Report

LATH
LIVERPOOL ASSOCIATES
IN TROPICAL HEALTH

Demonstrating the Results Of Activities

For the: Plus Dane Group

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ACRONYMS

CCG	Clinical Commissioning Group
ECCCG	Eastern Cheshire Clinical Commissioning Group
GIS	Geographical Information System
JSNA	Joint Strategic Needs Assessment
LAP	Local Area Partnership
LATH	Liverpool Associates in Tropical Health
MSOA	medium level Super Output Area
MWIA	Mental Wellbeing Impact Assessment
NHS	National Health Service
PDG	Plus Dane Group
SATs	Standard Assessment Tests
SOA	Super Output Area

EXECUTIVE SUMMARY

Plus Dane Group (PDG) is a large housing association in Cheshire and Merseyside with the mission of "doing everything they can to improve quality of life, choice and opportunity for the people the organisation was set up to serve". Hence they are working to improve the health and wellbeing of their tenants, as well as providing a high quality of housing.

PDG do not currently feel that they are fully communicating the impact they have on health and wellbeing to partner agencies, such as health, social services and education. This limits opportunities for joint working and the sharing of resources.

The consultancy team was asked to help them find ways to demonstrate their impact more effectively and to identify areas within health and wellbeing where they may be able to have a greater impact.

The consultancy team carried out a document review and spent one day of data collection, meeting and interviewing stakeholders and visiting Bromley Farm Estate in Congleton. The data has been analysed and synthesised to produce this report. A limitation of the process is that relatively few stakeholders were available to be interviewed, which may mean some conclusions are based on less data than is ideal and hence may be viewed as less robust.

It was observed that PDG is carrying out an impressive range of activities with tenants and other residents on Bromley Farm to improve health and wellbeing. Statistics currently reported on these activities give thenumber of people participating. It is recommended that any statistics reported should include a denominator of the number of people who could benefit from that activity, where possible, to give a better understanding of size of the issue and encourage more effective targeting of those who may benefit the most.

There is an opportunity for PDG to have informed discussions with partner organisations by identifying the relevant health related indicators partners are working to meet (see Annex 6). These can be used as the basis for planning activities and discussions with the organisation. A model for doing this is proposed.

A set of indicators for PDG to consider have been developed (see Annex 7). These can be piloted to see if PDG find them useful. A short formal health and wellbeing survey of tenants could be considered, to be repeated annually to assess wellbeing, but it is acknowledged that the individual results will be significantly affected by many factors outside PDG control.

Additional sources of data on health and wellbeing have been identified, as have some areas of health and wellbeing that PDG could consider for further work in collaboration with partners. It is recommended that this approach is reviewed in a year to establish what progress has been made.

INTRODUCTION

Plus Dane Group (PDG) is a large housing association, managing over 16,000 homes across Cheshire and Merseyside and has a turnover of over £52 million per year.[1] They have the mission of "doing everything they can to improve quality of life, choice and opportunity for the people the organisation was set up to serve".

As a result of this mission they are carrying out a range of activities for residents, which one informant described as *"above and beyond what you would expect from a housing association."*

They requested a short consultancy by LATH in May 2012 to assist them to identify ways to measure the results of their activities more effectively and to be able to relate them more successfully to partner organisations.

BACKGROUND

The national policy and funding environment for areas that PDG work in is changing markedly, with reforms of welfare, health and social care funding, and an emphasis on localism.

With these changes in funding and structures it is even more important that there are shared plans between partners and that available funding is used to best effect. PDG finds itself working with organisations that are not used to having a housing association as a partner. There is a need to find new ways to measure and communicate the outcomes of their work to partners, so that PDG is seen as a partner of choice to work with.

PDG do not feel that they are fully communicating, the impact they are having on the health and wellbeing of residents and others to their partners in health, local government and education. There is much anecdotal evidence showing what they have achieved and they believe they are having an impact on the wider determinants of health, and they are now looking to determine how best to measure outcomes and impact of their activities.

PDG described themselves as being on a journey and as part of this they need to develop better ways of talking to partners active in improving the health and wellbeing of parts of the population.

OBJECTIVE

The objective of the consultancy was agreed with the client as: helping PDG to develop ways to demonstrate the outcomes and impact of its activities on health and wellbeing and to identify where interventions may be directed with most effect. Refer to Annex 1 for the Terms of Reference.

METHODOLOGY

The consultant team utilised a variety of methods to collect both qualitative and quantitative data relevant to the objectives of this consultancy.

1. Background documents review: the primary objective of this review was to understanding the existing evidence and knowledge about linkages between the outputs of PDG activities and health and wellbeing outcomes. It also aimed to find out if there are any tools that could be used for measuring the outcomes of activities and what indicators were being used for this purpose. A standardised data collection form was developed and used to extract the data from 12 key documents (see Annex 9).

2. Key informant interviews: key informants were purposefully selected based on agreement between the consultant team and PDG. Seven stakeholders were interviewed using an in-depth open-ended interview structure guide. The interviews were aimed at bringing better understanding of the general environment and dynamic of the services, its outcomes, information system and stakeholders engagement.

[1] "Our Story 2009-2010" published by Plus Dane Communications 2010

3. Meetings: The team relied on discussion meetings to clarify the processes and monitoring system within the group. The team met with PDG Managing Director, the Engagement Manager and Health and Wellbeing Manager.

4. Site visit: Bromley Farm housing estate in Congleton was taken as an example of an area they work in. On the estate there are about 1200 houses. PDG manage about half the houses, but they work with all the estate residents, not just their tenants when carrying out activities. The orientation visit involved informal meetings with some of the residents from the neighbourhood who were asked about their perceptions of services and activities provided byPDG..

5. Demonstration of the Geographical Information System (GIS): a brief presentation was given to the consultant team of the current information system used in the group and how this could be used as part of the new M&E system.

Information from different sources was summarized and analysed using a customised framework that informed the process of reaching the main findings and conclusions.

A limitation of the process is that relatively few stakeholders were available to be interviewed, which may mean some conclusions are based on less data than is ideal and hence may be viewed as less robust. However, there were numerous other sources of data which enabled triangulation of the findings.

Findings and Recommendations

Much research has been carried out on the wider determinants of health. The model developed by Whitehead and Dahlgren (figure 1) is well established and serves to show the wide range of influences on health.

