To: **Ashford Health and Wellbeing Board**

From: **Faiza Khan, Consultant in Public Health**

Karen Sharp, Head of Commissioning Public health

Date: **20th January 2016**

Subject: **Public Health Programmes**

Summary

This paper gives an update on the transformation programme for Public Health commissioned services. Over the last few months a series of stakeholder and public consultation events have taken place, alongside a review of national developments, and a review of the performance of current services. This paper outlines some of the work to date, key findings and the recommended changes.

The Board are asked to:

1. Note and comment on the work.
2. Note the recommendations for future delivery.
3. Identify colleagues to be involved in the upcoming procurement processes.

1. Introduction

1.1. This paper gives an update of the work since then to review services commissioned from the Public Health grant. The services in scope for the review were services for children, including the Health Visiting service, School Public Health (school nursing) service and also the core public health programmes for adults, including healthy weight, health trainers and smoking cessation services.

2. Stakeholder engagement

2.1. During September and October the Public Health team engaged with a range of stakeholders to gather their input into the process. A number of themes come out of this stakeholder engagement. These include a much more effective approach to communication about health across the population, and also a much greater focus on tackling health inequalities. It was consistently clear that better use of data, intelligence and customer insight can be used to effectively message with a range of different communities and can also be used far more effectively to proactively target communities with the highest health inequalities.

3. Locally Flexible Services

3.1. The current approach to the commissioning of services has been based on a one size fits all model across Kent. Future procurement will include local

representation to ensure a model which can vary according to local priorities and reflect local need. Local representatives are welcomed to be involved in developing this model.

4. Children and Young People

4.1. Services in scope of the review included Health Visiting, the Family Nurse Partnership (FNP), the School Public Health Service (also known as the School nursing service) and the Young People's Substance Misuse Service.

4.2. A public consultation took place on Public Health services for children and young people aged 0 – 19 closed on December 15th and received a good level of response. The favoured delivery model from the consultation is for services to be focused more clearly across age groupings for 0 - 4, 5 – 11 and 12-19. The response suggests a clear preference for a model which has a much greater focus on addressing children's needs aligned to their age and developmental needs. There will be a series of meetings during January to follow this model up with key stakeholders.

4.3. Several focus groups were delivered throughout Kent with participants who are currently involved with, or who have had recent involvement with the Health Visiting service. The initial report identifies that whilst there is a largely positive experience of the service, there is a lack of a clear and consistent understanding of the priorities of the Health Visiting service and the breadth of the service offer. This consultation echoed the review of the School Public Health service which identified some positive experience of the service, but also particularly from professionals a lack of visibility of the service clarify on what the service should offer, the priorities for the service, and eligibility for the service. It also echoed consultation with the Kent Youth County Council on public health services for children and young people in which a majority of young people highlighted that the school nursing offer of service in secondary schools should be much more visible to students and should focus on managing emotional health and wellbeing as well as physical health needs. This supports the public consultation for a more focused approach on the specific challenges adolescents face.

4.4. Market engagement events have been held as part of the consultation. This brought a good number of local and national providers together and the event enabled service providers to feedback their views. Key considerations raised included making sure that in any model transition arrangements were clear and that there should be a fairer distribution of total resources across the age range. The feedback also clearly suggested that the skills to deliver drug and alcohol treatment interventions are significantly different to universal work with all families and that whilst these services should be clearly aligned in key pathways of care, an organisation skilled and experienced in substance misuse should with be procured, to deliver this aspect of the pathway.

4.5. In addition, a workforce modelling tool has been commissioned with the current providers of Health Visiting and School Nursing to assess the service's current capacity to deliver all aspects of the service. This with the needs

assessment for Ashford will ensure that the capacity of service that we commission is much more closely aligned with population size and community need.

4.6. Discussions are also underway with NHS England to explore the opportunities to align commissioning of their contracted services for school aged immunisations and the Child Health Information System. NHS England has confirmed that they would like to align their procurement process with KCC through the joint development of specifications and a joint evaluation process.

4.7. Both Ashford and the Kent Health and Wellbeing Board have identified tackling obesity as key priority and activity to address this is being embedded in future model development. Kent's Emotional Health and Wellbeing Strategy identified the need for a stronger approach in universal services on mental health for children and young people to meet need before issues escalate. The new service models will prioritise these issues contribute to this universal offer, ensuring that support is available at the earliest opportunity.

