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Portsmouth CITY COUNCIL

Agenda item:

Title of meeting:	Health and Wellbeing Board
Date of meeting:	17 June 2015
Subject:	Implementing the Integrated Wellbeing service
Report by:	Director of Public Health
Wards affected:	All

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1. Requested by Health and Wellbeing Board

2. Purpose

2.1 To update the Health and Wellbeing Board on progress towards the implementation of the integrated wellbeing service

3. Background Information

3.1 On 13 March 2014 the then Cabinet Member for Health & Social Care approved the commencement of planning for an integrated Wellbeing service (then named the Integrated Healthy Lifestyle Service), which would bring together current public health services commissioned independently of each other and therefore operating in silos.

3.2 The development and implementation of this Wellbeing service now forms part of the 2014 - 2017 Health and Wellbeing Strategy as well as the prevention work stream for the Better Care Programme (BCP).

4. Life expectancy & lifestyle factors

4.1 The health of people in Portsmouth is generally worse than the England average and there are significant health inequalities related to deprivation. Life expectancy for women is comparable to the England average, however male life expectancy is significantly shorter than the England average. Men living in deprived wards in the city live nearly 11 years fewer than those living in the least deprived wards.

4.2 The main, broad causes of death contributing to the gap in life expectancy between the most and least deprived in Portsmouth are circulatory diseases, cancers, liver disease and respiratory disease. These are linked to smoking, alcohol, poor diet and low levels of physical activity which for Portsmouth are higher than the England average.

4.2 The Kings Fund reported that "close to half of the burden of illness in developed 3 countries is associated with the four main unhealthy behaviours: smoking, excessive consumption of alcohol, poor diet and low levels of physical activity"[1].

4.3 The report found that around 70% of adults engage in 2 or more of these unhealthy behaviours, although the number of people engaging in 3 or 4 or these behaviours has reduced to 25% of the population, from 33% in 2003. However, almost all this behaviour change has been in the higher socio-economic and educational attainment groups. The poorest and those with no qualifications have seen little change. Those from unskilled manual backgrounds are more than three times more likely to have all four risk behaviours than professionals. Those with no qualifications are more than five times more likely to have all four risk factors than those with the highest level of qualification.

4.4 The report concluded that "a more integrated approach to behaviour change is required that links more closely to inequalities policy and is focused more directly on the government's stated goal to 'improve the health of the poorest, fastest'".

5. Portsmouth wellbeing service

5.1 This new service aims to help and support residents with the key factors that contribute to significant health risks like smoking, alcohol misuse, poor diet and lack of exercise as well as support around mental wellbeing.

5.2 The new service will be the culmination of a number of months work requiring the cancellation of a number of contracts with several providers in order to deliver a more cost effective and efficient service; the service will deliver a more integrated approach to behaviour change and at a larger scale than our current arrangements.

5.3 Importantly this service will work with other council services to provide help and support with debt, housing and unemployment, which tend to be contributory or underlying causes for poor lifestyle. This is why the service name has been changed to the Wellbeing Service, in recognition of the wide ranging needs of our population. By marrying these services together residents will be able to access a 'one-stop shop' to get the support they need to make changes to their lives and therefore reduce their long term dependence on services.

5.4 Currently, where services operate by having individual workers working with residents single issues, this format will be replaced by more generic 'wellbeing workers' able to work more integrated way across a broad range of issues. There will be support from specialist wellbeing workers within the service and links with partners where appropriate.

5.5 Wellbeing workers will be placed in locations across the city, in areas of deprivation where they are needed the most. It will be part of their role to work with the

[1] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/clustering-of-unhealthy-behaviours-over-time-aug-2012.pdf

residents and the community to understand what matters to them and develop and enhance the service through participative methods.

