



Public Health
England

Protecting and improving the nation's health

Paths to public health and wellbeing: examples of local authority action in the South West

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through advocacy, partnerships, world-class science, knowledge and intelligence, and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Foreword

Over the past 200 years, advances in environmental health and medical sciences have led to rapid improvements in the health of our population. But as we look forward in the 21st Century we are confronted by unprecedented challenges in sustaining a healthy population and reducing health inequalities. Chronic diseases and conditions that cause disabilities mean that we may be living longer but not necessarily healthier, the threat of new or re-emerging infectious diseases such as TB and the consequences of climate change have a negative impact, reducing individuals' quality of life, straining healthcare and social care services and potentially reducing our economic productivity and wealth.

The Health & Social Care Act 2012 marked the return to Local Government of the responsibility to improve the health of the local population, from the NHS. The Public Health duties of the Secretary of State for Health were also enshrined in the Act. The Act saw a major shake-up of the commissioning arrangements within the NHS. Such radical change is not without risk, nor without its critics. A year or so after the changes came into effect, the Directors of Public Health and the Directors of the Public Health England (PHE) Centres in the South West felt it would be worthwhile to review what progress had been made, what the emerging issues and challenges might be and whether there were examples of emerging good practice that could be shared with each other and more widely across the system. The result is this report, which contains case studies from across the South West, many of which show early promise in that the new system is bedding down and new approaches to wicked problems are being developed.

Public Health is described as the art and science of improving and protecting health through the organised efforts of society. The case studies demonstrate the art of system leadership, creativity and innovation, persuasion and negotiation. We must be careful, however, that we continue to pay attention to the science – making best use of the existing evidence base and ensuring that we invest in evaluation of new approaches and interventions. A number of the case studies in this report are at an early stage and it will be some time before we know whether they have achieved the desired impact on the health and wellbeing of local people.

It has been said that a journey of a thousand miles begins with a single step. This report is very much a snapshot of the first few steps taken in the new health and social care system, and, we believe there is much to both reflect on and to celebrate. We hope you enjoy reading it.

Felicity Owen
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Glossary

- **AQMA** – Air quality management area
- **B&NES** – Bath and North East Somerset
- **BME** – Black and minority ethnic
- **CCG** – Clinical commissioning group
- **DA** – Domestic violence and abuse
- **DVA** – Domestic violence and abuse
- **GHWB** – Gloucester Health and Wellbeing Board
- **GP** – General practitioner
- **HWB** – Health and wellbeing board
- **ICO** – Integrated care organisation
- **JSNA** – Joint strategic needs assessment
- **LNP** - Local nature partnership
- **LRF** – Local resilience forum
- **MMR** – Measles, mumps and rubella
- **NHS** – National Health Service
- **NICE** – National Institute for Health and Care Excellence
- **PGD** – Patient group directive
- **PHE** – Public Health England
- **QOF** – Quality and Outcomes Framework
- **STAC** – Scientific and technical advice cell
- **TB** - Tuberculosis

Introduction

Local councils are addressing their public health responsibilities in a range of ways following the reforms introduced in April 2013. A key aspect of this work is the delivery of programmes and initiatives through partnerships and alliances within and outside council departments. A range of activity is emerging in new ways of working, providing valuable insights about the opportunities and challenges being addressed in local authorities as they embed and fulfil their extended role as public health bodies.^{1 2}

The case studies presented here give a snapshot of the diversity of work being delivered in the South West across the four domains of public health. Some of the case studies illustrate a focus on developing joint strategies and processes to provide a strong foundation for future work, others demonstrate emergency responses delivered in a newly integrated public health system, and several present innovative approaches to addressing specific health priorities.

A significant amount of public health work is being undertaken in local councils in the South West. The fourteen case studies presented in this document represent just a fraction of the activity underway.

Background and aim

Participants in Public Health England (PHE) events held in the South region over the last year have drawn attention to examples of positive work emerging in the new public health arrangements and would appreciate access to more information. The South West Network of Directors of Public Health were also keen to produce a resource showcasing current efforts to share emerging practice and lessons learned.

