Prevention and Early Intervention Strategy Framework for Action: 2017-2020

APPENDIX 2

OVERVIEW

My life a full life

Improving health, narrowing the gap in health inequalities ensuring parity of esteem of mental and physical health is fundamental to unlocking the power and potential of Island communities.

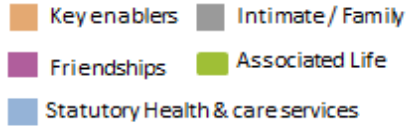
Shifting the focus of care to prevention, early help and resilience and delivering a sustainable health and care system on the Island requires simplified and strengthened leadership and accountability across the whole system.

The success of this strategy will depend on the **strength of partnership**, working across health, social care, housing, regeneration and other partners, to come together in a joined up approach to address the needs and aspirations of people living on the Island to live healthy lives for longer.

My Life a Full Life – New Model of Care

- My Life a Full Life is a vision of a new, sustainable health and care system for the Isle of Wight. A system in which:
  - Health and care services work together in a more coordinated, effective and efficient way
  - More care is delivered in the local community to enable people to managed their health more easily and live their lives to the full
- My Life a Full Life is a model of care that has been developed by the Island. It is not an organisation or a project
- Alongside the model of care is a system-wide transformation programme to help all organisations on the Island collectively deliver this vision

Current Model of Care



New Model of Care

The Prevention Vision and Aims

OUR VISION:
People living on the Island are supported to maximise wellbeing and to live their lives with confidence and resilience

Our four key aims are to:

- **Focus action to embed prevention and self-care**
- **Recognise and Nurture** the contribution and impact that our communities and places have on our health and wellbeing and harness these to aid our change in direction to prevention and self-care to enable people to live well
- **Enable people** to have access to high-quality information and lifestyle interventions that prevent their health and care needs becoming serious
- **Informed decision-making** at the right time and place to reduce and delay the need for care, recognising the need for people living with a health condition and their carers to have appropriate recovery services and the right information

Purpose and Scope

PURPOSE:

This strategy describes how Island residents will be supported to maintain their independence, health and wellbeing for as long as possible. This will be in line with the Care Act and the Five Year Forward View, STP, LA and CCG priorities to provide a shift towards preventing, reducing and delaying the need for care.

This approach should improve information sharing, advice and support, build individual and community resilience, enable access to high-quality services at an early stage to aid independence for as long as possible in communities and at home using the principal of **Promoting** , **Improving** and **Protecting** Wellbeing across the system.

In the context of significant financial constraints, long term sustainability and effectiveness of this strategy will depend on the effectiveness of our partnership. This is the most significant risk to the delivery of this agenda.

SCOPE:

This strategy advocates for a 'whole system' approach to prevention and early help. We recognise that the greatest contributor to our health and wellbeing are not 'health and care services' but the communities and environments that we live, grow, work and play.

This strategy includes actions to promote, improve and protect wellbeing which will be fully integrated into other strategies and services relating to wellbeing, health and social care.

Themes from stakeholder engagement

In developing this strategy we have undertaken a number of conversations and engagement sessions with stakeholders on the Island. The key themes from these sessions are summarised below, set against our core strategic objectives for improving health and wellbeing - Prevention, Access, Integration and Sustainability.

PREVENTION

- Focus should be on prevention in order to reduce service demand
- Need whole population education/awareness plus targeted approach for those with LTC/Mental health/health inequalities
- Appropriate training for all front line staff and community/voluntary sector
- Change the focus of commissioning to prevention
- Social prescribing for things that are not medical
- Equitable distribution of services across the island

ACCESS

- Early intervention and signposting should be embedded in all health and care sectors
- Need to improve access to information for those who find it difficult to access currently
- Clear information at the point of diagnosis or treatment and signposting to information centre
- Using digital knowledge – trusting the person to be responsible for their own health
- Consistent source of information and advice that is accessible and open without appointment

INTEGRATION

- Improve integration across services
- Commissioners (health and local authority) to act as one to give clarity of purpose for providers.
- Providers to be encouraged to build collaborative approach.
- Develop consistent minimum standards for prevention in all contracts
- Connectivity and continuity between services. It was perceived that access to one service should enable easy flow between services for prevention
- Strategic alignment would be required to identify preventative opportunities

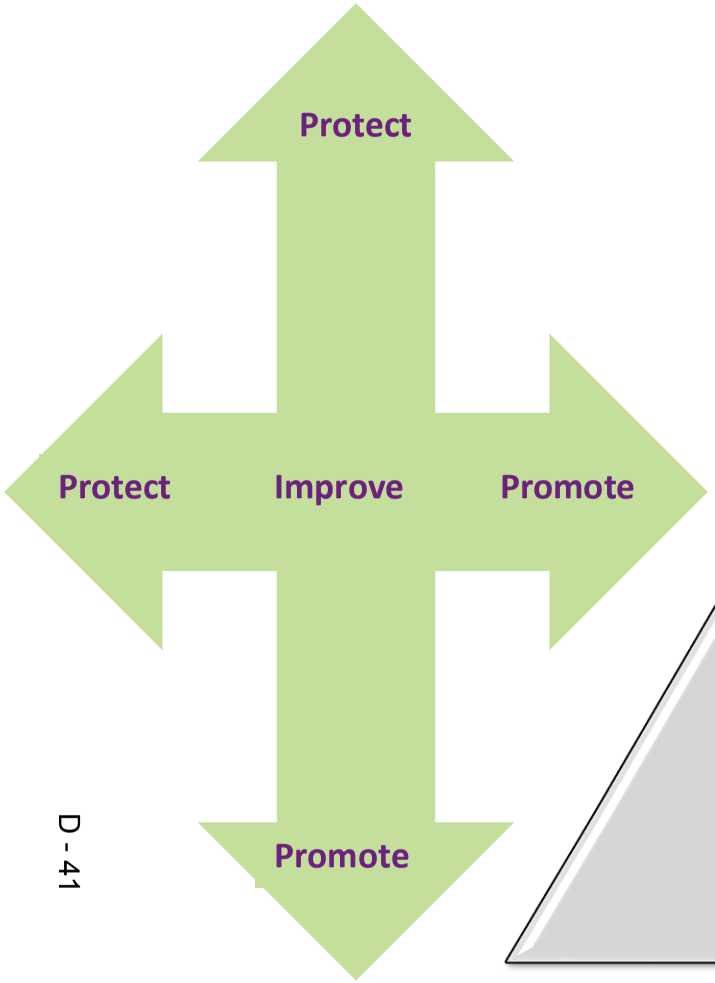
SUSTAINABILITY

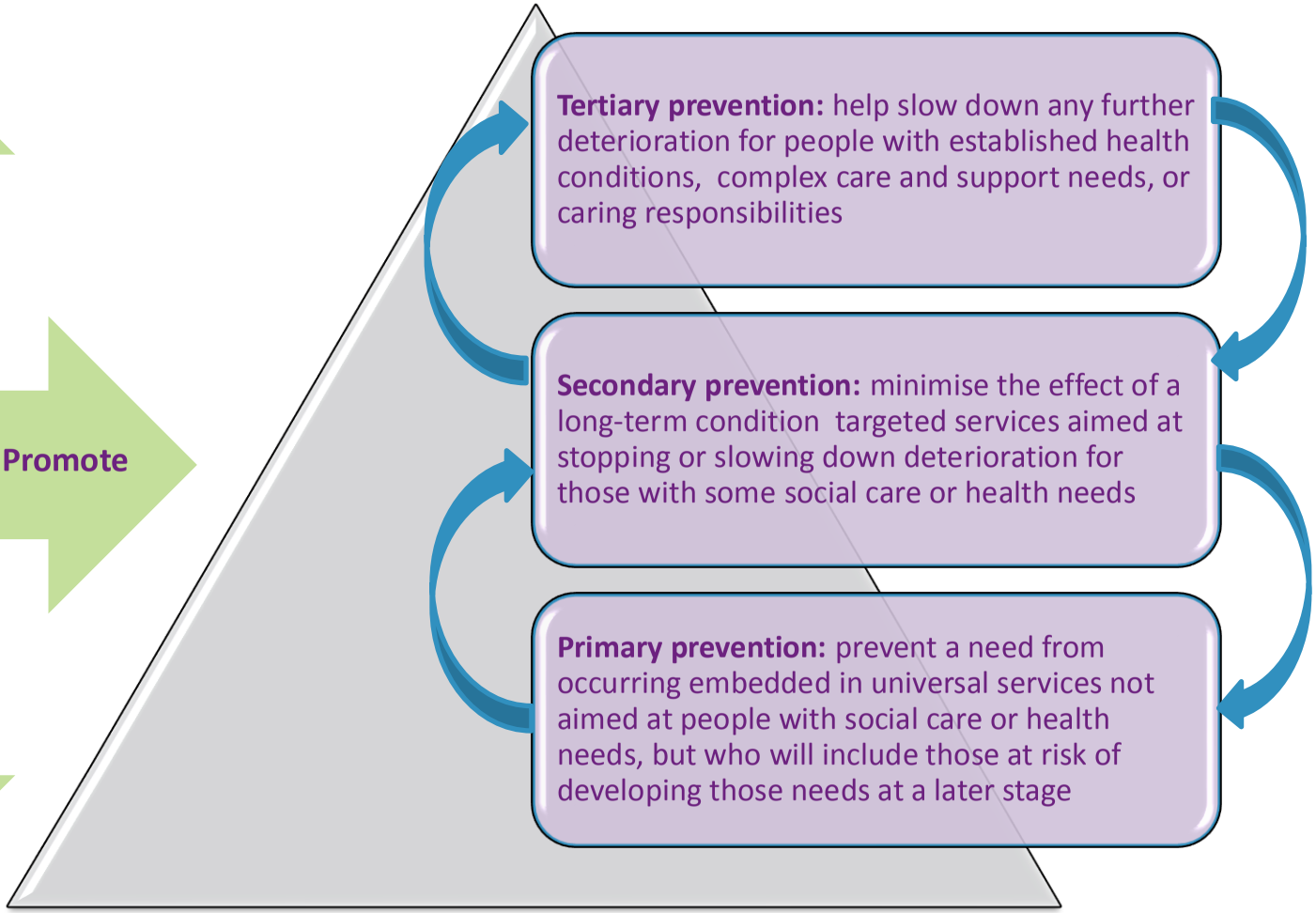
Group Island resources to commission more efficiently and effectively:

- Eliminate the duplication of effort
- Untangle the current governance to streamline decision making and actions.
- Agree common delivery outcomes across the Island (the what).
- Allow local delivery methodology (the how).
- Need for joined up approach to commissioning and resourcing of prevention services
- Voluntary and community sector are key to delivering outcomes for prevention

Prevention and PIP

As a Local Delivery System we are taking the prevention approach based on PIP - Promote Wellbeing, Improve Wellbeing, Protect Wellbeing





Prevention and Early Intervention Strategy Framework for Action: 2017-2020 . Rationale: This strategy sets out high level plans to transform the way Island residents will be supported to maintain their independence, health and wellbeing for as long as possible. This will be in line with the Care Act and the Five Year Forward View, Sustainability and Transformation Partnerships , Local Authority and Clinical Commissioning Group priorities, to provide a shift in service provision, with an increasing focus upon prevention with the aim of preventing, reducing and delaying the need for care. **Context**: This strategy includes actions to promote, improve and protect wellbeing which will be fully integrated into other strategies and services relating to wellbeing, health and social care.

Priorities	Activities	Outputs	Outcomes (S) = up to 2yrs (M)= 2-5yrs (L) = more than 5yrs	Impacts
Priority 1: Focus action to embed prevention and self-care across the system	**Wellbeing service**	All staff within the ILS will be trained	Improved wellbeing, physical and mental health of people (S)	**Building individual and community resilience** measured by: - Self reported service user surveys - Number of visits to GP/hospital - Respite usage
	Patient Activation Measure	2800 people engaged in year 1.	Improved support for vulnerable people (S)	
	Make Every Contact Count	Train number of staff/volunteers in 2017/18	People will be enabled to recover and regain independence as quickly as possible (S)	
	Breastfeeding	**Baby Friendly Initiative programme to be delivered**	Resources will be used/targeted in the most appropriate and cost effective way (S)	**Developing, regaining and sustaining independence** measured by: - Service user surveys - Acute admissions - Complaints/compliments - "Never" events - % of people with LD having healthchecks
Priority 2: Recognise contribution communities & places have on health and wellbeing	Childhood obesity	At least 95% of children are measured	Improved individual resilience through more appropriate support(S-M)	
	School offer	whole-school, family-centred approach	Reduced permanent admissions to residential care(S)	
	Sugar Smart	report outlining findings from engagement exercise in 2016	Services delivered locally around the person (S)	**Living as independently as possible** measured by: - Evidence of all care options/respite being explored - DTOCs
	Local Alcohol Action Area	Information sharing protocols	Reduced acute and long term care demand (L)	
	Healthy Housing	More people access heating and warming solutions	Care will be delivered closer to the persons home (M)	**Better use of resources,** measured by: Readmissions - Acute bed usage - Day care usage - Residential care usage
	Active Island	Regional Physical Activity and Sport strategy with local action plan	All staff will understand and implement the changes (S)	
Priority 3: Recognise and Nurture contribution and impact communities and places have on health and wellbeing and harness to aid change towards prevention	Local Area Coordination	Local area coordination in 9 areas of Island		
	Asset Based Community Development	Increased social capital through communities		
	Cancer Screening			
	Health Checks	All 40 to 74 offered Health Check		
	Digital Health			
	Sexual Health	sexual health promotion, information and advice		
Priority 4. Informed decision-making at right time and place to reduce and delay need for care and access appropriate recovery services and right information	Substance Misuse	Alcohol training delivered across primary care and front line staff		
	Suicide prevention			
	Better care fund			

Assumptions: national policy and funding remains as per 5yr FV, the demographics of the Island continues to grow as projected, new ways of working will result in better health and social care outcomes.

