

Venue

Duration - Date

Policy and Strategy Development to Improve Population Health & Wellbeing

Workbook

NAME:

ORGANISATION:

This Workbook is Personal & Confidential to the Programme Participant.

It has been designed in modular fashion to accommodate Pre-Workshop Activity, materials provided in the Workshop and also to facilitate optional Post-Workshop further learning and development. The Work-Book content will be delivered in sections/segments.

WE HAVE PROVIDED A PERSONAL ASSESSMENT FORM FOLLOWED BY BLANK PAGES FOR ANY NOTES



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WORKBOOK: POLICY & STRATEGY

In this Workshop, part of a series of five for Information and Intelligence personnel, participants are encouraged to explore and better understand the context and techniques involved in public policy development and its impact on the health and well being of populations and groups, with a particular focus on the iterative nature of policy development, planning, implementation and outcomes via a series of practical healthcare/public health relevant scenarios and situations.

Whilst, as required, workshops will provide insights into some of the basic and underpinning theories of policy and strategy development, our accent throughout will be on inter-activity via individual and team practical exercises encouraging participants to develop their knowledge and understanding and using the Workshop as a springboard for further development.

The use of a Learning Log provided to all those who attend Workshops in this series is intended to support this 'continuous learning' approach; additional Learning Log pages are included at the end of this Workbook.

Linked website: www.healthknowledge.org.uk

Sample Programme

09.30 Registration and Refreshment

10.00 Introductions, agenda, resources and case studies

10.15 Policy Development and Planning

- Public Health Policy Development
- Understanding the policy process
- Identifying issues within Public Health Policy development
- Policy Analysis and Impact Assessments
- Reflecting on organisational priorities
- Selecting policy instruments

11.30 Refreshment

11.40 Policy Implementation

- Understanding Co-ordination through Local Strategic Partnerships and Sustainable Community Strategy
- Introduction of tools for decision making and planning

12.30 Lunch

13.30 Policy Outcomes and Evaluation:

- The new Performance Framework
- Understanding Outcomes-based Accountability
- Applying an outcomes framework
- Monitoring the effectiveness & consequences of policy implementation

15.15 Refreshment

Session Feedback and Reflection

16.00 Close

Workbook Contents

CONTENTS	PAGE
Workshop Objectives	6
Key Literature Sources	7
Development of Case Studies	10
10 Steps to Building Your Case Study	11
Policy Development & Planning – Learning outcomes	14
• Policy & Strategy - Definitions	14
• A brief history of Public Health Policy Development	17
• Activity 1	19
• Understanding the Policy Process	21
• Identifying issues	22
• Policy Impact & Analysis	24
• Examples of UK health, social and public policy	26
• Activity 2	33
• Policy instruments	35
• Consultation	41
Policy Implementation & Policy Outcomes – Learning outcomes	42
• Co-ordination & Strategic Planning	42
• Decision making	44
• Activity 3	47
• Implementation & Evaluation	49
• Outcomes-based Accountability	50
• Activity 4	54
• Monitoring & Evaluation	59
Appendix 1: National Indicators for Health & Social Care	61
Appendix 2: Session Evaluation	65
Personal Learning Log	66

WELCOME to the Workshop on POLICY & STRATEGY

Workshop Objectives

The following workshop objectives are built upon the core area of knowledge required for *policy and strategy development and implementation to improve population health and wellbeing within the Public Health Skills and Career Framework*

(www.phru.nhs.uk/Pages/PHD/public_health_career_framework.htm)

Aim

To consider the context and techniques involved in public policy development and its impact on the health and well being of populations and groups

Learning outcomes

Policy Development and Planning

- Understand the strategic context of policy development
- Understand the process of policy development and its complexities
- Understand the importance and impact of public policy and legislation on health and wellbeing at individual, local, national and global levels
- Awareness of the major government policies related to health and wellbeing, health inequalities and their interconnections
- Explore the political environment in which one's own organisation is set and how this affects its policy and strategy

Policy Implementation and Policy Outcomes

- Awareness of the variety of tools that can be used to aid strategic decision making and planning
- Understand the different methods to assess the impact of policies on health and wellbeing
- Awareness and experience of how to communicate and implement policies and strategies to improve the population's health and wellbeing
- Experience the concepts of power, interest and ideology in policy development

Key Literature/Sources

Academic:

Acheson (1998) *Independent Inquiry into Inequalities in Health Report* London: DH

Adair, J (2007) *Decision Making and Problem Solving Strategies* London: Kogan-Page

Baggott, R. (2000) *Public Health Policy and Politics*. Basingstoke: Palgrave

Bridgman and Davis (2000) *The Australian Policy Handbook* and Walt et al (2008) 'Doing' health policy analysis: methodological and conceptual reflections and challenges *Health z*

Bruce, N.; Springett, J.; Hotchkiss, J.; and Scott-Samuel, A. (1995) *Research and Change in Urban Community Health*. England: Avebury

Johnson, G. and Scholes, K. (2001) *Exploring Public Sector Strategy*. England: Pearson Education

Dahlgren G, Whitehead M. (2006) *Levelling Up (part 2)*. Copenhagen: WHO Regional Office for Europe,

Davies, M. and Macdowall, W. (2006) *Health Promotion Theory* London School of Hygiene and Tropical Medicine

Friedman, M. (2005) *Trying Hard is Not Good Enough* Oxford: Trafford Publishing

Ham, C (2004) *Health Policy in Britain* Basingstoke: Palgrave Macmillan

Levin, P. (1997) *Making Social Policy* Buckingham: Open University Press

Hunter, D. (2007) *Managing for Health* Oxford: Routledge

Macdowall, W., Bonell, C. & Davies, D (2007) *Health Promotion Practice* London School of Hygiene and Tropical Medicine

Mcnamara, C. (2005) *Field Guide to Consulting and Organisational Development* Minnesota: Authenticity Consulting

Wanless, D. *Securing Good Health for the Whole Population*. London: HMSO, 2004.

WORKBOOK: POLICY & STRATEGY

Policy:

Cabinet Office (1999) *Professional Policy Making for the Twenty First Century*. Report: Strategic Policy Making Team

Department for Children, Schools and Families (2008) *The Children's Plan – Building brighter futures* London: HMSO

Department for Children, Schools and Families (2008a) *Better Outcomes for Children and Young people – From Talk to Action* London: Crown

Department for Children, Schools and Families (2008b) *Turning the Curve Stories* London: Crown

Department for Communities and Local Government (2007) *Delivering health and well-being in partnership: The crucial role of the new local performance framework*. London: Crown

Department for Communities and Local Government (2007) *Developing the future arrangements for Local Area Agreements* London: Crown

Department for Communities and Local Government (2007) *Negotiating New Local Area Agreements* London: Crown

Department for Communities and Local Government (2007) *Creating Strong, Safe and Prosperous Communities. The Local Government White Paper: Making it Happen – the implementation plan*. London: Crown

Department of Health (2004) *The NHS Improvement Plan* London

Department of Health (2007a) *Commissioning framework for health and well-being* London

Department of Health (2007b) *Guidance on Joint Strategic Needs Assessments*. London

WORKBOOK: POLICY & STRATEGY

Department of Health (2007c) *Delivering health and well-being in partnership: the crucial role of the new local performance framework* London

Improvement & Development Agency (2007) *Local leadership Academy local area agreements member workbook* London

Rittel, H.W. J. and Webber M.M. (1973) Dilemmas in a general Theory of Planning *Policy Sciences* Vol 4 155-159

World Health Organisation (1997c) *Health for All for the Twenty First Century. The Health Policy for Europe*, draft edition. Copenhagen: World Health Organisation.

WHO (2008) *Closing the gap in a generation Final Report of the Commission on Social Determinants of Health* Geneva

Development of Case Studies

Developing the Case Study Framework

The approaches used within each session will enable the creation of a learning environment in which each participant is able to consider and share their experiences in relation to the topic area. The use of case studies provide an interactive learning environment, provide participants with the opportunity to become involved and engaged with the session content, involve analysis and conclusions emerging from participants, encourage thinking and relevance to course content.

In order to achieve this learning, each participant will be required to build a short case scenario from their own experiences using a similar case study framework*

These will be completed prior to the first session, drawing from participants own experience, anonymised, and shared amongst the group. By sharing authentic problems encountered in the field each participant will draw on their own and others experience, applying the information and resources encountered during the sessions and building a portfolio of scenario based learning for future reference.

****Please collaborate with others from your organisation attending these sessions if you wish to produce only one or two case studies between you.***

Please follow the 10 steps to forming your case study overleaf

Thank you!

10 Steps to Building your Case Study

You are not required to complete all the steps if you do not hold sufficient information. This may be obtained or built during your modules. However, please identify as much as much information as possible in order that others can understand the area of priority, the activities underway and the potential concerns envisaged.

Step 1:

Naming your Study: Your case can be fictional or factual but will hold relevance for your role and organisational environment. Think about your current work, the specific health topics you are dealing with and describe a priority that needs to be addressed that has an impact on the health and well being of the local population.

Step 2:

Study background: You'll need to provide some factual background information concerning this priority. This needs to include, the target population, the main area of concern, the current evidence base for addressing this concern, the type of interventions proposed, the targets to be achieved with links to both your own organisation strategies and UK policy and identify other organisations involved.

Step 3:

Organisations, professionals involved? Your study will tell a story, it will therefore need to have some characters that are involved in addressing this priority. Please identify some by their role / involvement – they can be from any sector/organisation, not necessarily your own.

WORKBOOK: POLICY & STRATEGY

Step 4:

Activities to be undertaken: Your study will have a number of activities that need to be undertaken. Consider the responsibilities facing those who you've identified as being involved in this issue. What needs to be achieved? How will this be undertaken?

Step 5:

Problems and Dilemmas: Consider the emerging problems or dilemmas that need to be solved. Reflect upon those involved. What are their concerns? What are the barriers to them carrying out this work?

Step 6:

Current Actions: At this point some activity has already been undertaken. The work may still be in the planning stages, or interventions may have taken place. Please describe what is currently happening concerning the priority.

Step 7:

Community Participation: Please think about how the community of interest in this priority area has been involved so far. How has this happened? What has been their reaction? Are there any concerns at this stage?

