Kirklees COUNCIL

Name of meeting: Health and Social Care Scrutiny Panel
Date: 7 March 2017

Title of report: Integrated Wellness Model

Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	Yes
Is it in the Council's Forward Plan?	n/a
Is it eligible for "call in" by Scrutiny?	Yes
Date signed off by Director & name **Is it signed off by the Director of Resources?** **Is it signed off by the Assistant Director - Legal & Governance?**	Richard Parry, Director for Commissioning, Public Health & Adult Social Care n/a n/a
Cabinet member portfolio	Prevention, Early Intervention and Vulnerable Adults

Electoral wards affected: All

Ward councillors consulted: n/a

Public or private: Public

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1. Purpose of report

The Wellness Model has been agreed by the Health and Wellbeing Board and both Clinical Commissioning Groups. Governance is via the Integrated Commissioning Executive. There has been significant progress over the last year and this paper provides a position statement about progress thus far and also briefs Scrutiny about the overall context for the proposed model and likely benefits and the challenges to health improvement in Kirklees.

2. Key Points:

2.1 The vision of the wellness model is that: **People in Kirklees will live longer, healthier, happier lives and feel more able to look after themselves and others.**

2.2 To achieve this vision, we plan to develop one integrated offer across Kirklees to replace a range of existing specific services concentrating on single issues. Areas for inclusion in the model are physical activity, food and nutrition, smoking cessation, emotional health and wellbeing, resilience and self-care.

2.3 Physical activity will be at the heart of our new approach; our existing PALS (Practice Activity and Leisure Scheme) and physical activity services will be central and aligned with other health improvement interventions. Increasing evidence from our local services and from major national evaluations is demonstrating the importance of physical activity in preventing a series of major conditions, better managing health risk and existing conditions, and promoting emotional health and wellbeing.

2.4 Development and maintenance of strong links with community provision and settings will underpin the approach from the outset.

Why are we doing this?

2.5 As the number of people living with Long Term Conditions increases, a new innovative approach is required to ensure there is a sustainable pathway for users to access. This will help users to access appropriate support at the earliest opportunity and reduce demand on the wider health and social care system.

2.6 Access to health improvement support should be simpler, and easier to navigate by users.

2.7 To enable people to become more proactive in looking after themselves, and use services more appropriately, we need all wellness/health providers to work in a person-centred, motivational and holistic way. There is evidence to show that this is a more effective way to increase self-efficacy and sustain behaviour change.

2.8 Service integration should achieve consistency of care and support, follow an agreed set of principles (in this case, those based on prevention, and enabling the service user) and reduce duplication of effort and experience. This is an opportunity for commissioners and providers of related services to share the vision, and understand the value of the focus on user experience and outcome. Over the long term, we need to shift culture around health towards prevention and early intervention.

2.9 <u>Desired outcomes</u>

- Improved health and wellbeing generated by getting everybody active
- Early access to preventative interventions
- People feel more able to do more for themselves and each other
- Increase in healthy behaviours
- Strengthened resilience and emotional well-being
- People feel supported to manage their health conditions

- Early intervention and prevention of ill health, long term conditions, disability, early death
- Reduced demand on the health and social care system

2.10 Ways of working

- Person-centred, motivational and enabling
- Linking to, and building on, strengths and assets of communities
- Intelligence and insight led, rooted in and contributing to the evidence about what we know works
- We are one Kirklees, working together and people will tell their story once

2.11 Target populations

- Adults in Kirklees

2.12 Criteria for primary target group

- Adults with Long Term Conditions
- Adults at risk of developing LTCs. Key risk factors:
    - High BMI (25+)
    - Physically inactive
    - Mental health needs
    - Pre-diabetes
    - Smokers

  N.B. Criteria for risk factors only will be for those presenting with a combination of the above and not single-issues where other pathways already exist. Alcohol use will be considered alongside other risk factors unless requiring specialist treatment services. Other populations to be considered according to local needs data, and as the model expands.

2.13 What will the service look like?

- Open access with GP/health professional and social care referral/prescription
- A non-clinical focus, person-centred (branding and settings etc. to be informed by insight)
- Access to the service via self-referral (mechanism/pathway to be considered)
- Service integration may be physical (location or service function) or virtual (shared information and processes) in nature, and will entail closer, more coherent working between the wider NHS, health, local authority, and voluntary sector services.

2.14 How will it operate?

- Assessment of user needs on presentation
- Using a motivational, health coaching approach with tailored personal plans
- Brief interventions
- Access to other support e.g. social prescribing, IAPT, variety of group or 1-1 health interventions

- Referring back to health for clinical/specialist issues
- Outreach for those with lower level mental health conditions or mobility issues, as needed
- Signposting to other forms of support/advice where appropriate, reducing duplication

2.15 Potential additional benefits

- People will live longer lives in better health
- Improved physical and social outcomes for individuals, families and communities, contributing to reducing health inequalities
- Culture change in communities and the wider system, aiding transformation
- Gathering of further data to inform existing intelligence
- Greater economies of scale for existing services
- Reduced demand for acute, primary and social care services
- Services working interdependently sharing resources/capacity
- Stimulating providers/market to come up with innovative solutions/service design
- Providing involvement opportunities for local business and third sector

