

**DERBYSHIRE COUNTY COUNCIL
HEALTH IMPROVEMENT AND SCRUTINY COMMITTEE**

20th January 2014

Report of the Director of Public Health

DERBYSHIRE INTEGRATED WELLBEING APPROACH

1. Purpose of the Report

- 1.1. To seek approval to procure a new Derbyshire wide service to provide support and advice to the adult population to improve their own health and wellbeing

2. Information and Analysis

- 2.1. This proposal is to re-engineer three existing services, following review and evaluation into a new wellbeing service that is affordable, accessible and effective in terms of both supporting health and wellbeing improvement and addressing health inequalities. An overview of the new wellbeing service can be found in Appendix 1. The proposed overall budget for this new service is **£4.1m**, representing a saving to the authority of £720,000.

2.1.1. The three services are smoking cessation including tobacco control, weight management including physical activity and nutrition and health trainers. Health Trainers, for which Derbyshire has been a leading example of good practice nationally, was evaluated last year and the findings have been used to inform this approach.

2.1.2. The findings of the Smoking Cessation and Tobacco Control and Obesity, Physical Activity and Nutrition Reviews, which both concluded at the end of September, are the subject of two separate reports. The findings of the reviews and the Health Trainer Programme Evaluation are summarised below. The full reports are available from the Public Health department.

- 2.2. The aims of the **Tobacco Control Review** were to review existing public health investment in Derbyshire and to inform future commissioning intentions for tobacco control.

2.2.1. The review included consultation with stakeholders, evaluation of commissioned services, including data quality, outcomes and client satisfaction, value for money and assessing to what extent the services engaged with target groups.

2.2.2. The review concluded that efficiency savings could be made in service provision, resources should be allocated differently and prices standardised, standards should be consistent, "total trust"

payments for services should be discontinued and control measures should be put in place for NRT monitoring and usage.

2.2.3. The review outlined a number of service principles that should be applicable to all services.

- Services are equitable, accessible and proportionate to need
- Workforce that is competent, skilled and able to maintain competency
- Flexible service coverage at community level with the ability to respond to demand
- Take up by high prevalence populations and target groups (pregnant, mental health diagnosis) are proportionate to the local smoking population.
- Offer the optimum balance of high-efficacy treatment, reach and accessibility.
- Offer a range of evidence based interventions and pharmacotherapy.
- Efficient, affordable and value for money service provision

2.2.4. A specific recommendation from this review is that a more holistic approach to policy and practice should be taken in addressing unhealthy behaviours. An integrated model of care should be designed that incorporates lifestyle related services (inactivity, obesity, smoking and alcohol misuse) with a single point of access. The commissioned services within this designed model should adhere to the outlined service principles and utilise the specific recommendations from this review, where applicable.

2.3. The aims of the **Obesity, Physical Activity and Nutrition Review** were to review existing Public Health investment in adult obesity, physical activity and nutrition services in Derbyshire, and to inform future commissioning intentions for obesity, physical activity and nutrition services.

2.3.1. Following consultation, review of evidence and best practice, analysis of data and comparison with other services some key points were identified. These include; engage more people from under-represented populations; drive further efficiency in service provision; consider different methods of resource allocation; offer flexible access to support and learn from other areas.

2.3.2. The review outlined some principles that should be applicable to all services.

- Services that are equitable and accessible
- Workforce that is competent and skilled
- Flexible service coverage at community level with the ability to respond to demand and access and choice for service users
- Efficient, affordable and value for money service provision
- Providers delivering on a specified set of standards and outputs

- 2.3.2.1. With regard to obesity, the review recommends adhering to the existing, yet revised, Derbyshire Obesity Pathway which outlines a measured escalation process for service users. Service proposals are for a Tier 2 community weight management intervention with appropriate choice and access supported by a single specialist weight management service for the morbidly obese, vulnerable target groups and cases that would benefit from more intensive support.
 - 2.3.3. For physical activity the review recommends a universal, integrated offer of physical activity through community level schemes, continued delivery of the Walking for Health programme, centralised information via Active Derbyshire and the use of (Making Every Contact Count) MECC. To address the high rates of inactivity the creation of a fund to stimulate and incentivise an approach to tackling sedentary behaviour at a local level through existing partnerships should be established. Targeted delivery should be based upon the Derbyshire Healthy Lifestyle Hub with a market of accredited providers delivering a Health Referral Scheme and an offer of a wide range of activities. This would be decoupled from weight management in a change to current provision.
 - 2.3.4. For nutrition, the review recommends the development of a nutrition strategy, the implementation of a healthy eating approach named the Heart of Derbyshire (which is also the subject of a November 2013 Cabinet Paper) and exploration into whether cooking skills sessions should be delivered.
 - 2.3.5. The main recommendation from this review is that a model of care is designed that incorporates lifestyle related services with a single point of access. The commissioned services within this designed model should adhere to the outlined service principles and utilise the specific recommendations from this review, where applicable.
- 2.4. The **Health Trainer Programme Evaluation** has also informed the proposed approach:
- 2.4.1. Success criteria should be developed for different models of health trainer provision that are likely to achieve different outcomes.
 - 2.4.2. Further data analysis should be initiated to include trends in service use, client profile and achievement/part achievement of goals.
 - 2.4.3. Services should be periodically reviewed to ensure service providers are targeting the most vulnerable communities in Derbyshire e.g. BME groups
- 2.5. The population being targeted by this new proposed approach takes into account a number of sources of evidence and research. The concentration of need is predominantly in the more deprived and vulnerable communities, with multiple and complex combinations of lifestyle issues, emotional and socio-economic challenges, requiring a