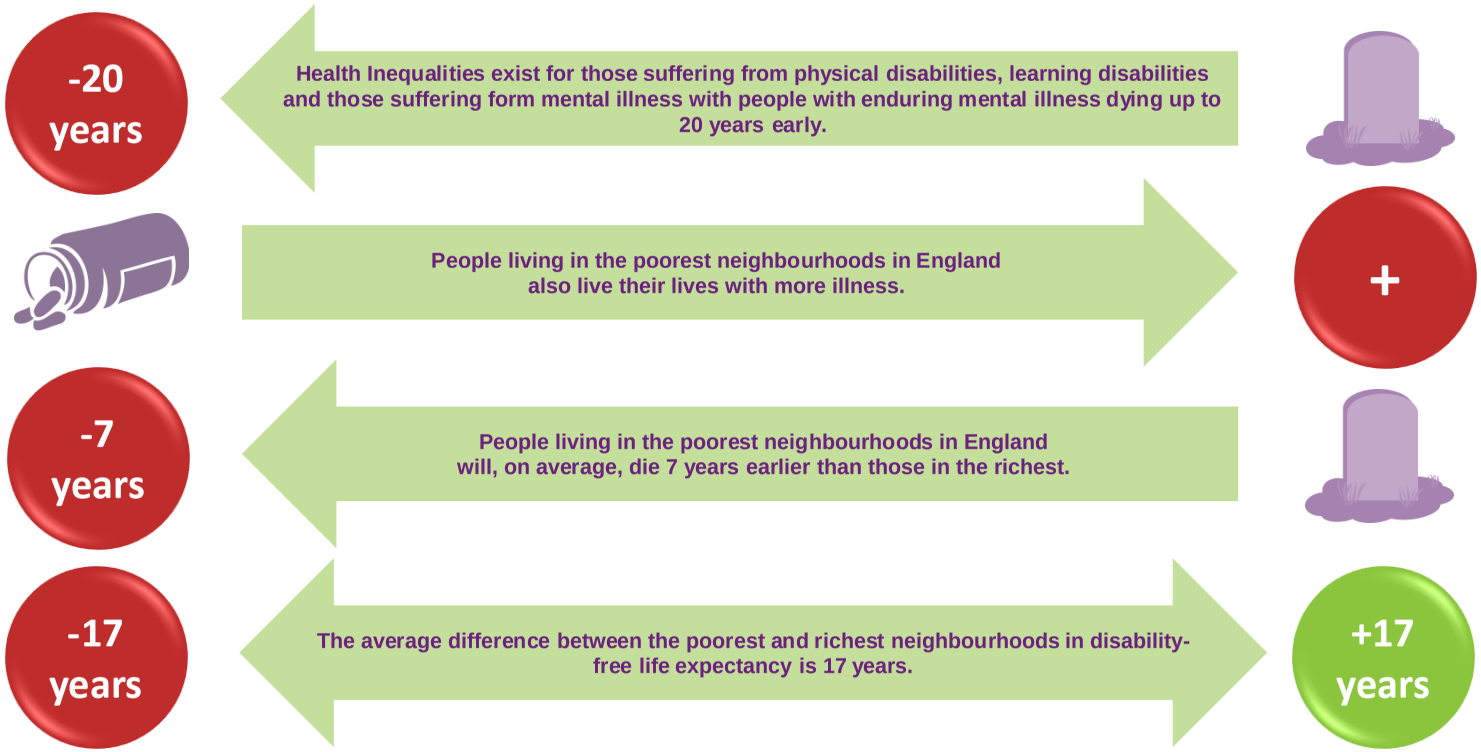
System Challenges

- Resources are held at the highest tier and mostly spent on residential/long term placements/acute care.
- Unable to move resources without investment to 'double run' as we strengthen and embed prevention and self care to reduce, prevent and delay the need of services.
- We will be seeking to implement the strategy within existing resources and through the redistribution of existing resources.
- Although progress has been made the commissioning landscape is not yet integrated across health, social care and PH.
- Health and social care, face significant pressures on existing services from an increasing, aging population, poverty, people/families with complex needs.
- The provider landscape is limited to one main NHS provider. We have a vibrant voluntary community sector and independent sector but both sectors are limited in growth and in the number of new entrants
- There is variability in service provision and outcomes across the system and a lack of consistent and accurate data on activity and outcomes.
- Improving the mental health of island residents, and providing reliable access to early help redressing the balance towards early intervention and prevention will improve family circumstances, help people find and keep good work, improve school attainment and strengthen communities.
- We operate in a larger system – STP/ devolution etc. and we need to influence the impact of that.
- NHS trust in special measures, children's services under direction of ministerial intervention, adult social care also at risk … leaders need to be inspirational!

National Context

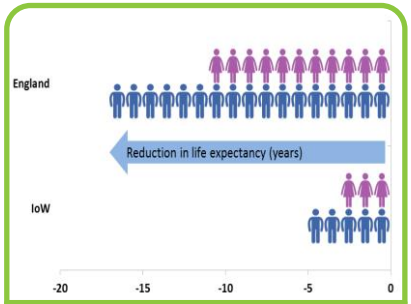
There is considerable evidence that indicates that early intervention and prevention is cost effective and, when delivered in a timely and effective way, will help transform the lives of vulnerable young people, individuals, families and communities. It is an important investment in the future of our people and communities.

According to the latest data (1999 to 2003):

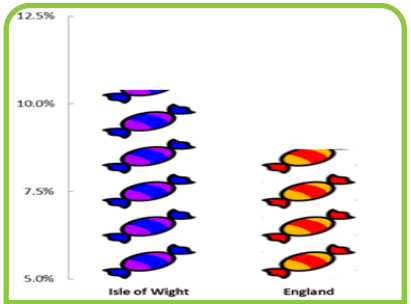


'Later interventions are considerably less effective if they have not had good foundations'.
The Marmot Review, 2010, Fair Society, Health Lives **(accessible at http://www.ucl.ac.uk/gheg/marmotreview/)**

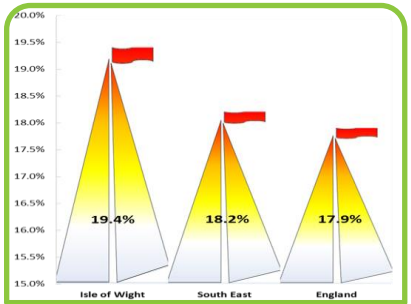
Isle of Wight Context



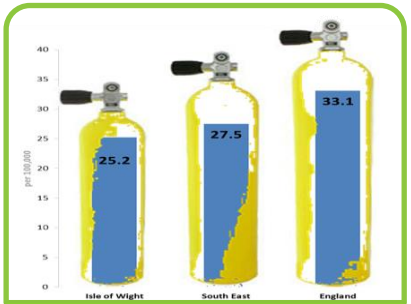
Inequality in life expectancy at birth



Diabetes Prevalence in over 16s (2017 estimate)



Utilisation of outdoor space for exercise/health reasons (all ages)



Under 75 mortality rate from respiratory disease

Measure	Isle of Wight	South East Region	England & Wales
Inequality in life expectancy at birth [1]	♂ 5.1 ♀ 3.3	-	♂ 17.3 ♀ 11.4
Learning disability: QOF prevalence (All ages) [2]	0.66%	0.39%	0.44%
Diabetes Prevalence in over 16s (2017 estimate) [3]	10.4%	-	8.7%
Utilisation of outdoor space for exercise/health reasons (all ages) [4]	19.4%	18.2%	17.9%
Under 75 mortality rate from respiratory disease [5] (Directly standardised rate - per 100,000)	25.2	27.5	33.1

Isle of Wight Context

A Lower Layer Super Output Area (**LSOA**) is a GEOGRAPHIC AREA. Lower Layer Super Output Areas are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales.

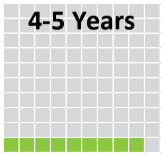
DEPRIVATION

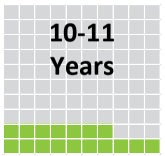
10 %	20 %	30 %	40 %	50 %	40 %	30 %	20 %	10 %

2 Island LSOAs in the 10% most deprived areas in England.

11 LSOAs in the 20% most deprived areas in England.

CHILDHOOD OBESITY



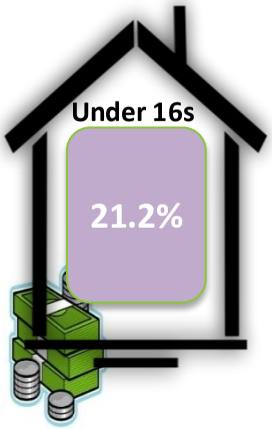


9.1% of 4-5 year olds and 17.6% of 10-11 years old are classified as obese.

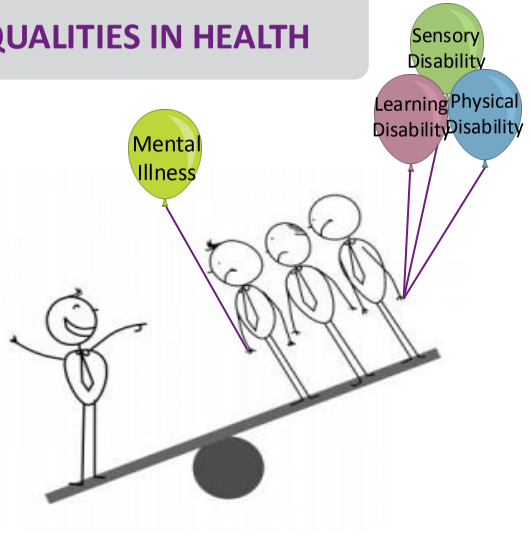
CHILDHOOD POVERTY

The rate of family homelessness is lower than the England average.

The level of childhood poverty is worse than the England average with 21.2% of children under 16 living in poverty.



INEQUALITIES IN HEALTH



Isle of Wight Context

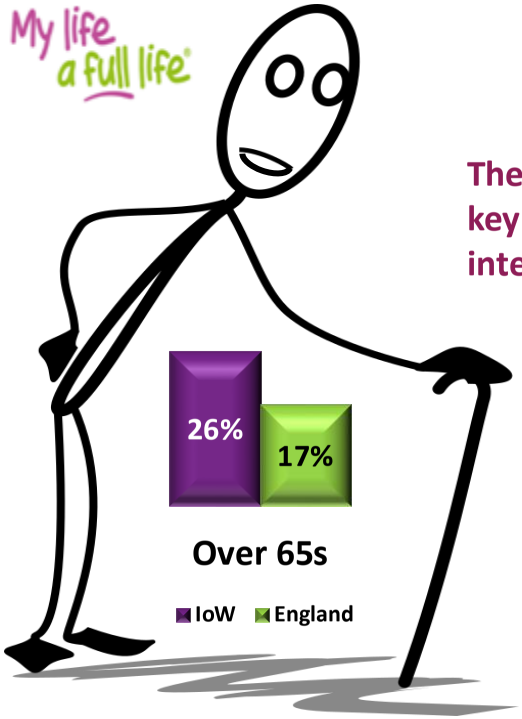
The Island's increasingly ageing population is a key factor in developing this strategy and our integrated health and care services.

