Nottinghamshire County Council

Report to the Public Health Sub-Committee

6th June 2013

Agenda Item: 7

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

HEALTH AND WELLBEING INTEGRATED LIFESTLE SERVICE

PURPOSE OF THE REPORT

1. This report outlines the proposal to explore the commissioning of an integrated lifestyle/wellbeing service for the population of Nottinghamshire County and presents the initial case for change.

Summary.

- People's lifestyles, whether they smoke, how much they drink, what they eat and if they exercise, are widely recognised as affecting their health and increasing their risk of dying young
- Recent Health policy whilst reducing unhealthy behaviours overall has led to an increase in health inequalities.
- People with no qualifications are five times as likely as people with higher education to engage in multiple unhealthy behaviours.
- The majority of people have multiple not single unhealthy behaviours and people have very different combinations of behaviours.
- There is a real opportunity to make a significant difference in Nottinghamshire for people with multiple lifestyle risks, whilst at the same time ensuring access for all to lifestyle services across the county by considering a more integrated, holistic approach to support people in making behaviour changes in order to improve their health

INFORMATION AND ADVICE

Background

2. People's lifestyles, whether they smoke, how much they drink, what they eat and if they exercise, are widely recognised as affecting their health and increasing their risk of dying young .

3. Less is known about how these lifestyle factors are reflected across populations over time.

4. Buck and Frosini, (The Kings Fund, Clustering of Unhealthy Behaviours, August 2012) identify that much has been achieved from 2003 to 2008 by tackling lifestyle behaviours as separate policy areas with a significant reduction in the numbers of people who have three or four unhealthy behaviours from 33% in 2003 to 25% in 2008 .

5. However, as the report also notes, closer examination of the data reveals that the reduction has not been equally distributed across society.

6. The effect of this unequal distribution has been to actually increase health inequalities, according to Buck and Frosini, **with people with no qualifications being five times as likely as people with higher education to engage in all four unhealthy behaviours in 2008, compared with only three times as likely in 2003.**

7. This is endorsed by the Lifecourse Tracker, Wave 1 Spring 2012, a baseline measure of lifestyle behaviour published in March 2013, which also identifies that households, in deprived areas and with lower levels of education tended to report more negative health behaviours. Household environment was also important, with those living with a smoker, drinker or drug user more likely to report those negative health behaviours themselves.

The Policy Context

8. Over the last ten years the government has adopted a generally target-driven approach to health policy around unhealthy lifestyle behaviours, focusing primarily on smoking and introducing a national smoking cessation service.

9. Policy and investment around the other lifestyle behaviours has not been as widespread.

10. Policies and plans have existed in siloes with little recognition of how these lifestyle risks were jointly distributed across the population or how people actually experienced them which was mostly more than one at a time.

11. The Coalition Government in 2011, building on the existing approach published separate documents on Tobacco Control, Obesity and Alcohol, although moving towards an outcome based approach rather than a target driven one.

12. The Marmott Review,(Fair Society, Healthy Lives, 2011) charged with the responsibility to identify, for the health inequalities challenge facing England, the evidence most relevant for future policy and action, recommended as one its six policy objectives, the need to strengthen the role and impact of ill-health prevention. However, although Marmott talks of the need to refocus needs assessment and the development of evidence based interventions that are effective across the social gradient he still separates out each lifestyle issue into individual areas.

13. More recently, the NHS Future Forum (2012) identified the need to Make Every Contact Count (MECC) to “build the prevention of poor health and promotion of healthy living into day- to-day business, by using every contact with patients and staff to encourage and help people to make healthier choices to achieve positive, long term behaviour change”.

14. This was adopted by the NHS Midlands and East as one of their ambitions for 2012/13 and will now be taken forward through the National Commissioning Board and Public Health England

15. MECC is a co-ordinated approach across all lifestyle areas, concentrating on giving staff the skills to have conversations around lifestyle issues and then signposting or referring as appropriate.

16. There is a real opportunity to build on this local ambition and to now develop local co-ordinated services across the lifestyle agenda.

17. From April 1st 2013 Public Health became the responsibility of the Local Authority. The move of the Public Health Directorate from the NHS to the Local Authority brings with it increasing opportunities to integrate work across Adult and Children's Health and Social Care and through this, increasing opportunities to impact upon the wider determinants of health.