5. Adult health improvement

5.1. Public Consultation

5.1.1. During November and December a proposed model to integrate core public health services such as smoking and healthy weight, was tested with the public through a consultation process and a series of focus groups. To ensure that a comprehensive picture was developed there were three elements to the consultation.

5.2. Online/Paper consultation

5.2.1. This involved a consultation document which was promoted for an online response, as well as paper copies which were distributed to GPs surgeries, Libraries among other community venues. This allowed us to engage with the wider public, explaining the proposed model, the options we have considered and to get opinions of how the service should be shaped.

5.2.2. The key findings were that the proposed model was generally well received. Three quarters (75%) of respondents agreed with the proposed model, and only 9% disagreed. Just over half (54%) of respondents felt that they should be allocated based on need, with the remaining respondents stating that they should be open to everyone (19%), 'by referral only' (18%) and 'other' (9%)

5.3. Focus Groups

5.3.1. The second element of the insight work, consisted of focus groups that were run to investigate further into people's attitudes to services, why they would or wouldn't access them, and testing our assumptions about the services and the proposed model. There were twelve focus groups that reflected different demographics.

5.3.2. The 12 workshops showed that Participants considered health to be about both their physical and mental health, they recognised the wider determinants of poor health and that people are acutely aware that health inequalities exist. There was huge support for an integrated model dealing with a range of health issues. However participants also recognised the limits to what services can and should do given that adults are in control of whether they engage in unhealthy behaviours. This suggests that the message about self-motivation as being key to success must be consistently conveyed.

5.4. Behavioural Insights

5.4.1. A behavioural insight study has also been undertaken, which focused on developing our understanding of why those people with the unhealthiest lifestyles are least likely to engage with our services. The report showed that people with no qualifications were more than five times as likely as those with higher education to engage in all four poor behaviours.

5.4.2. The Behavioural Architects were appointed to carry out a piece of in depth research, working with twelve people over a course of two weeks, understanding their daily choices, and the influences on their behaviour. The key findings from the work which supported the integrated model included

- Identity is strongly tied to local friends and family and the area around where people live
- Consistent habit loops for all four behaviours enables them to be used interchangeably
- Unhealthy habits reinforce one another through 'negative snowballing' clearly indicates that an integrated model would be more likely to support this group of people to make a sustained change.
- Unhealthy behaviours are incredibly accessible and offer a way to exert choice and control
- Unhealthy behaviours are often default coping strategies for dealing with more acute challenges

5.4.3. Each of these studies will enable us to create an informed service that has the person at the heart , whilst enabling us to develop campaigns that will help to motivate people to change their lifestyles, and then to engage with our services if they need support to make a change.

6. Market Engagement

6.1. A series of market engagement events have been conducted which indicated a strong willingness by many providers to engage in the transformation work. The exercise involved representatives from more than 80 service provider organisations from the public, private and community and voluntary sector. Feedback included a strong appetite to engage in the programme and suggestions that go beyond traditional 'service-based' approaches e.g. using behavioural science, technology and marketing approaches to generate motivation.

7. Next Steps

7.1. The key issues identified through service, stakeholder, public and market engagement will feed into the development of service specifications and our commissioning approach for Public Health services, with the procurement plan to be finalised during February 2016.

8. Timeline

8.1. The work to transform public health services has been divided into three phases and is on track for delivery. To deliver within this timescale any new procurement process will need to begin in March to deliver the new model to start by October 2016.

9. Conclusion

9.1. Development of a new approach is needed to meet the challenges faced in public health, the changing needs of the population and the financial envelope of the public health grant.

9.2. The stakeholder engagement phase of the project clearly supported the direction of travel.

10. Recommendations

10.1. The Board are asked to:

- Note and comment on the work.
- Note the recommendations for future delivery.
- Identify colleagues to be involved in the upcoming procurement processes.