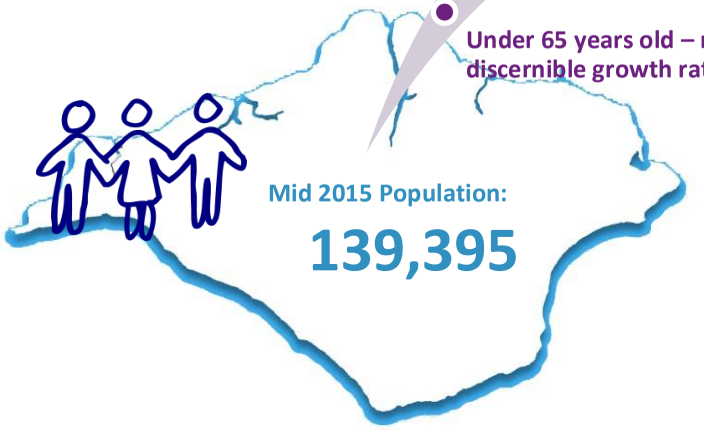
4.8%
Population Growth by 2024

Over 85 years old – approx. 20% growth in females, 60% in males.

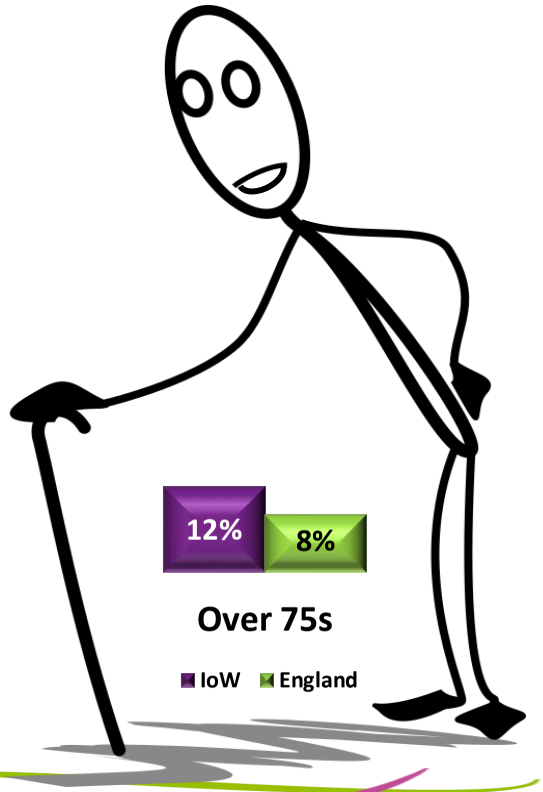
65-80 year olds – no gender difference in growth rate

Under 65 years old – no discernible growth rate



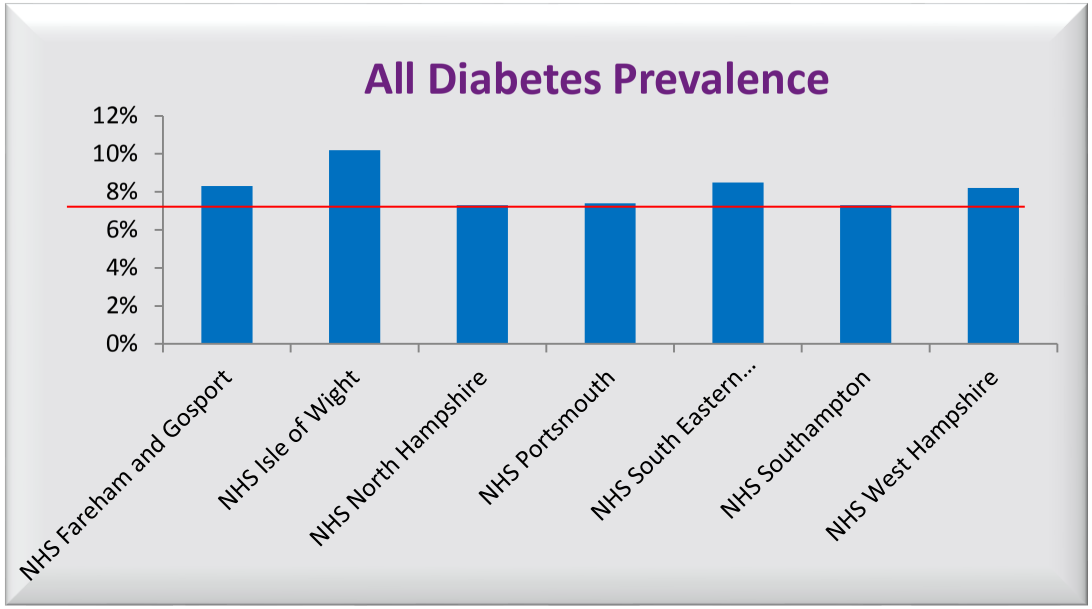


As people get older, the number of Long Term Conditions they experience is likely to increase. By the time someone reaches 65, they are likely to have at least 2 conditions, and this increases to 3 or more by the age of 75.



Source: ONS, 2014 mid-year estimate and 2012-based subnational population projections

Isle of Wight Context



The Island's prevalence for Diabetes is higher than our neighbours

Two thirds (66.2%) of IW adults are overweight or obese▪

▪Combined data from Active people survey 6 quarter 2 to Active people survey 9quarter 1 (mid Jan 2012to mid Jan 2015)

Where are we now and where do we want to be?

Where are we now	Where do we want to be	How will we get there
Fragmented commissioning for prevention and wellbeing programmes limited aligning/pooling of budgets under BCF	Cohesive and collaborative commissioning for prevention, to deliver stronger outcomes, deeper integration, pooled budgets and more community based models of support linked to wider island reform activity.	Simplify, consolidate and streamline current commissioning landscape to create a robust and accountable commissioning function which removes duplication, creates economies of scale and provides consistency. Determine a clear vision and understanding of what services should be provided at locality levels. Consolidate commissioning expertise and develop new payment and incentive mechanisms. Commissioning to Locality based model of care Review partnership contracts with Voluntary sector Invest in prevention and mental health
Medical-focussed model of care, which does not always pick up on the holistic and complex needs of the individual and their environment.	Prevention is 'everyone's business', enabling decisions for system wide outcomes supported by shared information. This includes mental health and social care, but more broadly the opportunities to consider the best approach across public services and the 3rd sector with a focus on community, early intervention and resilience building	Working collaboratively across local services to deliver the right support at the right time to help people address the factors which prevent them from realising their potential and build resilience in our people and communities.
Discrepancies in outcomes and quality indicators for prevention and early intervention for NHS providers, specialist provision and numerous voluntary sector providers results in care that can be inconsistent, misaligned and disrupted by transition points.	Standardised outcomes framework with minimum standards/outcomes and access across all providers of health and social care and shared approaches to strengthening communities and voluntary sector effectiveness.	Develop minimum standards, with a set of KPIs, which also cut across non-care settings, for all providers of health and social care
Health and well being not prioritised in the workplace and workforce development.	All employers promote good employment practice for wellbeing, building capacity for healthy conversations. Employees will be supported to feel happy at work and helped to achieve life satisfaction. All public sector organisations across have workplace policies in relation to managing stress, mental health issues, and driving wellbeing in the workplace.	We will ensure there is consistent support available across the Island for those currently unemployed and seeking employment working with the Regeneration plans for the Island and its corporate objectives of: Regeneration/Growth/Productivity and Confident, competent, critical thinking staff

2017/18
Implementation plan

This Strategy covers a three year period from 2017-2020

The following Framework implementation plan show the work will be focussing on during 17/18 to move us towards achieving our overall vision across four key objectives

Priority 1: Focus action to embed prevention and self-care across the system

Programme objective: Increase breastfeeding at 6-8 weeks to 52% by 2020

Breastfeeding

Programme Description –

The Isle of Wight has been implementing the Unicef Baby Friendly Initiative to bring about increases in breastfeeding rates. The main reason women stop breastfeeding is due to lack of support and most of these women feel that they could have breastfeed for longer with the right support. Maternity, Health Visiting and Family centre staff are working together to enable more women to have access to breastfeeding support.

There is still more that could be offered included dedicated paid breastfeeding supporters providing phone support, one to one home based support in the first 2 weeks and more drop in group support alongside peer support group drop ins.

More work is required with CCG to reduce formula supplementation and the risk and costs of Cows Milk Protein Allergy.

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
0-19 PH nursing contract awarded	→			
BFI next stage completed	→	→	→	

Outputs and benefits to be delivered

- Baby Friendly Initiative (BFI) programme to be delivered achieving next stage every 18 months
- Health visiting service to be commissioned to provide enhanced support for new mothers
- 0-19 early help service to be commissioned to deliver peer support drop in sessions in family centres
- More babies are breastfed for longer reducing their risk of poor health outcomes as a result of formula feeding.

Outcomes

At least 80% of babies are breastfeed initially with at least 52% at 6-8 weeks, resulting in fewer gastro and respiratory infections and hospital admissions, fewer children with milk allergy, fewer obese children, increased baby bonding and positive attachment .

