FORMAT FOR PAPERS FOR DISCUSSION AT THE HEALTH AND WELLBEING BOARD

KIRKLEES HEALTH & WELLBEING BOARD

MEETING DATE: 30 June 2016

TITLE OF PAPER: A COMMUNITY WELLNESS MODEL OF HEALTH IMPROVEMENT FOR KIRKLEES: CONTEXT, DESIGN PRINCIPLES AND OPTIONS

1. Purpose of paper

This paper outlines emerging plans to move towards commissioning an integrated wellness model of health improvement focused on integration and system change rather than narrower 'silo-based' based interventions. The paper is coming to the Board to inform, and consult with, Board members.

2. Background

This is a major service redesign based on integration of a number of services and interventions covering health improvement, self-care and long term conditions. Reasons for this approach include:

- Integration will improve outcomes: Potential to deliver both health improvement and prevention and early intervention outcomes at different points in the life-course.
- Integration will promote strategic alignment across the health and social care system as outlined in the Joint Health and Wellbeing Strategy.
- Integration is increasingly evidenced: A common skill-set focusing on behaviour change is applicable across health improvement interventions (with some tailoring to population groups and exceptions for the most vulnerable where elements of specialist provision may still be needed).
- People should tell their story once where possible: Ongoing health inequalities and people presenting with more than one issue necessitate a move towards a "one-stop shop" approach that minimises confusion and supports a system-wide approach.
- Integration will promote collaboration and innovation across providers and be rooted in community engagement and co-production.
- Integration will promote self-care, resilience and community connectedness.
- The current system is not financially sustainable as long term conditions are increasing and creating a larger burden on the health and social care system.

Key Considerations are:

- The money required to establish the service is available from current budgets as existing contracts end.
- The wider 'wellness model' architecture needs to be designed by all partners, including determining the approach to commissioning.
- The model needs to be integrated with, and is integral to, the council Early Intervention and Prevention Programme whilst also having broader aims than preventing people entering the social care system. It also aligns with and informs the NHS Five Year Forward View and Sustainability and Transformation Plans.
- People are living longer but many are living with extended periods of disability.
- Two-thirds of people are overweight and/or obese but we do not have the resources to offer medical treatment so a different and more effective approach is needed.

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3. Proposal

It is proposed that a range of services are integrated into a new approach. Some of these are noted in the paper. Decisions have not yet been made about the exact shape of the new model and discussions are needed about how best to implement a radical approach that will improve outcomes, reduce costs across the system and promote collaboration.

4. Financial Implications

Resources will be made available from existing budgets as current contracts end. It is anticipated that an 'integration dividend' will be achieved through economies of scale and merger of existing approaches.

5. Sign off

The paper has been discussed by both Greater Huddersfield and North Kirklees CCG.

6. Next Steps

As outlined in the paper, partnership based Governance structures are being set up, a Project Plan determined, consultation/insight developed and budgets/risks determined.

7. Recommendations

It is recommended that the Board note the paper and agree to support the development of an integrated wellness model for Kirklees.

8. Contact Officer

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A COMMUNITY WELLNESS MODEL OF HEALTH IMPROVEMENT FOR KIRKLEES

CONTEXT, DESIGN PRINCIPLES AND OPTIONS

1. SUMMARY

This paper outlines initial thinking and emerging plans to move towards commissioning integrated wellness models of health improvement rather than narrower 'silo-based' based interventions. Reasons for this approach include:

- Integration will improve outcomes: Potential to deliver both health improvement and prevention and early intervention outcomes at different points in the life-course.
- Integration will promote strategic alignment across the health and social care system as outlined in the Joint Health and Wellbeing Strategy
- Integration is increasingly evidenced: A common skill-set focusing on behaviour change is applicable across health improvement interventions (with some tailoring to population groups and exceptions for the most vulnerable where elements of specialist provision may still be needed).
- People should tell their story once where possible: Ongoing health inequalities and people presenting with more than one issue necessitate a move towards a "one-stop shop" approach that minimises confusion and supports a system-wide approach.
- Integration will promote collaboration and innovation across providers and be rooted in community engagement and co-production.
- Integration will promote self-care, resilience and community connectedness.