WORKBOOK: POLICY & STRATEGY

Step 8:

Current Approaches to Evaluation: Please consider how those involved propose to monitor and evaluate this work. Are monitoring arrangements in place? Are any specific tools used for this? What are the achievements documented so far?

Step 9:

Skill Mix: Please consider the current skills of all those involved in this work. Do you think there is the right mix of skills and abilities? Is anything missing? What is still required?

Step 10:

Ideas for the future: Please now consider the future direction for this work. Are the planned activities short or long term? How are resources to be made sustainable for ongoing work? Are there commitments in place for developing this work further?

POLICY DEVELOPMENT & PLANNING

LEARNING OUTCOMES:

- Understand the strategic context of policy development
- Understand the importance and impact of public policy and legislation on health and wellbeing at individual, local, national and global levels
- Awareness of the major government policies related to health and wellbeing, health inequalities and their interconnections
- Explored the political environment in which one's own organisation is set and how this affects its policy and strategy
- Understand the process of policy development and its complexities

Policy & Strategy - Definitions

Policy:

The term 'policy' for some has been described as:

"rather like the elephant – you recognise it when you see it but cannot easily define it"

Ham (1982:60)

'a web of decisions and actions that allocate values'

Ham (1999:97)

"broad statements setting out what is to be achieved and how"

Johnson & Scholes (2001)

Strategy:

The term 'strategy' is basically perceived in the shorter-term and applied to,

"top down, formal approaches to change as the plans for reaching objectives and goals"

Bruce et al (1995:263)

"Strategies can also develop as the outcomes of the organisation's cultural and political processes"

Johnson & Scholes (2001)

Policy making has been described as

“the process by which governments translate their political vision into programmes and actions to deliver 'outcomes' - desired changes in the real world”

Modernising Government White Paper (1999).

Public policy encompasses the laws, regulations, programmes and practices of government that address social needs and problems and spend public funds.

In the UK context policy generally refers to government (national or regional) level overarching policies which are usually but not always called *White Papers*. The role of government is to allocate resources to issues through policy. Funding goes to government departments who then direct how that money should be spent. Policies may be implemented across government departments e.g. *Choosing Health*, or within departments e.g. *Communities and Local Government*. Policies will usually include national level targets or expectations of delivery e.g. Public Sector Agreements (PSAs) and National Indicators.

The term strategy is usually used for the decisions that are made at sub-national levels (regional or sub-regional) to describe the ways in which, in that defined geographical area the policies are going to be implemented. Strategies will identify action plans across sectors and local targets i.e. what local organisations have agreed they can achieve within resources to meet local needs that contribute to national targets. Often government departments also offer guidance on implementation which may also be thought of as 'departmental' policies e.g. World Class Commissioning.

The policies dealt with as part of this session will include,

- **Health policies**
offering decisions regarding goals in health care, with plans for achievement as well as those in which the priorities and values underlying health resource allocation are determined (*Ham 1999*)
- **Social policies**
with a focus upon the changing, maintenance or creation of service and living conditions that have a direct impact on human welfare and wellbeing (*Levin 1997*)
- **Healthy public policy**
an approach characterized by an explicit concern for health and equity in all areas of policy and an accountability for health impact (*Davies & Macdowall 2006*)

Public Health is defined as

- the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society (*Acheson Report 1998*)
- “health care is vital to us some of the time, but public health is vital to all of us all of the time” (*C.Everett Koop, former US Surgeon-General*)

Key terms: (Macdowall et al 2007)

- **Health Inequalities**
Differences in health experience and health status between countries, regions and socioeconomic groups
- **Social determinants of health**
Conditions which affect people’s health such as their working and living environments, income, social networks and social position

A brief history of Public Health Policy Development

The movement from the treatment of disease in the 40's to advances in cosmetic surgery over the last 30 years demonstrate how far health care has travelled and the types of lifestyle treatments that people demand. Added to this the more recent focus on health care delivery and efficiency of primary and secondary services, as well as the increasing cost of health care services and unsustainable publicly funded systems, has lead towards a growing acceptance that there needs to be a rebalancing of policy away from downstream secondary care to upstream public health, focusing our efforts on illness prevention, certainly in the context of chronic or non-communicable disease – regarded as the epidemic of our time.

The LaLonde Report in Canada (1974) (Davies and Macdowall 2006)

A new perspective on the health of Canadians was a pioneering statement by a national government which explicitly recognised that health was created by the complex inter-relationships between biology, environment, lifestyle and the system of healthcare. The report opened the door to significant debates about the role of government in improving health through its policy decisions and the limitations of personal healthcare. The LaLonde Report from Canada and the subsequent WHO Health for All strategy, the Declaration of Alma Ata and Ottawa Charter (1986) co-ordinated through the World Health Organisation (WHO), led to all countries developing detailed public health policies with reducing inequalities identified as of major importance.

Health for All Strategy (1978) (WHO 1997)

The Health for All strategy adopted by the WHO in 1978 provided a strategic reference point for health education and disease prevention programmes, fostering a resurgence of interest in public health internationally, re-focusing attention upon social and economic determinants of health and their unequal impact on the health of populations. The focus of this strategy was, “...the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life”. The major social goals of equity and social justice emerged from this strategy have been continuously promoted by the WHO through a series of targets for improved health status that reflect the *Health for All strategy – Targets for Health for All 2000*. This report grouped targets into four major themes concerning, lifestyles and health; risk factors affecting health and environment; Reorientation of the health care system and the infrastructure support necessary to bring about the desired changes in these three areas.

Alma Ata Declaration (1978)

http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

This inspirational statement emerged through a landmark meeting organised by WHO and UNICEF with a focus on primary health care, prevention, recognition of the role of other sectors in creating health and causing ill health, and of community participation and ownership of health programmes.

Ottawa Charter (1986)

http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

The first international conference on health promotion was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialised countries, but took into account similar concerns in all other regions. It built on the progress made through the declaration on primary health care at Alma Ata, the World Health Organization's targets for 'health for all' document, and the debate at the World Health Assembly on intersectoral action for health. The Charter identified a set of five mechanisms which were later updated in the Jakarta Declaration 1997.

http://www.who.int/hpr/NPH/docs/jakarta_declaration_en.pdf

Ottawa Charter 1986

- Building healthy public policy
- Creating a supportive environment
- Strengthening community action
- Developing personal skills
- Reorientating health services

Jakarta Declaration 1997

- Promote social responsibility for health
- Increase investment in health development
- Consolidate and expand partnerships for health
- Increase community capacity and empower the individual
- Secure an infrastructure for health promotion

WORKBOOK: POLICY & STRATEGY

More recently WHO has reviewed the strategies for health promotion in recognition of the changing global context for health promotion which increasingly requires a focus upon health inequalities, environmental degradation, new patterns of consumption and communication, and increasing urbanisation. Concern over the increasing cost of health care services has also mounted and the need to shift the paradigm towards health improvement and prevention in order to manage demands on health care more effectively. Further, the reasons for a growing interest in public health lie primarily in an acknowledgement of what has been termed 'the neglected epidemic' of chronic disease (Hunter 2007). Within this changing landscape, the variety of strategies now emerging across government departments have a focus upon health, social and healthy public policy.

ACTIVITY 1

This activity will help you to be aware of the major current government policies related to health and wellbeing, and health inequalities

Which policies are you aware of which directly relate to your own areas of work?

Are you aware of the differences between these policies i.e. are they health, social or healthy public policy?

Feedback Activity 1

Participants mentioned the following policies and strategies that affect their areas of work;

Choosing Health; Tackling Health Inequalities; Transforming Social Care; Data Protection policy; the D'Arzi report; Our Health, Our Care, Our Say; Every Child Matters; Strong & Prosperous Communities .

Important initiatives that influence local implementation of policies mentioned included: The Local Area Agreement policy framework; World Class Commissioning; Practice Based Commissioning; the Vital Signs Framework; Joint Strategic Needs Assessments and National Indicators.

It was also noted that policies build on each other, they don't go out of date. Information analysis underpins the implementation of many policies, but participants sometimes felt they were too far removed from the actual policies and that the plethora of initiatives pulled them in different directions and sometimes created tensions with partnerships.

Understanding the Policy Process

The following explanations are sources from Bridgman and Davis 2000

The Policy Process

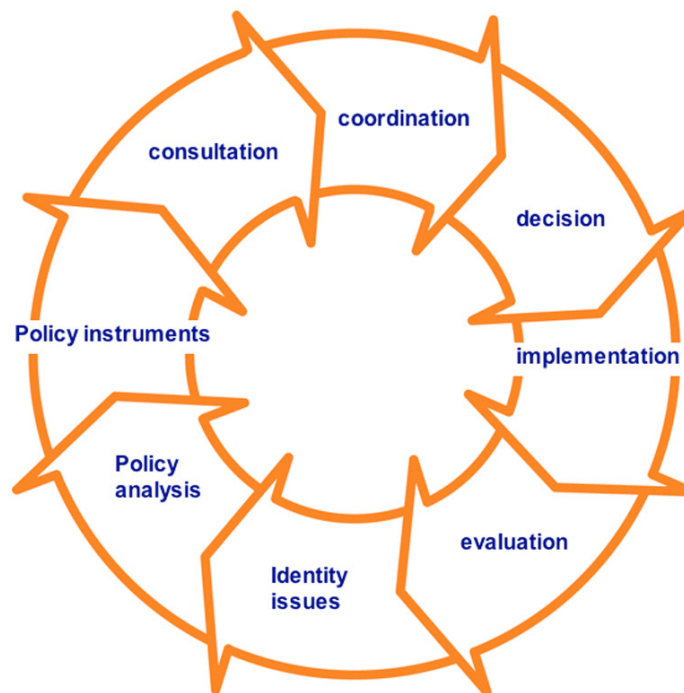
The health policy environment is increasingly populated by complex, cross-border, inter-organisational and network relationships, with policies influenced by global as well as by domestic actions. There is increasing recognition that policy processes are changing everywhere with shifts in both the nature of policy and policy making through a much larger group of stakeholders which now include both the private sector as well as not-for-profit organisations. Partnerships between public and private sectors have also changed the health policy environment.