Key Personnel

Maternity, health visiting, family centres, dietitians, allergy clinic, GPs

Stakeholders

Community assets including Babyccino, the BF FB group, Independent midwives, Jane Hawksley, Olivia ? and Emma Porter

Priority 1: Focus action to embed prevention and self-care across the system

Programme objective: Reduce the % of children in Year R and Year 6 who are obese to below the national average by 2025

Childhood obesity

Programme description

Childhood obesity is multifactoral and complex and different individuals are affected differently in similar circumstances therefore the solutions also need to be multifactoral. It is far easier to prevent than treat. Approaches need to be tailored to the individual whilst changing the obesogenic environment.
This work begins in pregnancy with support from midwives as mothers diet and weight impact on their children's future weight, continues through infant feeding , preschool eating and physical activity (health visitors and HENRY), the School Offer (inc school food, physical activity and healthy eating education), Sugar Smart, Change4life, school nursing support for targeted weight loss, with the family wellbeing platform ensuring families with children of all ages are supported to achieve healthy weight.

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
Award contract for NCMP	→	→		
Sugar Smart projects established	→	→		
School Offer begins to be delivered	→	→		

Outputs and benefits to be delivered

- At least 95% of children are measured in the NCMP programme
- fewer children measure as obese in 2025 than the national average.
- More families know how to (and successfully do) enable all members to maintain a healthy weight
- There is a reduction in the gap between the % obese in Year R to Year 6 b y 2025

Outcomes:

More children are a health weight so more children can live happy healthy lives free from bulling, low mood, anxiety, and increased risk of long term conditions.

Key Personnel

Health visitors, school nurses and support staff, early help staff, school staff (including catering), Dietetics.

Stakeholders

Sugar Smart partners, planning, leisure and physical activity providers, retailers and eating establishments

Priority 1: Focus action to embed prevention and self-care across the system

Programme objective: To improve the health, wellbeing and independence of Island residents and reduce the demand on services

Mental Health

Parity of esteem between mental and physical health is central to our quality of life, economic success and education, training and employment outcomes. It is also an important factor in tackling homelessness, violence and domestic abuse, drug use and crime.

At least one in four of us will experience mental health problem at some point. Around half of people with lifetime mental illness experience their first symptoms by the age of fourteen . People with a diagnosed severe mental illness die up to twenty years younger than their peers in the UK, predominantly due to higher rates of poor physical health. By promoting good mental health and intervening early we can help prevent mental illness from developing and support the mitigation of its effects when it does.

Mental health is everyone's business – individuals, families, employers, educators and communities all need to play their part to improve the mental health and well-being of the population and keep people well, by improving the outcomes for people with mental health problems.

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
Promote digital self help and informed choices	→	→	→	
	→	→	→	
Pilot CHIMP within schools as part of Public Health School Offer	→	→	→	
Childrens survey will enable informed decision and identify need	→	→	→	

Outputs and benefits to be delivered

People will know where to go for reliable and up to date information

People recognise the signs of mental ill health and know what to do to stay safe and well

Employers recognise when staff are emotionally vulnerable and know how to support them to recover

Outcomes:

Better informed population able to make informed choices
Improved access to therapy
More resilient people

Key Personnel

CCG
Pubic Health
Childrens Services

Stakeholders

People/Community/Emergency services/Primary Care /Voluntary Sector/Secondary Care

Priority 1: Focus action to embed prevention and self-care across the system

Programme objective: To improve the health, wellbeing and independence of Island residents and reduce demand on services .

Wellbeing service - Programme Description

Wellbeing advisors will work as part of the Integrated Locality Services to build capacity and capability to embed approaches that support independence, self-care and self management by:

- providing training in Making Every Contact Count (MECC), NCSCT online stop smoking training, Brief intervention and health coaching to ILS staff
- Provide one-to-one and group sessions for patients that require 'specialist' behaviour change support for : weight management , stop smoking, reduce alcohol consumption and increase levels of physical activity as per agreed local referral pathways

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
Relocation of wellbeing service to localities	→			
Training needs audit and develop training programme	→			
Delivery of training programme to locality staff		→		
Wellbeing advisor providing specialist behaviour change support to patients referred	→	→	→	

Outputs and benefits to be delivered

- All staff within the ILS will be trained and confident in their health coaching skills
- All patients where appropriate will receive brief intervention and coaching to support self-care and self-management from whichever staff member they see
- Each ILS will have a wellbeing adviser as part of the service providing ongoing training and support for staff
- Each ILS will have a wellbeing adviser as part of the service providing 'specialist' behaviour change support for patients that require it

Outcomes:

> reduction in GP visits
> Reduction in A&E visits
Contribution to reduction in disease
Diabetes /CVD/Cancer/Dementia

Key Personnel

PH Principal –Eleanor Bell
PH Snr. Practitioner Louise Gray
Wellbeing team

Stakeholders

Patients / CCG
Primary Care/NHS Trust
IW Council

Priority 1: Focus action to embed prevention and self-care across the system

Programme objective: To improve the health, wellbeing and independence of Island residents and reduce demand on services/ Action Plan 2017

Patient Activation Measure (PAM) - Programme Description

Patient Activation Measure (PAM) is a concept which describes the knowledge, skills and confidence a person has in managing their own health and health care. PAM is a validated measurement scale designed to assess the extent of person's activation, based on patients' responses to 13 statements about beliefs, confidence in the management of health-related tasks and self-assessed knowledge. A single score between 0-100 represents the person's concept of themselves as an active manager of their health and healthcare.

The PAM proposal on the Isle of Wight sets out the intention to embed PAM as a mechanism to understand local levels of individual activation towards self-management of their long-term condition(s) in relation to Diabetes (and possibly COPD, CHD, and multiple conditions 3 or more conditions). The PAM scores will provide a baseline and basis to support people based on their activation level, providing a systematic self-care support pathway for people through appropriate interventions (that are evidence-based) which improve individual confidence, skills and knowledge to better self-manage/direct support.

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
Licence and MOU agreements signed with NHSE				
Engagement with South LMT to identify practices to take part in pilot				
NHSE delivered workshops on PAM				
Project rollout				
Evaluation and shared learning				

Outputs and benefits to be delivered

2800 people will be engaged in the PAM project in year 1. Those with newly diagnosed Type 2 Diabetes /COPD/CHD

Patients will have a care and support plan tailored to PAM level from a care coordinator/health coach/clinician/trained volunteer

Patients are more confident and more able to manage their LTC and avoid crisis

After pilot in 17/28 is evaluated programme can quickly rolled out to other localities

Outcomes:

> reduction in GP visits

> Reduction in A&E visits

Contribution to reduction in disease Diabetes /CVD/Cancer/Dementia

Key Personnel

PH Principal Eleanor Bell

PH Practitioner Chad Oatley

South Locality Management team

Stakeholders

Patients / CCG

Primary Care/NHS

Trust

IW Council

Priority 1: Focus action to embed prevention and self-care across the system

Programme objective: To improve the health, wellbeing and independence of Island residents and reduce demand on services

Workforce Development: Making Every Contact Count (MECC)

The Context: NHS Five Year Forward View – increasing the support available to help people help to improve their own health and wellbeing; Hampshire and the Isle of Wight Sustainability and Transformation Plan – All NHS organisations will have a MECC plan .

What is MECC? It is an approach to behaviour change that utilises day-to-day interactions that organisations/individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations. The focus is on lifestyle issues: smoking, alcohol, healthy eating; being physically active, keeping to a healthy weight and improving mental health and wellbeing.

Target Audience: Staff across health, local authority and voluntary sectors, who have thousands of contacts every day with individuals and are ideally placed to promote health and healthy lifestyles.

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
Establish task and finish MECC group				
Draft plan of action for 2017/18: target groups, trainer availability				
Engage with target groups (delivery, embed, evaluate)				
Co-ordinate, deliver				

Outputs and benefits to be delivered

- Island residents taking action to improve their own lifestyle behaviours
- Train number of staff/volunteers in 2017/18
- Improved **access** to healthy lifestyles advice, improvement in morbidity and mortality risk factors
- **Enabler** of system wide transformation embedding prevention in every day action

Outcomes:

Lifestyle Public Health Outcomes:

- Reduction in obesity
- Reduction in smoking prevalence
- Reduction in alcohol consumption
- Increase in physical activity

Key Personnel

Island Health & Care Workforce Development Network Group
Senior Public Health Practitioner: Lauren Stott

Stakeholders

IW residents, IW NHS Trust, primary care voluntary sector, CCG, IWC (DEPENDENT ON TARGET GROUPS)

Priority 1: Focus action to embed prevention and self-care across the system

Programme objective: To improve the health, wellbeing and independence of Island residents

Support to children and their families through the 0-19 Public Health services which aims to enable positive parenting and improve all aspects of health and wellbeing for children and families.
The National Healthy Child Programme (HCP) aims to bring health, education and other key partners together to deliver an effective programme of prevention and support. In the early years (0-5) the focus is on giving every child a healthy start. Mandated assessments are carried out to ensure children are developing and are ready for school. Support is given to families to develop their own resilience and independence with regard to all aspects of health and wellbeing.
The school nursing service similarly support children, young people and their families/carers. They promote healthy life choices, self esteem and support children's safeguarding across the Island.
In addition the 0-19 service is instrumental in delivering the national immunisation programme.