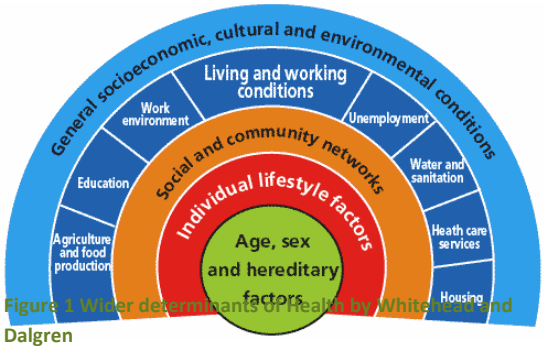

Figure 1 Wider determinants of Health by Whitehead and Dalgren

There is good evidence that housing and housing associations have a key role in health and wellbeing. Housing associations are better positioned than any NHS provider to have an impact on many of the wider determinants of health.[2]

As the Marmot report[3] says, *"for those of low social status, health is made worse by living in a poor area. There is a kind of double jeopardy".*

The quality of someone's housing and the quality of the neighbourhood in which they live has a significant impact on their ability to make the choices necessary to avoid ill health and can have a direct impact on their ability to cope with illness or disability [4].

Housing associations are uniquely placed to influence some of key health determinants. For example housing organisations can influence rates of domestic abuse, rates of physical activity, noise pollution, utilisation of green space for exercise, social connectedness, and emotional wellbeing of looked after children.[5]

In relation to working with the NHS to more effectively manage healthcare, areas that could be looked at include:

- reducing falls,
- the urgent care system and
- hospital discharge[6].

Reporting PDG activities

[2] interview with stakeholder
[3] Marmot et al (2010). The Marmot Review: Fair Society, Healthy Lives. Strategic review of health inequalities in England post-2010. The Marmot Review, London
[4] Sustaining health through housing published by Common Cause Consulting 2005
[5] Wellbeing Health and Place published by Our Life 2011 www.ourlife.org.uk
[6] Wellbeing Health and Place published by Our Life 2011 www.ourlife.org.uk

PDG carry out a wide range of activities, which are intended to improve health and wellbeing. These include: encouraging residents to grow vegetables and to eat a healthier diet; increasing physical activity; organising youth clubs and friendship groups; improving money management and income; reducing antisocial behaviour and promoting smoking cessation.

At present statistics reported appear to be limited to the numbers attending activities and using quotes and anecdotes when appropriate. This data can be effective in demonstrating some of the reactions and changes that have occurred. There is also some data available on the age and postcode of those attending which is not currently used. This could be used to assess whether only those who live nearby attend and which age groups are being reached.

Currently staff are piloting recording how confident or capable individuals feel at the beginning and end of an activity. This may show if the outcome is being achieved.

While the range of activities is impressive, it is not always clear from the supplied documentation, how appropriately the activities are targeted, and what proportion of the target group that could benefit from the activity or intervention attended.

For example, one of the activities is "To support tenants with long term life limiting illness and/or disability". The reports of activities normally state that xx people participated. While this activity is potentially important in enabling people to remain in their own homes for longer, it does not give much information. It is reported that 69% of the PDGs homeowners are permanently sick or disabled[7]. What proportion of the 69% who are permanently sick or disabled are being supported? It would be much clearer to partners the scale of work being undertaken. Providing a denominator of how many people there are with long term life limiting illness and or disability would make it clear what of the proportion who have attended and enable questions to be considered such as "are the most appropriate people being targeted?".

It may be that by targeting activities more effectively, a greater impact could be achieved. Also by checking the proportion that are accessing an activity, it may become clear that the activity needs to be carried out on a larger scale if it is going to have a significant impact.

Recommendations:

PDG should start to report the denominator population for activities where possible and also to use this to assess how effectively inventions are being targeted.

Consideration could be given to carrying out a survey of a representative sample of tenants to assess their wellbeing on an annual basis. A seven item questionnaire Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) which has been used across the North West of England[8] could be used. This would give PDG information on the impact their activities were having, but it is acknowledged that the scores will also be affected by factors outside PDG's control, such as welfare reforms.

EXISTING INFORMATION SYSTEM IN PDG

Availability of relevant data and recording systems

The current monitoring system, at PDG, provides descriptive information about the activities and the people who receive the services of those activities. The information system is linked to computerised information management system that gives the group considerable amount of data that might be used to enrich the knowledge about the outcomes they achieved that related to health and wellbeing. All of the information could be easily managed and

[7] PDG Supported Housing strategy 2012-2015 pub May 2012
[8] http://www.nwph.net/nwpho/NorthWestMentalWellbeingSurvey.pdf see section 2.3

linked with the existing Geographic Information System (GIS). The system is used to aggregate data based on the knowledge about houses and residents in the neighbourhoods.

PDG have an impressive Geographical Information System (GIS) with considerable detail of areas down to Super Output Areas (SOA). This can be used with the profiles they already hold on their tenants, however, the completeness of the profile data varies from 70 to 100%[9]. Usually profiles are updated annually and give information on employment, long term illness, benefits received as well as age and gender. They do not hold data on non PDG tenants who live on their estates and join in activities .

Identified desired missing data

Despite this volume of information data and information about the outcome measures of health and wellbeing is not currently available. Some health related data is available down to SOA which may be useful if PDG can obtain it at reasonable cost or from the Public Health Department. Some of this data may be useful for monitoring and evaluating what outcomes and impact the group has achieved as a result of its activities.

PDG does not collect data that provides continuous follow up of information about inputs and outputs of the activities and its linkage to the objectives and desired outcomes. Developing clear objectives in partnership with key stakeholders as illustrated in the next section can assist in identifying key indicators that can then be routinely followed up (as illustrated in figure 2 below).

INFORMATION NEEDS OF STAKEHOLDERS

Involvement of stakeholders

PDG is clearly aware of the changes taking place in the organisations it works with.[10] However in the documents reviewed for this assignment there is no reference to the outcomes frameworks that these organisations work to(see Annex 6). It is important that PDG aligns its monitoring and evaluation to the outcome frameworks used by key partners.

The impression based on the brief visit and document review, is that there are close links with some local stakeholders at a relatively informal level, but other stakeholders are less closely involved. It has not been clearly demonstrated that there is alignment at a strategic level with the health and wellbeing agenda of other partner organisations. For example, there was no mention of any common outcomes or priorities in the new Supported Housing Strategy document[11].

Recommendation

PDG should consider using a logic framework as outlined in figure 2. This encourages a logical approach to how activities are planned and what is expected in terms of outputs, outcomes and impacts.

