Better Lives – Progress on Prevention: Briefing for Doncaster Health and Wellbeing Board

Introduction

The purpose of this paper is to update the Health and Wellbeing Board of the progress made on prevention and early help as originally outlined in the Doncaster Place Plan (Oct 2016), to highlight key developments and potential next steps.

Background

The fact that 'prevention is better than cure' is widely quoted yet despite reductions in deaths from cardiovascular disease, cancer, motor vehicle accidents and tobacco most premature deaths in the UK can be attributed to a 'failure' of prevention. Overall reductions in premature mortality conceal differences in mortality in different populations groups with increased deaths from accidents, suicide and liver disease in young men and with the homeless often overlooked too.

In health a third of all deaths can be considered premature and related to four key risk factors smoking, physical inactivity, poor diet and alcohol abuse/misuse. These risk factors also cause long term conditions creating additional burdens on individuals, employers as well as health, care and 'Blue Light' services. A 2011 paper estimated these four risk factors cost the NHS £5.8b; for Doncaster it's estimated that these costs to the local NHS are in the order of £72m (with overweight and obesity £25.5m, smoking £16.5m, alcohol £16.5m and physical inactivity £4.5m).[1] Wider societal costs including impacts on adult social care are likely to be five times this approaching £360million. The costs are driven by the numbers of people with the risk factor i.e. smoking prevalence 19.7% or excess weight 71.5% together with the severity of the risk factor i.e. the number of cigarettes smoked.

The Wanless report in 2002 identified that two of the key drivers of health care costs were how well our health services became more productive and how well people became fully engaged with their own health.[2] However, even in the ' fully engaged' scenario health care spending would need to rise by 2.4% a year but this is significantly less than the 3.5% required under the 'slow uptake' model.

However, a focus on these behavioural risk factors alone may miss that approaches to psychosocial factors (stress), social cohesion and the 'causes of the causes' are equally if not more important (education, occupation, income, gender and ethnicity). Increasingly people are living with more than one health condition and/or risk factor, known as 'multi-morbidity' and it's not only mortality that is important but morbidity should also be considered, e.g. mental health conditions and musculoskeletal diseases.

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[1] Peter Scarborough, Prachi Bhatnagar, Kremlin K. Wickramasinghe, Steve Allender, Charlie Foster, Mike Rayner; (2011) The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs, Journal of Public Health, 33 (4) 527–535, https://doi.org/10.1093/pubmed/fdr033

[2] Wanless D (2002). Securing our Future Health: Taking a Long-Term View. https://www.yearofcare.co.uk/sites/default/files/images/Wanless.pdf

Doncaster Reponses

The importance of prevention is recognised in the vision of the Doncaster place plan 2016-21:

'Care and support will be tailored to community strengths to help Doncaster residents maximise their independence, health and wellbeing. Doncaster residents will have access to excellent community and hospital based services when needed.

This is further emphasised in the proposed approach to prevention (primary, secondary and tertiary) and early help with a focus on smoking and obesity (Appendix 1). There has been progress on early help and the 7 Areas of Opportunity have all identified prevention and demand management as key elements of those areas.

The Outcome framework for the Health and Wellbeing Board (a subset of Doncaster Growing Together) also recognises the importance of prevention (Appendix A). The June 2018 Board meeting identified the prevention and living well 'cell' as an area for future work.

The 'Overarching' Approach

There is local consensus as to the main contributors to health and wellbeing including clinical care, health behaviours, social and economic factors and the physical environment (table 1).

Table 1. Contributors to Health and Wellbeing

Clinical Care (20%)	Access to Care Quality of Care
Health Behaviours (30%)	Tobacco use Diet & Exercise Alcohol and Drug use Sexual activity
Social and Economic factors (40%)	Education Employment Income Family and Social Support Community Safety
Physical Environment (10%)	Air & Water Quality Housing and Transport

However, the recent commissioning and delivery of prevention approaches nationally and locally has been impacted by both reorganisation of the NHS and public health, a focus on the process of clinical care as well as austerity. Even more recently NHS England has taken an increasing role in prevention through approaches including the National Diabetes Prevention Programme. Unfortunately this can lead to not only a siloed organisational response to prevention, with the NHS taking responsibility for clinical care, public health the health behaviours and the council for social and economic factors and physical environment, but also a 'statist' response where induvial, family and community assets have been replaced by services.

Commissioners have innovated in an attempt to break down these silos. Commissioners have transferred commissioning responsibilities between themselves (with or without resources) have

invested their own resource in 'non-traditional' areas e.g. the CCG have invested in Fit Rovers, public health in maternal smoking and they have jointly used the flexibilities in the Better Care Fund e.g. approaches to reduce fuel poverty, social prescribing and community wealth building. Commissioners have also invested in 'Doncaster Talks' to understand the key drivers of health and wellbeing and how their service offer can support and build on individual, family and community assets and not disempower people. There is an increasingly dialogue with the Voluntary, Community and Social Enterprise (VCSE) sector and the faith sector. Finally a menu of prevention programmes has been proposed which will contribute to the life course approach to health and wellbeing. Together this has seen a widening of prevention from a focus on 'biomedical disease' processes to include approaches that may either reduce or delaying other complex issues e.g. domestic violence or the need for social care.

