Integrated Health and Wellbeing Service

What we have: working better

Richard Brown – Healthy Living & Sport Manager
Methodology

- Chief Officers asked to identify key service areas/teams for development of a Council Integrated Health and Wellbeing service
  - 1-2hr meetings with 20+ staff/teams
- Networking regionally and nationally
- Desktop research & literature review
- Collating of existing BwD proposals on Long Term Conditions/Self Care/Community Orientated Primary Care/Virtual Ward/Enhanced Integrated Community Service
Scoping

- Paula Spence – Head of Contracting (MH, Community and Social Care)
- Andy McHugh – Your Support, Your Choice
- David Almond – Health, Safety & Wellbeing
- Shane Agnew – Head of IT Strategy & Operations
- Ben Barr – Consultant in Public Health
- Alison Abbott – Self Care
- Janet Jackson – Education
- Mark Warren – Health Interventions
- Mark Campbell – Active Living
- Pete Soothill – Head of Community Commissioning
- Chris Allen & Denise Andrews – Public Protection
- Christain Geisselmann – Assistive Technologies Manager
- Pete Dillon – Falls/commissioning
- Heather Taylor – Head of Sustainable Neighbourhood Service
- Peter Cooke & Sally McAllister – DASH/Housing
- Claire Jackson – Associate Director of Commissioning and Partnerships (LTC work)
- Brian Wallace – Revenue & Benefits, Debt advice
- Karen Cassidy – DAAT Commissioning Officer
- Jules Wall – Equality and Diversity
- Rebecca Johnson – Head of Arts
- Simon Butt – Highways & Engineering Services
- Mike Cliffe – Strategic Transport Manager
- Kath Sutton – Head of Service, Libraries
- Ross McQueen – Contact Centre Manager
The Need for Change
People have multiple LTC and multiple risk factors:

- By the age of 60 about half of the people with an LTC will have more than one.
- 1 in 4 people with an LTC also are also current smokers.
- 1 in 3 people with an LTC are known to be Obese
- 1 in 4 people with COPD (lung disease) also have Coronary Heart Disease
- 1 in 3 people with COPD are also being treated for Depression
- 1 in 5 people with CHD are being treated for depression
The Need to Act: Local Evidence

People with LTC are high users of health and social care resources

- The 35% of the population with LTC account for 70% of health care expenditure, about £200 million in BwD.
- These 62,000 people will account for half of all GP consultations – nearly half a million consultations per year.
- They will account for 70% of all days spent in hospital.
- The number of people with LTC will increase rapidly over the next 10-20 years.
- People living in the most deprived parts of BwD are 50% more likely to have an LTC as compared to people of the same age living in the most affluent areas.

People with LTC particularly those with multiple LTC are at higher risk of poor health outcomes

- They are more likely to die prematurely – most deaths under 75 are the result of LTC.
- People with LTC rate their quality of life as 25% lower than those without LTC.
- People with LTC in deprived areas rate their quality of life as 20% lower than people with LTC in more affluent areas.
- Cardiovascular patients who also have depression are 2-4 times more likely to die prematurely than those without depression.
- Most people with LTC are of working age. 40,000 (65%) people with an LTC are of working age - Half of these people are out of work.
In simple terms…

1. Significant policy shift in NHS to create one plan to improve someone's wellbeing
2. Hospital admissions are the biggest cost and a major factor is LTC that are not effectively managed
3. Building resilience and the ability to ‘self care’ is crucial
4. Fairness of a service is vital with a continuing focus on reducing health inequalities
Findings

- A huge range of skills, knowledge, resources & experience
- **BUT** ....it’s not all joined up
- Current way of working **relies too much on** personal knowledge / individual team contact.
  - Needs to be **more systems/process driven** for consistent results **that are scalable**.
- Existing contact opportunities to exploit
- Organisational change within health and the council = **significant disruption & lack of continuity**
- **Risk of some duplication** & some confusion over terminology
Benefits of an Integrated Health and Wellbeing Service

- Removes reliance on individual knowledge of services
- Defines ‘products on the shelf’ for GP’s, Professionals and Key Partners to refer into
- Defines ‘products on the shelf’ to promote to the public
- Provides a simple mechanism to improve appropriate access to services
- GP’s provided with feedback on outcomes
- Provides stability, even if some of the teams/services within the Wellbeing Service change
- Realistic and achievable in the short term
- Provides stable platform for effective service development and transition
- Removes duplication and achieves a better use of resources
What is the target population?

- **Very high**: 0-0.5%
- **High**: 0.5-5%
- **Moderate**: 5-20%
- **Low risk**: 20-100%

*10% of emergency admissions*
*50% of Emergency admissions*

Integrated Wellbeing Service
What’s in the service?
What services and products?

- **Public Health**
  - Tier 1 & 2 Drug & Alcohol Services

- **Finance**
  - One Stop Shop/Contact Centre
  - Advice for All

- **Culture, Leisure, Sport & Young People (Healthy Lifestyles Team)**
  - Active Living - COPD, Falls Prevention, Cardiac and Stroke, Weight Management, GP referral
  - Health Interventions - Health Trainers, Healthy Communities Partnership, Community Physical Activity, Lifestyles for work, Self Care, Motivate
  - Free & paid leisure opportunities
What services and products?