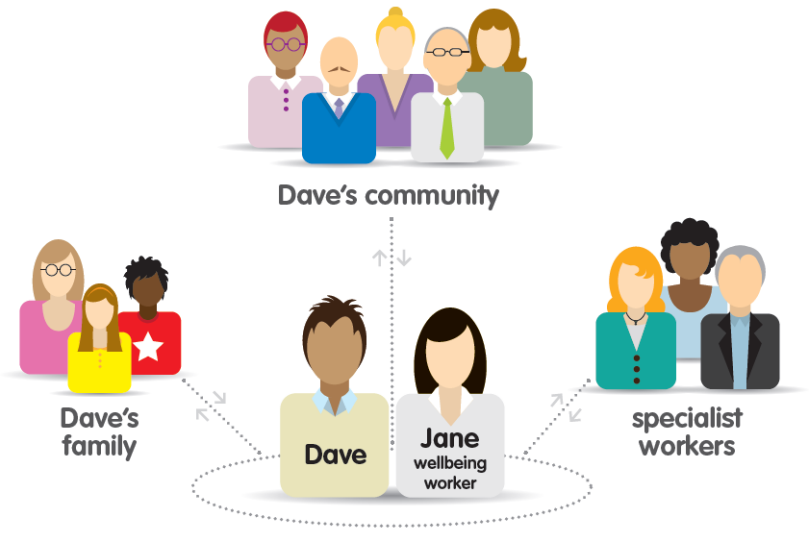
5.6 As part of core service provision front line staff, volunteers and members of the community will be trained to 'Make Every Contact Count' around key health and wellbeing factors and where to go for additional help.

5.7 Initially the focus for the service will be adult-based however children of adults entering the service will be involved as part of family interventions, where this is required. A 0-19 age group Wellbeing Service is also being developed in parallel and will mobilise at a later date.

5.8 The service will comprise in total 40 staff that will operate across the city in 3 localities and hospitals and probation settings. This level of staffing is estimated to support approximately 6000 adults and their families/per year with 3000 achieving positive outcomes through seamless pathways to other services including adult mental health, substance misuse, sexual health and 0 - 19yrs wellbeing service. The lack of historic output data for similar services is an issue when estimating the match of staffing levels to service throughput, as integrated wellbeing services are a new concept. Workforce modelling is currently being piloted in Somerstown, the data from which should inform and help shape the service workforce levels sufficient to support residents needs and make the impact on prevalence of population health risks.

5.9 The structure of the service will be a Service Manager and 4 Practice Leaders providing citywide expertise and training on smoking cessation, alcohol, healthy weight and mental health. Each Practice Lead will manage a team of Wellbeing workers (28). There will be 5 apprentices in health and wellbeing (4) and administration (1) roles.

The model shows how 'Dave', a Portsmouth resident, might interact with the wellbeing service when he meets 'Jane', a wellbeing worker:



5.10 Recognising the complexity and the flexibility required of this new type of service and expected changes which will evolve as the service beds in, it was agreed by the Health and Social Care Cabinet that the service would initially be established in-house. It is estimated that the service will cost approximately about £1.3M making efficiency savings of approximately £360K on existing services.

6. Consultation

6.1 We have undertaken consultation with the public and key stakeholders, including GPs and service providers. This consultation on the whole has supported the development of an integrated service, focusing on smoking, alcohol and weight management. A key requirement from residents is that they would like to visit one place and see one worker that can help them with a range of issues. In addition factors which address the wider determinants of health should be included, including debt, employment and housing advice. A report of the stakeholder consultation is attached for information (Appendix 1).

7. Implementation of the wellbeing service

7.1 The start date for the wellbeing service is 1 October 2015. Currently commissioned services including the quit smoking services, Pompey Quit and Solutions 4 Health, as well as Health Trainers have been given notice and service delivery will cease on 30 Sept 2015. Actions on the re-deployment of the alcohol intervention services within PCC to the wellbeing service have started. Exit strategies for existing services are aligned to mobilisation of the new service and the intention is for service continuity through transition.