A Policy Cycle Model

It is appreciated that policy development is not a linear process, neatly and predictably following a sequence of steps. Policy making is ambiguous and layered and not a single, uniform, transferable process. Bridgman and Davis suggest that a policy cycle can be used to understand and structure policy development, bringing a system and a rhythm to a world that might otherwise appear chaotic and unordered. The cycle structures the policy process into manageable units of analysis. As such, the policy cycle should not be read as a staged and ordered process but an active and iterative process. The policy cycle model does, however, outline the key components to be considered in developing and implementing policy.

We have divided the whole model into two parts:

- 1. Planning policies** - how policies are developed which includes, how issues are identified, understanding the current policy landscape, and the various tools, instruments and consultation processes used to agree policy (**issues, analysis, instruments & consultation**)
- 2. Implementing policies** by understanding the structures and processes used to co-ordinate strategic decision making at local level and evaluating the outcomes (**coordination, decision, implementation, evaluation**)



Identifying Issues:

Involves understanding the issue, problem or concern commanding the attention of government and requiring a policy response. Public health policy can emerge through interplay of ideas and knowledge, although the movement of an issue onto the political agenda is complex and shaped by several factors. A level of coincidence is recognised where these processes ‘in combination’ have been described as offering a ‘policy window’ *(Baggott 2000:8)*:

- identify problems
- promote ideas on how to tackle problems
- considers decision making and public debate e.g. government organisations, Parliament, pressure groups and the media.

Wicked Issues (Rittel and Webber 1973)

The changes within the health agenda and the problems facing health and social policy makers were highlighted in the early 70’s by Rittel and Webber (1973) in their seminal text concerning a general theory of social planning in America. The origins of terms used within the new approaches to public health can be traced back to this document which provides an insight into the emergence of the term ‘wicked issues’ and the general positivist / post positivist debates concerning the many problems facing social planners and policy makers

WORKBOOK: POLICY & STRATEGY

at that time. They use the term 'wicked' because of the ill-defined nature of the problems in social or policy planning, which rely on elusive political judgement for *resolution*, albeit they assert, 'not *solution*, social problems are never sorted...at best they are only *re-solved* over and over again'. The term is used in contrast to the tame or benign problems facing scientists, which are definable and separable with solutions that are findable. The term *wicked* is used as a meaning akin to tricky or vicious – as in a circle.

Examples of intractable wicked problems encompass the environment and the aspirations of sustainable development, the problems of crime and community safety, social exclusion and the aspiration of meaningful lives. The balance of setting objectives and targets which can both complement and conflict with each other, reflect the need to be aware of and address organisational demands and interests as well as those which lie within society.

Social Inequities in Health (Dahlgren and Whitehead 2006)

Globally it is now understood better than at any moment in history how social factors affect health and health equity. Social inequities in health are systematic differences in health status between different socioeconomic groups. These inequities are socially produced (and therefore modifiable) and unfair. The evidence points to the existence of extensive (and widening) social inequities in health in Europe today, at least in relative terms. The need to take action to reduce these inequities and their root causes is becoming ever more pressing as a major public health challenge. This calls for a new way of thinking about the direction of policy and also calls for renewed vigilance in monitoring impacts, to make sure that no segment of the population is excluded or loses out. Three principles of action have been identified by the *Commission on the Social Determinants of Health*:

To improve the conditions of daily life – the circumstances in which people are born, grow, live, work and age.

Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life

Measure the problem, evaluate the action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness (WHO 2008).

Policy Impact & Analysis:

(http://en.wikipedia.org/wiki/Policy_analysis)

Policy analysis is a multi-disciplinary approach and involves interactions between institutions, interest and ideas. Policy analysis can be defined as "determining which of various alternative policies will most achieve a given set of goals in light of the relations between the policies and the goals". However, policy analysis can be divided into two major fields:

- Analysis **of** policy is analytical and descriptive -- i.e., it attempts to explain policies and their development.
- Analysis **for** policy is prescriptive -- i.e., it is involved with formulating policies and proposals (e.g., to improve social welfare).

For either of these processes there is now a mandatory requirement to consider the health impact of all government policy. Please see links below for information.

The role of Health Impact Assessment (HIA)

<http://www.bmj.com/cgi/content/full/320/7246/1395>

HIA can be a valuable tool for helping to develop policy and assisting decision makers. Potential determinants of health considered in an HIA process

- **Biological factors:** for example, age, sex, genetics
- **Preconceptual and in utero exposure:** for example, maternal nutrition and health during pregnancy
- **Personal behaviour and lifestyle:** for example, diet, smoking, alcohol, exercise, risk taking
- **Psychosocial environment:** for example, family structure, community networks, culture, social exclusion
- **Physical environment:** for example, air, water, housing, transport, noise, waste disposal
- **Socioeconomics:** for example, employment, education
- **Public services:** for example, quality of, and access to, childcare, transport, shops, education, leisure, health, and social services
- **Public policy:** for example, economic, welfare, crime, transport, and health policies

Equality Impact Assessments

<http://www.nhsemployers.org/excellence/excellence-1871.cfm>

Equality Impact assessments (EqIA) are a way of examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. The duty to undertake impact assessments is a requirement of race, gender and disability equality legislation. Their purpose is to identify and address real or potential inequalities resulting from policy and practice development. EqIA should cover all the strands of diversity and ensure that all receive equitable attention.

Impact assessments will help to gain an understanding the functions of an organisation and the way decisions are made by:

- considering the current situation.
- deciding what is to be achieved - i.e. the objectives and intended outcomes of a function or policy.
- considering what evidence there is to support the decision.
- where the gaps are in terms of evidence to support the decision.
- making an informed decision.
- reporting / publishing that decision.

The Equality Impact Assessment provides a systematic way to ensure legal obligations are met and are also a practical way of examining new and existing, policies, and practices, to determine what effect they may have on equality for those affected by the outcomes. By ensuring that equality is embedded within their objectives from the outset, equality impact assessments will assist organisations in achieving their business objectives. EqIAs enable organisations to identify problems and make the necessary changes.

The future of public health policy and practice is fragile and unpredictable. A great deal depends on political climate, which is difficult to foresee. In order to introduce new policies requires an awareness of current major government policies relating to health and well being, health inequalities and their interconnections. Some political contexts and political administrations are more prone to social interventions than others. A great deal depends on how issues affecting social determinants are conceptualised and communicated (Hunter 2007).

Examples of UK social and healthy public policy and strategies:

Health Strategy in the UK (Welsh Health Planning Forum 1989)

Outlined a statement of strategic intent for the NHS, 'to take the people of Wales into the 21st century with a level of health on course to compare with the best in Europe. The strategy sets out long-term intentions, suggesting approaches for change and involving the (virtually) irreversible allocation of resources. Its foundation lay within Health for All 2000, as its guiding slogan indicated: adding years to life, and life to years.

Health of the Nation (England: DoH 1992)

The White Paper which set out a national framework for achieving health gains in five selected priority areas (Department of Health, 1992). This is a historic document in that it focuses managerial attention on the achievement of real health outcomes as opposed to health care processes such as waiting lists. England was the first nation to respond formally to the World Health Organisation's Health for All by the Year 2000 initiative.

Independent Inquiry into Inequalities in Health (Acheson 1998)

The Inquiry's report and its recommendations were instrumental in fostering widespread recognition that health inequalities need to be addressed, and that tackling their wider determinants is crucial to this process. The report's four major impacts were that it:

- acted as a prompt to new policies;
- engendered a climate of opinion favouring policies to tackle health inequalities;
- introduced a health inequalities dimension to current policies;
- acted as a reference book.

The report also provided the context for the public health strategy in England, *Saving lives: Our Healthier Nation* (The Stationery Office, 1999). Public health strategies in other parts of the UK have also drawn on the Acheson Inquiry's analysis and recommendations.

Saving Lives: Our Healthier Nation (Secretary of State 1999)

This White Paper set out the Government's approach to promoting healthier living and reducing inequalities in health in England. It confirmed many of the proposals outlined in the Green Paper of February 1998 *Our Healthier Nation: a contract for health*. The Government used this document to draw together many of its existing initiatives such as the introduction of Primary Care Groups and its plan to ban tobacco advertising from December 1999. It also reaffirmed the roles of health authorities, primary care groups, health action zones and healthy living centres in implementing health improvement programmes through increased co-operation, as announced in earlier Government Papers.

This White Paper envisages an integrated approach in a "three-way partnership" of all areas of Government, local organisations and individuals, with nurses, midwives and health visitors all having aspects of their roles strengthened to help promote public health. A series of targets were set in priority areas with the aim of preventing 300,000 deaths. By the year 2010 (with interim milestones for 2005) the Government aimed to:

- Reduce the **cancer** death rate in people under 75 by at least a fifth;
- Reduce the death rate from **coronary heart disease and stroke** in people under 75 by at least two fifths;
- Reduce the death rate from **accidents** by at least a fifth and **serious injury** by at least a tenth;
- Reduce the death rate from **suicide and undetermined injury** for those with **mental illnesses** by at least a fifth.

The Government White Paper (1999) - *Modernising Government*

Promised changes to policy making to ensure that policies are joined up and strategic, making sure that public service users, not providers are the focus and delivering public services that are high quality and efficient. The White Paper announced a programme of reforms which focus of five key commitments:

- Policy making would be forward looking to deliver outcomes that matter, not simply reacting to short-term pressures
- Providing responsive public which meet the needs of citizens, not the convenience of service providers
- Deliver quality public services, which are efficient and will not tolerate mediocrity
- Will use technology to meet the needs of citizens and businesses, and not trail behind technological developments
- Modernise public services, revising performance management, tackling the under representation of women, ethnic minorities and people with disabilities.

World Health Report (WHO 2002)

The World Health Report 2002 measures the amount of disease, disability and health in the world today that can be attributed to some of the most important risks to human health. Even more importantly, it also calculates how much of this present burden could be avoided in the next 10 years. The World Health Report 2002 represents one of the largest research projects ever undertaken by WHO, in collaboration with experts worldwide.