more intensive approach that is customer focused. This is not a new problem and will chime with the challenge faced by many services.

2.5.1 The scope of the service and the numbers of people engaged by the overall service provision will vary by the mode of delivery and intensity. This will range from a web based universal service accessible to all the people of Derbyshire, to providing a service to 8,560 smokers seeking support, through to the Wellbeing Service ambition of engaging 5% of the most vulnerable population through referral, signposting and outreach work in target communities. This will be subject to further work and consultation before being reflected in the specification KPIs.

2.6. The principles shaping the proposed approach are:

- That it is evidence based, affordable and meets quality standards.
- That people are able to access support wherever they live, with a component of choice.
- Resources are distributed equitably and reflective of the varying level of need across Derbyshire and within vulnerable communities.
- The components of the service work collaboratively and as part of an integral system to best achieve the health outcomes for the people of Derbyshire.
- For people experiencing vulnerability and deprivation, the service has to be responsive to the person's circumstances and the issues uppermost in their lives.
- The service needs to adopt a variety of approaches other than geographical location to meet the needs of vulnerable communities of interest.
- The overall service is coordinated and staff by a flexible generic skilled workforce.

2.6.1. The proposed Derbyshire Wellbeing Service is made up of a number of components that enable the provision of a universally accessible service combined with a targeted provision to address the needs of the most vulnerable population groups. The implementation of the proposed overall model will take some time to develop and some elements will progress quicker than others, all of which will require careful coordination and management. A schematic diagram of the model is included in Appendix 1

2.7. The **Wellbeing Service** is aimed at actively engaging people in greatest need to support them through an integrated service to achieve change

2.7.1. This would focus on people/communities that are least resilient, at greater measurable risk (e.g. health checks, welfare reform) of disease or harm, communities displaying a lack of engagement in

health behaviour, people not managing their condition effectively and frequent inappropriate users of services.

- 2.7.2. The distribution would follow the Marmot principle of “proportional universalism”. Allocation of resources proportionate to need, as measured by level of premature death at small area level, would result in a gradient of 1 unit of resource in the areas with the lowest levels of premature death to 5 units of resource in the areas with the highest levels of premature death. The model presented proposes a minimum of 1 day a week in the area of lowest premature death.
- 2.7.3. Self-referral for lifestyle behaviour change from the most vulnerable sections of the population groups, which this approach is targeting, is unlikely except in emergency. Engagement is more likely to come from referral, signposting and outreach work into community settings.
- 2.7.4. The approach to vulnerable communities will vary according to the “footfall” of people in greatest need. For the majority of people with the greatest need General Practice remains a main point of contact. However, for some communities of interest different models of delivery need to be considered. These may include training the existing workforce who work with that population (e.g. working with learning disabled people), attaching a Wellbeing Worker as part of a team working with a population (e.g. mental health teams) and/or recruiting from the population itself (certain minority and ethnic communities). Where General Practice is unable to accommodate the service, alternative locations will be sought in the local area.
- 2.7.5. The **Wellbeing Service** will be made up of a workforce competent in a core set of competencies common to health trainers, smoking cessation advisors, weight management advisors and physical activity specialists: primarily these are motivational support, coaching and goal-setting. Within the workforce, additional knowledge and experience in the individual behavioural issues will also be evident and develop within the service as a whole, enabling greater flexibility and responsiveness. Other skill-sets involved in parallel programmes, such as health checks, are being considered.

2.7.6. The key initial measure of success is engaging the most vulnerable in a process of goal-setting and achieving change. For this reason the proposed referral scheme will be as direct as possible. Where there is sufficient presence this may be managed locally, but where the presence of the Wellbeing Service is only partial, e.g. one day a week, the proposed mechanism will be by phone, online or by email.