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
Secure 0-19 service				
Improve and increase integration with other early help providers				
Explore potential new ways of working to ensure sustainability of services				
Evaluate services to ensure benefits are recognised				

Outputs and benefits to be delivered

Delivery of mandated HCP elements = Antenatal, New Baby, 6-8 week, 9-12 month and 2-2.5 year old checks

Children, young people and families have access to health promotion, preventive and early intervention services

Improvement of physical, emotional, social and cognitive development and wellbeing

Enhanced family resilience and reduced need for and reliance on statutory services

Outcomes:

- A robust 0-19 service tailored to local needs
- Improved health and wellbeing of the Island's children and young people
- Improved use of system wide resources as families are healthier and better able to self care.

Key Personnel:

- Public health nurses
- NHS Trust
- Childrens services providers
- Public health and children's services commissioners

Stakeholders

Families
Schools
Communities
Primary care
Voluntary Sector
Children's Safeguarding Board

Priority 1: Focus action to embed prevention and self-care across the system

Programme objective: To improve the health, wellbeing and independence of Island residents and reduce demand on services/ Action Plan 2017

NHS Diabetes Prevention Programme (DPP)- Programme Description

NHS DPP was announced in the NHS Five Year Forward View, published in October 2014, which set out the ambition to become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the new NHS Health Check.

NHS DPP is a joint initiative led by NHS England, Public Health England ("PHE") and Diabetes UK (the National Programme Team). The programme aims to deliver services which identify people with non-diabetic hyperglycaemia who are at high risk of developing Type 2 diabetes and offer them a behavioural intervention that is designed to lower their risk of onset of Type 2 diabetes.

The IW is part of the 2nd wave rollout as part of a Wessex collaborative. Wessex DPP project group has been established comprising 8 CCGs public health and local authorities. NE Hampshire & Farnham CCG went as part of first wave due to fit with local geography.

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
Provider of structured education procured				
Engagement and preparatory work with Primary care				
All island practices 'signed-up' to deliver NHS DPP				
Provider implementation plan for structure Education programme signed off by IW team				

Outputs and benefits to be delivered

- Wessex project group to develop prospectus and procure provider for structures education programme
- IW team will work with Primary Care on programme implementation across the Island to identified cohort of patients to be referred to NHS DPP
- IW team will work with provider of structured education to ensure effective delivery across Island
- Programme to 'go live' on Island and from late summer 2017

Outcomes:

to reduce the incidence of Type 2 diabetes;
to reduce the incidence of complications associated with Type 2 diabetes - heart, stroke, kidney, eye and foot problems related to diabetes; and
over the longer term, to reduce health inequalities associated with incidence of Type 2 diabetes.

Key Personnel

Head of PH strategy A Cameron-Smith
GP Ben Browne
CCG Caroline Morris
Emily Galt

Stakeholders

Patients / CCG
Primary Care/Ingenus
IW Council

Priority 2:Recognise the contribution that our communities and places have on our health and wellbeing

Programme objective: To enable people with LTCs and/or factors negatively affecting health to stay warm and well.

Eco-flexibility Healthy Housing Scheme

An Eco-flexibility Health Scheme has been developed between Public Health and Economy & Enviroment, supported by E-ON, to enable people with particular long-term conditions and/or wider factors affecting their health caused /perpetuated by the effects of cold weather to access heating and warming solutions which enable them to live and stay well.

This scheme is believed to reduce individual stressors associated to fuel poverty, promote and improve health and wellbeing through heating and warming solutions, reduce inequality across Island residents and pressure on health and care system caused by the effects of cold weather for people with LTCs/frailties/weakened immunity.

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
Agree Health Scheme Criteria	→			
Implementation Plan with Key Players	→			
Coordination of Health Scheme	→	→	→	→
Development of 'Healthy Housing 'Strategy based on evaluation of scheme				→

Outputs and benefits to be delivered

Broader, flexible approach to enabling people to access heating and warming solutions.

Reduction in Fuel Poverty on the Isle of Wight

Housing conditions for Island residents are improved.

Robust Evaluation into Health effects of Health Scheme on individual health and wellbeing

Outcomes:
Reduction in Fuel Poverty
People feel less stressed about fuel costs
People are better able to live and stay well through warmer housing
Reduced pressures on health and care caused by cold weather perpetuating LTCs)

Key Personnel

Public Health Practitioner, Chad Oatley
Public Health Senior Practitioner, Heather Rowell
Public Health Consultant, GP Ben Browner

Stakeholders

Jim Fawcett, Principle Officer, Economy & Environment
E-ON
Warmer Wight
LAC (support mobilisation)

Priority 2: Recognise the contribution that our communities and places have on our health and wellbeing

Programme Objective: Create the conditions for improved wellbeing through a 'health in every policy' approach

Sugar Smart

Sugar Smart: The Context: Local response to the Governments Childhood Obesity Strategy 2016 and the New evidence Review of Measures to Reduce Sugar Consumption Public Health England (PHE) (Oct. 2015).
Local data: On par with England nearly a quarter of Reception year children (aged 4-5 years) and a third of Year 6 (aged 10-11 years) are overweight or obese on the Isle of Wight. By adulthood, two-thirds are overweight or obese . On the Isle of Wight 26.4% of 5 year olds examined had signs of decayed, missing or filled teeth in 2014 compared to 24.8% in England.
Aim: The aim is to raise awareness of the impact of sugar consumption on health and to develop strategies to promote healthier choices.
Approach: The Sugar Smart Island initiative encompasses two approaches. 1) stimulation of a debate through a survey 2) developing responses to the debate in the form of projects which reflect the views and concerns of Island residents.

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
Publish the Sugar Smart engagement report	→			
Prioritise 2/3 projects for 2017/18 as part of steering group	→			
Establish task and finish groups to scope project plans	→			
Task and finish groups to deliver projects & evaluate findings		→	→	

Outputs and benefits to be delivered

- Sugar Smart report outlining findings from engagement exercise in 2016.
- Steering group to prioritise 2/3 projects informed by engagement with Island Residents
- Establish task and finish group to scope project plans and key performance metrics
- Implementation of projects with continued evaluation (engagement)

Outcomes:

Contribute to the reduction of :
Prevalence of overweight (including obese) among children Year Reception (4/5years);
Prevalence of overweight (including obese) among children Year 6 (10/11years)
Excess weight in adults (16yr+);
Contribute to the reduction in tooth decay in children (0-18 years) resident on the Isle of Wight

Key Personnel

Public Health Consultant/GP Ben Browne
Public Health Associate: Vikki Hodges
Senior Public Health Practitioner: Lauren Stott

Stakeholders

IW residents, IW NHS Trust, primary care, Chamber of Commerce, schools, voluntary sector, CCG, IWC

Priority 2:Recognise the contribution that our communities and places have on our health and wellbeing

Programme objective: Create the conditions for regeneration, growth and productivity and wellbeing through a 'health in every policy' approach

Physical Inactivity and Engagement to Physical Activity, Sport and Exercise

Despite the wider contribution of physical activity on individual health and wellbeing, society, the environment and economy. Levels of physical activity are low and worse in comparison to national average.

- The proportion of **physically inactive adults** locally (doing less than 30 minutes) is 28.3%, meaning **almost 3 in 10 adults on the Isle of Wight do less than 30 minutes of activity per week.**
- **Just over 3 in 10 adults play sport once a week,**
- **less than one in five Year 6** (primary school) pupils are physically active (meeting 150 minutes per week); **by Year 10** (secondary school) this significantly decreases **to less than one in ten.**

Furthermore, the association between physical activity and leading a healthy lifestyle means that issues of cost, access and cultural barriers need to be tackled.