[9] "Unity" customer annual report 2010/2011 edition
[10] PDG Supported Housing strategy 2012-2015 pub May 2012
[11] PDG Supported Housing strategy 2012-2015 pub May 2012

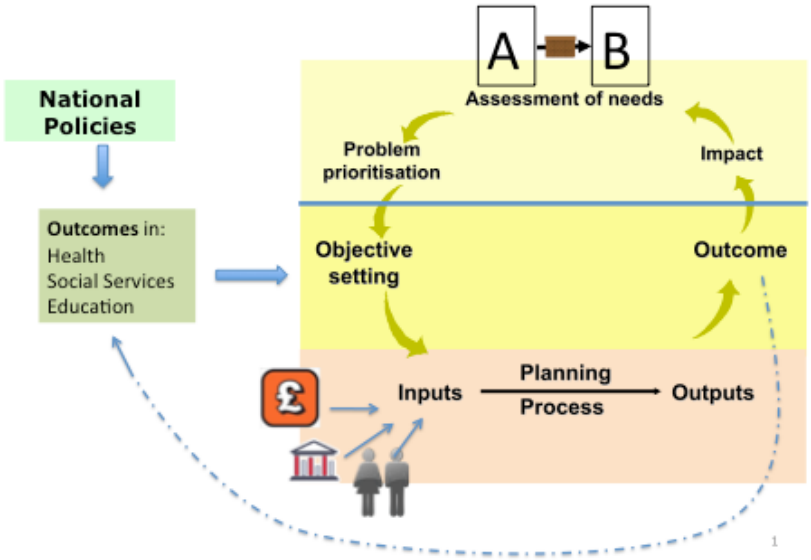

Figure 2 Suggested framework for planning

By explicitly linking the planning of activities to the outcomes of other partners as well as those of PDG , it should bring greater clarity how PDG can work with other partners and so be used as the basis of discussion with them as well as forming the basis of monitoring.

Perception of public health impact

Interviewees felt there was "huge synergy" with the work PDG does and the new Public Health outcomes. PDG is in a position to tackle the "causes of the causes" of poor health.

PDG will need to consciously work with the evolving commissioning architecture in order to position itself to best effect. It was suggested that PDG should request to give a presentation on its work to the shadow Health and Wellbeing Board, as this Board will bring together many of the influential partners. From April 2013 there will be greater scope to commission services differently.

Recommendations

PDG has the potential to make a significant contribution to asset-based commissioning in terms of linking residents, supporting patient groups and increasing patient involvement. PDG can do much to influence how people feel about where they live in terms of physical safety and feeling secure, noise, social connectedness and employment

Discharge from hospital to home and maintaining the independence of those with long term illness or disability are important areas where PDG can make a novel contribution. These areas are of considerable importance to the National Health Service (NHS) and Clinical Commissioning Group (CCG) commissioners, and they may not be fully aware of what PDG can do and is already doing.

Relevant information for stakeholders

There was limited scope for speaking to partner organisations during the visit, but all that were contacted were keen to work with PDG, receive information on health related activities and value PDG as a key partner.

The level of detail to be reported that is seen as appropriate varies with different audiences, from the relatively informal activity reports and anecdotes to formally presented figures. A variety of ways of reporting was encouraged.

This encompasses using specific reports, websites, with powerpoint slide sets available online, and contributing both hard and soft data to the Joint Strategic Needs Assessment (JSNA).

Information on areas which PDG could focus on

PDG asked if there were areas relating to health and wellbeing where they were likely to have a greater impact. This report identifies a number of information sources that can be used to identify the health priorities for PDG's tenants – using the Bromley Farm Estate as an example.

Bromley Farm Estate is a relatively small area, and getting specific data for it can be difficult. Even when it is available, for some topics the statistical confidence intervals may be wide, which means the estimate is not that accurate. Two lower Super Output Areas cover it. There is however data available and as part of the consultancy a variety of data sources were considered.

The 2010 Public health annual report[12] for Cheshire East gives a profile of Congleton Local Area Partnership (LAP) in chapter 3. It states that Congleton East MSOA, where Bromley Farm lies, is the most deprived in the LAP with the highest percentage of claimants of incapacity benefit and job seekers allowance, highest level of mental health problems and the lowest disability free life expectancy. This publication is a good source of further health related data and cites other data sources.

The ECCCG annual plan identifies health related areas within the area covered by the CCG (see Annex 5). Some of these would be relevant for Bromley Farm Estate.

At present the Joint Strategic Needs Assessment (JSNA) is relatively high level, but it is planned that over time it will become more detailed and so more useful at smaller geographical areas.

The GIS system used by PDG has considerable potential. Additional health data is available at medium and lower Super Output Area (SOA) level to complement the existing data. This could be explored, as it may be helpful in informing discussions and planning.

Monitoring & Evaluation Framework

The consultant team propose the following general monitoring and evaluation framework to PDG.

Purpose of the framework

The proposed framework could facilitate the establishment of monitoring and evaluation system on health and wellbeing outcomes in the neighbourhoods. The framework will help PDG in:

- Developing monitoring and evaluation tools that can provide a mixture of information about different part of the logic framework;
- Measuring performance and progress over time focusing on priority areas;
- Providing continuous feedback to improve planning and design of activities.

The logic of framework development process

The process of developing the proposed framework took into considerations all of the driving factors regarding the internal logic of the framework, the needs of the stakeholders and the nature of engagement that PDG has currently achieved and might achieve in the bigger context. The proposed framework was based on recommending a wide

[12] http://www.cecpct.nhs.uk/images/uploads/8_Annual_Public_Health_Report_2009-10_Chapter3.pdf

range of useful indicators that PDG might consider in order to capture its achievements in improving the health and wellbeing of its residents.

Recommended Structure of the framework

Annex 7 shows the matrix of selected indicators that PDG might consider for its monitoring and evaluation system in the areas of health and wellbeing. The matrix provided a wide range of indicators and measurement methods that link directly to areas including:

- maintaining good health and wellbeing;
- helping people to live healthy lifestyles;
- preventing avoidable ill health or injury; and
- supporting discharge from NHS to social care.

These areas cover both current and potential activities in addition to the priority areas identified as part of the national and local policies related to health and wellbeing.

initially PDG should consider selecting a small number of the indicators in order to test the effectiveness of the new system. Later, PDG might decide to expand the scope of the M&E system or to focus on specific areas depending on internal policy and strategy. Some of the indicators may require a survey, but this could be included with the routine process of updating the tenant profiles.

The matrix provides summary descriptions of each proposed indicator and the major domain of health and wellbeing that they are linked to. Annex 7 provides detailed descriptions about each indicator illustrating its usefulness, measurement method, required data, frequency of reporting, dissemination advice and references to its source.

This matrix should complement the approach discussed above, of identifying the outcomes of partner organisations and using these as a basis for developing planned activities and outcomes.

CONCLUSIONS

PDG is carrying out a wide range of activities which should have a beneficial impact on the participants. However it is not clear that when they are being planned that health related outcomes of importance to partners are identified and discussed, with the intention of having an impact and maximising opportunities for joint working.

PDG needs to continue to work to position itself effectively while the architecture of commissioning is changing. Opportunities to present to health and wellbeing boards should be sought so as to raise the profile of PDG and the opportunities they have to work in partnership to improve health and wellbeing.