Case study: Mrs Smith has an appointment with a health professional at her local GP surgery. Mrs Smith has ongoing health issues and visits the GP surgery regularly for different reasons. The health professional identifies that Mrs Smith has social and lifestyle issues that they have been unable to resolve. The health professional refers Mrs Smith to the Wellbeing Service. Mrs Smith attends an appointment with the Wellbeing Worker and they discuss a range of issues. Mrs Smith has been struggling to make repayments on a loan which is causing her a degree of anxiety and stress. The unpaid loan is causing her to drink more alcohol than usual. Mrs Smith and the Wellbeing Worker develop a plan to address the priority issues in her life. They agree to address the financial issue before the increased alcohol usage. To deal with the loan, the Wellbeing Worker makes an appointment with the Citizens Advice Bureau (CAB). A few days after the appointment with CAB, the Wellbeing Worker calls Mrs Smith to see if she attended the appointment and how things went. Three months later, the Wellbeing Worker follows up with Mrs Smith and arranges to meet her to review her situation and raise the issue of alcohol as a future goal in her wellbeing plan.

2.7.7. Guidance on proportional distribution for who is eligible for the Wellbeing Service will evolve, but cannot be too rigid. There is evidence that the most vulnerable people are more likely to present with multiple complex inter-related issues, therefore complexity is likely to be one of the key determinants for who is directed to the service, rather than them being directed to other parts of the system.

2.7.8. It is proposed that the commissioning of this model will be based on expected levels of engagement by the service, calculated at small area level using premature death. Reliance on referrals may be insufficient to meet the expected levels and therefore there will be an expectation that outreach work will be undertaken to actively engage with target communities. This would be an integral part of the planned approach to locality working, subject of a previous Cabinet paper presented in October.

2.7.9. The proposed Wellbeing Service will be for a budget of **£1,300,000** with an anticipated workforce of 61 wte.

Case study: Where appropriate, the Wellbeing Worker will also engage with local vulnerable communities and take opportunities to work in partnership with a range of other professionals/agencies and the local community to contribute to the Locality Plan. It has been identified that there is a low response to the Health Check programme on the St Augustine estate in Chesterfield. The Wellbeing Service linked to the local Practice participates in planned outreach work on the estate led by the Public Health Locality team. This involves local survey work and a “drop in” at the local church. Through this a number of local people are engaged in setting wellbeing goals and plans, Health Check uptake is boosted and a number of other potential initiatives are being explored.

2.8. To complement the targeted Wellbeing Service approach, and to ensure it is not overwhelmed, people in Derbyshire should have universal access to **information and advice** via a range of sources that support their pursuit of health & wellbeing.

2.8.1. This proposes that a single website portal would provide access to information about local services and opportunities, tools for self-help, links to established health information websites and downloadable sheets on key conditions. Audio content could also be considered in relevant community languages. This overall approach may be achieved by linking to existing websites and/or developing new content, but with the aim of a singular simple access point for the public and frontline staff.

2.8.2. Whilst at least two thirds of the population use the internet, increasingly via smart phone, it is recognised that there are age related and other barriers to consider. Therefore the complementary universal offer could be provided through the “Health Zones” located predominantly in libraries, supported by staff use of the website portal and also potentially in other settings identified to have high levels of footfall to ensure reach/access.

2.8.3. Another development that this model is proposing is a single phone number for access to support and advice for health and wellbeing. This could utilise the existing “Call Derbyshire” number as a portal to a health and wellbeing information and advice infrastructure supported by the website content as well as providing some specific support services e.g. smoking cessation by phone.

2.8.4. Such a web based resource can also underpin the MECC approach outlined in a previous CabCo paper in October 2013, equipping staff with up to date information and resources for use in their work with clients/the public. As with pre-internet paper based health directories, the key to success will be keeping information alive and current and simplifying access. It would also be a

valuable resource for social media based approaches to engage different elements of the population in health and wellbeing initiatives.

- 2.8.5. There is also work currently underway by existing services to explore the creation of personal web space that would enable clients to store progress in terms of food diaries and physical activity logs. This may be an important future feature not only of more intensive services, but also for encouraging self-motivated activity and self-monitoring as identified in a recent evidence review.
- 2.8.6. This universal offer is a vital component of a system wide integrated approach to supporting behaviour change and enabling general access to support and advice that is affordable and does not overwhelm the more targeted effort to engage those elements of the population in the greatest need. This provision will engender easy access to support for the general public to improve their health and wellbeing, and to staff who are “making every contact count” by supporting people to pursue health and wellbeing.
- 2.8.7. The proposed budget allocation for the development and maintenance of a web page infrastructure and telephony service is **£43,000**

Case study: Mr Jones would like to be more active. He mentions this in a conversation with a librarian. The librarian has undertaken Making Every Contact Count (MECC) training and is aware of how to support Mr Jones. Mr Jones is not computer literate, so the librarian shows him the new “Wellbeing” webpage. By putting in his postcode this shows what is available near where he lives. The website has information on local opportunities to be more active and he joins a local walking for health group.