Key considerations:

- The money required to establish the service is available from current budgets.
- The wider 'wellness model' architecture needs to be designed by all partners, including determining the approach to commissioning.
- The model needs to be integrated with, and is integral to, the council Early Intervention and Prevention Programme whilst also having broader aims than preventing people entering the social care system
- The current system is not financially sustainable as long term conditions are increasing and creating a larger burden on the health and social care system.
- People are living longer but many are living with extended periods of disability
- Two-thirds of people are overweight and/or obese but there are insufficient resources to offer medical treatment so a different and more effective approach is needed.
- We must prioritise reducing the impact of key risk factors at an avoidable earlier stage whilst promoting better self-management for people with more serious needs

2. CONTEXT

2.1 Widening the scope of Public Health interventions

A number of existing Public Health "lifestyle" service contracts end between March 2016 and March 2018. This paper sets out the case for recommissioning services as an integrated Wellness Service as part of a wider wellbeing model that is better aligned with New Council and the Target Operating Model, Early Intervention and Prevention and the NHS Five Year Forward View. The Joint Health and Wellbeing Strategy and Transformation and Sustainability Plans outline the importance of system-wide change and this approach offers a genuine opportunity to deliver an improved collaborative offer across Kirklees.

There are many definitions of wellness; broadly they all emphasise a proactive, preventive approach that focus on the whole person and which works to achieve optimum levels of physical, mental, social and emotional health. Good nutrition, healthy weight, exercise, increased resilience, emotional health and wellbeing and avoiding risk factors such as tobacco and alcohol misuse all play a role in wellness, as does a feeling of community connectedness and social capital.

The wellness approach goes beyond looking at single-issue, healthy lifestyle services with a focus on illness, and instead aims to take a whole-person and community approach to improving health. Based on self-care and intervening as early as possible but as late as necessary, it is clear that individuals who manage their own lifestyles are healthier, more productive, have fewer absences from work, and make fewer demands for medical and social services. Early intervention and prevention, keeping people healthy and out of acute and expensive urgent services, has direct financial advantage to the Council and NHS and longer term health and wellbeing advantages for residents.

2.2 From a top-down deficit model to a provider/community-led approach

The previous public health paradigm focused on using a combination of legislation, campaigns and direct intervention to generate top-down change. Successes included reduced smoking and drug use and control of major infectious diseases such as HIV. Whilst the recent Sugar Tax shows that legislation will remain a key lever, the emerging public health paradigm is centred on promoting health and wellbeing across the life-course but rooting this within an approach focused on building social capital and strong, resilient communities. Individual health behaviour is increasingly understood within the context of the social and economic influences on health and the multiple, diverse systems people inhabit (Marmot, 2010). Working across these systems to promote healthy lifestyles and so prevent and delay the onset of non-communicable disease, promote healthy ageing and tackle health inequality is therefore a key function of the New Public Health.

However, increased academic understanding about the importance of system-wide change is within the context of smaller public services, reduced budgets and devolution. This will require providers that are better able to innovate, are flexible enough to work across silos and inclusive enough to put the user/patient before organisational demands. Changing our local culture to one that promotes health improvement also means providers must challenge themselves and the system to generate new ideas about service improvement. Closer to the ground and more agile, providers should be effective collaborators across systems using partnership building and leadership to develop trusting and strong networks. New models also require a workforce that prioritises relationships over technical skills and are able to operate at the edges of their authority.

A distinctive Kirklees approach would also utilise an Assets and Strengths based approach to promote community connectedness and social capital and be rooted in a user-led approach with community builders, local champions and volunteers integral to delivery as a result of the need to promote culture change. Three of the most successful current public health interventions are PALS, Health Trainers and Auntie Pams. All are rooted in communities, use a network of volunteers, promote resilience and self-care and are essentially social learning interventions that increase the confidence of users to develop their whole being and think more widely than the issues that have initially motivated them to attend the services in question.

3. HEALTH IN KIRKLEES – A REMINDER

- The average life expectancy in Kirklees is 79 for men and 83 for women, lower than the England average. Healthy life expectancy is also lower.
- In 2015 men living in the most deprived areas of Kirklees could expect to die 9 years before those living in the least deprived, the gap for women is 6.3 years.
- 70% of deaths before 70 years of age are considered preventable.
- Two thirds of the adult population are overweight and/or obese (66%, up from 62% in 2012) as well as one third of children aged 11.
- Kirklees has more physically inactive people and fewer active people than the English and West Yorkshire averages.
- Diabetes mortality is significantly higher than the England average and increasing
- Emotional health and wellbeing remains a major concern across all age groups.
- 1 in 4 people have one or more long term condition and the number is rising

These are system-wide issues requiring a system-wide response. Tackling them has been compounded by the silo-based approach to the commissioning and provision of health prevention services based on single issues and by single organisations e.g. smoking, obesity. Currently services are provided by a range of organisations, in a variety of different locations, with individual contact numbers and different methods of access. Professionals and the public are often unaware of the full range of services on offer due to the complexity of navigating pathways through services. Whilst there are some people that might need single issue support, many service users present with more than one issue and skills for the promotion of behaviour change are common ones that can be applied generally to health improvement and self-care if the right training and support is provided.