2.16 Process

- Gathering learning and experiences from other areas in England (complete/ongoing)
- Identification of PH services in scope (complete)
- Generation of public insight via research (in progress, May 2017)
- Stakeholder engagement and information gathering (event Feb 2017)
- Specification (complete by end July)
- PH service element live (April 2018)
- Potential future events depending on outcome of procurement discussions

3. Consultees and their opinions

Not applicable

4. Next steps

4.1 Commissioning options are being determined via procurement, finance and legal colleagues.

5. Officer recommendations and reasons

5.1 That the Panel note the information provided.

6. Cabinet portfolio holder recommendation

Not applicable

7. Contact Officer

Carl Mackie, Public Health Manager

8. Assistant Director responsible

Sue Richards, Assistant Director for Early Intervention & Prevention

9. Background Papers

Appendix 1 – Briefing Note – A Community Wellness Model of Health Improvement for Kirklees

APPENDIX 1

A COMMUNITY WELLNESS MODEL OF HEALTH IMPROVEMENT FOR KIRKLEES

CONTEXT, DESIGN PRINCIPLES AND PROGRESS

1. SUMMARY

This paper outlines plans to move towards commissioning integrated wellness models of health improvement rather than narrower ‘silo-based’ based single 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 and Sustainability and Transformation Plan.
- 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 and a saving will be made on existing contract prices.
- 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
- Evidence is increasingly demonstrating the importance of physical activity and the association between insufficient activity and development of long term conditions.
- 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 2017 and March 2018. This paper outlines plans and progress towards 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 Sustainability and Transformation Plan 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 discussion 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 Hea”.

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 local Assets and Strengths 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.

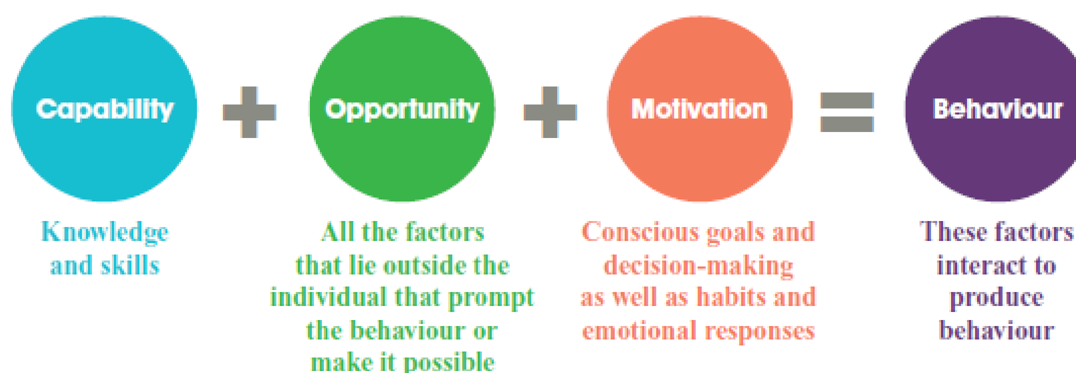
4. EVIDENCE BASE AND COST EFFECTIVENESS

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 instigated a community of practice approach in West Yorkshire to co-design this approach across the district.

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



5. AIMS, OBJECTIVES AND DESIGN PRINCIPLES

5.1 Aim

The wellness aim is that "People in Kirklees will live longer, healthier, happier lives and feel more able to look after themselves and others".

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. Included services are:

- Diet and nutrition
- Physical activity and exercise on prescription
- Weight management and diabetes prevention
- Tobacco/smoking cessation
- Mental wellbeing and links to IAPT and personal resilience
- Self-care including Expert Patient Programme
- NHS Health Checks (based in primary care)
- Health trainers

Other services integral to the wider model:

- Mental health services, particularly IAPT
- 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, debt advice

6. DELIVERY OPTIONS

Whilst the overall design emphasises the importance of the broader partnership model and the priority will be to integrate services and make physical activity, emotional health and wellbeing and prevention and better management of long term conditions the heart of the model expanding on the effectiveness of the current PALS and Health Trainers services. This reflects increasing evidence that the association between physical activity, mental health and long term conditions is crucial to individual health as is outlined in Figure 2 below (reference included at bottom of table). The best means of achieving this, via a community focused and primarily non-clinical model, is still under discussion with colleagues in public health with procurement, legal and finance engaged in workforce planning and commissioning discussions.

Physical Activity contribution to reduction in risk of mortality and long term conditions		
Disease	**Risk reduction**	**Strength of evidence**
Death	20-35%	Strong
CHD and Stroke	20-35%	Strong
Type 2 Diabetes	35-40%	Strong
Colon Cancer	30-50%	Strong
Breast Cancer	20%	Strong
Hip Fracture	36-68%	Moderate
Depression	20-30%	Moderate
Hypertension	33%	Strong
Alzheimer's Disease	20-30%	Moderate
Functional limitation, elderly	30%	Strong
Prevention of falls	30%	Strong
Osteoarthritis disability	22-80%	Moderate

14 Start Active, Stay Active (2011) based on US Department of Health and Human Services Physical Activity Guidelines Advisory Committee Report (2008), Washington D.C.

7. NEXT STEPS

7.1 Public Health held a community focused partnership event in February with representatives from a wide range of community and partnership organisations, and insight into the views of the public and service users has been commissioned to inform the model. As previously noted, commissioning models are being investigated and the provisional start date for the new approach will be 1 April 2018. Existing services are aware of the approach taken and have been encouraged to work closely together before the new approach begins.

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