Dr Gro Harlem Brundtland, Director-General of WHO, describes this report as "*a wake up call to the global community*". The report quantifies some of the most important risks to human health, and examines a range of methods to reduce them. The ultimate goal is to help governments of all countries to lower major risks to health, and thereby raise the healthy life expectancy of their populations. The risk factors range from underweight and unsafe water, sanitation and hygiene to high blood pressure, raised cholesterol and obesity. The report's findings give an intriguing - and alarming - insight into not just the current causes of disease and death and the factors underlying them, but also into human patterns of living and how some may be changing around the world while others remain dangerously unchanged. Dr Brundtland says: "*This report helps every country in the world to see what measures it can take to reduce risks and promote healthy life for its own population.*"

Securing Our Future Health: taking a Long-Term View (Wanless 2002)

This was an independent review and the first ever evidence-based assessment of the long-term resource requirements for the NHS. Wanless identified that people need to be supported more actively to make better decisions about their own health and welfare because there are widespread, systematic failures that influence the decisions individuals currently make. These failures include a lack of full information, the difficulty individuals have in considering fully the wider social costs of particular behaviours, engrained social attitudes not conducive to individuals pursuing healthy lifestyles and addictions.

He also highlighted the significant inequalities related to individuals' poor lifestyles and their tendency to be related to socio-economic and sometimes ethnic differences. He suggested that they can be tackled not only by individuals but by wide-ranging action by health and care services, government – national and local, media, businesses, society at large, families and the voluntary and community sector. Collective action must however respect the individual's right to choose whether or not to be "fully engaged". It concludes that in order to meet people's expectations and to deliver the highest quality over the next 20 years, the UK will need to devote more resources to health care and that this must be matched by reform to ensure that these resources are used effectively.

Every Child Matters Green Paper (2003)

The Government has invested heavily in policies designed to give all children the chance to succeed with significant improvements in educational achievement, and reductions in teenage pregnancy, re-offending and children living in low income households. This Green paper set out policies to reduce the number of children who experience educational failure, suffer ill health, become pregnant teenagers, are the victims of abuse and neglect, or become involved in offending and anti-social behaviour.

Choosing Health: making healthy choices easier (2004)

Following the Wanless report, the government announced a consultation on the future of public health. This resulting White Paper set out the key principles for supporting the public to make healthier and more informed choices in regards to their health. The Government aimed to provide information and practical support to get people motivated and improve emotional wellbeing and access to services so that healthy choices are easier to make.

The NHS Improvement Plan (2004)

This document sets out the priorities for the NHS over the last four years. The plan proposes a vision where the founding principles underlying the NHS are given modern meaning and relevance in the context of people's increasing ambitions and expectations of their public services. The NHS Plan reforms and investment are transforming the NHS, with dramatic improvements in cancer and coronary heart disease.

The Local Government White Paper (2006) – *Strong and Prosperous Communities*

recognised that no single organisation can achieve success on the complex issues of improving public health, reducing poverty, tackling crime or sustainable economic development. The Paper emphasises a new focus on improving outcomes for local people and places – rather than on processes, institutions and inputs. Underpinning these aspirations are a range of new opportunities aiming to create:

- Responsive services and empowered communities
- Effective, accountable and responsive local government
- Strong cities, strategic regions
- Local government as a strategic leader and place shaper
- A new performance framework
- Efficiency - transforming local services
- Community cohesion

This means changing the way we work, so local partners can respond more flexibly to local needs; to reduce the amount of top-down control from central government; and to enable citizens and communities to play their part.

***Our health, our care, our say: a new direction for community services* (HMSO 2006) Health Challenge England – next steps for Choosing Health DH**

This White Paper explains in detail the improvements the Government is going to make to health and social care services, why it feels these changes are necessary and the steps it is taking to make sure they happen. This White Paper is an important new stage in building a world-class health and social care system. It meets the health challenges of the new century, and adapts to medical advances while responding to demographic changes in our society and increasing expectations of convenience and customer service from the public who fund the health service. It confirms the vision set out in the *Independence, Well-being and Choice* Green Paper which was published in March 2005. It describes how services should increasingly focus on promoting individuals' health and well-being within integrated settings of support, such as within people's own communities.

The Local Government and Public Involvement in Health Act 2007

Introduces a number of measures relating to local government as well as involvement of local communities. One of the measures the bill introduces is the establishment of Local Involvement Networks (LINks), which replace Patients' Forums, and the Commission for Patient and Public Involvement in Health in 2008. The bill also clarifies and strengthens the existing duty on NHS bodies to involve and consult patients and the public in the planning and provision of services.

Informing Healthier Choices – Information and Intelligence for healthy Populations (DH 2007)

One of the commitments given in the *Choosing Health* white paper was to develop and implement a comprehensive public health information and intelligence strategy. This work was led by a specially constituted Task Force and informed by extensive public and professional consultation conducted in 2006. The resulting strategy sets out an approach that will strengthen health information and intelligence resources across England. This includes supporting and developing the skilled information workforce in NHS and Local Government organisations. It also provides a framework to integrate the work of different agencies with a role in this field and to guide the development of innovative information systems where these are needed. As well as necessary attention to processes and infrastructure, the strategy aims to improve the availability of basic data and knowledge to support Choosing Health objectives.

The Children's Plan - Building brighter futures 2008

The Children and Young People's Plan (<http://www.everychildmatters.gov.uk/health/>) aimed to make England the best place in the world for children and young people to grow up. Policy makers and healthcare providers are responding to the challenges and shaping the child health agenda by making significant changes to the way health services are planned and delivered the new status given to children and health by the Government is increasing the momentum for change and improvement. An important element of the reforms, underpinned by the Children Act 2004 determined that all areas are to produce a single strategic, overarching plan for all services affecting children and young people. The plan has emerged from the new Department for Children, Schools and Families and is a result of direct consultation with parents, teachers, professionals and children and young people. The Children's Plan will strengthen support for all families during the formative early years of their children's lives, take the next steps in achieving world class schools and an excellent education for every child, involve parents fully in their children's learning, help to make sure that young people have interesting and exciting things to do outside school, and provide more places for children to play safely.

ACTIVITY 2

This activity aims to explore the political environment in which your own organisation is set and how this affects its policy and strategy

How well does your organisation prioritise public health issues?

Consider the table below and tick the most realistic response boxes in relation to the characteristic statements. Reflect on who may know and who maybe responsible for enabling these activities to occur.

Organisational Characteristics	No	Not sure	This is discussed	Yes Definitely	Who is responsible?
It has public health at its centre					
There is a public health ethos throughout the organisation					
It intervenes as early as possible in the continuum of health and addresses the issue of potentially avoidable deaths with urgency					
It maximises the use of existing preventive initiatives such as breast screening or vaccination for other health improvement activities					
It is confident of its long-term agenda					
There is commitment from the Chief Executive and the Board					
It acts as a responsible corporate citizen, fulfilling its economic potential to improve health					
Finance, commissioning, modernisation and health improvement strategies are integrated					
Primary care organisations provide data to inform preventive activities in primary care					
The health improvement agenda is reflected in workforce development					
There are ring fenced resources for public health					

Feedback Activity 2

Groups thinking about the characteristics of their organisation and how well their organisational environment supports public health made the following observations:

Public health ethos is important but the lack of it throughout the organisation can have a negative effect on prioritising public health issues, organisational stability helps prioritisation of public health issues. Some organisations use the words but don't always follow through in action.

Public health strategy needs to be better resourced in order to be visible throughout the organisation and to drive strategy, in some PCTs this is beginning to happen, especially where Chief Executive and Board commitment is demonstrated. However in secondary care public health is not seen as a priority.

Workforce development is necessary to ensure that throughout the organisation there is the culture and capacity for implementing public health policy. World Class Commissioning has positively increased the demand in PCTs for more public health information. Despite this difficulties may still be noticed in integrating finance, commissioning and health improvement strategies. Framing public health issues in short-term cost-benefit language would help here.

Policy Instruments:

Are the way and means of the policy process. They maybe laws e.g. Acts of parliament, programmes, informative materials, infrastructures e.g. hospitals, schools or a combination of many of these. The choice of instrument is of major concern where costs and benefits, accountability and legality are all considered as well as the timing of policy implementation.

Two key instruments currently supporting the planning and delivery of public health policy are:

World Class Commissioning

<http://www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm>

World –class commissioning is about creating world-class clinical services and a world-class NHS. By improving their commissioning and by working closely with local authorities, PCTs will be better able to invest in order to achieve high-quality and personalised services that improve health and wellbeing for their local population (IdeA 2007). There are four key elements to the programme; a vision for world class commissioning, a set of world class commissioning competencies, an assurance system and a support and development framework.

The Local Government and Public Involvement in Health Act (2007)

Changes the statutory landscape upon which the new local performance framework, in particular, the new Local Area Agreements, are founded.

The Act includes provisions for,

- **a Joint Strategic Needs Assessment (JSNA)**, to be undertaken by local authorities and PCTs, of the health and well-being needs of their communities
- **the agreement of LAA targets**, to be determined by local authorities and named statutory partners (including PCTs, NHS Trusts and NHS Foundation Trusts), of which up to 35 will be national priority targets agreed with central Government
- **partners to have regard to those targets they have agreed**

WORKBOOK: POLICY & STRATEGY

- **the establishment of new Local Involvement Networks (LINKS)**, which will help ensure local communities have a stronger voice in the process of commissioning health and social care.

The following descriptions highlight these and related current instruments.

Joint Strategic Needs Assessment (JSNA) (DH 2007b)

The proposed new statutory Joint Strategic Needs Assessment is a critical tool to inform the development of Sustainable Community Strategies (these set out the vision for the sustainable improvement of the economic, social and environmental well-being of each area) and Local Area Agreements (the delivery agreement for the Sustainable Community Strategy). A good strategic needs assessment, which many areas are already doing, is based on a joint analysis of current and predicted health and well-being outcomes, an account of what people in the local community want from their services (those provided by the statutory sector and the wider market), and a view of the future, predicting and anticipating potential new or unmet need. It could include opportunities for disinvestment and resource transfer. And it should incorporate views of the local population, not just existing users of services, and include and be informed by equality impact assessments.

The Place Survey

Department of Communities and Local Government (2008) *Place Survey 2008-09 Manual* London: CLG

The Place Survey is one tool which is available to councils and their partners to understand the views of local people and has been developed by Communities and Local Government (CLG). The development process included work with a reference group drawn from Government departments, local agencies, the Local Government Association and the Audit Commission. There was also a consultation on the survey between December 2007 and February 2008, and it has been subject to extensive piloting and cognitive testing with focus groups. The new National Indicator Set contains 25 indicators which are informed by citizens' views and perspectives. To reduce the number of surveys being undertaken by local authorities, 18 of these will be collected through this single Place Survey to be administered by each local authority. The place shaping role also actively encourages participation from the third sector to ensure that LAAs are more effective and that a

WORKBOOK: POLICY & STRATEGY

partnership approach is clearly embedded in the way they are agreed and delivered. Central Government will support local authorities in meeting their obligations to coordinate and support this broad based partnership approach.