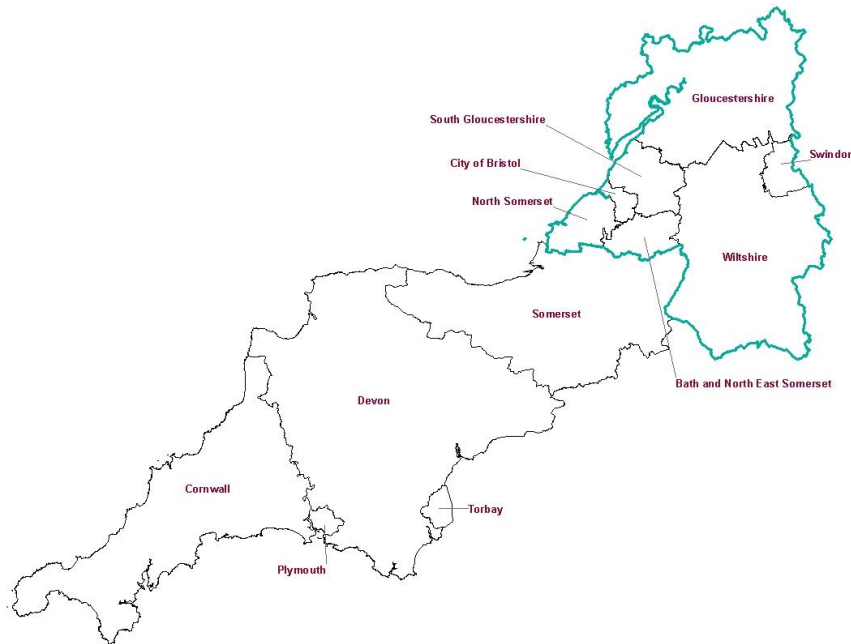
This project was commissioned in response to these requests and aspirations by PHE Avon, Gloucestershire and Wiltshire Centre. It was developed in partnership with PHE South region and the South West Network of Directors of Public Health.

Project aim

The project aim was to identify and present work being progressed in the South West, in the new integrated public health system. The intention is to share good practice and lessons learned by providing an overview of selected initiatives; contact details are included in each case study for further information.

¹ Buck, D. and Gregory, S. Improving the public's health: A resource for local authorities. Kings Fund 2013

² Local Government Association and Public Health England. Public Health Transformation nine month on: bedding in and reaching out. Local Government Association 2014



Local Authorities covering Avon, Gloucestershire and Wiltshire and Devon, Cornwall and Somerset Public Health England Centres

Methodology

The project was developed and undertaken by a full time health improvement project manager and a steering group convened to guide and support the work. All steering group discussions were conducted by teleconference and email.

A number of options were discussed by the steering group regarding the project aim, geographic area to cover, case study themes and what could be achieved in the available timescale. The main purpose of the project was agreed as being to identify and present case studies highlighting progress to give a snapshot of work being undertaken in the South West and share lessons.

A director of public health on the steering group undertook a significant amount of work to communicate the project to other directors of public health in the South West and coordinate initial submission of topics for consideration by the steering group as potential case studies. This work was essential to designing the project, getting it moving swiftly and securing participation from respondents to provide feedback within a relatively short period of time.

Identification of initiatives

The steering group agreed that directors of public health in the South West would be asked to identify and submit public health work being delivered in their local authorities, in the new integrated public health system. A few initiatives would be selected from the

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information submitted to develop as case studies with the aim of achieving good representation in terms of geography and topic.

Directors of public health in each of the twelve local authorities in the South West were asked to submit core topics (eg flood response) of initiatives they wanted to share as potential case studies, under the four domains of public health:

- Health Protection: reducing the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation
- Health Improvement: supporting people to make healthier choices and reduce health inequalities
- Wider Determinants: addressing the social, economic and environmental factors that impact on health
- Healthcare Public Health: supporting sound decision making and policy changes within the NHS that deliver, evaluate and improve effective clinical preventive services that drive public health

A table setting out these domains was circulated to directors of public health to complete and return with their topics set out under the relevant domains. All returns were collated into one table presenting topics and domain by local authority area to assist with selection of potential case studies.

Selection of initiatives

Over ninety initiatives were submitted across the twelve local authorities. The task of the steering group was to select one initiative from each local authority for development as a case study. This was achieved by each steering group member voting for two initiatives, one first and one second choice, from each local authority for inclusion as potential case studies. Second choice votes provided a fall-back position to be considered in the event of a tie in first choice votes, or insufficient representation of initiatives across the four public health domains.

It was also agreed to include an additional two initiatives, one which demonstrated an emergency response to flooding in the South West and the other a response to the national call for action on measles, mumps and rubella (MMR) vaccine uptake; both were likely to have useful lessons for others.

A total of fourteen initiatives were selected for development as case studies and are presented in table 1. Each selected initiative was checked with the appropriate director of public health to ensure they were happy with the choice; no changes were suggested or made to the steering group selection.