- 2.9. This approach to information and advice will improve universal access for people seeking support for behaviour change and inform them of a **choice of lifestyle services** available in local areas proportionate to need.
 - 2.9.1. Services that support people to pursue improvements to their health and wellbeing need to be easily accessible in local communities and form part of an overall offer that allows choice and reflects quality standards expected for public health services
 - 2.9.2. Access to basic support through MECC and brief intervention (sometimes referred to as tier 1) are universally available in communities through the core business of services such as GP practice, pharmacies etc. These will be supported through the proposed information and advice website and telephone access.
 - 2.9.3. The level of service provision at tier 2 (more intense support) in an area, will be based on the level of need identified in the JSNA. The likely demand that is needed to assure quality but also addresses issues such as rurality and access. Therefore, in some areas of Derbyshire there may only be sufficient business for a

sole provider with the element of choice being met through other means such as telephone support.

- 2.9.4. This approach proposes the development of an accredited market of providers as part of an overall integrated system. Accreditation will depend on adherence to a set of standards based on best practice, sufficient throughput to maintain quality, competent staff and a commitment to the integrated system approach e.g. engagement in MECC by staff in the organisation.
- 2.9.5. The focus of these services is predominantly 1:1 support for smoking cessation, weight management and physical activity, which historically have been provided by GP practice, pharmacies leisure providers and community health promotion services. The mode of support will combine a number of approaches based on evidence, including group run sessions and face to face as well as use of telephony, text and social media.
- 2.9.6. In terms of tier 2 physical activity provision, the proposal is that any accredited provider avails the client a choice of a minimum of six different activities within easy access. These will include low impact exercise options and walking. An accredited provider for physical activity should be able to evidence that their offer reflects the expressed need from people, to ensure choice and responsiveness to different levels of ability.
- 2.9.7. The proposed budget allocation for tier 2 community smoking services is **£360,000**. The proposed budget for tier 2 community weight management services is **£250,000**. The proposed allocation for the healthy lifestyle physical activity referral service is **£300,000**. All of these allocations are based on a local tariff cost reflecting an intervention of determined content and duration and includes an emphasis on incentivising outcome. As with other aspects of the overall programme, these are based on existing service costs and benchmarking work reflecting services in similar areas. The proposed budgets within the overall envelope may change as a result of any feedback following consultation.

Case Study: Mrs Johnson visits her GP and states that she would like to stop smoking. The GP asks Mrs Johnson whether he can share her contact details with the Wellbeing Service in order to discuss the best approach for her. The GP submits her contact details to the centre. The service contact Mrs Johnson by phone. The Wellbeing Service is able to provide detail on the range of intervention options available. Mrs Johnson decides that the best approach for her is 1:1 support. The Wellbeing Worker is able to provide Mrs Johnson with information on accredited providers near her home. She selects a pharmacy that is just down the road and the Wellbeing Worker makes an appointment for her. She attends the appointment the next day and is supported to stop smoking over the next few months.

2.10. An additional component in the integrated system this paper proposes is that service users identified as requiring intensive support have access to **specialist services** to enable them to make changes to lifestyle behaviour.

2.10.1. With all health and wellbeing issues, even when highly motivated, some people find they need more intensive support having tried the more widely available support services.

2.10.2. Agreed policy and pathways provide a process and criteria for enabling people access the support they need, whether 1:1 or in groups of common interest. These will need reviewing in the case of weight management due to the revision to national guidance and newly creating in regards to smoking cessation and physical activity.

2.10.3. A key feature of this approach will be building on the success of the existing psychologically led tier 3 service and the community based “Waistwise” programme to help individuals gain more insight into the underlying issues that are preventing them from achieving their desired goal of weight loss.

2.10.4. It is also important that there is issue-specific specialised support to the overall integrated system including the Wellbeing Service and tier 2 services, to ensure quality assurance through training, advice and monitoring.

2.10.5. This proposes a new specialist weight management service that builds on the existing tier 3 psychology led service and a new specialist tier 3 smoking cessation service. The criteria for access to each of these services would be determined by a pathway agreed across the health community, but would focus on those who have tried other methods, and require a fresh intensive approach.

Mr Black attends an appointment with his GP. He has spent over a year trying to lose weight by attending community weight management programmes, but has been unable to despite good compliance.