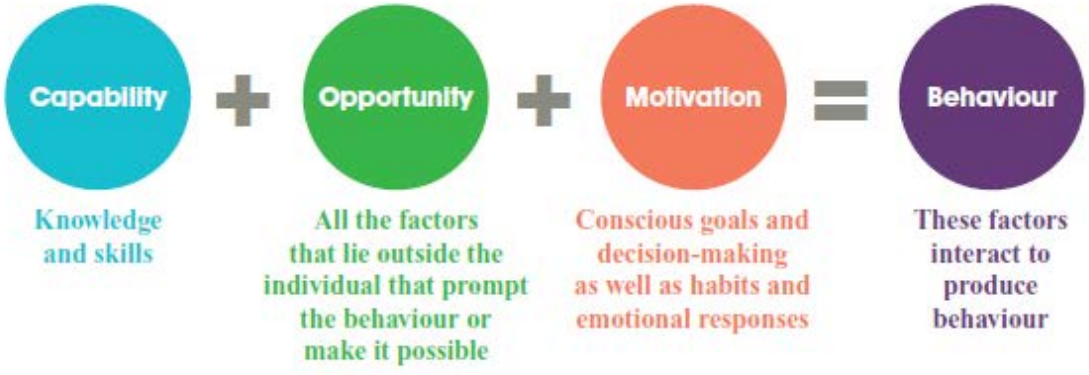
4. EVIDENCE BASE AND COST EFFECTIVENESS

Researchers have identified three main components that need to be present to influence behaviour (NESTA, 2016, see Figure 1 below). Whilst knowledge and skills are a key starting point, the great majority of, for example, obese people know that moving more often and eating a better diet is necessary. Opportunity, driven by wider factors, and motivation, influenced by culture and habits are at least as influential. The importance of wider factors and cultures that lie outside the immediate control of the individual demonstrate why a system-wide approach rooted in an integrated model is more likely to exert positive influences on individuals and populations than a silo-based approach to health improvement. With the wellness model, although a number of interventions are embedded, the same background awareness of the influences on behaviour are present and the staff work out which aspects of behaviour needs to be changed for each individual and a tailored programme developed.

The Liverpool Public Health Observatory review of wellness approaches concluded that they "*showed potential to give a return on investment and save future costs due to ill health. Some initiatives not only made savings in care costs, but improved quality of life, enabling individuals to live independently".* The report also found that wellness services could provide an effective longer term response to frequent attendees in primary care by tackling the underlying causes of their visits. Many of the services (such as social prescribing where patients are linked to the non-medical facilities and services available in their wider community) had low costs when compared to medical treatment (Public Health England/JMU 2012). Since 2012 other areas have adopted this approach, in particular the North East of England (Sunderland, Gateshead, Tyneside, Durham have all integrated services to a greater or lesser extent). Research is ongoing in each area but initial findings are positive. Public Health England has proposed the development of a community of practice approach

in West Yorkshire as Leeds and Calderdale are also considering this approach. Nonetheless, it is acknowledged by the Kings Fund (2015) "that because of the shortages of academic research evidence on the usefulness and cost-effectiveness of different approaches, commissioners will need to innovate and take risks". Because there is no national blue-print for this project, Kirklees commissioners and providers have an opportunity to develop a cutting edge approach that seeks to meet the requirements of a wide range of partners and improves outcomes across our diverse communities.