Local Area Agreements (LAA)

[\(<http://www.localpriorities.communities.gov.uk/LAAOverview.aspx>\)](http://www.localpriorities.communities.gov.uk/LAAOverview.aspx)

Local Area Agreements are a three year agreement between a local authority and central government that details the priorities that a local area will focus on and determine how various agents (including public, private, and third sector bodies) will work together through a local strategic partnership (LSP) to improve quality of life for citizens. Four major changes have been made to reflect the new LAAs from June 2008 which include place-shaping, performance management, community leadership and reconfiguring public services (IDeA 2007). Local Area Agreements (LAAs) are about what sort of place you want to live in. They set out the local priorities that will make your town, city or community a better place to be; they have been negotiated between all the main public sector organisations in your area, your local authority and central Government. The ideas behind them are to:

- recognise that 'one size does not fit all' and local services should reflect what local people want;
- give more flexibility to local authorities and other public sector organisations in the ways they deliver services for local people;
- make local authorities and other public services more accountable to local people;
- reduce red-tape and improve value for money; and,
- enable local people to get more involved in decisions about local services.

Local Area Agreements (LAAs) represent a radical new approach to the way local authorities and their partners can use government funding to support the implementation of national and local priorities in local areas. They are agreements struck between government, the local authority and its partners in an area (working through the local strategic partnerships) to improve public services.

WORKBOOK: POLICY & STRATEGY

Guidance on the negotiation of Local Area Agreements has been developed in two parts:

Negotiating New Local Area Agreements, published on 18 September 2007

[*http://www.communities.gov.uk/publications/localgovernment/negotiatingnewlaas;*](http://www.communities.gov.uk/publications/localgovernment/negotiatingnewlaas;)

**Development of the New LAA Framework Operational Guidance 2007
published 20 November 2007**

[*http://www.communities.gov.uk/publications/localgovernment/laaoperationalguidance*](http://www.communities.gov.uk/publications/localgovernment/laaoperationalguidance)

Working with the Regional Government Offices LAA Data Management group, the Audit Commission has reconfigured the Area Profiles data profile around the four LAA policy blocks:

- Stronger and Safer Communities (NI 1-49)
- Children and Young People (NI50-118)
- Adult Health & Well-being and Tackling Exclusion & Promoting Equality (119-150)
- Local Economy and Environmental Sustainability (151-198)

Multi-Area Agreements (MAA)

[*\(http://www.maforum.org.uk/maa-faq\)*](http://www.maforum.org.uk/maa-faq)

A Multi-Area Agreement (MAA) is a framework in which adjoining local authorities work in partnership. Through MAAs local authorities can go beyond their administrative boundaries to better reflect the real economic geography of their area and work in a more strategic and coordinated way to meet challenges. An MAA is formed through a voluntary agreement between local authorities who enter into a contract with central government, but rather than conforming to top-down prescribed instructions, MAAs are bottom-up organic formations.

Whilst Local Area Agreements (LAAs) have local focus, Multi-Area Agreement MAAs collate sub-regional priorities, and provide a framework for cooperation in achieving collective targets. An MAA operates at a broader spatial level than an LAA and guidance from Communities and Local Government (CLG) states that the relationship should not be hierarchical and must be complementary.

Of course, MAAs must have an implicit understanding of the local issues in order to suitably address regional issues, although the two areas for scope will remain separate

WORKBOOK: POLICY & STRATEGY

and distinct. An MAA is therefore relevant where bridging boundaries will add value to what could be achieved through the work of individual local authorities or LAAs (Local Area Agreements).

Additionally, the creation of MAAs is intended to give teeth to the Government's place shaping agenda. In driving economic growth, and encouraging agencies to work sub-regionally, the new structures are anticipated to be instrumental in closing the gap with top performing areas in the country, specifically concerning transport, housing, planning, worklessness, and skills.

The New National Outcome and Indicator Set

(CLG 2008) National indicators for Local Authorities and Local Authority Partnerships: Handbook of Definitions)

As part of the Comprehensive Spending Review announcement the Government recently published the single set of 198 national indicators which underpin the new performance framework for local government. These National Indicators meet the Government's commitment, as set out in the local Government White Paper Strong and Prosperous Communities, to introduce a clear set of national outcomes and a single set of national indicators by which to measure them. The national indicators have been derived from Public Service Agreements (PSAs) and the Departments' Strategic Objectives (DSOs) and provide a clear statement of Government's priorities for delivery by local government and its partners over the next three years. They will be the only indicators on which central government will be able to set targets for local government. This single set of indicators replaces all previous Central Government sets for local government including BVPIs and PAF, removing duplication and wasted effort. It represents a drastic reduction in the number of indicators against which local government is required to report. In addition, Government is committed to working with other bodies who have powers to set indicators for local government, to seek ways for them to achieve their outcomes in a way that fits with the new local performance framework.

This new framework aims to reform the way in which public services are delivered – in health, welfare, housing, employment, education, communities, economic development, policing and community safety, the environment and beyond. Strong partnerships will encourage choice, influence and user involvement in the design of public services.

WORKBOOK: POLICY & STRATEGY

The national indicators will be the only indicators against which local authorities' performance, alone or in partnership, will be reported to Central Government. They will therefore be the only measures against which Government can agree targets with a local authority or partnership, through Local Area Agreements (LAAs), and the only trigger for performance management by Central Government, other than concerns highlighted by the inspectorates in the Comprehensive Area Assessment or other inspection activity.

By using the Local Priorities website you are able to identify Area Results tables appropriate for your geographical area. The first table you will be presented with are all the targeted priorities agreed between the local area and Government (up to 35 priorities could be chosen). The second table shows the 16 statutory priorities that all areas of England have to target. The statutory priorities all related to education.

The NHS in England: the Operating Framework for 2008/09

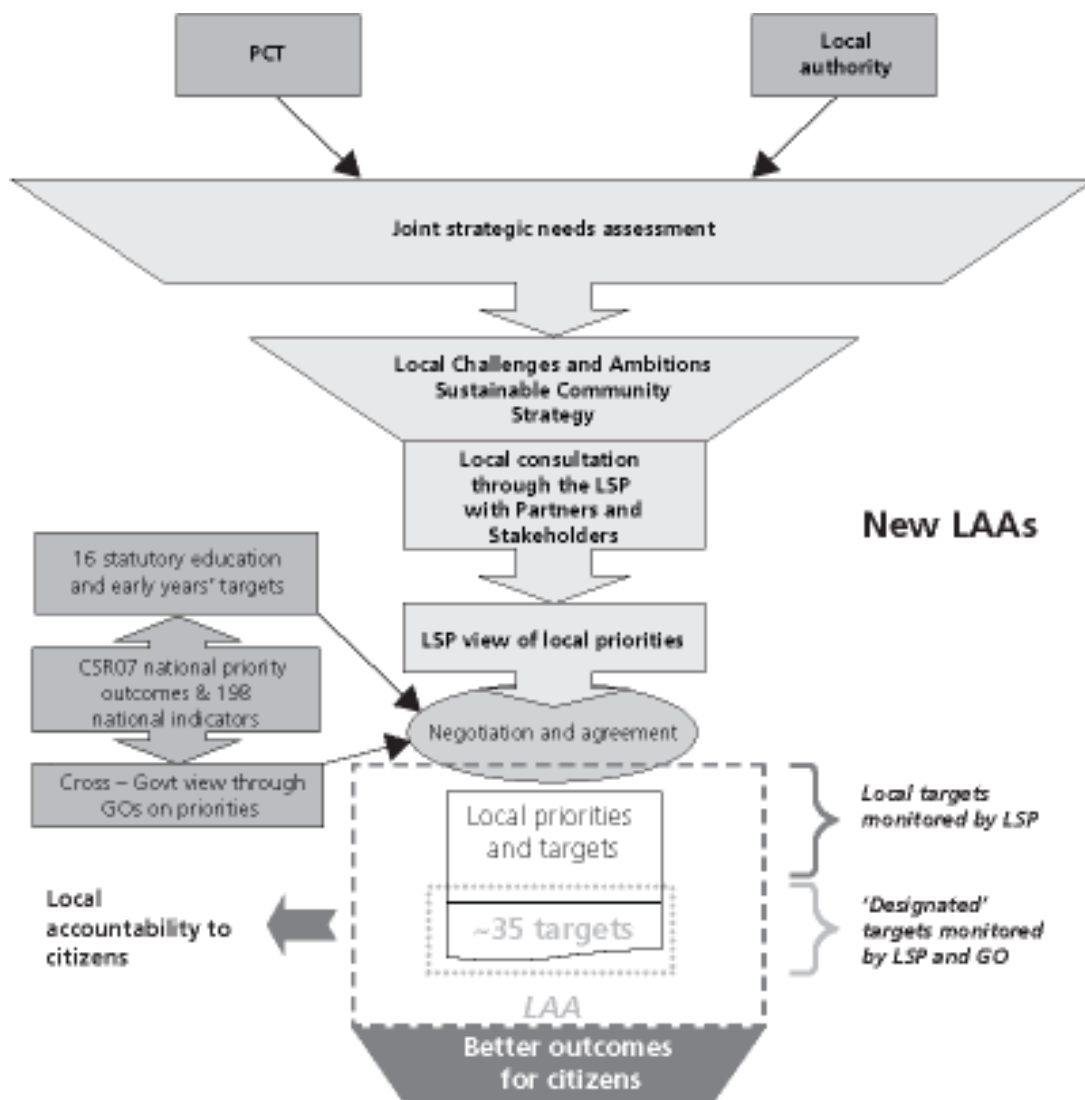
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094

The importance of partnership working is echoed in this document with recognition of the need for contributions from other partners in order to transform local services around NHS treatment. It specifically sets out the process by which PCTs, NHS trusts and NHS foundation trusts will agree plans for delivering both DH national priorities and LAA targets with Strategic Health Authorities (SHA). It makes clear that LAAS and PCT operational plans have the same level of standing in the local health and social care economy with PCTs taking into account the outcomes of the JSNA and areas of under-performance in comparison to other PCTs. IT sets out the important role of SHAs in working with the Department of health regional team in each Government Office to help and support PCTs in agreeing their LAAS.