Public Health Improvement Commissioning Strategy

Ashford Health & Wellbeing Board 20th January 2016

Kent County Council
kent.gov.uk

PH Transformation Programme - Drivers for Change

NHS Five Year Forward View

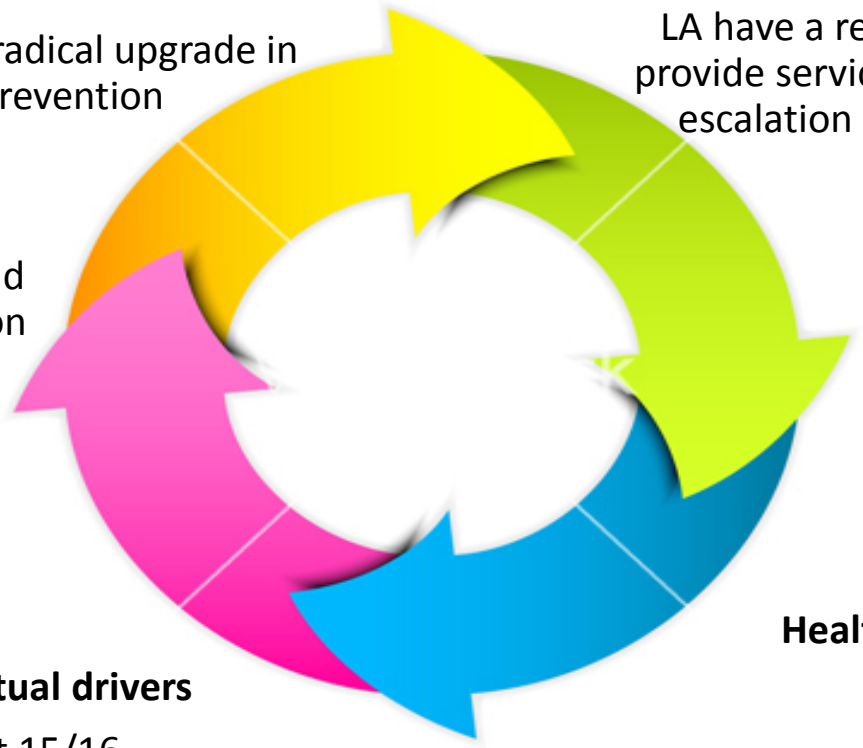
Calls for radical upgrade in prevention

Care Act

LA have a responsibility to provide services that prevent escalation of care needs

Demographics

A growing, ageing and diversifying population



Health & Wellbeing Board priorities

Calls for radical upgrade in prevention

Financial and contractual drivers

Reduction in grant 15/16

Health inequalities

Improving healthy life expectancy

Timeline

Phase 1:
Whole system engagement and consultation

Phase 2:
Revised models Procurement

Phase 3:
Transition to new service models

March – September 2015:

- Member briefings and Cabinet Committee
- Stakeholder consultation
- Outcomes agreed
- Analysis and Review
- Health and well being boards consultation
- Market engagement
- Contract management

October 2015 –April 16

- New models of provision and specifications developed
- Public Consultation
- Key decisions taken
- Resourcing agreed
- Invitations to tender issued
- Procurement processes run
- KCC Making Every Contact Count

April 2016 onwards:

- Transition to new service models
- Staff reconfiguration
- Change management and communication

Public Health Transformation - Our Key Questions

- Are our services fit for purpose?
- Do we invest our grant in the right way?
- What is mandated and what is discretionary?
- How many people and do the right people benefit from our services?
- How do our services perform?
- How do our contractual arrangements limit what we can do?
- Are we planning for the future?