18. As future standards are developed for local authorities and the NHS, and as the every contact counts policy is rolled out, commissioners need to consider that:
    - the majority of people have multiple not single risks
    - people have very different combinations of risks

The National Context

Weight management

19. In 1980 six per cent of men and eight per cent of women were classed as obese in the UK.

20. In 2002, it was estimated that the economic cost of obesity for the NHS, was between £3.3 and £3.7 billion, rising to £4.2 billion in 2007.

21. The Department of Health estimated in 2007 that obesity was responsible for more than 9,000 deaths a year in England. Being obese is also a major risk factor for developing other diseases including heart disease and cancer.

22. It is estimated that one million fewer obese people in England could mean:
    - 15,000 fewer people with coronary heart disease
    - 34,000 fewer people developing type 2 diabetes
    - 99,000 fewer people; living with high blood pressure.

Smoking

23. In England around 79,100 deaths (18% of all deaths of adults aged 35 and over) were estimated to be caused by smoking. The main causes of death are cardiovascular disease, cancers and respiratory disease (Health and Social Care Information Centre, 2012).

24. Smoking causes around 86% of deaths from lung cancer, around 80% of deaths from bronchitis and emphysema, and about 17% of deaths from heart disease.

25. More than one quarter of all cancer deaths can be attributed to smoking. These include cancer of the lung, mouth, lip, throat, bladder, kidney, stomach, liver and cervix (ASH; Smoking Statistics May 2012).

26. There were approximately 1.5 million hospital admissions with a primary diagnosis of a disease that can be caused by smoking. The annual number of admissions has been rising steadily since 1996/97, when the number of such admissions was 1.1 million.

27. Around 459,900 hospital admissions were estimated to be attributable to smoking. This accounts for 5% of all hospital admissions in this age group.

28. In the UK about 8 in 10 non-smokers live past the age of 70, but only about half of long-term smokers live past 70 (ASH; Smoking Statistics May 2012)

Alcohol

29. Alcohol misuse is now estimated to cost the NHS £2.7 billion a year, almost twice the equivalent figure in 2001 and is expected to continue rising to £3.7 billion.

30. The cost of alcohol to society as a whole is even greater, estimated to stand at £20 billion, a year through its health, crime and social impacts.

31. Evidence suggests that heavy alcohol consumption can increase the risk of mortality from conditions such as cardiovascular disease and cancer, as well as suicide and injury.

The Local Context - What we do now

32. Locally implementation of the lifestyle agenda has echoed national policy, driven often by an NHS target driven top down approach. As with the national outcomes this has delivered local successes in separate areas but could be challenged on the impact upon health inequalities locally.

33. The Joint Strategic Needs Assessment for the county identifies that the All-age, all-cause mortality (AAACM) in Nottinghamshire, is falling over time, with a corresponding increase in life expectancy. However the rate of improvement varies by gender and by deprivation with the male AAACM rate improving faster than for females between 1999 and 2009 and the gap in life expectancy between the most and least deprived communities in Nottinghamshire (9 years for men and 7.6 years for women) increasing for women between 2001 and 2010, but not for men.

Key Headlines

Obesity

34. Obese people are more likely to develop diabetes, colon cancer, hypertension (high blood pressure) and heart attacks, and obesity also has an impact on psychological well-being.

35. Adult obesity is high in the areas of Mansfield, Ashfield, parts of Bassetlaw and specific wards of Gedling, Broxtowe and Rushcliffe, largely mirroring levels of deprivation.

Smoking

36. Smoking prevalence in Nottinghamshire is 20.9%. This is slightly higher than the England and East Midlands average; however this figure masks local variation as exemplified in figure 1. For example in Rushcliffe in the south of the county, smoking prevalence is 14.8% and by contrast Ashfield in the north of the county has a smoking prevalence of 29.4%.

37. Deaths through smoking related illness amount to 1,347 across Nottinghamshire County including Bassetlaw every year (English Public Health Observatories, 2012), with 200 more deaths in males than females (Nottinghamshire Public Health Informatics, 2012). Smoking related hospital admissions are also above regional and national averages in Mansfield and Ashfield; in the same way the prevalence rates are some 9% higher than the England average (English Public Health Observatories)

38. Both Nottinghamshire and Bassetlaw NHS are above the national average for women who smoke during pregnancy. For Nottinghamshire County, smoking status at the time of delivery is 17.8%. For Bassetlaw, it is 20.6% and in the East Midlands this figure is 15.7% (All data taken from the English Public Health Observatories, 2012, based on 2011/12 data).