At present, activities are reported in terms of numbers participating, but there is no denominator data, to give an idea of the proportion of the target group who are attending. This greatly reduces the information given, in terms of the potential impact. Better use of existing data could show segmentation by age and geographical spread of attendees.

By using a logic framework those planning activities may find it easier to identify outputs, outcomes and impacts in line with national, regional, local and stakeholder priorities.

There are many indicators used by partner organisations (see Annex 6) Some of them can be used as the basis of outcome measures for PDG. Some are not yet fully defined, which reflects the difficulty even at national level of devising suitable indicators for areas which are agreed to be important to measure.

Some of the indicators described above and in Annex 7 should be piloted to see if they provide the level of information PDG is seeking.

Consideration could be given to carrying out a health and wellbeing survey annually.

These recommendations and the work that has proceeded from them should be reviewed in a year to see if PDG can benefit further from the suggested approaches.

NEXT STEPS

1. Additional sources of health and wellbeing data have been identified. These can be used to identify some of the greater needs of the local area.
2. Before new activities are planned, relevant outcomes of partners should be identified and used to orientate the anticipated outcome of the activity and as a basis for discussion with partners.
3. The logic framework should be used in planning, in order to clarify what is intended to result from activities.
4. A denominator should be used, as far as possible, when reporting activities, in order to give a clearer understanding of the proportion of the target group that has been reached. If it is only a small percentage it raises questions about why more do not want to attend.
5. A few of the proposed indicators in Annex 7 should be piloted to see if they are found to be useful and integrated into the normal data collection.

ANNEX 1: TERMS OF REFERENCE

Client: Plus Dane Group Housing Association

Title: Design Study of a monitoring an evaluation tool/framework

Background Information

The Plus Dane Group is a housing association based in Merseyside and Cheshire, owning and managing around 20,000 homes. The group provides affordable homes for families and single people as well as specialist housing and support services to people who are homeless or may have particular needs such as experiencing mental ill health. Many of the people we work with are dependent on welfare benefits or are in low waged or insecure employment.

Our homes are spread over Cheshire and Merseyside and are often in areas of high deprivation in terms of income levels, unemployment, educational attainment and health indicators. Many of the areas we work in suffer some of the highest levels of ill health and poor wellbeing both in terms of physical ailments and mental health. Consequently much of our work is intended to address these issues in partnership with a range of other agencies including health professionals. This varies from operating expert patient projects, health and leisure groups, dietary advice and a range of debt advice and financial inclusion activities.

As a neighbourhood investor we regard housing as a major element in determining peoples health and wellbeing. At its simplest poor housing correlates strongly with a range of health issues including respiratory illness, depression and in the case of older people hypothermia relating to fuel poverty and inadequate insulation. However the other key determinants of wellbeing relate to issues such as poverty, inadequate diet, social isolation, unemployment, lack of aspiration, education and opportunities for self-fulfilment.

While clear medical conditions require clinical interventions the Plus Dane Group is working with individuals and groups to address some of the broader issues of health and wellbeing including such issues as social isolation as mentioned above. Consequently our health and wellbeing activity ranges from providing specific support to people for example, experiencing poor mental health to addressing issues of poverty and exclusion.

Rationale:

Plus Dane Group works as a neighbourhood investor, creating conditions where people can thrive and grow. Having developed a range of activities/services that support the health and wellbeing agenda, the

group wishes to better monitor and evaluate these activities by developing a tool/framework to demonstrate the impact of its neighbourhood activities that are contributing to improved health and wellbeing outcomes. This would also need to consider the issues identified by health and other external agencies.

Purpose:

To develop a monitoring and evaluation tool/framework to demonstrate public health impact of the Plus Dane Group services and support.

Objectives:

1. To review the Joint Strategic Needs Assessment for Cheshire East and identify relevant health targets and public health challenges in which the activities of the Plus Dane group can potentially impact
2. To engage with a range of stakeholders (staff, GPs, public health, health workers in neighbourhood, local counsellors/activist) to identify their key priorities in relation to (social) housing that contribute to the health and well being agenda
3. To develop a draft monitoring and evaluation tool/framework, to guide the Plus Dane Group in better capturing the nature of the outcomes/impact it achieves in relation to the health and well being agenda.
4. To make recommendations on how the Plus Dane Group can incorporate the M&E tool/framework into their routine work.

Specifics Tasks

1. Briefing with client
2. Identification and agreement of appropriate stakeholders to be consulted
3. Selection of appropriate data collection methods to achieve objectives including;
    - Document review/internet search
    - Focus group discussion
    - Staff/stakeholder interviews
    - Telephone interviews
    - Secondary data review
4. Debriefing with client

Expected Outputs

1. Written report (refer to LATH report guidelines)
2. Power point presentation (max 25 minutes followed by Q&A)

Expertise Required

A 3-5-person consultant team will be required for this assignment with expertise in the following key areas:

- Knowledge and experience in monitoring and evaluation of public health programmes
- Knowledge and expertise in social housing and its relation to public health
- Understanding of the UK health and wellbeing agenda
- Experience in the management of strategic partnerships/alliances
- Demonstrated leadership skills
- Application of qualitative and quantitative research methods
- Excellent presentation and communication skills
- Ability to work in a multidisciplinary team

- Ability to work under pressure to strict deadlines
  Experience of working in the UK on a similar assignment would be desirable

Time Frame

Tues 22/05/12	• Preparation & client briefing • **3 pm @ Seminar Room 2, Liverpool School of Tropical Medicine**
Fri 25/05/12	• Field work – data collection
Sat 26/05/12 – Wed 31/05/12	• Analysis and report drafting • Report finalisation and preparation of presentation • Hand in report
Thurs 31/05/12	• Presentation and client feedback • **1.45pm @ Nickson Room, Liverpool School of Tropical Medicine**

Key Contact Persons

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Background Documents/Resources Available

1. www.neighbourhoodinvestor.com
2. Housing Learning and Improvement Network. http://www.housinglin.org.uk/index.cfm
3. http://www.cheshireeast.gov.uk/community_and_living/research_and_consultation.aspx
4. For neighbourhood information and a copy of the latest Joint Strategic Needs Assessment. http://www.doriconline.org.uk/
5. Integrated Care Network (2008). Commissioning Housing Support for Health and Wellbeing. Care Services Improvement Partnership.
6. Sustaining Health through Housing (2005). Common Cause Consulting.
7. Central & Eastern Cheshire Primary Care Trust. http://www.cecpct.nhs.uk/publications/corporate-publications/
8. Central & Eastern Cheshire PCT Strategic Plan 2010-14; Better, Longer Lives
9. Health and Wellbeing Board. http://www.cheshireeast.gov.uk/council_and_democracy/your_council/health_and_wellbeing_board.aspx

ANNEX 2: ACKNOWLEDGEMENTS

The consultancy team are very grateful to a number of people who willingly gave time to talk to the team and facilitate their visit.