Review

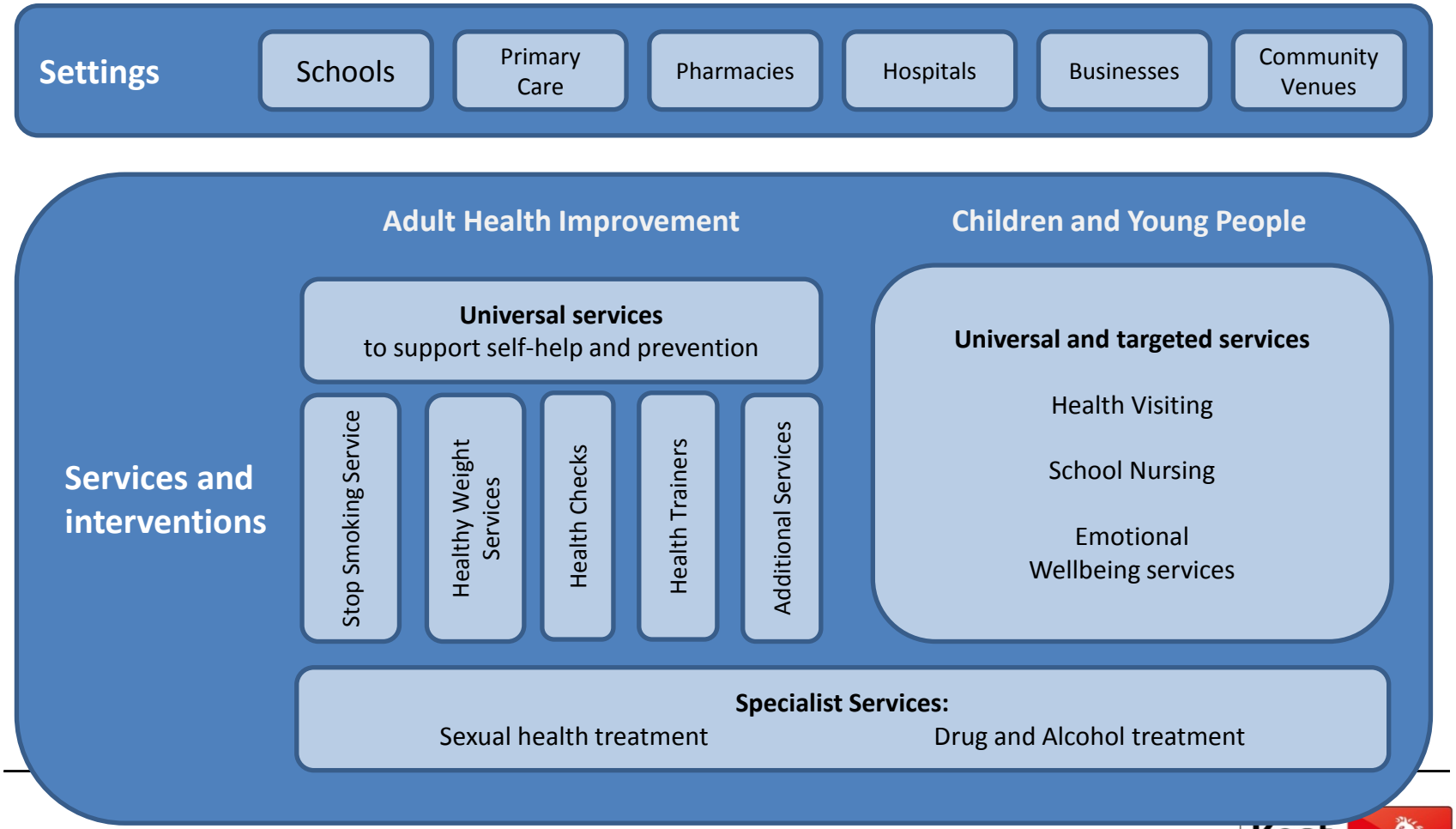
- Reviewed:

  - Outcomes
  - Spend
  - Performance of services
  - Health profiles across Kent
  - National developments and Key research
  - The Market
  - Wider system priorities
  - Customer insight