Alcohol

39. There are an estimated 123,529 'increasing risk' [1]drinkers and 110,248 'binge'[2] drinkers over the age of 16 in Nottinghamshire.

40. The number of alcohol related admissions to hospital in Nottinghamshire has increased 56% from 9,956 in 2002/03 to 17,599 in 2011/12 [3].

41. There is a clear north/south divide across Nottinghamshire (north higher than south) in terms of alcohol related admissions in both males and females.

42. All districts are experiencing a year on year rise in increasing risk drinkers

Drugs

43. In Nottinghamshire in 2010/11, there were 3,035 adult drug users in treatment.

44. The majority of those in treatment are using heroin or crack cocaine, with cannabis and alcohol the most commonly used substances in young people.

45. There were 147 drug related deaths (age 20 and above) in the county between 2006 and 2010. The highest numbers were male and in the 30-39 age range. Alcohol use was a significant contributing factor.

[1] Increasing Risk drinkers (an increasing risk of developing alcohol related illness) are males who drink 3-4units of alcohol a day and females who drink 2-3 units of alcohol a day

[2] Binge drinking is defined as males drinking more than 8 units of alcohol at any one time and females 6 units of alcohol

[3] http://www.lape.org.uk/natind.html accessed 11.03.13

What can we do in the future and what we can achieve

46. If current policy is having a limited effect and is not evidencing a reduction in health inequalities nationally or locally, the challenge is to consider a new approach.

47. It would seem sensible as 70% of the population still have two or more unhealthy behaviours (The Kings Fund, Clustering of Unhealthy Behaviours, August 2012) to consider a more integrated, holistic approach to support people with behaviour changes in order to improve their health.

48. Nationally policy and research have not explored this area in much detail yet and evidence so far is limited, but Paiva et al (2012) and Johnson et al (2008) have shown, in separate studies, that people who have success in changing one behaviour are more likely than their peers then to be successful at changing others.

Wellness Services

49. It would seem that national and local evidence supports the development of local person centred services across a number of lifestyle issues.

50. Building upon the MECC agenda the development of a wellness service across lifestyle issues would have the potential to impact upon individual behaviours and community involvement to improve health outcomes and, if targeted appropriately, reduce health inequalities.

51. A recent briefing on wellness services issued jointly by the NHS Confederation and the Faculty of Public Health (NHS Confederation 2011) commented: 'Wellness services provide support to people to lead healthy lives. The wellness approach goes beyond looking at single-issue, healthy lifestyle services and a focus on illness, and instead aims to take a whole-person and community approach to improving health.

52. It appears therefore that there is strong support for this direction of travel at the highest level.

What are others doing locally?

53. Locally, organisations have commissioned a variety of models of integrated services from a single point of access to specialised services to a full wellness service incorporating assessment, intervention and ongoing support. These will need to be scoped in more detail if this proposal is agreed.

Bassetlaw

54. In Bassetlaw a range of holistic health & well-being interventions have been established, to include:
    - 'Holistic exercise referral for adults, commencing 2010 via a contract with the district council. Outcomes include a 4% increase in adult physic activity during 2011-12.
    - Holistic brief intervention training been established in line with the national MECC.
    - Workplace Health (the Bassetlaw Well-being at Work scheme). Aim to use the workplace as an umbrella theme for promoting the key C4L (change for life) themes across local workplaces.

- Life Education scheme; this is delivered by the Nottinghamshire Life Education Centre via a SLA with Bassetlaw CCG. They are delivering holistic life style messages (in line with the key C4L themes); to include a real focus on wider well-being, self-esteem and valuing the body. This is delivered through an interactive educational model in local schools and early years settings (age range 3-11). Outcomes include model delivered in 58 schools from most deprived areas facilitating engagement of children, teachers and wider families in the adoption of healthy lifestyles.
- Children's weight management prevention programmes such as 'inneractive' and Lets Get Moving', being delivered through local contracts. Aims to promote health and well-being, focusing on improving self-esteem of children and their families aged 5-16. Outcomes include those involved loosing 5% weight loss and increased uptake of physical activity and play.

Derby City

55. Derby City Council has commissioned an Integrated Lifestyle Service, following a local pilot, which commenced on April 1st.
    - Derby have commissioned a Lifestyle Service with a generic "hub" where referrals are received and clients and their families offered the support of a health champion/trainer who is skilled in working with them to maximise motivation and develop an individualised change plan referring then to specialist services as required through a modular programme of interventions. Appendix 1
    - Following a Public Consultation and Market Analysis Derby chose a Master Vendor model, with one lead service provider who sub commissions specialist services.
    - Following a procurement process Derby City Council Leisure Services were successful in tendering for this service and commenced on April 1st 2013.

