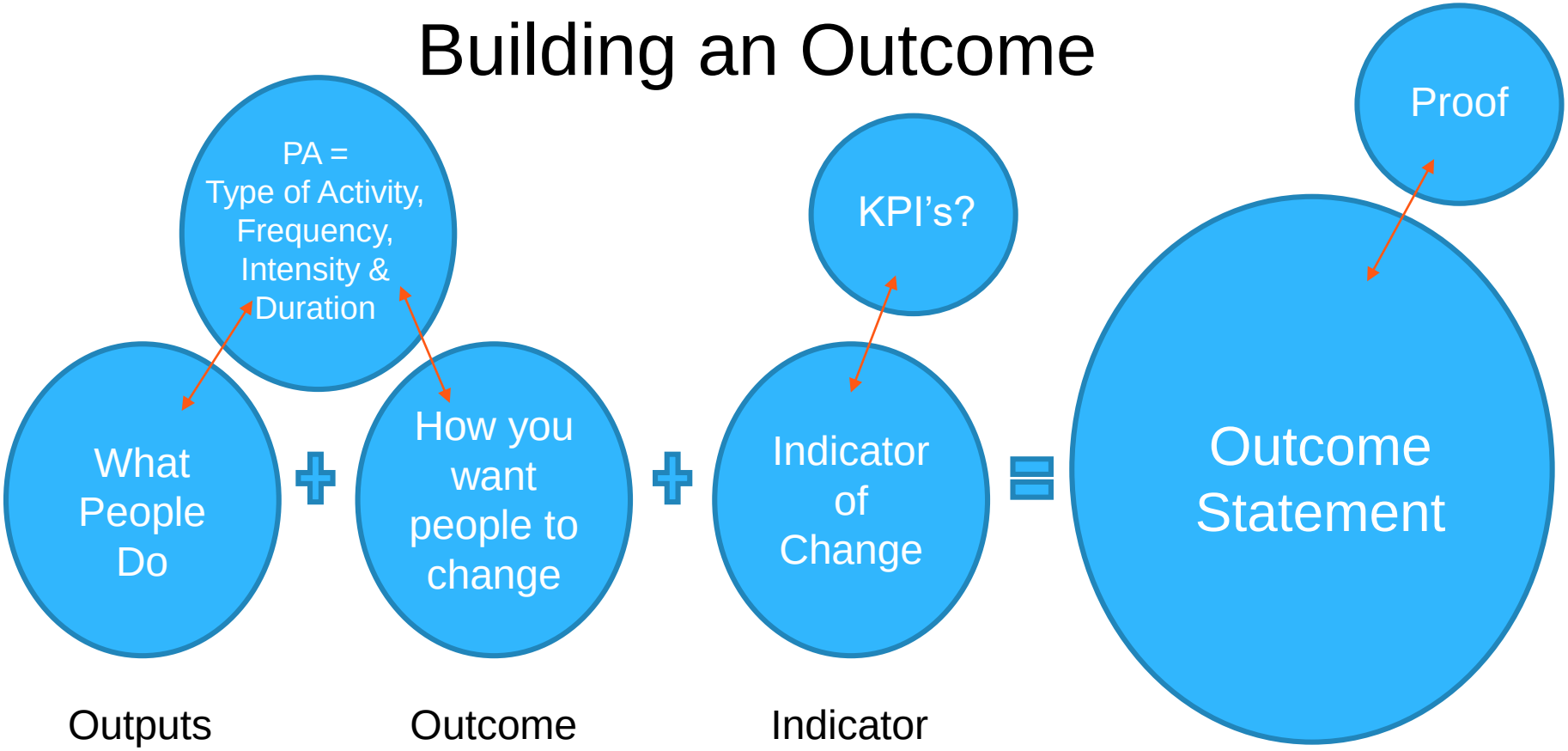
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/

Building an Outcome



Outcome = Benefits and/or changes a person/population demonstrate/achieve during or after their engagement with an intervention

Outcomes might relate to: knowledge, skills, attitude, values, behaviour, condition or status

Contribution to Health & Wellbeing
The Quest Module

The Quest Assessment Process

Gplus 5 – Contribution to Health & Wellbeing

Module Outcomes

- Programmes and interventions are embedded in core offer and clearly demonstrate how they address local H&W priority issues
- Programmes and interventions have been agreed with local H&W stakeholders and pathways exist to encourage participation from priority populations
- Health and wellbeing targets reflect local priorities and evidence exists to demonstrate impact

Are you Ready to Tell the Story ?

Identifying ways to tell the backstory - the difference it makes to the individual

Links to the Behaviour Change, Barriers to Participation & Under-representation themes which are clearly articulated within Sporting Future and Towards An Active Nation

Seeking out qualitative information is now as important as the number crunching the sector has relied upon:

Being able to tell a story, tracing the customer journey, down to the individual level presents a significant challenge.