The GP identifies that Mr Black would benefit from more intensive support. According to the Derbyshire Obesity Pathway, Mr Black meets the criteria for referral to specialist weight support through his current BMI measurement and previous attempts at weight loss. The GP makes a referral directly to a local specialist weight management provider.

2.10.6. Such an approach may also be more applicable to certain vulnerable population groups, such as pregnant women and people with enduring mental health problems.

2.10.7. The prevalence of smoking at delivery in Derbyshire has been and remains consistently higher than the average for England. For example, in 2012/13 the England prevalence of mothers who smoked at time of delivery (SATOD) was 12.7% while in Derbyshire the prevalence was 15.75%. There are eight

providers of maternity services in Derbyshire and the smoking at delivery prevalence by provider ranges from 9% to 28%. These figures reflect the relative deprivation in the areas being served by each provider.

- 2.10.8. The specialist stop smoking service commissioned to help pregnant women to quit has not made a difference to outcomes, in other words, it does not work and as such is a poor use of the estimated £152,000 that it costs.
- 2.10.9. Recent evidence suggests that financial incentives can be effective in helping pregnant women to stop smoking. Following NICE guidance (2010), Derbyshire Public Health is piloting such a financial incentive scheme in partnership with the Centre for Studies of Incentives for Health (CSI), led by health psychologist Professor Theresa Marteau. The pilot is located in Chesterfield and ends in November 2013. Results to date show a quit rate of 9% at delivery compared to less than 1% quit rate without the incentive scheme.
- 2.10.10. Derbyshire County Council has prioritised reducing smoking in pregnancy. It has approved the extension of the financial incentive scheme to Derby Hospitals and the areas of the County which have a prevalence of SATOD that is higher than the England average. This would see the scheme restarted at Chesterfield Royal and extended to Derby, Stockport, Nottingham University Hospitals and King's Mill (Sutton-in Ashfield). Once SATOD data for Glossopdale becomes available it is likely to be extended to Tameside Hospital.
- 2.10.11. The estimated cost of the smoking in pregnancy scheme is £157,000. This will be phased-in through working with the different maternity providers serving Derbyshire, commencing with Chesterfield.
- 2.10.12. As with other services in this integrated system, these specialist services will adopt a suitable mix of evidence based support approaches and are available reflecting client choice, accessibility, timeliness and cost.
- 2.10.13. The proposed budget for a specialist "tier 3" smoking cessation service is **£369,500** (this includes the smoking in pregnancy scheme). The proposed budget for a specialist "tier 3" weight management service is **£450,000**. All of these allocations are based on a local tariff cost reflecting an intervention of determined content and duration and include an emphasis on incentivising outcome. As with other aspects of the overall programme, these are based on existing service costs and benchmarking work reflecting services in similar areas. The proposed budgets within the overall envelope may change marginally as a result of any feedback following consultation.
- 2.10.14. An important feature in the integral system is oversight and adherence to policy guidance and pathways, in particular the use of **prescribing** in the achievement of successful behaviour change. In the case of weight management Orlistat is still prescribed, but its usage has declined. Although it is not funded

from the public health ring-fenced budget, it is still important to ensure that any use is accompanied by appropriate referral and behavioural support.

- 2.10.15. Nicotine Replacement Therapy (NRT) through the voucher requisition scheme is funded from the public health ring fence budget. Recent guidance from Public Health England and the Department of Health issued after the review had completed, informs local authorities that *“The public health allocations therefore are intended to cover the full costs of supplying medicines via prescription forms. This means that where a local authority commissions a service which includes prescription medicines/devices as part of a public health intervention, the cost of the prescription should be met from their public health allocation”*. The budget for NRT costs for the voucher (requisition scheme) is £528,000 in 2013-14; costs in 2012-13 were £441,000. The cost of pharmacotherapy which includes NRT, varenicline (Champix) and bupropion (Zyban) through prescription was £563,049 in 2012-13. Further work is needed to determine the level of prescribing that has taken place as part of the commissioned service as compared to prescriptions issued by GPs as part of their general service provision.
- 2.10.16. A new formulary was put in place in June 2013 for the distribution of Nicotine Replacement Therapy. The new formulary recommends using cheaper NRT products which are as effective whenever possible. It is anticipated that the new agreement will contribute to the control of the medication budget. The new agreement will be monitored. Pharmperform, an online claim system to monitor NRT usage is not being systematically used by all community pharmacies. Pharmperform should be used by all pharmacies to monitor NRT usage and verify claims.
- 2.10.17. The National Institute for Health and Care Excellence (NICE) has now published guidance on tobacco harm reduction. The guidance supports the use of licensed nicotine containing products to help smokers not currently able to quit to cut down and as a substitute for smoking, indefinitely where appropriate.
- 2.10.18. The proposed budget for smoking cessation related medication is **£381,000**. This excludes any prescribing outside of a commissioned service. Any commissioned service will require adherence to the Formulary and the accompaniment of a behaviour change intervention to the standards set out in a specification.
- 2.11. Another component arising from the reviews undertaken is identifying how best to generate **healthy communities** that create supportive environments in places where people live and work to encourage healthy decision-making.
- 2.11.1. This paper considers two areas of investment that contribute to and complement the wider public health approach to healthy communities, which will be the subject of its own CabCo paper.