Nottingham City

56. Nottingham City Council has also commissioned a Single Point of Access hub for Lifestyle Services since 2011.
    - The *Healthy Change* Lifestyle Referral Service provides a single referral point for patients aged 18 years and over with one or more lifestyle risk factors, and a pathway into other commissioned services and community-based suppor.t to help clients change behaviour.
    - Within Healthy Change, Health Trainers assess the individual needs and readiness to change of clients and support them to achieving behaviour change goals.

Wellness Services and Cost Effectiveness

57. In November 2010 Liverpool Public Health Observatory published a review of Wellness Services locally and nationally (Wellness Services – Evidence based review and examples of good practice).

58. The review analysed wellness services and models across the country and developed helpful guidelines and standards for future development of Wellness Services.

59. The report concluded that:
    - "In cost-effectiveness analysis there is often considerable uncertainty associated with the findings as a result of the assumptions and parameters used, therefore even when a sensitivity analysis is undertaken a degree of caution is required when reading the results.

- Nevertheless, the majority of services reviewed, that considered costs, were found to be cost-effective and have shown the potential to bring a return on investment and to save on future costs of ill-health through early intervention. They can provide significant value for money in return for the resources that they consume.

OTHER OPTIONS

60. Other options have been considered that would have the potential address the issues identified.

61. **Option 1. No Change To Current Services**
This option would maintain the current model for commissioning of lifestyle services, where these are commissioned by the separate policy teams in line with their own separate agendas.
Whilst this model would continue to address lifestyle behaviours, working in isolation from other policy areas will not address the health inequalities that this model has unintentionally created and the opportunity will be missed to work in an holistic, person centred way.

62 **Option 2. Provide an In House Assessment Service**
This option would require Public Health to establish a co-ordinated lifestyle model which can deliver an in house assessment service for people that are identified as having several unhealthy lifestyle behaviours.
Working collaboratively across the lifestyle agenda in house will be integral to the success of any proposed intervention, however, delivering this in house will not allow for the opportunity to commission for integration across the provider model with the associated efficiencies.

PROPOSAL

63 It is proposed that locally an integrated lifestyle model of delivery be explored.

64 Currently spending on Lifestyle Services across smoking and obesity alone is around 3.5m across the county and the proposal would be to use this funding more effectively through the development of the proposed model. Existing staff resource will be used to support the initiation of the programme. The project will develop a fully costed model for the new service for further consideration by the Public Health Sub-Committee in due course.

65. An example of the model in Appendix 2 gives an outline of a proposed hub approach but this would need to be explored as part of the programme.

66. Appendix 3 shows models used in other areas to support the wellness concept.

67. Subject to approval from the Public Health Sub-Committee a project plan and timescale can be drawn up with regular reporting to the Sub Committee to be agreed within this.

RECOMMENDATION

68. The Public Health Sub Committee is asked to approve the establishment of a project to explore the development of an Integrated Lifestyle/Wellness Service for Nottinghamshire County.

STATUTORY AND POLICY IMPLICATIONS

69. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

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Constitutional Comments (SLB 22/05/2013)

70. The Public Health Sub-Committee is the appropriate body to consider the content of this report.

Financial Comments (ZKM 28.05.2013)