Consultation:

Enables participation in policy making by identifying and liaising with individuals or groups with an interest or stake in the issue. Fundamental to this are questions about who is affected by the issue and in what way and leads to the identification of these people, committees or organisations. Although, capturing and measuring levels of resources, values, beliefs and power of diverse stakeholders is difficult. The diagram below highlights current instruments that have been designed and developed in order for the appropriate interconnections between people, structures, organisations and targets to be made.

The New Local performance Framework (DCLG 2007)



POLICY IMPLEMENTATION AND POLICY OUTCOMES

LEARNING OUTCOMES:

- Awareness of the variety of tools that can be used to aid strategic decision making and planning
- Understand the different methods to assess the impact of policies on health and wellbeing
- Awareness and experience of how to communicate and implement policies and strategies to improve the population's health and wellbeing
- Experience the concepts of power, interest and ideology in policy development

Co-ordination & Strategic Planning:

During the process it is important to facilitate consistency with the government's overall strategy, and the development of priorities and objectives need to occur through communication across a wide range of departments in order to synergise the actions being proposed and taken. At a local level this is undertaken through the formation of Local Strategic Partnerships and development of Sustainable Community Strategies.

Local Strategic Partnerships

<http://www.communities.gov.uk/localgovernment/performanceframeworkpartnerships/localstrategicpartnerships/>

The Local Strategic Partnership (LSP), is a single body that brings together at a local level the different parts of the public sector as well as the private, business, community and voluntary sectors; so that different initiatives and services support each other and work together. This non-statutory partnership provides a single overarching local co-ordination framework within which other partnerships can operate and it is responsible for developing and driving the implementation of Community Strategies and Local Area Agreements (LAAs).

Local Strategic Partnerships at the single tier or county council level will agree with Central Government up to 35 designated targets for their area as part of their Local Area Agreement. These will reflect local priorities for improvement against the national indicator set. In addition, statutory targets will be set against educational attainment and early years national indicators. Local partners will also agree any additional local targets that they



WORKBOOK: POLICY & STRATEGY

wish, but will not have to report, and will not be performance managed on these by Central Government. If Local Strategic Partnerships want to agree designated targets in their LAA for a particular sub-group or groups of a national indicator defined at the universal population level, they may seek to do so on the basis that they will voluntarily report the performance against that group in addition to the national indicator requirements.

The *Development of the New LAA Framework Operational Guidance 2007* gives more detail as to how target setting for smaller areas within an authority or subsets of the general population will work.

Sustainable Community Strategies

(<http://www.lga.gov.uk/lga/core/page.do?pagelid=18884>)

Partners brought together under the umbrella of the 'Local Strategic Partnership' (LSP), agree a Sustainable Community Strategy (SCS) for its area. The SCS is a long term strategy for the local area based on consultation with local people about the sort of place they want the area to be. The LAA is based on the objectives in the Sustainable Community Strategy and the LAA translates these into targets to secure the improvements local people want to see.

The starting point in negotiating the LAA is through the creation of strong partner relationships and alignment of views around the Sustainable Community Strategy (SCS). The SCS provides visions, values and aspirations, and is rooted in the evidence base and analysis that tells the 'story of the place' providing a rationale for the areas 'up to 35' improvement targets. The community and voluntary sector will play a crucial role in providing a baseline of need reflecting very local perspectives, and that include the voice of communities that are traditionally disengaged from mainstream public service delivery and elected structures. The Local Government and Public Involvement in Health Bill requires responsible authorities to have regard to their SCS in the preparation of their LAA. A strong and ambitious Sustainable Community Strategy, based on extensive engagement locally, agreed by the council or councils and the Local Strategic Partnership, is fundamental to the success of LAAs. The SCS sets out where the area has come from, where it is at, and where it wants to be with social, economic and environmental goals incorporated in a joined up way to contribute to sustainable development. It will set out ambition over a much longer timescale than the three year LAA. The Sustainable Community Strategy should

WORKBOOK: POLICY & STRATEGY

interrelate with the spatial planning for the area, set out in the Local Development Framework.

In two-tier areas, the duty in the Local Government Act 2000 to produce a Community Strategy applies to district and county councils. Areas have developed a range of approaches to give expression to this. Although LAAs will be agreed at county level, they should reflect the Community Strategies of districts and counties. Central departments see the LAA as a delivery mechanism for the Local Strategic Partnership's Sustainable Community Strategy (SCS)¹. The SCS provides the local area's 'story', and should therefore articulate the longer term ambition, evidence and rationale behind the focus of an LAA.

Decision making

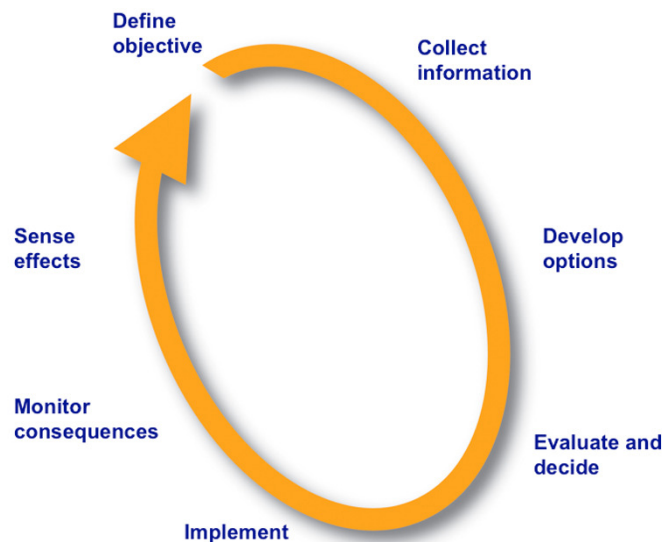
Policy decisions involve choosing the policy option most likely to attain the desired goals. These decisions can be taken by a variety of people both within government and at regional and local levels depending on the nature of the policy. The process however may be opaque and obtaining relevant papers either problematic or in contrast there can be an excess of information.

Models of Decision Making:

The following three models have been identified in order to support different forms of decision making within the planning context.

1. The Spiral (Adair 2007)

Sometimes it is useful for the mind to have a framework for approaching potentially difficult tasks.



- The spiral process begins by **defining the objective**, by writing this down it can help attain clarity of mind.
- The next stage of **collecting relevant information** involves both surveying what is available and acquiring what is missing.
- By **generating feasible options** one moves from a host of possibilities to a diminishing set of feasible options, these are the courses of action that are practicable given the resources available.
- In **making the decision** you are able to grade against your chosen success criteria which the proposed course of action, MUST, SHOULD and MIGHT meet. You will need to assess the risks involved, those consequences that are obvious and those that may occur later.
- **Implementing and evaluating** the decision is part of the overall process. You may hardly notice the actual point of decision. The cut off point is when the thinking ends – your mind is made up – and you move into the action or implementation phase. However you are still evaluating the decision and you can always turn back if the early signs dictate

2. Reframing Problems (McNamara 2005)

Quite often, finding the right problem is more important than finding the right answer. Particularly with complex issues in organisations, there is a presenting priority (or set of symptoms) caused by a real (or root) problem. Recognising the presenting priority and getting to the root causes can be a major challenge.

The reframing technique can be done by using a variety of other techniques:

Ask 'Why' Five Times Technique

This can be a powerful means to really dig deep into the dynamics and causes of a problem. For example if the original problem is "We do not have enough funds" then try asking why five times...

Or,

These six questions can help people fully examine all aspects of a current, major problem:

The What, Who, Where, When, Why Technique

3. DECIDE to ensure Comprehensive Decision Making (McNamara 2005)

This handy acronym can help group members ensure that they take a comprehensive approach to making their decision, considering perspectives of all key stakeholders in the situation.

- D** = What is the **Dilemma** or decision that must be made?
- E** = What have been the **Effects** or results, of the dilemma on others?
- C** = Who should be **Consulted** – who has special expertise or knowledge that should be involved in making the decision?
- I** = Who else should be **Involved** in making the decision?
- D** = What should be the final **Decision** – what is the course of action that should be taken?
- E** = What will be the final **Effect**, or result, of the decision on the dilemma?

ACTIVITY 3

This activity aims to raise awareness of the variety of tools that can be used to aid strategic decision making and planning

Each group will be allocated one of the three decision tools and provided with a case study scenario. Use the tool to address the decision required in the example. Groups will be asked to feedback their observations on the usefulness of their tool in reaching the decision.

Feedback – Activity 3

DECIDE

It was felt that the use of the **DECIDE** tool helped to give focus to decision-making, but that it was necessary to start in the right place. It gave a systematic structure to decision-making and was likened to the front cover 'decision sheet' used for papers presented to the PCT Board. Disadvantages were that it could become too direct if the focus on the question became too narrow. It was felt that the template was useful for use in group processes, the logical series of questions can unearth other issues around the decision. It might be helpful to combine it with the '5 Why's' method below to ensure each question was explored fully.

5 Why's / Who, what, when, where, why?

The effectiveness of this tool can be very dependant on the correct start point, without this it is possible to do down too many 'blind alleys'. The **5 Why's** tool, was a new process to many who found it quite difficult but refreshing to use. The tool can appear to 'drill too deeply' into a specific area. In contrast the 'Who, what, when etc' question technique allowed for wider exploration of the breadth of an issue. It was noted that in meetings there is often a desire to get to a solution too quickly without exploring the issue in depth in this way.

Spiral

Participants using this technique found that they got rather stuck at the beginning as the tool does not provide the detailed questions required to move from one stage to another. Following the steps could however be useful to provide evidence for a decision, or to defend a decision when challenged.

Implementation and Evaluation:

The policy is introduced into practice after the decision to adopt a course of action is taken. At all stages of the cycle it is important to consider practical, achievable implementation strategies. There can well be tensions between the long-term nature of policy development and implementation and the short-term nature both of funding for policy research and of policy makers' demands for quick answers and remedies
(Bridgman & Davis 2000).