7.2 Communication of the start of the new service and the exiting of existing services is key. A newsletter for stakeholders and the public will become available from July onwards. Wider stakeholder consultation events were held on 22 and 23 April.

7.3 Some elements of the service are being tried out and phased in, particularly in Somerstown as part of the CCG funded Health and Wellbeing Community Assets Programme that is due to provide a final report to the CCG Clinical Strategy Committee meeting on 1 July 2015.

7.4 We are looking to work with primary care over the next months to develop community profiles based on GP and public health data, identifying areas for focus. We plan to work with the community in those targeted areas to develop the service

7.5 Management and governance of this programme is overseen by a programme board chaired by the Director of Public Health comprised of stakeholders from the city council, CCG and voluntary sector. The programme is formed on eight workstreams, updates from which are provided for information at Appendix 2 which includes current risks and issues.

8. Aligning Local Commissioned Services (LCS) to the wellbeing service

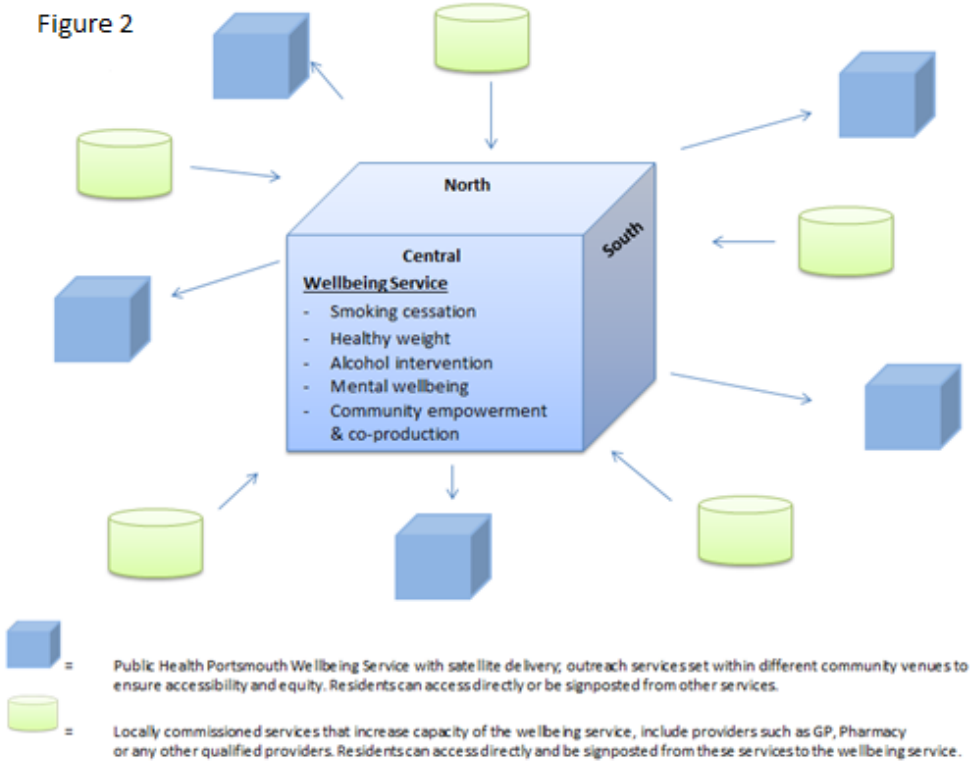
8.1 Using a similar service model Public Health Portsmouth wants to align the existing LCS (previously known as Local Enhanced Services)(LES)) currently delivered by

GP and community pharmacy to enhance the capacity of the wellbeing service as well as provide a more diverse and specialist service for residents.

8.2 The current LCS contract is due to expire on 31 March 2015 and a waiver has been agreed to extend these existing contracts for a further 12 months in order to allow engagement and redesign as well as time to complete the tendering of a new model. The expectation is that the market for the service will widen beyond GP and pharmacy to any qualified provider, potentially including children's centres, job centres, QA hospital etc, where appropriate.