71. The financial implications of this report are outlined in paragraph 61.

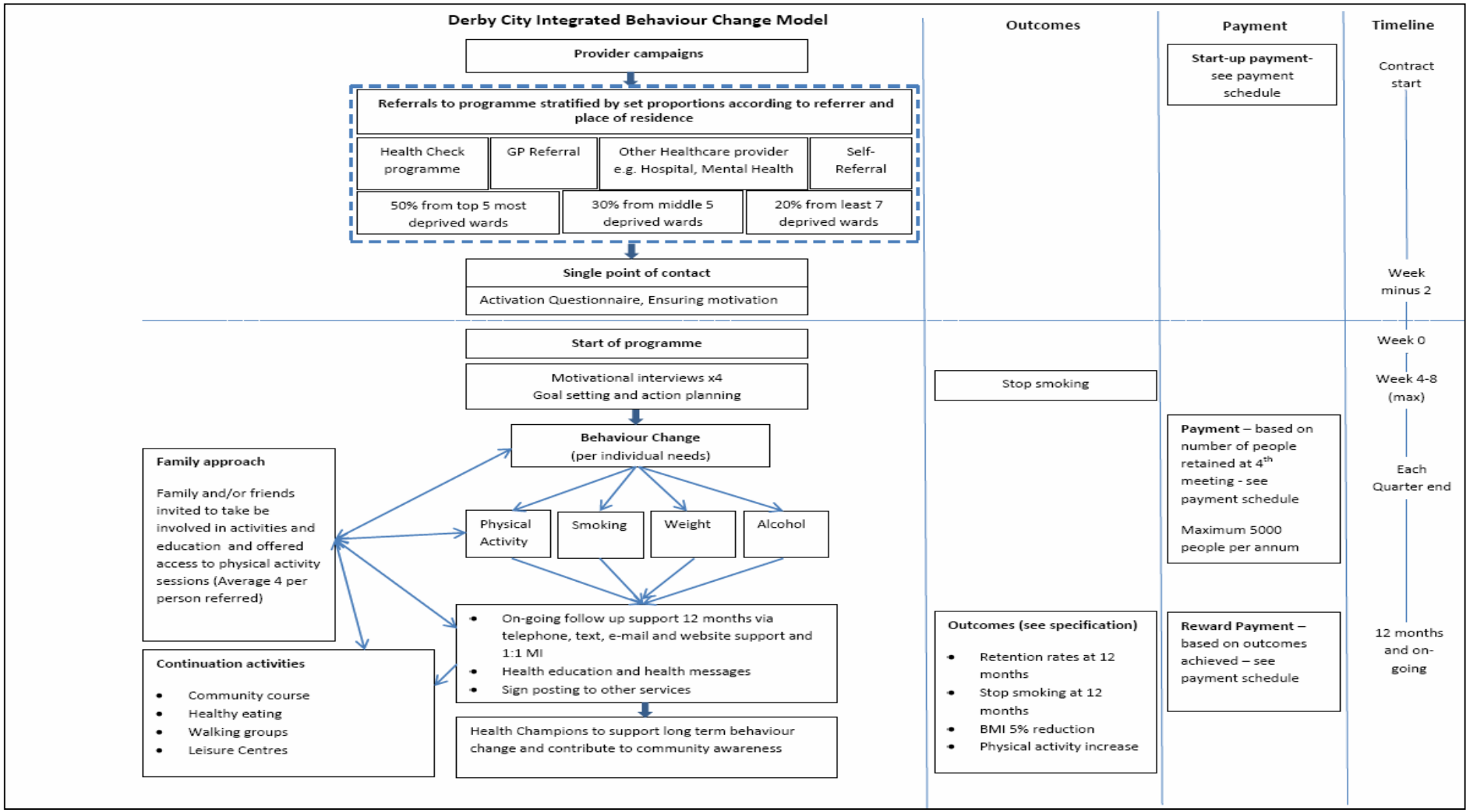
Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Electoral Division(s) and Member(s) Affected

All

Appendix 1


Derby City Integrated Behaviour Change Model
Provider campaigns
Referrals to programme stratified by set proportions according to referrer and place of residence
Health Check programme
GP Referral
Other Healthcare provider e.g. Hospital, Mental Health
Self-Referral
50% from top 5 most deprived wards
30% from middle 5 deprived wards
20% from least 7 deprived wards
Single point of contact
Activation Questionnaire, Ensuring motivation
Start of programme
Motivational interviews x4
Goal setting and action planning
Behaviour Change
(per individual needs)
Physical Activity
Smoking
Weight
Alcohol
Family approach
Family and/or friends invited to take be involved in activities and education and offered access to physical activity sessions (Average 4 per person referred)
Continuation activities
Community course
Healthy eating
Walking groups
Leisure Centres
On-going follow up support 12 months via telephone, text, e-mail and website support and 1:1 MI
Health education and health messages
Sign posting to other services
Health Champions to support long term behaviour change and contribute to community awareness
Outcomes
Stop smoking
Outcomes (see specification)
Retention rates at 12 months
Stop smoking at 12 months
BMI 5% reduction
Physical activity increase
Payment
Start-up payment- see payment schedule
Payment – based on number of people retained at 4th meeting - see payment schedule
Maximum 5000 people per annum
Reward Payment – based on outcomes achieved – see payment schedule
Timeline
Contract start
Week minus 2
Week 0
Week 4-8 (max)
Each Quarter end
12 months and on-going