The New Performance Framework

<http://www.idea.gov.uk/idk/core/page.do?pagelId=6493621>

A new performance framework for monitoring and regulating local government was set out in Chapter 6 of the Local Government White Paper: Strong and Prosperous Communities, October 2006. It is being implemented through the Local Government and Public Involvement in Health Act 2007 and various pieces of guidance. Key elements of the new framework include:

- a new 'comprehensive area assessment' (CAA)
- proposals for local government sector-led challenge and support of improvement
- a new national indicator set of 198 performance indicators
- a new targets regime for local area agreements (LAAs).

Further tensions can be identified when planning implementation of policy in identifying targets and expected outcomes. The introduction of local area agreements and the associated national indicator set, integral to the reforms, set out in Strong and Prosperous Communities and are a significant advance towards an outcome focused system of change and improvement. A careful distinction between 'outcomes' and process indicators is important, because measuring success on the basis of outputs alone can be misleading. The technique of '*Turning the Curve*' is one approach to clarifying the planning for better outcomes at 'population level' or where an improvement in service 'performance' is being sought
(Friedman 2005).

Outcomes-based Accountability – OA

(DCSF 2008)

<http://www.raguide.org/PDF%20and%20document%20files/RapaComplete.pdf>

Outcomes based Accountability is a disciplined way of thinking and taking action that can be used to improve the quality of life in communities, cities, counties, states and nations.

OA makes a key conceptual distinction between:

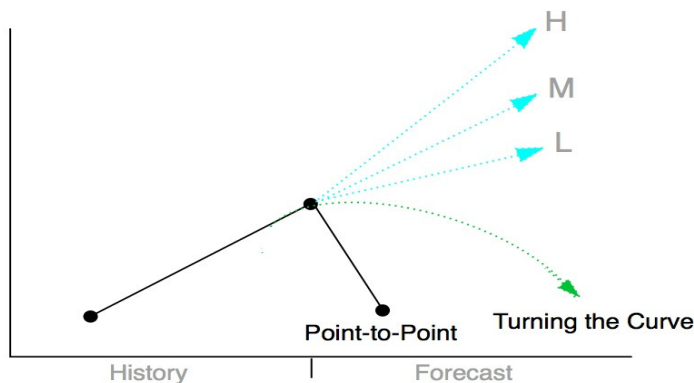
- **population accountability** – where the aim is to achieve better outcomes for particular groups (such as children and young people) in a defined geographical area; and
- **performance accountability** – intended to improve outcomes for the users of individual services and departments as a contribution towards achieving better outcomes at population level.

By separating population from performance accountability one can acknowledge the important fact that no single agency or department is solely responsible for improving outcomes. OA enables partnerships to assess their progress by asking crucial questions about whether services are helping to improve people's lives and life chances.

Turning the Curve stories is a phrase used to describe case studies illustrating the different ways that Outcome-based Accountability has been planned and implemented. It describes a process that enables stakeholders to identify the priority outcomes they wish to improve. By analysing and understanding trend data, they can construct a strategy for achieving better outcomes. When presented in graphic terms their plans demonstrate how future investment in better services coupled with the contribution of non-governmental partners is expected to shift the indicator or performance measure data in a positive direction – thereby **Turning the Curve**.

The graph on the next page is a baseline of historic data, followed by projected trend data using high (**H**), medium (**M**) and low (**L**) forecasts. Friedman argues that forecasts showing an outcomes curve turning in the desired direction provide a more fair and realistic measure of success than short-term targeted for point to point improvement that can lead to premature claims that a strategy has failed.

WORKBOOK: POLICY & STRATEGY



(after DCSF 2008)

Friedman reminds us that strategies are made up of our best thinking about what works, and include contributions from many partners. The emphasis continues to be that no single action by one agency can create the improved results we want and need. In considering what works and what do we think would work you could consider:

- What has worked in other places outside our community?
- What does the research tell us?

What does our own personal experience tell us about what would work here?

The answers should draw on the possible contributions of partners; and should involve no-cost and low-cost ideas. Finally managers must also ask and answer what works to improve performance.

Monitoring the effectiveness and consequences of the policy includes consideration of the operational processes as well as whether it is achieving the desired results. Evaluation seeks to relate and assess the connections therefore between actual policies and changes in the areas they are supposed to be influencing.

All performance measures that have ever existed for any program can be derived from thinking about quantity and quality of effort and effect. The distinction between quantity and quality is familiar: how much we did versus how well we did it. The distinction between effort and effect is simply the difference between how hard we tried and whether we made a difference in the lives of our customers.

WORKBOOK: POLICY & STRATEGY

The following questions can be used as the labels for different types of performance measures. Instead of words like 'input, output, outcome', consider:

- How much did we do?
- How well did we do it?
- Is anyone better off?

The technique of *Turning the Curve* helps to bring manager and staff together with other stakeholders in order to:

At Population Accountability level...

- agree which outcomes will be prioritised for improvement
- examine baseline data-including projections of where the outcome indicators are heading if no further action is taken
- analyse the story behind the baseline to determine what factors and circumstances are driving each trend
- compare evidence gathered from needs assessments and public consultation with the availability and coverage of existing services
- determine what action is needed to turn the indicator curve towards better outcomes
- decide which partners must work together in order to achieve the necessary changes
- agree an action plan, a budget and a timescale for *Turning the Curve*, while ensuring that monitoring and evaluation arrangements are in place

At Performance Accountability level...

... help managers to identify key performance measures for their service that distinguish between **quantity** and **quality** and between **effort** and **effect**. Once the relationship between these dimensions has been understood, they can be used to monitor performance more effectively – making clearer how the service or agency can play its part in delivering better outcomes.

As with **population accountability** managers need to take account of relevant data trends as well as the views of service users before they determine **the story behind the baseline**. They must also consider how best to work in partnership with stakeholders in order to improve their performance.

WORKBOOK: POLICY & STRATEGY

The following examples highlights the types of results you can achieve using this form of monitoring. The background to these results have been described in the following table as example of the questions posed during the Turning the Curve Activity.

Population Accountability:

e.g. In Newcastle monitoring showed there had been a substantial drop in the proportion of young people aged 16 to 19 who are not in Employment, Education or Training - from 15% in 2003 to 9.3% in 2007. Also the number of interventions from voluntary and community organisations working with young people had increased.

Performance Accountability:

Improvements in service delivery was also identified by the Connexions Service displayed in the quadrant below and relates to the review of staff deployment within the Newcastle Connexions office, and the discovery that the number of clients attending on Monday mornings was unacceptably low.

ACTIVITY 4

The aim of this activity is to be aware of how to communicate and implement policies and strategies and understand different methods to assess impact of policies on health and wellbeing

The programme time for undertaking the Turning the Curve Activity is as follows:

5mins: Starting Points

- Time keeper and reporter, geographic area

5 mins: Who is at the table?

- Partners who have a role to play

15mins: Performance measures

- Put entries in the four quadrants (page 45)
- Choose 1 or 2 best measures
- Create a baseline with a forecast

15mins: Story behind the baseline

- Causes and forces at work
- Information and research agenda

15mins: What works

- What could work to do better?
- Each partners contribution
- No-cost/low-cost ideas
- Information and Research agenda

5 mins: Feedback

- Program, partners & baseline story
- 3 best ideas
- Off the wall/funniest idea

WORKBOOK: POLICY & STRATEGY

Take time to read the Case Study and then use the questions on the following pages and the quadrant on page 57 to guide you through the activity.

Turning the Curve Activity (Friedman 2005)

Please complete the following questions once you have read your case study (examples in italics have been drawn from DCSF – *Turning the Curve Stories*)

What is our population group?

e.g. All young people living in Newcastle aged 16-18

What outcomes are we aiming for?

e.g. Reduce the number of young people not engaged in employment, education or training (EET)

What experience leads us to this outcome?

e.g. More young people involved in EET– fewer young people become disengaged from learning and employment



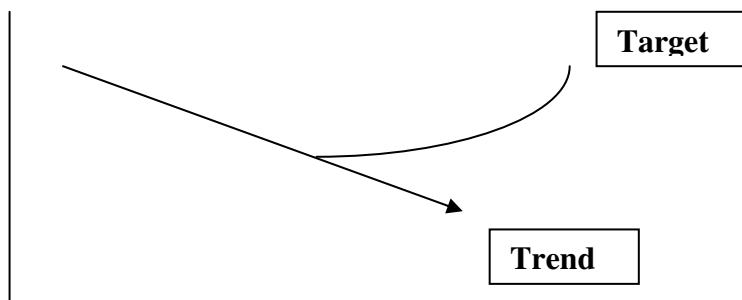
WORKBOOK: POLICY & STRATEGY

Which indicators will tell us if we're getting these outcomes or not?

e.g. number and proportion of young people 16-18 who are not in EET and participation rates in learning for 16-18 year olds

What are the current trends? Provide a baseline example relating to your indicator that demonstrates targets and trends

e.g. number of years 16-18 year not in EET and target for 2010



What is the story behind the baselines that reflects many different opinions about causes, and to consider both service and non-service solutions that will make a difference

e.g. high levels of poverty & deprivation; teenage pregnancy rates high; high levels of childhood obesity; agencies working in isolation to improve outcomes for children

Who are the partners who have a role to play in doing better?

e.g. Connexions, Local Skills Council, education services, youth offending service, schools, voluntary sector, health, JobCentre Plus

What actions are needed to succeed? What Works?

e.g. new strategies for preventing and tackling young people's non-involvement in EET; maintain close contact with young people and track their progress, using improved co-operation between agencies; change the culture of organisations so there is a focus on outcomes for young people rather than individual aspects of service delivery



What No-cost, Low-cost ideas are there?

e.g. a personal advisor sending Christmas Cards to young people with whom she had lost touch

Action Plan or Strategy:

Is the idea specific, can it be done? How much difference the action make on results, indicators and turning the curve? Is it consistent with our personal and community values? Is it feasible and affordable?

e.g. agree objectives to reduce the percentage of people identified as not in EET

What is your Budget?

e.g. money to implement YP strategy has come from the Connexions Service

For example:

	How much did we do? Quantity of effort (least important)	How well did we do it? Quality of effort (second most important)
E F F O R T	<p>BEFORE Three people seen Monday morning</p> <p>AFTER ACTION 10 young people seen Monday morning</p> <p>Appropriate call-ins by personal advisers and referrals from partner organisations</p> <p>Personal advisers able to get clients appropriate interviews for the same week</p>	<p>BEFORE No complaints</p> <p>AFTER ACTION On average one complaint per month dealt with by procedures</p>
Is anyone better off? Quantity & Quality of effect		
E F F E C T	<p>BEFORE Of 12 young people per month seen Monday morning, an average of three moved to employment, education or training</p> <p>AFTER ACTION Of 40 young people per month seen Monday morning, an average of 18 moved to EET</p>	<p>BEFORE Of 12 young people per month seen Monday morning, on average 25% moved to employment, education or training</p> <p>AFTER ACTION Of 40 young people per month seen Monday morning, an average of 45% moved to EET</p>

APPENDIX 1

National indicators which health and social care organisations have an interest in: (DH 2007c)

Stronger communities		
NI 1	Percentage of people who believe people from different backgrounds get on well together in their local area	PSA 21
NI 2	% of people who feel that they belong to their neighbourhood	PSA 21
NI 3	Civic participation in the local area	PSA 15
NI 4	% of people who feel they can influence decisions in their locality	PSA 21
NI 5	Overall/general satisfaction with local area	CLG DSO
NI 9	Use of public libraries	DCMS DSO
NI 10	Visits to museums or galleries	DCMS DSO

Safer communities		
NI 39	Alcohol-harm related hospital admission rates	PSA 25
NI 40	Drug users in effective treatment	PSA 25
NI 18	Adult re-offending rates for those under probation supervision	PSA 23
NI 19	Rate of proven re-offending by young offenders	PSA 23
NI 20	Assault with injury crime rate	PSA 25
NI 21	Dealing with local concerns about anti-social behaviour and crime by the local council and police	PSA 23
NI 23	Perceptions that people in the area treat one another with respect and dignity	HO DSO
NI 26	Specialist support to victims of a serious sexual offence	PSA 23
NI 41	Perceptions of drunk or rowdy behaviour as a problem	PSA 25
NI 42	Perceptions of drug use or drug dealing as a problem	PSA 25

WORKBOOK: POLICY & STRATEGY

Adult health and well-being		
NI 119	Self-reported measure of people's overall health and wellbeing	DH DSO
NI 120	All-age all cause mortality rate	PSA 18
NI 121	Mortality rate from all circulatory diseases at ages under 75	DH DSO
NI 122	Mortality from all cancers at ages under 75	DH DSO
NI 123	16+ current smoking rate prevalence	PSA 18
NI 124	People with a long-term condition supported to be independent and in control of their condition	DH DSO
NI 125	Achieving independence for older people through rehabilitation/intermediate care	PSA 18
NI 126	Early access for women to maternity services	PSA 19
NI 127	Self reported experience of social care users	PSA 19
NI 128	User reported measure of respect and dignity in their treatment	DH DSO
NI 129	End of life access to palliative care enabling people to choose to die at home	DH DSO
NI 130	Social care clients receiving Self Directed Support (Direct Payments and Individual Budgets)	DH DSO
NI 131	Delayed transfers of care from hospitals	DH DSO
NI 132	Timeliness of social care assessment	DH DSO
NI 133	Timeliness of social care packages	DH DSO
NI 134	The number of emergency bed days per head of weighted population	DH DSO
NI 135	Carers receiving needs assessment or review and a specific carer's service, or advice and information	DH DSO
NI 136	People supported to live independently through social services (all ages)	PSA 18
NI 137	Healthy life expectancy at age 65	PSA 17
NI 138	Satisfaction of people over 65 with both home and neighbourhood	PSA 17
NI 139	People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently	PSA 17

Tackling exclusion and promoting equality		
NI 145	Adults with learning disabilities in settled accommodation	PSA 16
NI 146	Adults with learning disabilities in employment	PSA 16
NI 149	Adults in contact with secondary mental health services in settled accommodation	PSA 16
NI 150	Adults in contact with secondary mental health services in employment	PSA 16
NI 140	Fair treatment by local services	PSA 15
NI 141	Number of vulnerable people achieving independent living	CLG DSO
NI 142	Number of vulnerable people who are supported to maintain independent living	PSA17
NI 147	Care leavers in suitable accommodation	PSA 16
NI 148	Care leavers in employment, education or training	PSA 16

WORKBOOK: POLICY & STRATEGY

Children and Young People		
NI 113	Incidence of Chlamydia in under 25 year olds	DCSF DSO
NI 55	Childhood obesity rate (reception year children)	DCSF DSO
NI 112	Teenage pregnancy (reduce by 50%) by 2010	PSA 14
NIS 51	Evaluating the impact of Children and Adult Mental Health Service (CAMHS) (% of PCTS and Local Authorities who are providing a comprehensive CAMHS)	DCSF DSO
NI 54	Services for children with a disability	PSA 12
NI 53	Improve breastfeeding rates at 6-8 weeks	PSA 12
NI 166	Average earnings of employees in the area	BERR DSO
NI 173	People falling out of work and on to incapacity benefits	DWP DSO
NI 174	Skills gaps in the current workforce reported by employers	DIUS DSO
NI 175	Access to services and facilities by public transport, walking and cycling	DfT DSO
NI 184	Food establishments in the area which are broadly compliant with food hygiene law	
NI 151	Overall employment rate	PSA 8
NI 152	Working age people on out of work benefits	PSA 8
NI 153	Working age people claiming out of work benefits in the worst performing neighbourhoods +	DWP DSO
NI 156	Number of households living in Temporary Accommodation	PSA 20
NI 158	% decent council homes	CLG DSO

Local economy		
NI 166	Average earnings of employees in the area	BERR DSO
NI 173	People falling out of work and on to incapacity benefits	DWP DSO
NI 174	Skills gaps in the current workforce reported by employers	DIUS DSO
NI 175	Access to services and facilities by public transport, walking and cycling	DfT DSO
NI 184	Food establishments in the area which are broadly compliant with food hygiene law	
NI 151	Overall employment rate	PSA 8

WORKBOOK: POLICY & STRATEGY

Local economy		
NI 152	Working age people on out of work benefits	PSA 8
NI 153	Working age people claiming out of work benefits in the worst performing neighbourhoods	DWP DSO
NI 156	Number of households living in Temporary Accommodation	PSA 20
NI 158	% decent council homes	CLG DSO

Environmental sustainability		
NI 186	Per capita CO2 emissions in the local authority area	PSA 27
NI 187	Tackling fuel poverty – people receiving income based benefits living in homes with a low energy efficiency rating	Defra DSO
NI 188	Adapting to climate change	PSA 27
NI 185	CO2 reduction from local authority operations	PSA 27
NI 194	Level of air quality – reduction in NOx and primary PM10 emissions through local authority's estate and operations	PSA 28

APPENDIX 2

Session Evaluation

- What worked well for you today? (PINK)
- What key learning points will you take away and put into practice? (YELLOW)
- What are your Future Learning Needs? (GREEN)
- What could be improved – and how? (BLUE)

Please place your completed Post-Its on the relevant parts of the Wall

Thank You

Policy & Strategy Learning Log

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PERSONAL LEARNING LOG

NAME:

DATE:

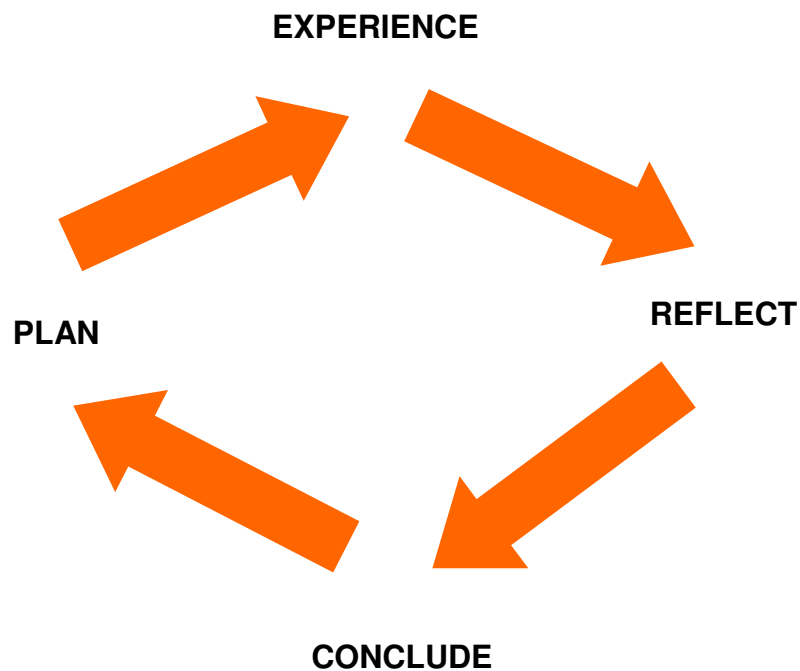
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THIS DOCUMENT IS DESIGNED TO HELP YOU BUILD ON THE LEARNING AND ACTIVITIES FLOWING FROM YOUR INVOLVEMENT IN THE 'I & I' PILOT WORKSHOPS. THE LEARNING LOG AND ITS CONTENTS ARE CONFIDENTIAL TO YOU

WORKBOOK: POLICY & STRATEGY

The Personal Learning Log is intended as a record of all the learning points that you gain during the training programme. The Learning log is a way of capturing the key points that you want to remember.

The Learning Log is made up of a series of blank pages - one for each workshop in which you have participated. These pages are based on the learning cycle shown below.



- You have a learning experience, be it a training session, workshop, a group discussion or syndicate exercise
- You reflect on the experience
- You come to various conclusions, identify some further activities and/or learning you would find useful
- You plan to incorporate your conclusions in your working and/or personal life

Please complete this Learning Log at the end of each Workshop that you attend.

POLICY AND STRATEGY DEVELOPMENT

EXPERIENCE

What main areas of Content were covered and how?

REFLECT

What are the main learning points for you?

CONCLUDE

What conclusions have you reached about the knowledge/skills/processes you have gained and need to develop further?

PLAN

How will you use these new skills/knowledge/processes in your work? How will you build on them? What actions do you plan to take? And when?

WORKBOOK: POLICY & STRATEGY

ADDITIONAL PAGES FOR YOUR NOTES

WORKBOOK: POLICY & STRATEGY

ADDITIONAL PAGES FOR YOUR NOTES