- 2.11.2. **Tobacco control** is vital if there are to be further inroads into the prevalence of smoking in Derbyshire. The proposed approach includes continued investment in preventing uptake by young people. A proposal for the use of a proposed budget of **£75,000** will be presented to a future CabCo by the Public Health children's team.
- 2.11.3. The job of developing a Derbyshire wide strategic approach to tobacco control was historically passed over to the current cessation providers along with the leadership of Derbyshire Action on Smoking. This paper proposes that this function is brought into the Public Health team. A proposed budget of **£75,000** has been identified for Tobacco Control. This excludes the new investment of £56,000 to support the approach against illegal and illicit tobacco, a contribution to the Regional Coordinator post for illicit tobacco and alcohol (£5,310) and investment in tobacco control through TMBC (£15,500).
- 2.11.4. Further investment in illicit tobacco has been identified and was the subject of a previous October 2013 CabCo paper. This complements additional investment in an East Midlands wide approach to work with Customs and Excise.
- 2.11.5. As well as recommending the continuance of the Public Health contribution to Derbyshire Sport of **£20,000**, the "Walking For Health" network support with a small increased budget of **£70,000**, and the Derbyshire Healthy Lifestyle Hub referral scheme for physical activity targeting the sedentary population who access through healthcare, the paper also proposes the creation of a fund to support and reward success at local level to decrease **adult sedentary behaviour and inactivity**. This work would be overseen by the Active Derbyshire arm of Derbyshire Sport, complementing the wider locality approach.
- 2.11.6. Whilst some funding would be made available to the local physical activity "community" to stimulate innovation, there would also be a reward component for impact on reducing the number of sedentary adults. Such a reward could then fund further activity determined at the local level. The proposed budget for this approach is **£260,000**.
- 2.11.7. Other aspects of the healthy community approach being proposed through a series of papers being presented to CabCo all interweave with this wellbeing approach: the locality work, Healthy Workplace and the Heart of Derbyshire Healthy Eating Campaign. In addition, review work by the Public Health Children's team will identify their proposed approach to lifestyle change, and how it relates to the integral wellbeing approach.
- 2.12. Ultimately the outcome sought by all aspects of this proposed integrated wellbeing approach is that people are equipped with the skills and confidence to be **resilient** in dealing with their health and wellbeing and health will improve as a result.
- 2.12.1. As part of this approach there is a proposal to explore and pilot ways of giving greater control and choice to the individual in determining how resources are utilised. An example of this would

be a **personal wellbeing budget**. The most plausible approach that can be trialled would be the use of vouchers that can be redeemed in a market place of accredited providers.

2.12.2. This has the additional benefit, which is explored further under financial considerations, of only paying where there has been usage by the client as opposed to the current system of block payment irrespective of success or completion.

2.12.3. If a pilot proves popular and effective, ideally an electronic card based system would be explored as this would enable easier monitoring by the client and the services. Again, this paper proposes that the administration and monitoring of activity would be a component of a provider managed integrated system.

2.13. This system of multiple services and access points could result in a high level of transaction costs and inefficiency if there is not a strong sense of partnership, **co-operation and system management**. Whilst all of the services will be specified as separate services, this paper proposes that if a suitable eligible provider can be secured to manage the whole system based on a single contract with the County Council, this would result in the optimal service and use of available resource for the people of Derbyshire. It is also recognises that if demand is to be managed and costs controlled within agreed parameters, it is important that all parts of the system work towards the same outcome. A proposed budget of **£75,000** recognises the costs involved in administrating, monitoring and marketing the overall system. The Public Health team are currently researching whether any other areas of the country are operating such a system and propose that this is considered as part of the consultation process for this new approach.

3. Considerations (to be specified individually where appropriate)

3.1. In preparing this report the relevance of the following factors has been considered: financial, legal, prevention of crime and disorder, equality and diversity, human resources, environmental, health, property and transport considerations.