Key Outcomes

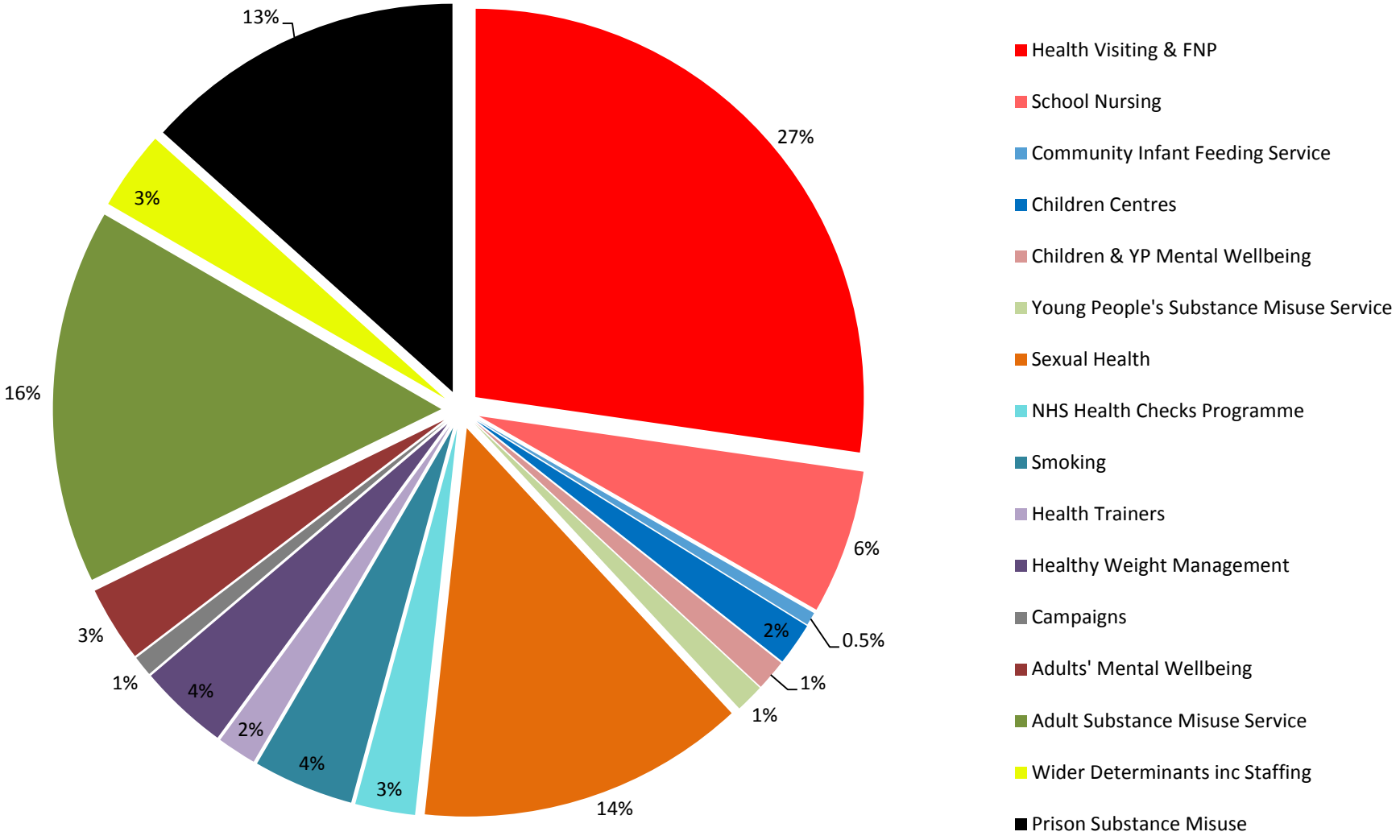
	Starting Well	Living Well	Ageing Well
Smoking	• Reduce smoking prevalence in general • Reduce in target populations		
Healthy Eating, Physical Activity & Obesity	• Reduce levels of excess weight • Increase levels of physical activity • Increase levels of breastfeeding • Reduce levels of tooth decay in children (5 year olds)		
Alcohol & Substance Misuse	• Reduce alcohol-specific admissions to hospital • Increase successful completions for drug and alcohol misusers		
Wellbeing (including Mental Health and Social Isolation)	• Improve wellbeing of population • Reduce self harm and suicide rates • Reduce social isolation • People >65 with mental ill health are supported to live well		
Sexual Health & Communicable Disease	• Maintain access to specialist sexual health services • Reduce rates of sexually transmitted infections • Reduce levels of teenage pregnancy • Reduce excess <75 mortality rates		