Without their input this consultancy would not have been possible.

Mike Doran Managing Director, Plus Dane Group

Emma Sneyd, Engagement Manager, Plus Dane Group

Andy Tester, Health and Wellbeing Manager, Plus Dane Group

Glen Williams, Councillor for Congleton Town Council

ANNEX 3: THE CONSULTANT TEAM

Amjad Idries PhD, MPH, PG Dip PH, B.Pharm, IDipMBA, FlstPM
Kemi Ottun-Emaimo MSc, MSW, BSc, CIA, FIDA, FISOW
Ewan Wilkinson MB,ChB, FFPH, DTM&H, DRCOG

ANNEX 4: LIST OF PEOPLE INTERVIEWED AND FACILITIES VISITED

People interviewed

Mike Doran Managing Director, Plus Dane Group

Ian Reed, Head of Excellence, Plus Dane Group

Andy Tester, Health and Wellbeing Manager, Plus Dane Group

Emma Sneyd, Engagement Manager, Plus Dane Group

Alex Hill Information Officer, Plus Dane Group

Glen Williams, Councillor for Congleton Town Council

Ann and Ellen, residents with Plus Dane Group

Davena Parr, Assistant Director of Public Health, Eastern Cheshire

Peter Coates, Deputy Headmaster, Blue Coates School, Chester

Facilities visited

PDG offices in Congleton, Cheshire

Bromley Farm Estate, Congleton

ANNEX 5: SOME AREAS WHERE HOUSING DIRECTLY AFFECTS HEALTH

Accident prevention

Research[13] on accident prevention interventions related to housing design showed that:

• The use of stair-gates, outlet covers, cupboard latches and poison stickers shows some reduction (10%) in accidents, provided that it is supported by advice and provided that it is installed for people;

• The installation of fire alarms with supporting educational material is shown to be effective;

• The provision of cupboard locks shows some benefit although greater awareness of poisonous household products and their disposal may also be a factor;

• The fitting of hand-rails, grab bars, and non-slip stripping reduces falls amongst older people. Grab rails are least likely to be removed at a later date

Environmental Noise

Environmental noise can have a profound on quality of life and some circumstances can lead to hypertension. Noise is generally defined as unwanted sound.

Unwanted noise can elicit different emotions including anger, fear and depression. The impact of noise is likely to be greatest if it makes the individual feel fearful.

Beyond annoyance and sleep disturbance, there is good evidence for a causal relationship between environmental noise and both hypertension and heart disease.[14]

Crime

Areas with high crime rates tended to exhibit higher mortality rates from all causes suggesting that crime and population health share the same social origins. Crime is a mirror of the quality of the social environment[15]

[13] Sustaining health through housing published by Common Cause Consulting 2005
[14] Sustaining health through housing published by Common Cause Consulting 2005
[15] Sustaining health through housing published by Common Cause Consulting 2005

ANNEX 6: RELEVANT OUTCOMES USED BY PARTNER ORGANISATIONS

Many organisations, particularly in the public sector, need to demonstrate how they are performing against agreed standards or "outcomes". Funding and the outcome of performance assessments may depend on how well these outcomes are being achieved.

These standards or outcomes are therefore important to the executive team of an organisation. PDG has the potential to identify outcomes or standards that they can assist the partner organisation achieve, and use this common interest as the basis of a discussion of how they can work together to achieve

In the sections below some of the relevant standards or outcomes in areas that PDG currently carry to activities have been extracted or highlighted.

In future, activities being planned by PDG should be linked to these, and modified as needed in discussion with partner organisations.

Health

NHS Eastern Cheshire Clinical Commissioning Group (ECCCG) is the CCG that commissions health care for Congleton and surrounding areas. It has a budget of £239 million and one of its values is "working together.[16]

Relevant priority areas described in their recent annual plan are presented below

- Main causes of premature mortality (deaths under 75 years) are due to cardiovascular disease (ischaemic heart disease and stroke) and cancers. They cause about two-thirds of all premature deaths. Respiratory and digestive diseases are the next two largest contributors of premature deaths.
- Although the prevalence of desired lifestyle indicators in ECCCG compares favorably with the England average, there remains room for improvement. For example, in the adult population (16 years and above) the prevalence of 'healthy eating' is 27%, physical activity is 26%, obesity is 21%, excess alcohol use is 21% and smoking is 17%.
- The teenage pregnancy rate (under 18 years) in the ECCCG area is lower than the English average but there are local areas within ECCCG with higher rates.
- Smoking in pregnancy and breastfeeding initiation rates are worse than the English average
- Ageing population - In addition to the condition-specific picture, an ageing population profile is likely to lead to increasing need for services related to the care of the elderly, such as care related to falls, stroke, dementia and other long term conditions. Eastern Cheshire has one of the most rapidly increasing older populations in England.

Table 1 Specific outcomes in the ECCCG annual plan under the Healthy Communities programme

Key initiatives	*Outcomes*
Autism Services Mental Health Access	Reduction in the impact of mental health issues
Falls Prevention	Reduce number of falls, related harm and improved rates of re-mobilisation
Alcohol Awareness	Reduced impact of alcohol abuse on health, crime and other indicators
Carers Strategy	Carers report a positive impact on their own health and wellbeing

Education

[16] NHS Eastern Cheshire Clinical Commissioning Group 2012/13 Annual Plan www.ec3health.co.uk accessed 28th May 2012

Secondary schools are assessed on the results their pupils achieve in SATS (Standard Assessment Tests) at the end of Key stage 4 against estimates of pupil achievement made at the end of Key Stage 2.

Schools are assessed against FFT B and FFT D. FFT stands for Fischer Family Trust and FFT B is an indicator that compares against the same progress as similar pupils in similar schools nationally, while FFT D estimates the same progress as similar pupils in the top quartile of similar schools

Particular areas of interest to schools is performance in Maths and English, reading recovery, and emotional intelligence. Emotional intelligence can include counselling and how to handle bullying.

Some schools operate reward systems for attending extra classes to avoid the summer dip in pupil performance.

There is some funding available for schools and some other organisations to run summer schools

Adult social care.

The Adult Social Care Outcomes Framework17 is a set of outcome measures, which have been agreed to be of value both nationally and locally for demonstrating the achievements of adult social care. It is not a national performance management tool. It will be for councils to set their own local priorities, driven by both the framework and by their local Joint Strategic Needs Assessments and joint Health and Wellbeing strategies. Its main use is for 'benchmarking' and comparison between areas.

The outcomes framework is outlined below. Outcomes which may be relevant to the work of PDG are highlighted.