Table 1 – Initiatives selected for development as case studies

Local Authority	Topic selected by the steering group for development as case studies	Public health domain
Bath and NE Somerset	Air quality evidence review and local assessment of health impact	Health Protection
Bristol	Crush – DVA intervention with teenagers	Health Improvement
Cornwall	Food and Cornwall – system leadership	Health Improvement
Devon	Local nature partnership, planning and environment work	Health Improvement
Gloucestershire	System Leadership Programme breaking the intergenerational cycle of obesity	Wider Determinants
North Somerset	Hepatitis C outreach testing and treatment services	Health Protection
Plymouth	Implementation of scheme to stop sale of high strength beers and ciders	Healthcare Public Health
Somerset	Using Apps for sexual health	Health Improvement
South Gloucestershire	Meningococcal outbreak in a care home	Health Protection
Swindon	Domestic violence and abuse JSNA	Wider Determinants
Torbay	Embedding prevention work in re-design groups	Healthcare Public Health
Wiltshire	Diabetes summit and work with CCG	Healthcare Public Health
Additional initiatives		
Bristol	Measles vaccination uptake in inner city Bristol.	Health Protection
Somerset with Public Health England	Flood response.	Health Protection

Case study respondents

Directors of public health were asked to identify the best person to provide further information on the initiative selected for their local authority. A ‘Topics for discussion’ sheet (see appendix 1) was sent with the request to identify respondents in order to

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provide an indication of the topics to be covered. Respondents providing case study information are presented below.

Respondents providing case study information

- public health specialty registrar
- three public health consultants
- senior health promotion specialist
- public health specialist
- lead commissioner - Health Improvement
- senior public health commissioning and policy manager
- health promotion manager
- Public Health England centre director
- director of public health
- two interim directors of public health
- GP in public health

Data collection

A number of options were discussed by the steering group regarding the type of information to be collected and the best method for doing so within the available time and other resources. It was agreed that individual case studies should aim to summarise key points regarding development and delivery of the initiative and provide contact details for readers wanting to access further information.

Case study data was collected from individual respondents by telephone discussion, lasting approximately 45-60 minutes per case study, based on the headings outlined in appendix 1. Some factual data such as demographics was gathered ahead of, or after, the telephone discussion and some data, such as documents summarising aims and rationale, was forwarded by respondents following the telephone discussion.

Respondents were also asked if they were happy for visuals to be included in the resource and to submit any appropriate photos or illustrations.

Case study sign off

The data collected was transcribed into case study format for each local authority and sent to individual respondents to check for factual errors and any key omissions. Draft case studies updated with feedback from respondents were sent to directors of public health for a final edit and sign off.

Timescale

A health improvement project manager was appointed in early May 2014 to take the work forward. A steering group was convened and held the first teleconference within two weeks of the project commencing.

Telephone discussions with respondents to collect case study data were conducted between late June and early July 2014. This document was prepared for publication by September 2014.

Emerging themes

The case studies demonstrate a range of initiatives and partnerships delivering on public health. Some were already under way prior to the public health reforms coming into force in April 2013, others have involved forming new alliances. Whether progressing work through established partnerships or forging new ones, a number of themes emerge from the case studies regarding factors that have been supportive or challenging to delivering public health in the new system.

Building good relationships

Good working relationships based on mutual trust, shared vision, aims and values are identified as being of central importance to developing and delivering effective work, especially that delivered in partnership. It has been highlighted that where such relationships are not already in place, it is worth investing time and effort to develop them because of their potential significant influence on future outcomes. Effective partnership work is said to demonstrate:

- shared aim, purpose and commitment
- agreed common ground
- shared values
- aligned priorities that link public health priorities with strategic priorities of all partners
- collective ownership of outputs and outcomes
- clarity of purpose for each partner agency

Strong partnerships are described as creating environments in which open and honest dialogue can take place, challenges are addressed effectively, and constructive criticism is embraced as a mechanism for learning and improving practice. In particular, responses to emergencies require good partnership work to be implemented swiftly and effectively.

The location of public health in local councils is said to be supportive to building alliances and developing joint work across the range of council directorates and departments. Forming a common understanding between diverse departments and on diverse topics is also identified as a potential challenge, addressed by effective leadership and allowing sufficient time to reach common understanding and agreements.

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“Excellent collaborative working was enabled by established, good personal relationships which trumped systems and bureaucracy. This was crucial to co-ordinating a swift response that required organising mass vaccination.”

Meningococcal Outbreak, South Gloucestershire.

High level sign up

Sign up and backing from senior leaders is described as important to the effective development and delivery of a number of initiatives. Where directors of public health, local councillors and heads of other directorates and departments gave their backing to specific areas of work, this helped to give the work profile and generate support for partnership working. Joined up work at a senior level, for example where directors sit on each other's Boards, is also said to be supportive to wider partnership work.

“The director of public health sitting on the LNP Board has been important to establishing a wider partnership and providing necessary impetus and profile to get the initiative under way.”

Local nature partnership, Devon

Involvement of relevant people

Identifying key stakeholders and securing their participation from as early as possible, is considered important not only to effective partnerships but also to developing a comprehensive understanding of the topic or issue of interest. Diverse agencies bring a wealth of knowledge, perspectives and networks that can have a wide reach. For example, the contribution of public health has been highlighted as beneficial to establishing health impacts of a range of council policies, programmes and the work of specialist teams located in a range of directorates and departments. Similarly, the contribution of community based organisations and staff such as GPs and linkworkers is described as providing important information about local communities and community assets without which some public health initiatives could be at risk of being less effective.