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
'School Offer' development, implementation and coordination.				
Partnership development between IW College, SSU and partners to create infrastructure, resource and workforce				
Regional PA and Sport strategy produced and local action plan agreed and implemented				
New community physical activity and sports network				

Outputs and benefits to be delivered

- School Offer planned, implemented and coordinated by Public Health and partners to increase and improve quality and experience of physical activity and sport for students alongside other health areas.
- New Regional Physical Activity and Sport strategy with local action plan to achieve priorities set nationally aligned to local context.
- Partnership development and management to create the infrastructure, workforce and resource for achieving local priorities and objectives.
- New Monitoring and Evaluation approach to better understand what works, for whom, how and why and wider impact on community and system.

Outcomes:

To increase PA across the lifecourse
Reduce Physical Inactivity and sedentary lifestyles
Reduce obesity across lifecourse
Reduce incidence of Type 2 Diabetes, related disease and cancer(s)
Improve Social Capital through sport/physical activity development

Key Personnel:

Public Health Principle, Eleanor Bell
Public Health Practitioner, Chad Oatley

Stakeholders:

Leisure Services, Sports Unit, CCG, NHS Trust, Chamber of Commerce, Voluntary Sector, Town and Parish Councils , ISF and Energise Me

Gap in investment - ££ SIGNIFICANT – DEPENDENT ON SCALE AND PACE

Priority 2: Recognise the contribution that our communities and places have on our health and wellbeing

Programme Objective: Create the conditions for regeneration, growth and productivity and wellbeing through a 'health in every policy' approach

Alcohol Action Areas –Programme Description

Alcohol related violent crime has increased in Ryde and Newport over the past year and there has also been an increase in young people committing anti-social behaviour when they are using alcohol .There has also been a notable increase in neighbourhood noise complaints which is alcohol related.

In addition to this the local NHS Trust is severely challenged on a Friday and Saturday night in response to alcohol related incidents.

In the recent OPCC community survey the majority of respondents stated that alcohol and drug related ASB is their main priority in reducing crime.

Three key objectives:
1.Reducing alcohol related harm
2.Reducing alcohol related crime and disorder
3.Creating a more diverse and vibrant night time economy

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
Develop a Community Alcohol Partnership (CAP) for IOW	→	→		
Multi agency approach including enforcement, diversionary activity and design out crime	→	→	→	→
Explore possibility of developing evening events in Newport with wider partners	→	→	→	→
Improve collection, sharing and use of data between A&E departments, local authority and the Police	→	→	→	→

Outputs and benefits to be delivered

- A robust partnership group with protocols and procedures to share and use data
- Effective Newport pilot model for movement of people expanded and rolled out across the Island
- Reduced sale of alcohol to people who may commit or be a victim of crime
- A more diverse and vibrant night time economy

Outcomes:

Reduction in alcohol related violent crime
Reduction in Violent crime hospital admissions for violence
Reduction in the rate of complaints about noise

Key Personnel

PH Principal Sharon Kingsman
PH Senior Practitioner Gilles Bergeron
Community Safety Operations Manager Helen Turner

Stakeholders

Police
Public Health
Community Safety
Licensing
Licensees

Priority 2: Recognise the contribution that our communities and places have on our health and wellbeing

Programme Objective: 'School Offer'; Building and Mobilising Capacity to Improve School-aged Student Attainment, Aspiration, Health and Wellbeing across the Isle of Wight

'Schools Offer'

Locally, there is a variation in uptake of 'evidence-based, quality' provision(s) by schools, alongside differing levels of engagement in implementing health promoting policies and incorporating key domains which span Public Health. Equally, there is a lack of opportunities for schools to share best practice and identify and address emerging areas of 'concern' with key stakeholders.

By taking a whole-school, family-centred approach, the 'School Offer' aims to reduce inequalities affecting attainment and aspiration by working holistically with key stakeholders and schools, to offer an effective, evidence-based range of interventions and network of support to 'Schools' .

Buying into the 'School Offer' membership could support schools with:

- Healthy Schools Self-Assessment
- PSHE & SRE
- Mental Health, wellbeing and resilience
- Healthy eating and Physical Activity
- Citizenship, Participation & Sustainability
- Safeguarding and Safety
- Training and Support (resources, info.)

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
Engagement and partnership development of stakeholders	→	→		
Finalise School Offer for 17-18	→			
School Offer' development, implementation and coordination	→	→	→	→
Support Stakeholder network learning, sharing and development		→	→	→
Co-produce and mobilise M&E with partners	→	→	→	→

Outputs and benefits to be delivered

Coordinated, effective approach to working with, and within, schools to improve health and wellbeing and reduce inequalities

Collaborative, engaged and enabled stakeholders in improving attainment, behaviour and wider health and wellbeing

Pooled resource utilised more effectively in achieving wider impact, and greater role in influencing partners towards health and wellbeing outcomes.

Mobilise robust M&E framework

Outcomes:

Improve student attainment, aspiration, health & wellbeing inc. emotional resilience
Better equip staff to improve students attainment, aspiration, health & wellbeing
Improve stakeholder engagement in support of local issues

Key Personnel

PH Principle: Eleanor Bell
PH Practitioner: Chad Oatley
PH Associate: Victoria Paris

Stakeholders

IoW Schools and Colleges, EduMove, PSSC, and providers, wider LA and health colleagues, Voluntary Sector and key stakeholders

Priority 3(1,2&4) Nurture our Island's rich assets and harness these assets to aid our change in direction

Programme objective: to address the fact that often support is not available until the person is in crisis & then only to meet the need that has a service solution already designed & available. Much of the support available to people is not place based or community rooted & often does not support people as contributors as well as clients.

Local Area Coordination (LAC) - Programme Description

Local Area Coordination is an approach to supporting people as valued citizens in their communities. It enables people to pursue their vision for a good life and to stay safe, strong, connected, healthy, and in control. Local Area Coordination works to:

- Provide an accessible point of contact in the local community
- Focus on people's own visions for a good life beyond services or formal support
- Help people build on their own assets and natural supports before looking to service solutions
- Walk alongside people building their capacity (not dependency) for as long as both agree
- Build trusting relationships with individuals, wider community members and workers in organisations
- Ensure that the Coordinator is a well-connected, contributing member of the local community with a link back into the service system
- Support system reform by bringing together all partners
- Find low cost /no cost solutions first before service solutions
- Focus on people 's strengths rather than needs .

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
Become the first point of contact within each community	→	→	→	→
Multi-agency approach to support the health and wellbeing for people with Learning Disability	→	→		
Area Plans developed in partnership with each community	→	→	→	→
Programme Evaluation	→	→	→	→

Outputs and benefits to be delivered

Deliver LAC in 9 areas of Island with approx. population of 12000 in each area

Each Local Area Coordinator working alongside 50-60 individuals and families at any one time - to build resilience

Increased social capital and more welcoming and inclusive communities

Programme evaluation Report in partnership with Southampton Solent University

Outcomes:

reductions in isolation, visits to GP surgeries and A&E, referrals to Adult Social Care or Mental Health. evictions and costs to housing, dependence on formal health & social services, safeguarding concerns –people leaving safeguarding sooner. A Social Return on Investment: £4 return for every £1 invested, and an increase in community connections and capacity.

Key Personnel

PH Principal Eleanor Bell
PH Snr. Practitioner – Heather Rowell
Local Area Coordinators

Stakeholders

People/ Communities/T&P councils/Primary Care/NHS Trust ASC/CCG/Housing/ Police/Fire

Priority 3(1,2 &4) Nurture our Island's rich assets and harness these assets to aid our change in direction

Programme objective: To support communities across the Island who have an interest and welcome for ABCD

Asset Based Community Development (ABCD) - Programme Description

Asset Based Community Development (ABCD) is a strategy for sustainable community-driven development rather than development driven by external agencies.. ABCD is concerned with how to link micro-assets to the macro-environment. The appeal of ABCD lies in its premise that communities can drive the development process themselves by identifying and mobilizing existing, but often unrecognized assets, and thereby responding to and creating local economic opportunity and health assets which enable people to live and stay well.

ABCD builds on the assets that are already found in the community and mobilizes individuals, associations, and institutions to come together to build on their assets - not concentrate on their needs. Freshwater have built up a degree of experience in this model and would be willing to share their learning and experience with other T&P councils who have expressed an interest.

ABCD efforts are linked to empowering people, and communities, reducing reliance on services , micro-enterprising and stronger individual social network typologies of support.

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
ABCD stakeholder training and support				
Ideas Fayre , community engagement and mobilisation				
New themed activity				
Monitoring and Evaluation of ABCD activities and effects				

Outputs and benefits to be delivered

- Increased social capital through communities developing and sustaining assets which protect, improve and promote health and wellbeing and reduce inequalities
- Redefined role and contribution of the system in working alongside communities to achieve local priorities.
- Increased community identification, mobilisation and utilisation of assets which enabled people to live and stay well, reducing avoidable pressure and reliance on services.
- New evidence and approach to monitoring and evaluation community-based approaches to improving health and wellbeing.