[17] The Adult Social Care Outcomes Framework Handbook of Definitions, March 2012, http://www.dh.gov.uk/health/category/policy-areas/social-care

2011/12 Adult Social Care Outcomes Framework at a glance

from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133335.pdf

**Included in/consistent with NHS OF **Included in/consistent with Public Health OF*

1 Enhancing quality of life for people with care and support needs		2 Delaying and reducing the need for care and support
Overarching measure 1A. Social care-related quality of life		**Overarching measures** 2A. Permanent admissions to residential and nursing care homes, per 1,000 population *Placeholder: Effectiveness of prevention/preventative services*
Outcome measures **People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.** 1B. The proportion of people who use services who have control over their daily life 1C. Proportion of people using social care who receive self-directed support, and those receiving direct payments **Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.** *Placeholder: Effectiveness of prevention/preventative services* **Carers can balance their caring roles and maintain their desired quality of life.** 1D. Carer-reported quality of life * **People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.** 1E. Proportion of adults with learning disabilities in paid employment *** 1F. Proportion of adults in contact with secondary mental health services in paid employment *** *Placeholder: Proportion of working age adults in contact with social services in paid employment (to replace 1E/1F)* 1G. Proportion of adults with learning disabilities who live in their own home or with their family ** 1H. Proportion of adults in contact with secondary mental health services living independently, with or without support **		**Outcome measures** **Earlier diagnosis, intervention and reablement mean that people and their carers are less dependent on intensive services.** 2B. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services* *Placeholder: Effectiveness of early diagnosis, intervention and reablement: avoiding hospital admissions* **When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.** 2C. Delayed transfers of care from hospital, and those which are attributable to adult social care* *Placeholder: Effectiveness of reablement: regaining independence*
3 Ensuring that people have a positive experience of care and support		**4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm**
Overarching measure **People who use social care and their carers are satisfied with their experience of care and support services.** 3A. Overall satisfaction of people who use services with their care and support 3B. Overall satisfaction of carers with social services		**Overarching measure** 4A. The proportion of people who use services who feel safe**
Outcome measures **Carers feel that they are respected as equal partners throughout the care process.** 3C. The proportion of carers who report that they have been included or consulted in discussions about the person they care for **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.** 3D. The proportion of people who use services and carers who find it easy to find information about services **People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.** *This information can be taken from the Adult Social Care Survey and used for analysis at the local level.*		**Outcome measures** **Everyone enjoys physical safety and feels secure.** **People are free from physical and emotional abuse, harassment, neglect and self-harm. People are protected as far as possible from avoidable harm, disease and injuries. People are supported to plan ahead and have the freedom to manage risks the way that they wish.** 4B. The proportion of people who use services who say that those services have made them feel safe and secure *Placeholder: Effectiveness of safeguarding services*

Overview of Public Health outcomes and indicators[18]

Vision

To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest.
Outcome measures
Outcome 1: Increased healthy life expectancy, ie taking account of the health quality as well as the length of life.
Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

1 Improving the wider determinants of health

Objective *Improvements against wider factors that affect health and wellbeing and health inequalities*
Indicators

- Children in poverty
- School readiness (Placeholder)
- Pupil absence
- First time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- People with mental illness or disability in settled accommodation
- People in prison who have a mental illness or significant mental illness (Placeholder)
- Employment for those with a long-term health condition including those with a learning difficulty/ disability or mental illness
- Sickness absence rate
- Killed or seriously injured casualties on England's roads
- Domestic abuse (Placeholder)
- Violent crime (including sexual violence) (Placeholder)
- Re-offending
- The percentage of the population affected by noise (Placeholder)
- Statutory homelessness
- Utilisation of green space for exercise/health reasons
- Fuel poverty
- Social connectedness (Placeholder)
- Older people's perception of community safety (Placeholder)

2 Health improvement

Objective *People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities*
Indicators

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions
- Child development at 2-2.5 years (Placeholder)
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- Emotional wellbeing of looked-after children (Placeholder) •
  Smoking prevalence – 15 year olds (Placeholder)
- Hospital admissions as a result of self-harm
- Diet (Placeholder) • Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- Cancer diagnosed at stage 1 and 2 (Placeholder)
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible
- Self-reported wellbeing
- Falls and injuries in the over 65s

[18] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132559.pdf accessed 28th may 2012

3 Health protection

Objective *The population's health is protected from major incidents and other threats, while reducing health inequalities*

Indicators

- Air pollution
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for tuberculosis
- Public sector organisations with board-approved sustainable development management plans
- Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)

4 Healthcare public health and preventing premature mortality

Objective *Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities*

Indicators

- Infant mortality
- Tooth decay in children aged five
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- Mortality from communicable diseases (Placeholder)
- Excess under 75 mortality in adults with serious mental illness (Placeholder)
- Suicide • Emergency readmissions within 30 days of discharge from hospital (Placeholder)
- Preventable sight loss
- Health-related quality of life for older people (Placeholder)
- Hip fractures in over 65s
- Excess winter deaths
- Dementia and its impacts (Placeholder)

ANNEX 7: POSSIBLE INDICATORS FOR PDG USE

General framework matrix

Domain	Indicator	Index
Tackling the wider determinants of health **(Overall summary indicators)**	Healthy Life Expectancy	1
	Comparison between selected health outcomes of the neighbourhood compared with other neighbourhoods	2
	Proportion of people within the neighbourhood in long-term unemployment	3
Maintaining good health and wellbeing	Percentage of PD projects/proposals (services or activities) that demonstrated impact using Mental Wellbeing Impact Assessment (MWIA) toolkit out of the total number of projects/proposals (services or activities)	5
	Proportion of people with mental illness and/or disability in employment	6
	Older people's perception of community safety	7
	Percentage of the population affected by environmental, neighbour, and neighbourhood noise	8
	Percentage of respondents satisfied with their neighbourhood as a place to live	9
	Percentage of tenants suffering from fuel poverty received support services out of targeted tenants	10
	Percentage reduction in ASB incidents compared to previous year	11
	Real life stories (videos, case studies)	12
Helping people to live healthy lifestyles	Area of parks and green open spaces per 1000 head of population compared against other selected neighbourhoods	13
	Green space accessibility measures (walking distance and distribution) in the neighbourhood	14
	Green space utilisation measures (e.g. number/area at selected times) in the neighbourhood	15
	Real life stories (videos, case studies)	12
Preventing avoidable ill health or injury	Percentage reduction of abuse recorded incidents (different categories) compared to previous year's level	16
	Percentage reduction of fall incidents among the neighbourhood residents compared to previous year's level	17
	Cost/effectiveness ratio of reducing selected preventable negative outcomes	18
Supported discharge from NHS to social care	Percentage of people with mental illness and/or disability in settled accommodation out of the total number identified in the neighbourhood	19
	Percentage of older people which is 65 and over who were still at home 91 days after discharge from hospital into rehabilitation services	20
	Real life stories (videos, case studies)	13