- Environment, Housing & Neighbourhoods
  - Housing
    - DASH: Decent And Safe Homes
  - Sustainable Neighbourhood Service
  - Information and Guidance Team, Work clubs, Community Development Tutors, Community Officers (Healthy Communities Partnership links)

- Key Partners
  - GP’s, ‘Your Support, Your Choice’, Occupational Health, Pharmacists, Adults / Reablement, ASC project, plus many more…
What does it look like!?
Integrated Wellbeing Service

**Condition Specific Programmes**
- Active Living Team: (existing pathways):
  - COPD
  - Cardiac & Stroke
- Active Living Team:
  - Motivate (Physical Activity for Adults with LD)

**General Wellbeing / Universal / Self Referral**
- Stop Smoking Service
- Drug & Alcohol Services - Tier 1 & 2
- Healthy Lifestyle Courses (CDT's)
- Walking & Cycling
- Paid Leisure Opportunities
- Healthy Communities Partnership / community activities
- Free Leisure offer
- Community CVD Checks
- re:fresh Sport
- Books on Prescription / Home delivery Service

**Benefits/Welfare/Debt advice**
- Advice For All (Respected Advisors, CAB, Age UK)
- One Stop Shop / Contact Centre

**Children/Families**
- Schools & education Youth Services
- Work Clubs
- Lifestyles for Work

**Employment**
- IAG
- DASH

**Housing**
- Volunteering Opportunities & Community Groups:
  - e.g. Your Call, Health Trainers, HCP, Neighbourhoods, Walking/cycling, CVS, libraries

**Population : Community : Individual**

**Outcomes, Evaluation, Integration, Communication, Quality**

**Higher Risk groups**
- Older pop / dementia

**Wider Determinants / Self Referral**

**Range of Key Partners**

**Well-being HUB**

**GP referral**

**Self Referral**

**Your Support, Your Choice**

**Active Living Team:**
- Exercise referral
- Adult Weight Management
- Family Weight Management
- Falls Prevention
- Cancer Management

**Higher Skill**

**Schools & education**
- Youth Services

**Well-being HUB**

**Range of Key Partners**

**GP referral**

**Self Referral**

**Your Support, Your Choice**
Example of Public Facing collateral

• Builds on Existing Health and Wellbeing brand and investment
• Advances & differentiates from generic re:fresh branding
• GP referral focus – current GP schemes part of re:fresh

Check your heart health...

❤️ What will re:fresh PLUS do for me?
The re:fresh PLUS team will support you to make changes to improve your health. We will keep in touch and help you through the difficult times. We can provide free access to helpful services such as weight loss groups, exercise classes and health improvement schemes.

❤️ What will I have to do?
Commit to change your lifestyle to improve your long-term health. We have a team of people and services available to help you make that change.

❤️ How do I sign up?
Joining re:fresh PLUS is simple; just call 01254 682037 or ask your GP to refer you to the service, and we will discuss how we can help you to start making realistic improvements to your health and wellbeing.

want to find out more?
T: 01254 682037
www.refreshbwd.com
# Key Marketing Messages

<table>
<thead>
<tr>
<th>Professionals</th>
<th>Public</th>
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<tr>
<td>• Single Point of Access – Online, phone, email.</td>
<td>• Support, advice and guidance</td>
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<tr>
<td>• Removes need to specific knowledge of services</td>
<td>• Single number – access to lots</td>
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<tr>
<td>• Patient centred approach / whole person</td>
<td>• Understanding / low key</td>
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<td>• Structured triage &amp; assessment</td>
<td>• We know it’s confusing &amp; hard to make changes – call/email us, we’ll help</td>
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<td>• Easy access to the wider determinant of health &amp; wellbeing</td>
<td>• Making changes made easier / more simple</td>
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<tr>
<td>• Support, follow-up (of patient) &amp; feedback (to GP)</td>
<td>• Simple</td>
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<tr>
<td>• Provides Stability</td>
<td>• Longer term = build in wider messages</td>
</tr>
<tr>
<td>• Simple</td>
<td>• Improve health / healthy lifestyle / healthier choices / wellbeing</td>
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System we’re providing is the key benefit

“Helping you make a positive change”
The Wellbeing Hub

Critical for success
The Hub

- **Access:**
  - Phone, referral forms, web, email
- **Hours:**
  - 8am – 8pm M-F, 9am – 3pm Sat & Sun

Phase 1: Sept 2013
Phase 2: Early 2014
How will it actually work?

- Hub Advisors will contact referred individuals to discuss reasons for referral and options available.
- Using motivational interviewing techniques, they will be able to assess readiness and explore importance to change plus be able to offer brief intervention and advice.
- Shared Decision Making

- Data recording
  - Referral data will be recorded on a database, which will include interventions referred to, conversations plus outcomes and follow up calls needed (if applicable).

- Insufficient information
  - The Health Advisors will contact necessary GP Practices or partners to gain information that is missing or requiring clarification.

- Failed access to services
  - The Health Advisors will make reasonable attempts to contact individuals, if unsuccessful, feedback to referrer will be given.
  - If individuals fail to engage with services this will also be given as feedback to the referrer.

- Outcomes
  - Initially a positive outcome will be measured by the successful engagement of an individual through the service.
Person Centred Approach

From this…

To this
Next Steps

1. Decision making and approval processes
2. Develop Internal and external communications plan & with branding insight
3. Establish assessment processes
4. Confirm referral pathways
5. Recruit Wellbeing Hub
6. Further sub-group meetings/workshops if required

- **Soft Launch: Autumn 2013**
- **Full operation: Early 2014**
Thank you.

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