Outcomes:

Improved individual health and wellbeing
Reduced inequalities
(in)direct support to self-manage long-term conditions
Increased contribution and volunteering
Increased activity and resource within communities
Increased micro-enterprising.
Reduced pressure and reliance on services.

Key Personnel

PH Principal Eleanor Bell
PH Practitioner –Chad Oatley
Freshwater Community
Freshwater Community Builder

Stakeholders

People/ Communities/T&P councils/Primary Care/NHS Trust ASC/CCG/Housing/ Police/Fire/ Nurture Development

Priority 4 Enable people to have access to high-quality information and lifestyle interventions that prevent their health and care needs becoming serious

Programme objective: Implement prevention at scale improving uptake of the NHS Health Check Programme

NHS Health Checks - Programme Description

NHS Health Checks aims to prevent heart disease, stroke, type 2 diabetes and kidney disease, and raise awareness of dementia both across the population and within high risk and vulnerable groups. In April 2013, NHS Health Check s became a statutory public health service in England. Local authorities are responsible for making provision to offer an NHS Health Check to eligible individuals aged 40-74 years once every five years .

NHS Health Check is made up of : risk assessment, risk awareness and risk management. During the risk assessment standardised tests are used to measure key risk factors and establish the individual's risk of developing cardiovascular disease. The outcome of the assessment is then used to raise awareness of cardiovascular risk factors, as well as to inform a discussion on, and agreement of, the lifestyle and medical approaches best suited to managing the individual's health .

The original Department of Health modelling showed the average annual cost of the programme as £332m each year at full roll out and the benefit as £3.7bn with a cost per quality adjusted life year (QALY) of around £3,000. This modelling also suggests that it is cost effective with potential savings to the NHS of around £57m per year after four years, rising to £176m per year after 15 years.

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
Increase % uptake of NHS Health check	→	→	→	→
Increase uptake of NHS Health check of Routine and manual workers	→	→	→	→
Evaluation of data collected to target delivery	→	→	→	→
Reduce inequalities	→	→	→	→

Outputs and benefits to be delivered

Everyone eligible aged 40 to 74 to be offered an NHS Health Check once in every five years and for them to be recalled for another check every five years after, while they remain eligible.

Identify individuals who have undiagnosed conditions such as hypertension or chronic kidney disease (CKD) and people who are at high risk of developing cardiovascular disease or diabetes

Clinically appropriate lifestyle advice, to help manage and reduce their risk

Reduced rates of preventable Cardio vascular disease

Outcomes:

Health Improvement – reduction Smoking Prevalence (over 18), excess weight in adults, percentage of inactive adults

Healthcare Public Health and Reducing Mortality – Emergency readmissions within 30 days of discharge from hospital

Key Personnel

PH Principal Eleanor Bell
PH Snr. Practitioner – Louise Gray
NHS Trust Jenni Edgington
Primary Care – Caroline Morris

Stakeholders

Chamber Health/People/ Communities/T&P councils/Primary Care/NHS Trust ASC/CCG/Housing/ Police/Fire

Priority 4 Enable people to have access to high-quality information and lifestyle interventions that prevent their health and care needs becoming serious

Programme objective: Sexual Health

Good sexual health enables healthy relationships, planned pregnancies and prevention of disease. It is important to all individuals throughout their life course and contributes to maintaining and improving population health.

Sexual ill health is not equally distributed within the population. Strong links exist between deprivation and Sexually Transmitted Infections, Teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men, teenagers, young adults and black and ethnic minority groups. Similarly HIV infection in the UK disproportionately affects MSM and Black Africans in the UK.

Some groups at higher risk of poor sexual health face stigma and discrimination , which can influence their ability to access services.

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
Continue to promote use of online services and apps such as FreeTestMe Service for STI and HIV				
Work with all partners (including STP) to continue to improve uptake of Long Acting Reversible Contraception				
Working with all partners to ensure sustainability of provision				

Outputs and benefits to be delivered

Provide sexual health promotion, information and advice → increased knowledge and promote positive behaviour change → reduce the stigma associated with STI, HIV and unwanted pregnancy → Harm Reduction

Outcomes:

Improved health and wellbeing
Maximisation of existing resources
Improved integration of interventions
People feel more in control of own sexual health/wellbeing

Key Personnel

Senior Public Health Practitioner (Sexual Health Commissioner)
NHS Trust / Sexual Health Team
Primary care

Stakeholders

Communities /Schools/Primary Care/ NHS Trust ASC / CCG

Priority 4. Informed decision-making at the right time and place to reduce and delay the need for care, recognising the need for people living with a health condition and their carers to have appropriate recovery services and the right information

Programme objective: Substance Misuse

Programme Description

"Prevention" in the context of substance misuse may include policies, programmes or activities that aim to prevent (primary prevention) the use of drugs or alcohol and its negative consequences. It is also important to consider the role and value of delaying or reducing (secondary and tertiary prevention) the harms caused by substance misuse as these are complementary.

A range of prevention interventions are currently being delivered on the island. Whilst these are wide ranging there is an acknowledgement that more needs to be done to identify those adults and young people at risk of or actively engaged in harmful drinking or substance misuse, provide better more integrated harm minimisation advice in a wide variety of settings and promote our treatment interventions.

The Isle of Wight recognises the need to coordinate interventions holistically, in partnership and across multiple settings, including communities, primary care and schools.

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
To systematically identify individuals at risk of drug or alcohol related harms as they enter clinical settings	→	→		
Promoting resilience skills training for children and young people	→	→	→	→
Providing information to adults who are vulnerable to drug and alcohol misuse	→	→	→	→
Developing opportunities to target 'increasing' and 'higher' risk drinkers	→	→	→	→
Review PSHE framework to develop a better, inclusive offer based on "resilience"	→	→	→	→

Outputs and benefits to be delivered

AUDIT C training delivered across primary care and front line staff in other agencies (ie: third and independent sectors)

Trained workforce confident in providing low level substance misuse interventions.

→ People are better informed about their drinking , substance misuse and harm levels

→ Implementation of MECC agenda across the IOW

→ Improved resilience for children and young people as part of a holistic and revised PSHE offer

Outcomes:

Reduction in Drug related deaths
Reduction in alcohol related admissions to hospitals
Reduction of prevalence of harmful drinking
Overall positive impact on costs of services and RoI

Key Personnel

PH Principal Sharon Kingsman
Senior Public Health Practitioner Gilles Bergeron

Stakeholders

Primary Care
NHS Trust/IRIS ASC/CCG/Housing/ Police

Priority 4 Enable people to have access to high-quality information and lifestyle interventions that prevent their health and care needs becoming serious
Priority 1: Focus action to embed prevention and self-care across the system

Programme objective: Implement prevention at scale improving uptake of the NHS Health Check Programme

Family Wellbeing Platform

Programme Description

A range of services are working together to deliver a range of Public Health outcomes to the people they work with fitting in with the usual work that they do so for example in libraries there will be displays on health promotion campaigns, support to access information to support health and self care, provision of 'books on prescription', encouraging reading to support mental health etc. The Fire service carry out 'safe and well' checks to reduce fire and accident risk and can at the same time identify a range of other health risks and encourage people to make changes to self care. The stakeholders in the Family Wellbeing platform are sharing good practice with each other and agreeing where through cooperation and partnership working a better service can be delivered to people preventing the need for more intervention at a later time. One of the key aspects is for all service areas to deliver MECC training.

Milestone: 2017/18	Qtr. 1	Qtr.2	Qtr.3	Qtr. 4
Stakeholder group established	→			
some members of all teams have received MECC	→	→	→	
Family Wellbeing Platform action plan agreed	→	→	→	
FWP and ILS working together	→	→	→	→

Outputs and benefits to be delivered

Stakeholder group formed and action plan developed → Multiagency MECC training regularly delivered until all staff are trained → FWP and ILS working together to prevent health risks developing and support people in self care → More people live healthy lives and are better able to manage their long term conditions

Outcomes:

Health Improvement – reduction Smoking Prevalence (over 18)
Healthcare Public Health and Reducing Mortality – Emergency readmissions within 30 days of discharge from hospital

Key Personnel

PH Principal Eleanor Bell
PH Snr. Practitioner – Louise Gray
NHS Trust Jenni Edgington
Primary Care – Caroline Morris

Stakeholders

People/ Communities/T&P councils/Primary Care/NHS Trust ASC/CCG/Housing/ Police/Fire