Progress against the Place Plan

The Doncaster place plan identified prevention and early help as a cohort of activity. Initially 10 areas for development were identified.

Initial piece of work	Progress
Renewed emphasis on the use of the full range of local authority powers planning, licensing, section 106 monies	
Agreement about brief and very brief interventions that could be wrapped into specification (primary, secondary care and social care)	
Prototyping the enhanced Safe and Well check delivered by the Fire Service	
Reviewing the lifestyle service offer (smoking cessation, physical activity, food, weight management and alcohol)	
Mainstream funding of social prescribing services complemented by community navigators and Asset Based Community Development	
Renewed emphasis on CVD risk reduction and particularly Blood pressure (going beyond QOF)	
Blue Light approach to resistant drinkers (assertive outreach)	
Employment support for those out of work linked to Sheffield City Region Pilot	
Focus on the first 1001 days	
Public Mental health and development of resilience in young people	

Taking Stock

Prevention refers to policies, practices, and interventions that reduce the likelihood that an individual, family or community will experience the outcome or condition of interest. It also means providing those who experience that outcome with the necessary resources and supports to stabilize them, enhance integration and social inclusion, and ultimately reduce the risk of the recurrence.

- Health starts long before illness in our homes, schools and workplaces
- Our communities or jobs shouldn't be hazardous to our health
- Everyone should have the opportunity to make the choices that allow them to live a long healthy life regardless of their income, education or ethnic background

Emerging Doncaster 'People Powered' approach to Better Lives

- **Build on Strengths and Assets.** Identify individual family and community strengths and co-create resilience/capacity/community wealth to increase health, social and financial inclusion e.g. Asset Based Community Development, Stronger families, healthy settings, healthy places and Well North.

- **Create the conditions.** Adopt a Health in All Policies approach to statutory roles e.g. the local plan, planning and licensing and non-statutory approaches e.g. Doncaster Growing Together (housing, employment, transport, community safety and financial security).

- **Community Wellbeing Hubs.** Build on existing statutory (e.g. primary care) and non-statutory hubs to align a network of community wellbeing hubs including access to Information Advice and Guidance resources e.g. Your Life Doncaster, technology and campaigns.

- **Civil Society Alliances.** Support and co-create alliances to address specific challenges e.g. Expect Youth, Loneliness Alliance, Safe and Well visits, Get Doncaster Moving, Good Food Doncaster, mental health and suicide prevention, smokefree places, Baby Friendly Initiatives, Best Bar None and responsible retailer schemes.

- **Community Navigation**. Continue to connect people to people and between people and both non-statutory and statutory services (e.g. wellbeing officers, social prescribing or recovery city in order to build connectedness, hope, identity, meaning and empowerment.

- **New 'practice' models and guidelines**. Use strengths based approaches, motivational interviewing, asset based community development, trauma informed practice, Making Every Contact Count together with life course specific approaches including patient activation and self-management.

- **Reorientate Health and Care Services.** Starting with clinical prevention services (secondary prevention) improve, integrate and incentivise identification and risk reduction approaches including NHS health checks, diabetes prevention, smoking cessation, 'Blue Light' approaches for resistant drinkers, employment support and weight management.

Possible next steps

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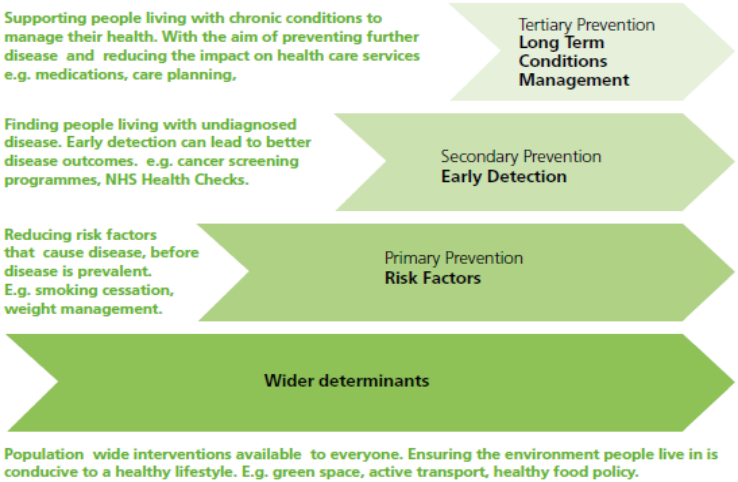
Appendix 1

We recognise that in order to achieve our desired impacts, the shift in thinking around prevention needs to start now. We see prevention as the corner stone for all other offers for all the other health and social care work that we do.