3.2. Financial considerations

A summary of the proposed investment which reflects a 15% saving is shown below. The figures may change as a result of the consultation, but this will be within the proposed total of £4.1m.

Description	Proposed Annual Cost (£)
Wellbeing service	1,300,000
Web page infrastructure and telephony	43,000
Community smoking services	360,000
Community weight management	250,000
Healthy lifestyle physical activity referral service	300,000
Specialist smoking cessation service	369,500
Specialist weight management service	450,000
Smoking cessation medication	381,000
Preventing uptake of smoking (Children's)	75,000
Tobacco control	75,000
Illegal and illicit tobacco	56,000
Tobacco Control (Tameside Metropolitan Borough Council)	15,500
Derbyshire Sport	20,000
Walking for health	70,000
Community physical activity	260,000
Co-operation and system management	75,000
TOTAL	4,100,000

3.2.1. This proposed integrated model recognises the need for controls and assurance on demand led services, in particular the medication budget. This will require agreement with the CCGs and professional bodies following consultation of the best option of managing NRT distribution. Services elsewhere range from using a prescription only approach, a voucher scheme through to direct supply. It is proposed that consideration of which approach best fits Derbyshire should be determined through the consultation period and finalised in time for the procurement process.

3.2.2. This approach is working on a tariff basis that can be paid directly to a provider, but Public Health is keen to pilot a personal budget approach via voucher to test whether this increases choice, commitment and to secure greater value for money.

3.2.3. The approach proposes the consideration of a potential "master vendor" approach to ensure control of costs and to ensure integration between services and with other

programmes and initiatives commissioned by the County Council.

- 3.2.4. The approach proposes the use of outcome based incentive payments as an integral aspect of the approach whether to the individual, as trialled with smoking in pregnancy, or to the delivery organisation.

3.3. Equality and diversity

- 3.3.1. The approach proposed is designed with equality and diversity considered throughout, whether through the use of a resource formula that implements Marmot principle and the recognition of the need for bespoke approaches to key vulnerable population groups.

3.4. Human Resources

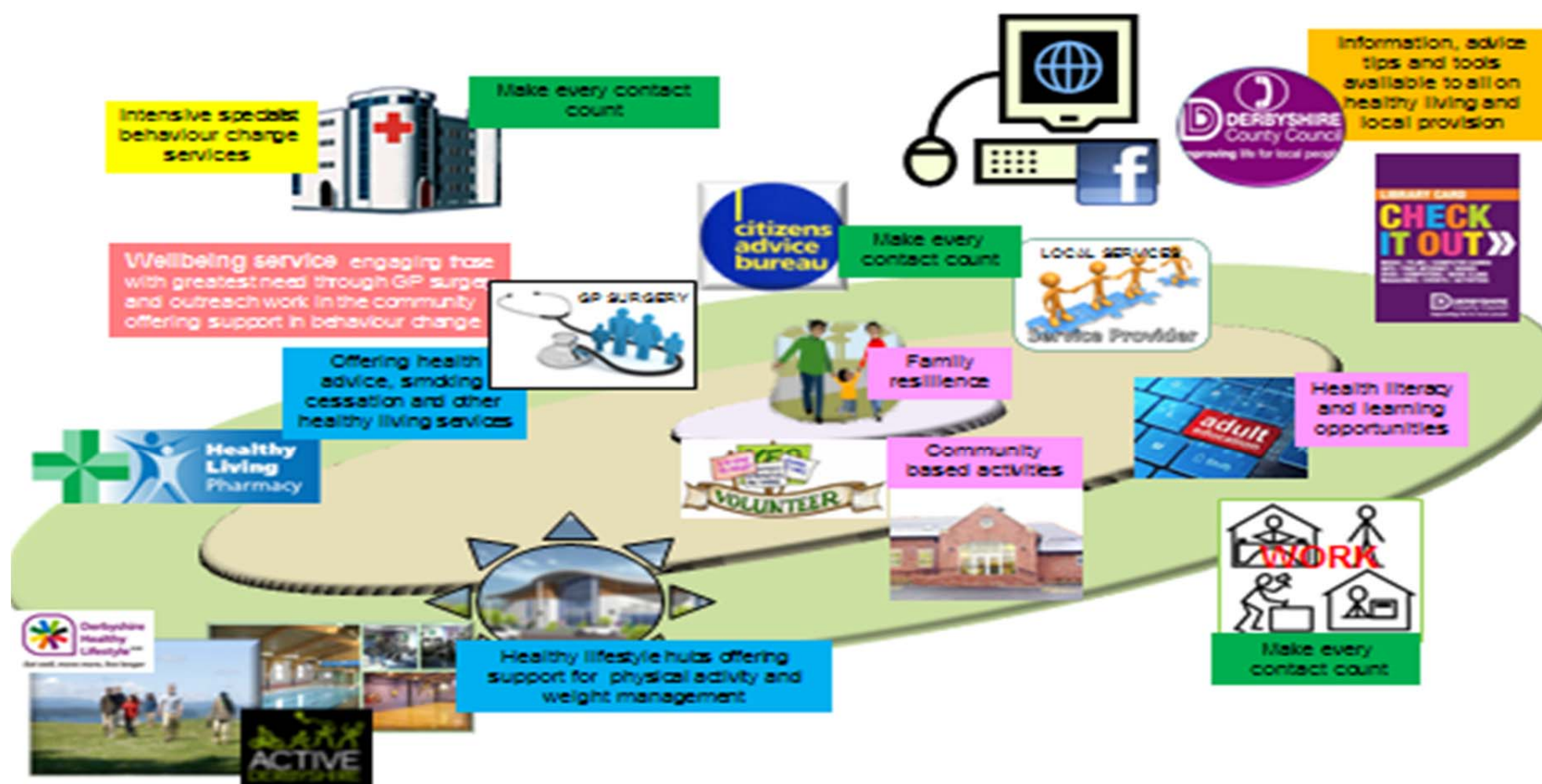
- 3.4.1. It is not anticipated that the current Public Health employees will be affected by the proposed contracting changes in 2014.
- 3.4.2. During consultation on the contracts for services, consideration will be given on the application of the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE), and further Legal and Human Resources advice considered where necessary.