Current Model



Kent County Council
kent.gov.uk

Ashford Public Health Spend Breakdown 15/16 - based on NHS England Formula



Starting Well – Ashford

	Agreed Outcomes	Current Health Performance *Source: PHOF unless stated*	PH Activity
Smoking	Reduce smoking prevalence at age 15	Smoking prevalence at age 15 (2009-12) – *regular smokers only*: Ashford: 9.1%	Stop Smoking Service Tobacco control programmes
	Reduce smoking prevalence at time of delivery	Smoking prevalence at time of delivery (Q2 14/15) Ashford CCG: 10.1%	
Healthy Eating, Physical Activity and Obesity	Reduce levels of excess weight in children	% children classified as overweight or obese (2013/14) 4-5 yr olds (YR): 22% 10-11 yr olds (Y6): 35%	Early Help Workforce funding Ready Steady Go Change4Life
	Increase levels of breastfeeding	% all mothers who breastfeed their baby in first 48hrs after delivery (breastfeeding initiation) (2013/14): Kent: 71.3%	Community Infant Feeding Service
	Increase physical activity in young people	*No data available*	Sky Ride
	Reduce levels of tooth decay	% children with one or more decayed, missing or filled teeth (aged 5 years) (2012): Kent 19.8%	Dental Health Programmes
Alcohol & Substance Misuse	Reduce under 18 hospital admissions due to alcohol	Alcohol specific admission rate per 10,000 population aged <25 (2011/12 to 2013/14) – Source: SUS, ONS Ashford: 7.0	Young People's Substance Misuse Service
	Reduce levels of drug taking and use of legal highs	Drug specific hospital admissions: rate per 10,000 population aged <25 (2011/12 to 2013/14) – Source: SUS, ONS Ashford: 6.6	
Wellbeing	Increasing emotional resilience in families and young people	Admissions for mental health, rate per 1,000 population, ages 0-17 (2011/12 to 2013/14) – Source: SUS, ONS Ashford: 1.1	Domestic Abuse Projects Mental Health First Aid Youth Mental Health Matters Helpline Positive Relationships Social Integration Activities Project Young Healthy Minds
	Ensure levels of social and emotional development	School readiness: % children achieving a good level of development at end of reception year (2013/14) Kent: 68.5%	
	Reducing levels of self-harm and suicide rates	Deliberate self harm admission rate per 10,000 population aged 0-17 (2011/12 - 2013/14) – Source: SUS, ONS Ashford: 10.4	
Sexual Health, Communicable Disease	Reduce rates of Chlamydia	chlamydia positivity screening rate/ 100,000 15-24yrs (Q2 14/15) Ashford: 934	Condom Programme Integrated Sexual Health Service National Chlamydia Screening Programme Pharmacy Sexual Health Programme
	Reduce rates of STIs	all new STI diagnoses (exc. Chlamydia <25 yrs) 15-64 yrs/100,000 (2013) Ashford: 578	
	Reduce levels of teenage pregnancy	<18 conception rate /1,000 (2013) Ashford: 23.5	
All Priorities	As above	As above	Children Centres Health Visiting & FNP School Nursing

Living Well – Ashford

	Agreed Outcomes	Current Health Performance *Source: PHOF unless stated*	PH Activity
Smoking	Reduce smoking prevalence in general population	Smoking prevalence in general population 18+ (2013) Ashford: 21.1%	Smoking Cessation Service Tobacco Control
	Reduce smoking prevalence in routine and manual workers	Smoking prevalence in routine and manual workers (2013) Ashford: 34.7%	
Healthy Eating, Physical Activity and Obesity	Reduce levels of excess weight	% excess weight in adults (2012) Ashford: 67.4%	Ready Steady Go Change 4 Life Fresh Start Tier 3 Weight Management
	Increase levels of physical activity	% physically inactive adults (2013) Ashford: 24.2%	Health Walks Exercise Referral Scheme
Alcohol & Substance Misuse	Reduction in number of people drinking at problem levels	Alcohol specific admission rate /10,000 population aged 25 - 64 (2011/12 - 2013/14) – Source: SUS, ONS Ashford: 37.0	Adult Substance Misuse Service
	Reduction in hospital admissions due to alcohol	Drug specific hospital admissions, rate per 10,000 population aged 25+ (2011/12 to 2013/14) – Source: SUS, ONS Ashford: 8.2	
	Reduction in drug misuse		
Wellbeing	Improve wellbeing of population	Mental Health Contact rate per 1,000 people, aged 25-64 (2014) – Source: KMPT, ONS Ashford: 35.3	Domestic Abuse Projects Kent Sheds Mental Health Community Services Mental Health First Aid Mental Health Matters Helpline Mental Wellbeing Programmes Primary Care Link Workers
	Reduction in suicide rates	age-standardised mortality rate from suicide and injury of undetermined intent/100,000 population (2011-13) Ashford: 7.6	
	Reduction in domestic abuse	rate of domestic abuse incidents (recorded by the Police) /1,000 (2013/14) Kent: 18.1	
Sexual Health, Communicable Disease	Increase early diagnosis of HIV	Late diagnosis of HIV % newly diagnosed with a CD4 count less than 350 cells per mm² (2011-2013) Ashford: 42.9	Integrated Sexual Health Service Pharmacy Sexual Health Programme Psychosexual Counselling
	Reduce rates of STIs	all new STI diagnoses (exc. Chlamydia <25 yrs) 15-64 yrs /100,000 (2013) Ashford: 578	
	Reduce excess under 75 mortality rates	Mortality rate from diseases considered preventable (persons) /100,000 (2011-2013) Ashford: 147.8	NHS Health Checks Programme
All Priorities	As above	As above	Children's Centres Health Trainers Healthy Living Pharmacies Learning Disability Health Improvement Programme NHS Health Checks Programme