Prevention at the heart of all we do

Our prevention approach is based on developing community assets and resilience, and on bringing together our response to the wider determinants of health. The Doncaster Health and Wellbeing board have adopted the following model to progress the Doncaster approach to prevention:



The focus initially in Doncaster will be smoking and obesity and it is likely that initial early work will see:

1. Renewed emphasis on the use of the full range of local authority powers planning, licensing, section 106 monies
2. Agreement about brief and very brief interventions that could be wrapped into specifications (primary and secondary care, plus social care)
3. Prototyping the enhanced Safe and Well check delivered by the Fire Service
4. Reviewing the lifestyle service offer (smoking cessation, physical activity, food, weight management and alcohol)
5. Mainstream funding of social prescribing services, complemented by community navigators and Asset Based Community Development
6. Renewed emphasis on CVD risk reduction and particularly Blood Pressure (going beyond QOF)
7. Blue Light approach to resistant drinkers (assertive outreach)
8. Employment support for those out of work linked to Sheffield City Region pilot
9. Focus on the First 1001 days
10. Public mental health and development of resilience in young people

Team Doncaster have also set an ambition to ensure an integrated response to those in Doncaster with the most complex need - individuals and families whose lives can become chaotic, highly complex, blighted by an interdependent combination of factors including drugs and alcohol misuse, mental ill health, homelessness and domestic abuse .This goes beyond existing early help, stronger families and the 2% the CCG use for case management and provides a common purpose and focus for a radical change in the offer for this group. Team Doncaster is working to develop a joint approach to this group. This will ultimately cover all of the three place plan cohorts describe above, but will start with a focus on early help and prevention, including primary, secondary and tertiary prevention – placing a focus on partnership action at key risky transition points in the lives of individuals and families. This will be taken forward through initial prototyping work late in 2016 and early 2017.

Appendix A

OUTCOME FRAMEWORK SUMMARY PAGE

	All ages	Starting Well (Delivered by Children and Families Executive board)	Living Well	Ageing Well
Well-being	T1:Healthy Life Expectancy at birth (years) Male	T2:Percentage (%) of children scoring themselves medium or high on the composite resilience score (Pupil Lifestyle Survey Q84/85)	T2:% point gap in the employment rate between those with a learning disability and the overall employment rate	T1:% of adult social care users who have as much social contact as they would like
	T1:Healthy Life Expectancy at birth (years) Female		T2:% point gap in the employment rate between those accessing mental health services and the overall employment rate	
	T1:Life Satisfaction Survey (ONS Well Being)			
Prevention	T1:% of population that achieve 150 mins Physical activity per week	T2:Percentage (%) of children born with a low birth weight	T2:Smoking Prevalence in Adults	T2:Emergency hospital admissions for injuries due to falls in persons aged 65+
	T1:% of people using outdoor space for exercise/health reasons	T2:Excess weight in childhood at 5 Years	T2:Hospital admissions for alcohol-related conditions	T2:% of eligible adults aged 65+ who have received the flu vaccine
	T1: Preventable deaths in local population (Mortality Rate per 100,000)	T2:Excess weight in childhood at 11 Years	T2:% of Adults Overweight or Obese	
Care (Delivered by ACP)	T1:Delayed Transfers of Care from Hospital (all) per 100,000 population per day	T2:Hospital Admissions for Self-harm (aged 10 - 24 rate per 100,000)	T2: Cancer mortality rate(<75)	T1:Emergency Hospital Admissions (65+) to Hospital
	T1: satisfaction with experience of care and support services.	T2:Inpatient Admissions rate: mental health disorders for 10-17 year olds (per 100,000)	T2: Cardiovascular disease Mortality Rate (<75)	T1:Rate of permanent admissions to Residential Care per 100,000 (65+)
	T1: The proportion of people still at home 91 days following a period of reablement		T2:Complications associated with diabetes	T1: Requests for Support for Adult Social Care (65+) per 100,000 population
Support (Delivered by ACP)	T2: Proportion of people who use services and carers who find it easy to find information about services	T3:Percentage (%) of children in care with an up to date health assessment	T2:Adults in contact with Mental health services who are living in stable and appropriate acoomodation	T2: % of people who have a terminal diagnosis have an End of Life plan
		T1:Proportion of Children in Need per 10,000 population		T2: Dementia diagnosis rate
		T1:Proportion of Children in Care per 10,000 population	T2:Adults with a learning disability who are living in appropriate accommodation	

Key (national benchmark used)

	No assessment against benchmarks
	Worse than national benchmarks
	Similar to national benchmarks
	better than national benchmarks

T1	Tier 1 Population indicator contained within the DGT Outcomes
T2	Tier 2 Population Level Indicator
T3	Tier 3 Service Level performance measure

	Better / Higher than Previous Period
	Worse / Lower than previous Period
	No Previous Data or no change