Figure 2 shows the final overall model for the wellbeing service

Figure 2



9.0 Finances

9.1 The existing services listed above and other current spend linked to our wellbeing work totals £1.75 million. As part of the savings requirement within Portsmouth City Council and the remodelling, we anticipate the budget for the Wellbeing Service would be approximately £1.3 million per year recurring, with some additional pump priming over the first 2-3 years.

9.2 Whilst this level of saving would obviously reduce the level of service available across the city, we consider that by using a new integrated approach and by working closely with our more deprived communities, we can continue to support those that are in need of help. Whilst we have anticipated that the service will be able to support 6,000 individuals / families per year, with approximately half making a positive change, a combination of the service being successful and high prevalence of risky behaviours across our population is likely to present a significant

risk that this service will not be able to meet demand. Such a scenario would mean that additional funding could be needed in future years.

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Signed by: Director of Public Health

Appendices:

1. **Report on consultation with stakeholders**
2. **Update reports from programme workstreams**

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

Appendix 1

Report on consultation with stakeholders

Workshop Notes

Summary of themes arising from workshop sessions on 22 and 23 April.

Buy-in / support for the service	Clarity of communication / Mis-information	Advice / areas for consideration / recommendations
• Single point of contact • Holistic approach • Relationships / trust with WW • Joined up approach • Environment (relaxed/informal/comfortable) • Locality working multi-agency team • Evidence of this model working well in other areas / for other services • Prolonged contact with clients • No falling through the gaps • Asset based approach • Prevention • Addressing social isolation • Adds capacity to GP role • Located in the community • Offers of premises • Promoting maximum utilisation of resources in the community • Reducing silos • Coaching (rather than advice) reduced dependency • Creates community resilience • Accessible	• Quality assurance (qualifications/training of WW) • Loss of specialisms • Duplication with existing services (e.g. pharmacy, social workers) • Dismantling of services before new one in place • What is the demand? • Referral pathway • Need for wider social support/drop ins for families/peer support • How do WW decide what to do first? • Who can refer?	• Named WW contact for each GP practice • Scope of service • Capacity of service (number of WW, hours of support for each client) • Evening and weekend provision • Sharing data / sending information back to the referrer • What are the 'touch points' at 'wobble points' - are we engaged? • Accessibility (physical location, language) • Continued dialogue with stakeholders • Information governance • Home visits • Safeguarding (need for operating procedures) • Link to Healthwatch • Ex-forces access

WW - wellbeing worker

Stakeholders mentioned by name:

Stakeholders	
• Schools • Learning disabilities • League of Friends • Sustrans • Community pharmacies • GPs • Solent Trust - Adult mental health • Pompey in the Community • Diabetes Research • Portsmouth CCG • Libraries (inc. mobile libraries)	• Portsmouth FC • Big Lottery Fund • Job centre • John Pounds Centre • Probation • Solent MIND • RELATE • Learning Links • Home Start • CAB • Learning disabilities colleagues (Mark Staples) • You Trust Advice Centre - North End

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Appendix 2

Updates reports from Integrated Wellbeing Service programme workstream including risks and issues

Governance, Quality and Performance, Finance

1. The Programme Board with terms of reference has been set up with monthly meetings since February 2015.
2. The Programme Implementation Group with 8 work packages leads meet monthly.
3. The work on Quality assurance framework, evaluation, Equality Impact Assessment in progress.
4. Financial budget for the service has been costed and will be reviewed nearer to October 2015.

Communications

1. A communications strategy and action plan has been developed.
2. Presentations were made to our colleagues in Public Health, Alcohol Intervention teams, Health and Social Care Cabinet, Better Care Fund for All, Tobacco Alliance, Wessex Public Health workforce leads, Public Health England Wessex Health Promotion team and Pharmacists Learning Day.
3. A paper was presented to the CCG Clinical Governance Committee on 4 March 2015.
4. Two stakeholders workshops with 89 external delegates were held on 22 and 23 April 2015 with active discussion and feedback. Follow up actions and engagement with interested stakeholders is in progress.
5. Briefings were sent to GPs via the CCG system.
6. Presentations and further dialogues are planned for 3 June 2015 GP commissioning event and at June TARGET event.
7. Various communications mode are being piloted in Somerstown with evaluation.