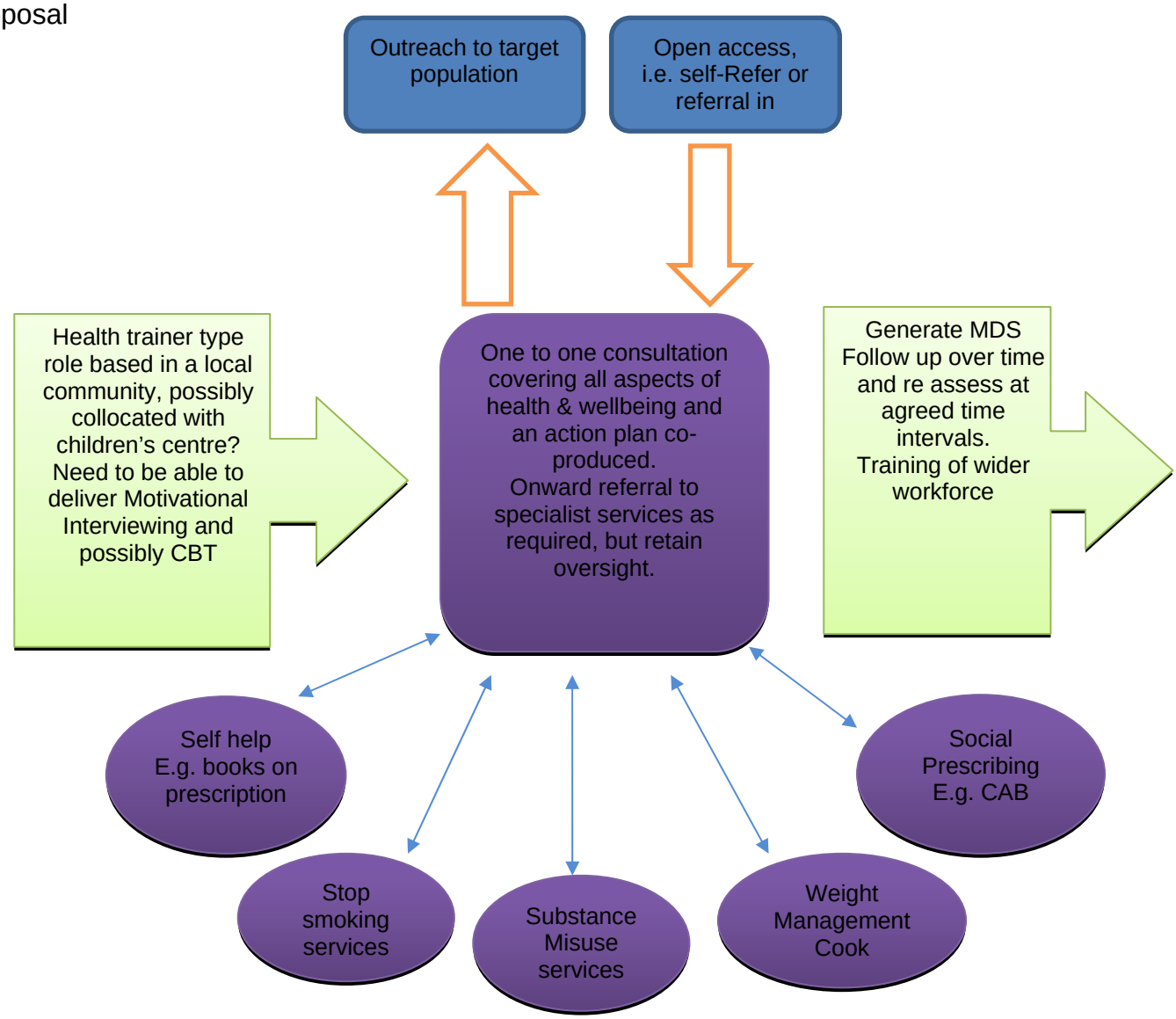
Appendix 2

Integrated Healthy Lifestyles

Rationale/Context

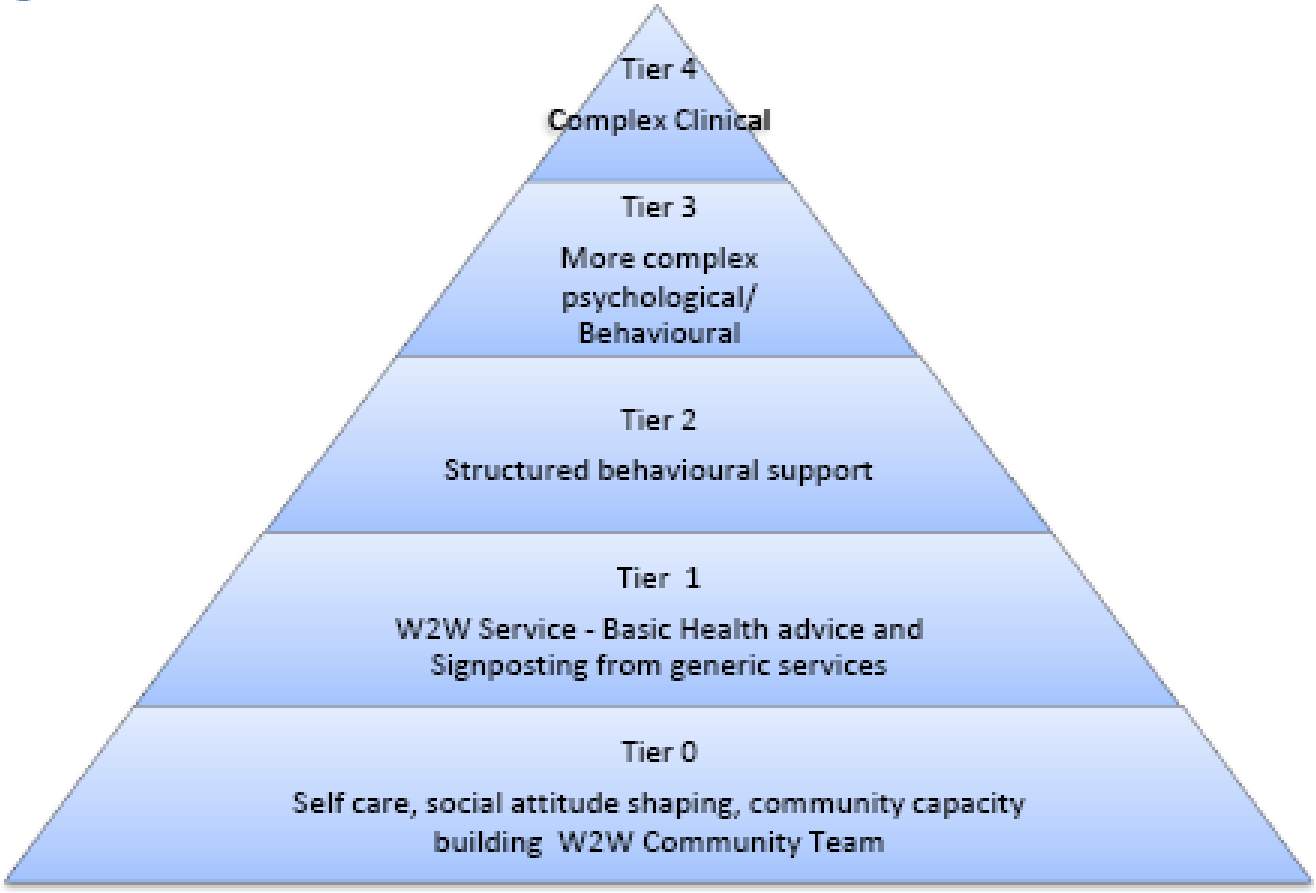
- Move of PH to LA, sickness to health and well being
- Clear mandate to reduce health inequalities
- Need to move to a person centred approach - History of silo commissioning (single issues) even though we know about clustering of unhealthy behaviours