4. OFFICER'S RECOMMENDATION

That the Committee receives and notes the overall approach to an integrated wellbeing approach and the overall proposed budget.

Elaine Michel
Director of Public Health

APPENDIX 1



Derbyshire Wellbeing Service

APPENDIX 2

Derbyshire County Council

Consultation Brief for the Derbyshire Integrated Wellbeing Approach

DCC Public Health will consult on the proposed Derbyshire Integrated Wellbeing Approach for a period of 3 months. The consultation will run from Friday 22nd November to Friday 7th February 2014.

It is proposed that there are four strands to the consultation;

1. Public questionnaire
2. Service-user questionnaire
3. Road-shows
4. Professional including existing service providers

All strands will be promoted through relevant networks

1. Public questionnaire

Purpose

To give residents of Derbyshire an opportunity to comment

Format

Short questionnaire available on 'Have your Say' on the DCC website and in paper form

Start date: Friday 22nd November

Finish date: Friday 7th February (12 weeks)

2. Service-user questionnaire

Purpose

To engage and consult with existing service-users on the proposed new approach

Format

Short questionnaire (including a diagram/description of the new model below) to be distributed by existing service providers

Start date: Friday 22nd November

Finish date: Friday 17th January

3. Road-shows

Purpose

The road-shows will give people in Derbyshire an opportunity to hear about and comment on the proposed new approach. These are proposed to be held at the following five locations across the county;

1. Alfreton

2. Buxton
3. Chesterfield
4. Glossop
5. Swadlincote

Format

Proposed keynote speeches from Councillor Dave Allen (cabinet member for Public Health) and Stephen Pintus (strategic lead).

Market-stall approach with stalls for weight management, physical activity, stop smoking, wellbeing service and website/telephony services.

Stall information:

- How each of the services will look in Derbyshire, with a focus on a particular area
- What the local prevalence is in Derbyshire, with a focus on a particular area. For example how many people smoke, are obese etc.
- How people might access the proposed services, with a focus on a particular area. This may include a series of pathways
- Example case studies to illustrate who might be eligible to use the service, how people might access the service and what the services might offer

Ability to comment through questionnaires

Attendees

Open to the public

Dates

Between December 2013 and February 2014

4. Professionals (including current service providers)

Purpose

To engage and consult with professional groups on the proposed new approach including price, service principles, commissioning model (master-vendor), target groups and referral pathways.

Who

Including:

- Local Medical Committee (Derbyshire and Glossop)
- Local Pharmaceutical Committee (Derbyshire and Glossop)
- Active Derbyshire Partnership
- Derbyshire Leisure Officers Group
- 5 Clinical Commissioning Groups (including Tameside CCG)
- Derbyshire Community Health Services (as a current provider)
- Health Trainer providers
- General Practices in Derbyshire
- Royal Derby & Chesterfield Royal Hospital Trusts
- Healthwatch Derbyshire
- Derbyshire Walking for Health County Group
- Derbyshire Obesity Steering Group

How

As appropriate: attend scheduled professional meetings, organise meetings, consult via letter/e-mail/phone, questionnaire, open responses

Start date: Friday 22nd November

Finish date: Friday 31st January