Contracts

1. The current services: Health trainers, Pompey Quit and Solutions for Health contracts will end on 30 Sept 2015.
2. Active discussion is in progress about the transition plan: handover of clients information, information about services venues prior to October 2015.
3. The Internal Alcohol Intervention services will be deployed.

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Human Resources

1. Internal consultation with staff from Alcohol Interventions Team and Somerstown pilot Wellbeing team concluded on 19 May 2015 with job matching by beginning of June 2015.
2. Recruitment for Service Managers, Practice Leads (Smoking and Mental Health), Wellbeing workers and administrator is planned from June 2015.
3. The work on developing the apprenticeship scheme is in progress internally. Health Education Wessex is interested in piloting a national trailblazer Health and Wellbeing apprenticeship scheme with this service.

Workforce development

1. A Skills competency framework for Wellbeing staff has been developed and a training programme drafted. This includes mandatory training on PCC policies and procedures, essential training such as Making Every Contact Count Level 3, National Committee On Smoking Cessation Training (NCSCT) Smoking Cessation Levels 1 & 2, Nutrition and Healthy Weight Level 3, Award in Understanding Alcohol Misuse, GP Exercise on Referral for Health Management, Mental Health First Aid.
2. Plan to include reflective practice, supervision and audit is included.

Information Technology

1. The service specification for a Client Record Management system has been developed.
2. Procurement for this system is planned for early June 2015 with the aim of testing in September 2015. We are also exploring the potential to use the same client record management system now being introduced by Portsmouth general practices and the community provider (System One) provided by the company TPP. The purpose of this is to align patient referrals across the health economy.

Somerstown neighbourhood pilot

1. An assets map has been produced.
2. The Wellbeing workers are developing relationships with residents, colleagues from Housing, children centre, Pharmacy and local agencies.
3. The team has been developing and testing the service delivery and community approaches.
4. Since January 2015, the Somerstown team has worked with 55 clients on a 121 basis. This number excludes group sessions.
5. Evaluation with case studies of clients, staff focus group, 121 interviews with staff and stakeholders is done.
6. A report will be presented to the CCG Clinical Strategy Committee on 1 July 2015.
7. Learning will be used to inform roll out of the city wide service.

Community Profiling and Co-production

1. A toolkit of community development approaches will be developed for city wide use
2. Rapid Participatory Appraisal will be piloted in Paulsgrove in summer and to be rolled out citywide.
3. Information will be used to inform JSNA, work of this service and other programmes.

Significant risks and issues

1. Unable to recruit quality staff impacting on the service

   Mitigation

   - To recruit widely and starting from June 2015.
   - To sell on CPD opportunities to potential applicants.

2. Tight timescale for IT system impacting on time to test out teething issues

   Mitigation

   - Procure earlier and have longer testing time

3. Lack of Smoking cessation expertise

   Mitigation

   - To recruit Practice Leader (Smoking) early June 2015
   - To commission North 51, recommended by the National Committee for Smoking Cessation Training to provide advice, consultancy and face to face training.

4. Lack of buy-in from key stakeholders

   Mitigation

   - To have active engagement with key stakeholders e.g. GPs, NHS Trusts, Pharmacists, Third Sector via events, visits, communication briefings
   - To request CCG and GP Alliance to be champions

5. Lack of clarify in the transition prior to October 2015 launch date

   Mitigation

   - To have exit and transition plans from current providers including mapping of current services, venues, live cases, data to ensure continuity and seamless transfer to the new service.
   - To provide clear communications and joint briefing with current providers for stakeholders about the transition, the scope of new service, referral routes and contacts etc.