Ageing Well – Ashford

	Agreed Outcomes	Current Health Performance *Source: PHOF unless stated*	PH Activity
Smoking	Reduce smoking prevalence	Smoking prevalence in general population 18+ (2013) Ashford: 21.1%	Smoking Cessation Service Tobacco Control
Healthy Eating, Physical Activity and Obesity	Reduce levels of excess weight	% excess weight in adults (2012) Ashford: 67.4%	Fresh Start Tier 3 Weight Management Health Walks Exercise Referral Scheme
Alcohol & Substance Misuse	Reduction in number of people drinking at problem levels	Alcohol specific admission rate /10,000 population aged 65+ (2011/12 - 2013/14) - Source: SUS, ONS Ashford: 21.3	Adult Substance Misuse Service
	Reduction in hospital admissions due to alcohol		
Wellbeing (inc Mental Health & Social Isolation)	Improve wellbeing	Mental Health Contact rate per 1,000 people, aged 65+ (2014) – Source: KMPT, ONS Ashford: 34.8	Kent Sheds Mental Health Community Services Mental Health First Aid Mental Health Matters Helpline Mental Wellbeing Programmes Primary Care Link Workers
	Reduce social isolation	% adult social care users who have as much social contact as they would like (2013/14) Kent: 45.8%	
	People with mental ill health are supported to live well	Mental Health Contact rate per 1,000 people, aged 65+ (2014) – Source: KMPT, ONS Ashford: 34.8	
Sexual Health	Reduce rates of STIs	*No data available for 65+*	Integrated Sexual Health Service
All Priorities	As all above	As all above	Health Trainers Healthy Living Pharmacies Learning Disability Health Improvement Programme NHS Health Checks Programme

Market Engagement and research 1

- Much research points to understanding issues with clustering of unhealthy behaviours (King's Fund analysis)
- Providers keen to explore new opportunities and diversify their service offer to engage with us
- Many providers are doing a great deal of thinking about their strategies - some are re-focusing their service offer to respond to the potential market for health improvement
- Organisations included integrated health improvement hub models that have recently been established e.g. Live Well Dorset, Live Well Suffolk.

- Some providers expressed concern about the idea of creating an integrating health improvement model. Eg dilution of specialist expertise, risk of restricting the market

Market Engagement

- Suggestions for commissioning programmes that go beyond traditional ‘service-based’ approaches e.g. using behavioural science and marketing to generate motivation for healthier lifestyles .

- A number of different providers suggested commissioning a generic ‘behaviour change service’

- Providers wish to understand more about how VCS can come together in partnerships to bid

- Pharmacies are keen to engage in health improvement agenda offer a wider range of public health services

- Few suggestions for reductions in spend; most suggestions on principles of ‘invest to save over the long-term’