Detailed description of the indicators and tools

Indicator 1	Healthy Life Expectancy
Usefulness	This indicator gives a general overview on overall impact of different interventions that contributed to reducing the health inequalities among the population (part of that PDG contribution among others). The PD should consider the indicator as part of its planning process to its activities by understanding the actual population needs
Measurement method	The measurement of this indicator is usually complicated and it required many data and inputs to measure it. Usually the Public Health Observatories of England regularly publish update about indicator for each local authority and primary care organisation (PCO) in England
Required data	
Frequency	
Dissemination advice	
References	http://www.dh.gov.uk/health/2012/01/public-health-outcomes/

Indicator 2	Comparison between selected health outcomes of the neighbourhood compared with other neighbourhoods
Usefulness	In this context, this is not an indicator rather it is a comparative analysis using a set of selected indicators (basket indicators) that help the group its overall performance with other neighbourhoods or areas
Measurement method	Using the GIS maps will be very important in this aspect.
Required data	Performance on the key selected indicators for the neighbourhood and benchmarked neighbourhood(s) will be needed. This will depends on the availability of data and information at SOA level
Frequency	Annual analysis.
Dissemination advice	This will depends on the purpose of the analysis and the set of selected indicators. In general, this will be of interest to local authorities and policy makers.
References	This is proposed indictor or analysis tool.

Indicator 3	Proportion of people within the neighbourhood in long-term unemployment
Usefulness	The employment status is well known factor that has its impact on the health and wellbeing. The group provides many activities linked to this area. By measuring the changes in the status of its residents; the group will have the chance of providing strong argument about the impact of its efforts to tackle the wider determinants of health.
Measurement method	Survey will be the most appropriate method. Putting all of the survey-related indicators into one data collection process (one survey) is wise decision and might be considered.
Required data	The indicator should be built on measuring the status of the same group of people over time. By identifying the targeted people and providing to them the relevant services, the group will need to repeat the survey to analysis the progress of the group. This may be available from tenant profiles.
Frequency	It depends on the scale of activities the group will do. Generally half-annually and annually would be appropriate frequency
Dissemination advice	This will be of interest to local authorities and policy makers.
References	The NHS Outcomes Framework 2012/13 (Department of Health) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf

Indicator 4	**Percentage of PD projects/proposals (services or activities) that demonstrated impact using Mental Wellbeing Impact Assessment (MWIA) toolkit out of the total number of projects/proposals (services or activities)**
Usefulness	Mental Wellbeing is an important dimension in which the group has considerable proportion of activities and services. The group is advised to use the MWIA toolkit (annex) for better understanding of the anticipated impact and outcomes of its activities. The results of the assessment will properly need to be done at the planning and assessment stages should help the group to design smart interventions that will bring the required change into effect.
Measurement method	Using already existed tool with adequate description of all the methods, data and processes.
Required data	
Frequency	
Dissemination advice	The outcomes of the assessment might be shared with the potential funders for the projects or the services as well as the beneficiaries. It will be of interest to local authorities, policy makers and health and public health professionals.
References	http://www.apho.org.uk/resource/item.aspx?RID=95836

Indicator 5	**Proportion of people with mental illness and/or disability in employment**
Usefulness	The special attention given to people with mental illness and/or disability is an obvious indicates its importance and priority within different health and social care systems. Demonstrating the support for this group of population should resulted in better outcomes in terms of employment opportunities.
Measurement method	Survey will be the most appropriate method.
Required data	Identification and location of mentally-ill and/or disabled residents will be important for measuring this indicator; verifying and continuously monitoring their employment status will be required. This may be available from tenant profiles
Frequency	It depends on the scale of activities the group will do. Generally half-annually and annually would be appropriate frequency
Dissemination advice	This will be of interest to local authorities, policy makers and health and public health professionals.
References	The NHS Outcomes Framework 2012/13 (Department of Health) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf

Indicator 6	**Older people's perception of community safety**
Usefulness	Older people now become at the heart of NHS priorities. The group has wide range of activities targeting this group in addition to ASB interventions. The indicator will give combined measurement for these activities and help in understanding its outcomes.
Measurement method	Survey will be the most appropriate method as part of the health and wellbeing survey
Required data	This indicator requires both qualitative and quantitative data to better understand the general perception and to have more insights about any complains and where they locate.
Frequency	It depends on the scale of activities the group will do. Generally half-annually and annually would be appropriate frequency
Dissemination advice	This will be of interest to local authorities, policy makers and health and public health professionals.
References	The NHS Outcomes Framework 2012/13, *This indicator was part of the draft framework*

Indicator 7	**Reported complains from neighbourhood residents about environmental, neighbour, and neighbourhood noise**
Usefulness	The indicator should help the PD group in demonstrating their contribution in terms of reducing or maintaining low level of noise (of all kind) that is linked to its activities in this area.
Measurement method	Simple analysis of recorded cases, if there is already established baseline or benchmarking level this could be used to measure the reduction of complains received.
Required data	Continuous monitoring of complains about different source of noise.
Frequency	Annual reporting will be quite adequate and suitable
Dissemination advice	This might be of interest to local authorities and policy makers.
References	The NHS Outcomes Framework 2012/13 (Department of Health) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf

Indicator 8	**Percentage of respondents satisfied with their neighbourhood as a place to live**
Usefulness	This is useful indicator and it brings different dimensions into one single measurement summary. It should be part of bigger survey tool and should be asked at the very ends because it will summarize the perceptions of the residents about the neighbourhood
Measurement method	Survey consider as part of the health and well being survey
Required data	The survey should include demographic information about the respondents and this will help PD to understand the satisfaction among different groups (older males and females, young males and females, people with mental illnesses and those who are disabled, etc)
Frequency	Annual data collection will be adequate, however, better to extend that over longer period as it will provide more likely changes overtime if any.
Dissemination advice	This will be of interest to local authorities, policy makers and health and public health professionals.
References	North West Public Health Observatory http://www.nwph.net/nwpho/NorthWestMentalWellbeingSurvey.pdf

Indicator 9	**Percentage of tenants suffering from fuel poverty received support services out of targeted tenants**
Usefulness	This is proxy indicator for what the PD provides as support services to the tenants and their families to mitigate fuel poverty. It is generally indicating the overall support efforts and not only that linked to alleviating the fuel poverty.
Measurement method	Records analysis
Required data	Data about services provided compared with the targets identified before the interventions. Data may be available from tenant profiles.
Frequency	Annual summary and dissemination is adequate and appropriate.
Dissemination advice	This will be of interest to local authorities, policy makers and health and public health professionals.
References	This indicator is proposed based on the activities reported by PDG.