Figure 1: Influences on behaviour (Michie, Atkins and West, 2014)



5. AIMS, OBJECTIVES AND DESIGN PRINCIPLES

5.1 Aim

The proposed aim is *"to support people to live longer, healthier, happier lives through greater integration and by moving resources towards a life-course based approach rooted in prevention and early intervention and away from avoidable treatment and care".*

5.2 Design Principles underpinning the process

- Improved health and wellbeing
- Supporting independence, promoting resilience; helping people do more for themselves and each other
- Enabling healthy behaviours and reducing inequalities across the life-course
- Prevention and early intervention
- Self-care and better management of existing long term conditions, preventing these conditions worsening and utilising community focused approaches as well as preventative medicine
- Strengths and assets based approach to communities
- Collaboration and integration and clear pathways at all levels
- Intelligence and insight led
- Evidence based without hampering creative approaches and innovation
- Embedding behaviour change approaches that utilise the most effective behaviour change techniques tailored to each individual
- Long term thinking and planning horizons

5.3 Wellness Model Strategic Outcomes

The Wellness Model will support the aims of New Council to empower people to live their lives to the fullest possible potential by enabling people to increase control over their health through making changes to their lives. It will support the NHS 5 Year Forward View and Sustainability and Transformation Plans by diverting people from primary and secondary healthcare services towards prevention pathways, helping to contain rising healthcare costs. Pathways will be streamlined and consideration will be given to self-referral, drop-in and outreach approaches.

5.4 Integration

The primary objective of the Wellness Model is to provide a person centred, integrated, single point of access wellness service within a wider wellness network. The services that might, after partner discussion, be included are|:

- Diet and nutrition
- Physical activity and exercise on prescription
- Weight management and diabetes prevention
- Tobacco/smoking cessation
- Alcohol early intervention?
- Mental wellbeing and links to IAPT and personal resilience
- Self-care including Expert Patient Programme
- NHS Health Checks (based in primary care)
- Health trainers
- Volunteer Community Health Champions
- Health psychology and behavioural insights
- Promoting cancer prevention and engagement with screening
- Social marketing and community insight
- Digital health improvement

Other services integral to the wider model:

- Services for vulnerable adults (drugs, domestic abuse, offender health etc)
- Planned care e.g. pain services
- Proposed national diabetes prevention service
- Carers services and recovery services
- Social prescribing (Better in Kirklees etc)
- Schools as community hubs

Strong links to systems tackling wider factors influencing health within the model:

- Communities – including community development, sporting and third sector
- Healthy environments – leisure, parks/open spaces, active travel, food growing
- Housing advice and support – all tenures
- Employment advice and support
- Anti-poverty approaches including food banks, proposed credit union

6. DELIVERY OPTIONS

Whilst the overall design emphasises the importance of the broader partnership model consideration needs to be given to the approach to commissioning. Four possible service delivery models could be investigated for options appraisal:

- Maintain current service provision under several providers (no change option)
- Establish a virtual Wellness Service with several providers in a clearer collaboration based approach. Model and service would be 'emergent' and build on existing strengths/relationships
- Establish a fully integrated Wellness Service by bringing together existing lifestyle services under a lead provider model with sub-contracted specialist provision where necessary
- Establish a fully integrated service under a single provider

Other areas have opted for the second and third of these options. Some have instigated a "year zero" type approach and ended a series of contracts, others have taken an approach based on aligning contract end dates. Most existing Public Health contracts end in October 2017 and March 2018. A pragmatic approach would be to plan an approach in which different components of the service go live at different points in time, with the full approach going live on 1 April 2018.

7. NEXT STEPS

7.1 Determine Governance – it is proposed that a partnership project board is set up, chaired by the Project Sponsor (TBC) with representation from CCGs, Council EIP Programme, Healthwatch, Public Health, Community Engagement, Third sector leaders group, Communications. The Wellness project board would report via the new Health Improvement Integrated Commissioning Group to the Health and Wellbeing Board and CCG Governing Bodies. Procurement, legal, HR and finance support would be utilised as necessary.

7.2 Insight and engagement with public and providers - a public engagement exercise should be undertaken to ensure that resident needs are defined and used to inform the design process for the Wellness Service, as well as obtaining insight into community perceptions of potential approaches. Likewise, insight from existing and potential new providers will be important to generate mutual understanding about what may or may not be the best options for Kirklees.

7.3 Understand risks – initial conversations with other commissioners elsewhere in the country have outlined service related risks related to thresholds of intervention, attracting the worried well, a universal vs targeted approach. System issues appear to concern marketing, branding and ownership across the health and social care system, not losing added value inherent in (some) existing interventions and losing organisational memory.

7.4 Leadership and management – the Head of Health Improvement would lead the process reporting to the Project Sponsor, determining the resources needed to manage the process of designing the wellness model. A Project Initiation Document will be drafted with clear timelines between April 2016 and April 2018.

Tony Cooke, Head of Health Improvement, June 2016.