There are loads of tools that can help you:

iPAQ, EQ5D, SEF-PA (NOO), Pedometers, Behaviour Change Assessments, Self Reported Questionnaires, Self Reported Diaries, Observational Techniques, Modifiable Activity Questionnaire, PAQE (physical activity questionnaire for the elderly), Upshot, iMPACT, Views (Substance) - what about Video Blogs

Pre Validation Day (*Non Prep Day*)

- Contact established with lead representative and phone calls and emails are exchanged
- Date for Validation agreed and booked - validator then book travel arrangements / hotel etc)
- Information is shared which helps you plan your day - some details as to expectations are shared
- A template Validation Day Programme is shared
- At least 5 days before = 2 x 2500 words synopsis is sent to validator with the final programme for the day

Validation Day Programme

Focus Groups and Key Individuals

TIME	GROUP & INDIVIDUAL/S	EVIDENCE TO BE DELIVERED TO SUBSTANTIATE STORY
9am 30 minutes max	**Set the scene** - Validator, manager/ other key staff as deemed appropriate	At this point I will highlight any areas that based on the submissions received I know I will require additional info, also opportunity for team to brief me on anything I need to be aware of in respect of any of the participants.
	Two separate Management and Staff focus groups allow up to 1.5 hours each	**Notes**
9.30am - 10.30am Increasing Participation and Reducing Inactivity 10.30am-11.30pm Leadership	**Management Team Focus Group** Named individuals required. An appropriate mix of Management Team members who are best placed to shape the discussions around the 2 modules being validated. Probably best to limit this group to 6 so all can have input and add value to process. The right people are those most relevant to the modules you have selected and the story you are seeking to tell in your submissions.	State name and role State why (not just job title) in each case the individual is part of the focus group. This gets you thinking up front as to each person's contribution to the whole story (each of the modules) and you will be clear as will they why they are there, you will also be clear why others are not.
11.45 – 12.45	**Staff Focus Group** An appropriate mix of Staff / Team members who are best placed to shape the discussions around the 2 modules being validated. Probably best to limit this group to 6 so all can have input and add value to process.	Include those from your wider team who might deliver activities or shape delivery at a local level. These will assist the validation process by confirming the story being told.
1.00pm	**Lunch - A short break of 30 minutes** (you provide refreshments)	

Right Directions

Quest & NBS is managed in partnership by Right Directions Ltd and Leisure-net Solutions Ltd on behalf of Sport England

Leisure-net Solutions Ltd

Validation Day Programme

1.30-2.45	**Stakeholder Focus Group** Identify those who will help validate your story. These must be people at an appropriate level from organisations who can help generate insight and assist your story telling. It is for you to determine who are best able to support/provide compelling evidence that matches the modules being assessed.	Split across those you work with, through and for. This session aims to add to the story you are telling and adds another level of validation. Think about who you need to have in attendance and how their perspective compliments the modules you are being assessed against.
2.45-3.45	**Customer Focus Group** Enables you to invite customers, those in receipt of your services, to tell their story. Who might help inform the validation process? What insight can they add?	I'd expect these to be of a senior position based on the modules you are being assessed against so they can articulate the local 'fit' and how value working with you is achieved / recognised.
3.45-4.30	**Strategic Stakeholder Session/s**	An additional stakeholder session could be with local decision makers (local councillor's / politician's and/or strategic individuals). Probably good to have max of 2 strategic people / orgs
4.30-4.45pm	**Wash-up Session**	Any clarifications required will be shared and responded to.
4.45-5.30pm	Assessor's consolidation time to help determine the result of the day.	An interim decision will be announced at the end of this session.

TESTIMONIALS FROM STAKE HOLDERS/CUSTOMERS WHO ARE UNABLE TO ATTEND FOCUS GROUPS acceptable but focus groups will be the main source for evidence gathering.

Allow Some (but limited) scope during the day for Individual interviews of KEY stakeholders/staff who are unable to make focus group session or it is felt more appropriate that they have an individual discussion. Approx. 1/2 hour available over the day possibly more, rather depends on size of focus groups more compact ones tend to require less time.

Right Directions

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Leisure-net Solutions Ltd

Pre Validation Day (*With Prep Day*)

- Contact established with lead representative and phone calls and emails are exchanged
- Date for Prep Day & Validation Day agreed and booked - validator then books travel arrangements / hotel etc)
- Information is shared which helps you plan your day - some detail as to expectations are also shared
- A template Validation Day Programme is shared
- Validator shares information that will help plan for the Prep Day - Helping to identifying areas of Outstanding Practice

Prep Day

- During the Prep Day we will focus on the Story Telling
- We will identify the areas which you want to highlight - I call these your “Spotlight Interventions”
- One of the objectives is to ID those that can help you tell the story - your stakeholders, partners & customers. Ensuring these are the right people is crucial.
- Agree a format for the day & start to populate the Programme

Question & Answer Session

Your chance to ‘Ask Anything’

Questions ?

Thank you

Carl Bennett
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