Indicator 10	Percentage reduction in ASB incidents compared to previous year
Usefulness	The indicator is proxy indicator; it summarizes the efforts done by the group to prevent the anti-social behaviour (ASB) in the neighbourhood. The efforts done in this area should result in less ASB incidents in comparison with previous periods. Decreasing or maintaining zero level is positive indication of the outcomes in this area.
Measurement method	Records analysis, Crime figures
Required data	Comparing the previous recorded incidents (analyzing its location and other linked information) and comparative data overtime to monitor the progress.
Frequency	Annual reporting.
Dissemination advice	This will be of interest to local authorities and policy makers.
References	This indicator is proposed based on the activities reported by PD.

Indicator 11	Real life stories (videos, case studies)
Usefulness	The power of presenting true life stories is very powerful presentation of the true achievements and success of certain interventions or activities. This should be well designed and developed to reflect the actual achievements.
Measurement method	Qualitative description
Required data	Qualitative data and themes
Frequency	Annual reporting or as needed.
Dissemination advice	The outcomes of the assessment might be shared with the potential funders for the projects or the services as well as the beneficiaries. It will be of interest to local authorities, policy makers and health and public health professionals.
References	This is proposed measurement process.

Indicator 12	Area of parks and green open spaces per 1000 head of population compared against other selected neighbourhoods
Usefulness	This indicator will strongly show the advance position of the PD neighbourhoods in terms of provision of parks and green open spaces in comparison with other neighbourhoods. It will better give picture about the efforts of putting in place these spaces and the efforts to manage and maintain it for proper utilization.
Measurement method	Using available records and GIS analytical maps.
Required data	GIS data.
Frequency	Since no rapid changes of this indicator is anticipated, then better to be measured for the records and future comparisons.
Dissemination advice	The outcomes of the assessment might be shared with the potential funders for the projects or the services as well as the beneficiaries. It will be of interest to local authorities, policy makers and public health professionals.
References	The NHS Outcomes Framework 2012/13 (Department of Health) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf

Indicator 13	**Green space accessibility measures (walking distance and distribution) in the neighbourhood**
Usefulness	This indicator provides strong description of the interventions done by the PD group to provide accessible public green spaces in the neighbourhood.
Measurement method	GIS maps and summary.
Required data	Measurement of average walking distance to the nearest green space. Distribution of the green space in the neighbourhood and its accessibility to areas with the bulk of old and disabled residents.
Frequency	Since no rapid change is expected, analysis might be useful once and then if any changes (new public green areas) were introduced
Dissemination advice	It will be of interest to local authorities, policy makers and public health professionals.
References	This indicator is derived from NHS healthy lifestyle outcomes measurement. http://www.nhs.uk/news/2008/11November/Pages/Parksandhealth.aspx

Indicator 14	**Green space utilisation measures (e.g. number/area at selected times) in the neighbourhood**
Usefulness	Similar to above indicator focusing on the utilization of the spaces
Measurement method	Surveys and observations recording and analysis.
Required data	Number of people occupying specified public green spaces at selected time points over the year divided by the area in terms of square yards
Frequency	4 times per year measurement survey will be useful.
Dissemination advice	It will be of interest to local authorities, policy makers and public health professionals.
References	This indicator is derived from NHS healthy lifestyle outcomes measurement. http://www.nhs.uk/news/2008/11November/Pages/Parksandhealth.aspx

Indicator 15	**Percentage reduction of abuse recorded incidents (different categories) compared to previous year's level or other benchmarks**
Usefulness	This indicator is very useful in monitoring different dimensions of wellbeing (especially mental dimension) among the residents in the neighbourhood. The less incidents reported or recoded indicate the outcomes of the activities done in this area to reduce and maintain low levels of abuse recorded incidents.
Measurement method	Records analysis. Crime figures
Required data	Data about abuse incidents of all kinds overtime with data about its distribution and demographic data about the residents involved in reported incidents, if any.
Frequency	Annual reporting will be useful.
Dissemination advice	It will be of interest to local authorities, policy makers and public health professionals.
References	

Indicator 16	**Percentage reduction of fall incidents among the neighbourhood residents compared to previous year's level**
Usefulness	This indicator will demonstrate the efforts of PD in preventing the fall incidents in terms of orientation activities and routine repair services that contributed in preventing the occurrence of more incidents.
Measurement method	Records analysis. Falls resulting in a fracture and/or admission to hospital
Required data	Data about previous level of fall incidents reported in the neighbourhood with continuous monitoring of any changes to this level.
Frequency	Annual reporting is adequate.
Dissemination advice	It will be of interest to local authorities, policy makers and public health professionals.
References	The NHS Outcomes Framework 2012/13 (Department of Health) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf

Indicator 17	Cost/effectiveness ratio of reducing selected preventable negative outcomes
Usefulness	This is a strong measurement tool that will help the PD group in demonstrating its impact on preventing negative outcomes in terms of preventing its occurrence in association with the activities and support the group provided to the vulnerable groups to these negative outcomes.
Measurement method	Housing Health and Safety Rating System (HHSRS) Spreadsheet Calculator (Costing tool developed by XXXX)
Required data	Data about the number of residents and the estimated number of negative incidents prevented (falls, excess cold, damp, etc)
Frequency	Annual reporting is useful.
Dissemination advice	It will be of interest to local authorities, policy makers and public health professionals.
References	http://www.communities.gov.uk/publications/housing/hhsrsoperatingguidance

Indicator 18	Percentage of people with mental illness and/or disability in settled accommodation out of the total number identified in the neighbourhood
Usefulness	This indicator will be useful in monitoring care and support services provided to people with mental illness and/or disability and the ability to locate them within the neighbourhood. In most of the cases, the people stay in PD houses will be considered having settled accommodation. However, and for the purpose of monitoring, this needs to be continuously documented.
Measurement method	Survey together with records analysis will be useful. This data may be available from the tenant profiles.
Required data	Data about people with mental illness and/or disability; where they are, what services they access to and the changes in their residency status if any (e.g. if they are new comers from non- settled accommodation, etc)
Frequency	Annual reporting is useful.
Dissemination advice	It will be of interest to local authorities, policy makers and public health professionals.
References	The NHS Outcomes Framework 2012/13 (Department of Health) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf

Indicator 19	Percentage of older people which is 65 and over who were still at home 91 days after discharge from hospital into rehabilitation services
Usefulness	The indicator will show the capacity of group and its support services that enable those whom are above 65 and they were discharged under social care services. This is an opportunity to the group to provide support to this group of the residents and to record this support.
Measurement method	Records analysis.
Required data	Data about the targeted groups over one year.
Frequency	Annual reporting will be useful.
Dissemination advice	It will be of interest to local authorities, CCG commissioners and public health professionals.
References	The NHS Outcomes Framework 2012/13 (Department of Health) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf

ANNEX 8: KEY DOCUMENTS

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