Key themes

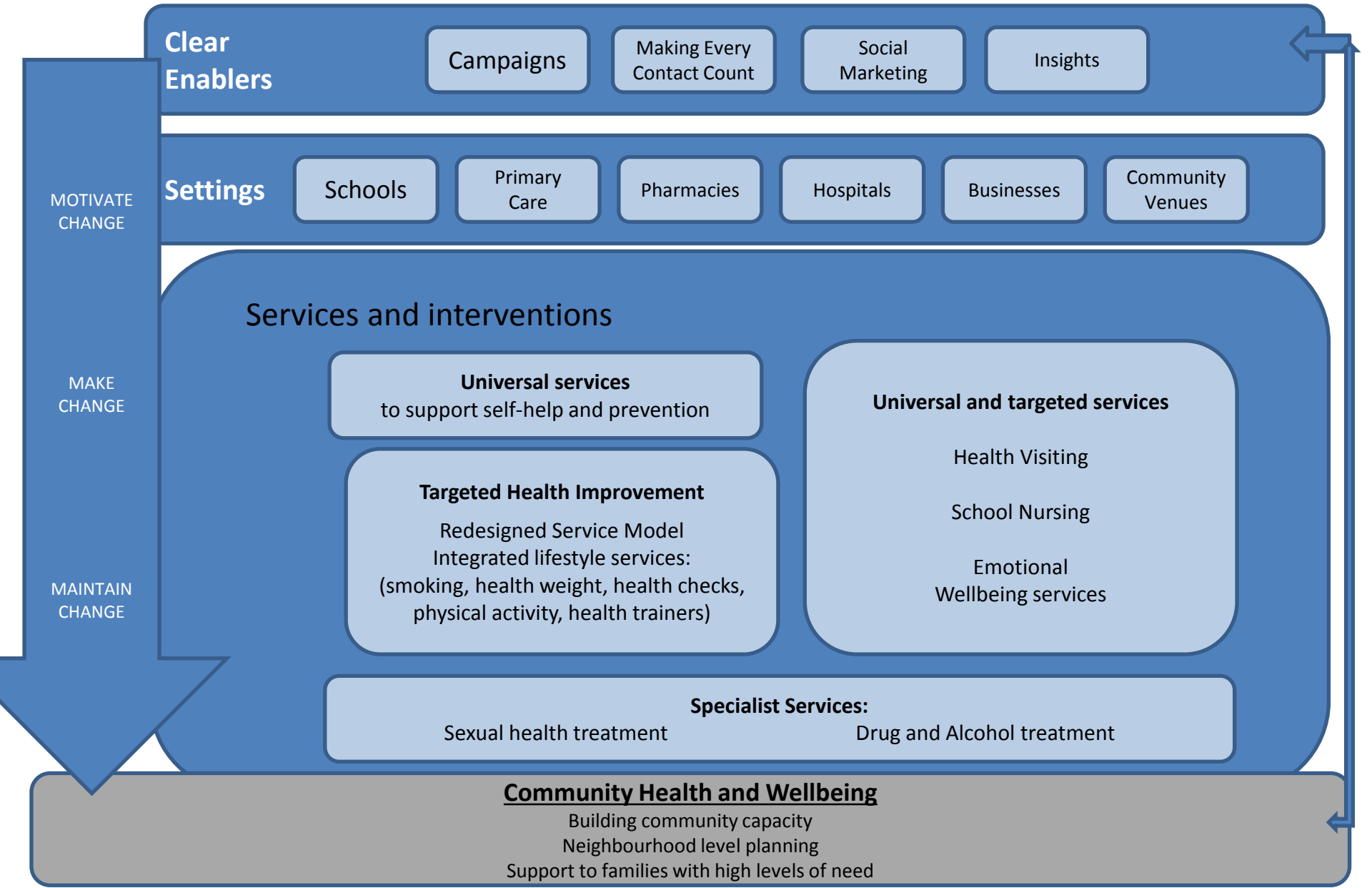
- Health Promotion across the population
  - Co-ordination with partners
  - Enhancing the approach to motivation
- Focus on health inequalities
- Locally flexible services (co-design)
- Integration of adult health improvement services
- Children and young people's services
  - Better visibility and Shared records
  - Better and further integration of services
- Embedding a the focus on emotional health and wellbeing

The 9 High Impact Areas

- The Best Start in Life
- Healthy Schools and Pupils
- Helping People find and stay in work
- Active and Safe Travel
- Warmer and Safer homes
- Access to Green and Open spaces
- Strong communities, Wellbeing and Resilience
- Public protection and regulatory services
- Health and Spatial services

Improving the Public's health – The 9 High Impact areas The Kings Fund 2013

Adult and Children Health Improvement Model



Local Public Health Model

Local priorities to inform approach, with mental and emotional wellbeing underpinning everything we do

Whole Population Health Promotion

Campaigns and communications Making Every Contact Count Community Champions

Websites and social marketing Partner Communications

Universal Access Services

Health Visiting School Nursing Health Checks

Healthy Living Centres Healthy Living Pharmacies

Universal Health Improvement Services

Targeted Health Improvement Services

Integrated Adult Health Improvement Service

Motivational approaches

Specialist Services

Alcohol, drugs &
Sexual health

Motivate Change

Make Change

Maintain Change

Integrated community approaches

Community Health and Wellbeing

Building community capacity and improving access to community resource

Next Steps

- Stakeholder engagement continues
- New models of provision developed
- Public Consultation
- Further customer insight work
- Resourcing agreed
- Models and specifications finalised
- Procurement processes as appropriate