Proposal



Appendix 3

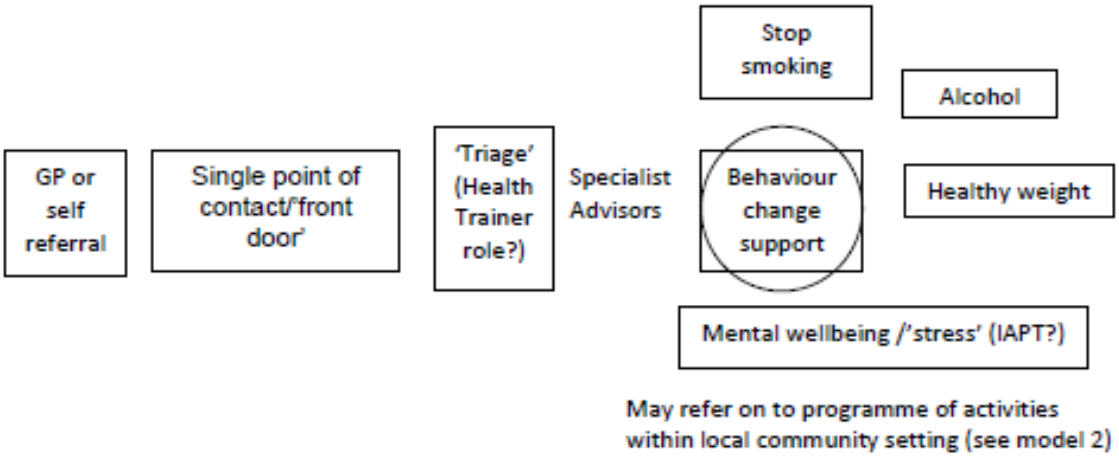
Figure 3: Model of Salford Wellness Services



Source: A Wellbeing Service for Salford[109]

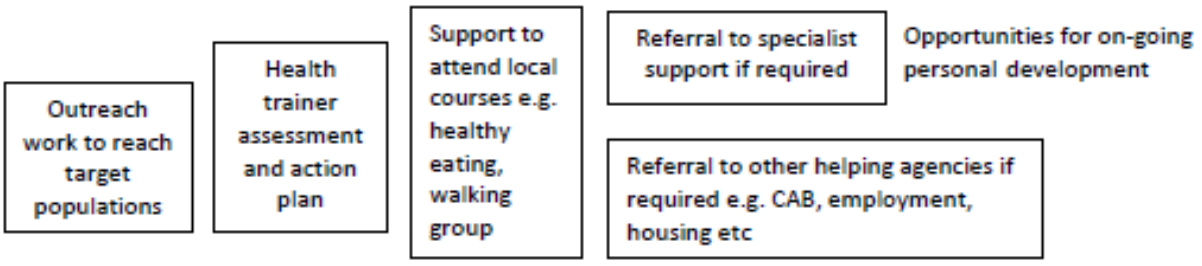
Some existing models of integrated lifestyle services to inform development of 'wellness services'

Model 1: Integrated lifestyle services (plus mental wellbeing) for individuals (clinical model)



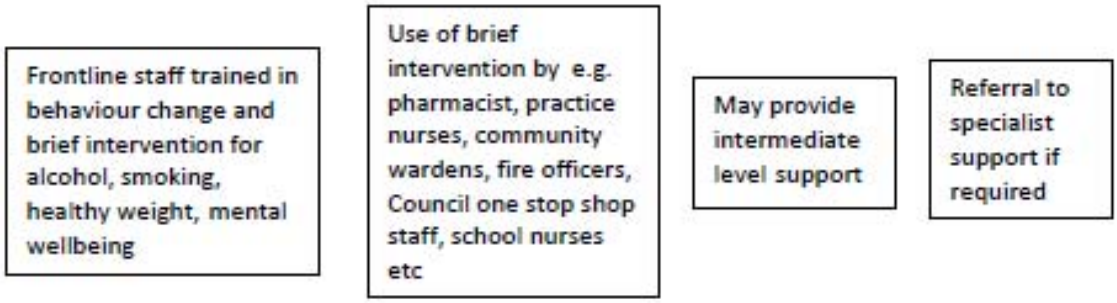
Benefits: use of GP referral enables systematic industrial scale targeting (linked to 'health check')

Model 2: Integrated lifestyle services within a community setting (community health development approach)



Benefits: family, and/or friends' approaches; peer support available; links to wider determinants; use of social marketing techniques; in the home or street level interventions
Services 'wrapped around' everyday life e.g. local shops, local champions, children's Centre, door knocking, web-based, local pubs, supermarket etc. (e.g. Wirral smoking programme)

Model 3: Basic support for lifestyle change within other service



Benefits: opportunity for integration of lifestyle change into wider determinants workforce; opportunistic use with target populations; potential for further development following public health integration with local authorities

Model 4: Case management approaches (e.g. Job Centre Plus – Condition management programme)

Benefits: Lifestyle groupwork support within the context of health related worklessness; ongoing peer support helps to overcome social isolation; individual assessment of outcomes up to 6 months following programme; on-going support through programme by Case Manager (clinically trained and JC+ Personal Advisor. NB funding from JC+ ceases April 2011

Figure 1. Nottingham City CVD/LTC prevention pathway