“Ensure that relevant directorates, agencies and professionals are involved from the early stages. Having the relevant people around the table can generate strength, support, funding and knowledge about who the programme should be targeted at.”

Crush, Bristol

Leadership

Strong leadership is considered important to building and sustaining effective partnerships, as is the willingness to engage in models of leadership not previously considered or utilised. Some of the case studies have found the System Leadership³

³ <http://www.leadershipacademy.nhs.uk/support/system-leadership/>

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model to provide a particularly valuable approach in developing partnership work based on its ethos of collective and distributive leadership, whereby partners lead on the areas in which they have specific knowledge and expertise.

“Collective leadership and a move from a hierarchical style to a different way of working in which partners lead on areas in which they have specific expertise.”

Food, Cornwall

Embracing change

A willingness to take risks and experiment in new ways of working is described as necessary to making the new public health system effective. Indeed, this new system is said by some to provide important opportunities for piloting new approaches, embracing the uncertainty presented by new ways of working and adopting a collaborative approach to addressing challenges. Some partnerships have found the contribution of external facilitators valuable in providing objective opinions and challenging established ways of working.

“Willingness of members of the Project Board to adopt an experimental approach and not be bound by a rigid process.”

Obesity, Gloucestershire

Tried and tested systems

Adapting and applying existing tried and tested models to address new areas of work have been described as a useful approach because they can inspire confidence among partners to build on an established method.

“The Bristol clinical team had developed a prison in-reach service, so they were familiar with some of the issues that needed addressing. People were therefore confident that the model could work and were supportive of it.”

Hepatitis C Outreach, North Somerset

Resources

Access to relevant resources and clarity regarding responsibility for funding are described as important aspects of delivering work in partnership and minimising any adverse impacts resulting from resource related issues. In addition to financial resources, the need to allocate necessary project management and administrative support have also been highlighted as has the benefit of being prepared to revise agreed timescales if deemed necessary, especially by new ways of working. Individuals often contribute to partnership work as part of their overall work schedules and it is important to be realistic regarding expectations, otherwise there is a risk that initiatives may be adversely affected due to understandable constraints on what people can realistically deliver.

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“Being able to identify and secure funding to enable the programme to be delivered more widely, following the initial delivery funded by Women’s Aid.”

Crush, Bristol

GP contribution and involvement

Some case studies present initiatives that were developed following issues raised by GPs to public health. The GP role is seen as an important contributor to identifying public health concerns based on frontline work. Collaboration between GPs and public health teams is described as essential to identifying and addressing local public health issues effectively.

“The GP and public health role have been significant; a GP communicated knowledge gained from frontline healthcare to public health and the issue is now being taken forward as part of the public health agenda in Wiltshire.”

Diabetes, Wiltshire

Necessary groundwork

Undertaking necessary groundwork is considered key to maximising successful outcomes, this may require revision of initial agreed timescales but considered worthwhile to maximising long term success. Activities such as establishing an evidence base, undertaking community consultations or addressing potential challenges to partnership work can be time consuming but considered essential to achieving successful outcomes.

“Establishing a balance between working towards pre-stated targets and outputs versus the time and flexibility necessary to support organic development and to allow for innovation (can be challenging). The words of one GP summed up the dilemma well, ‘We might hit a target but completely miss the point’”.

Obesity, Gloucestershire

Specialist skills and expertise

Access to the range of knowledge, skills and expertise required to successfully deliver some initiatives is considered important to effective development and delivery of programmes. For example, the contribution of public health to activities such as establishing an evidence base and contributing expertise in field epidemiology have been identified as necessary and valuable to the work undertaken. Without access to relevant skills and expertise some activities, such as evaluation, may not be undertaken or not undertaken robustly.

“Access to the national field epidemiology team at Public Health England was important. Specialist skills were needed, for example for data analysis, making sense of the data would not have been possible without access to the right expertise.”

Measles Uptake, Bristol

Evidence and evaluation of impact

The case studies illustrate how initiatives are at different stages in relation to evidence and evaluation of impact. Individual initiatives were discussed with respondents regarding their location on the Nesta rating scale⁴ (See also appendix 1), which provides five ratings from 'promising' at level 1 to more robust and replicable work at level 5.

All initiatives met the level 1 Nesta rating in that they could describe the work being undertaken and why it was needed. Beyond this, a number of factors impacted on classification further up the scale. Some initiatives were able to use an existing evidence base or establish a new one to inform development and delivery of the work; others found that either a lack of sufficiently robust data, or lack of access to expertise, acted as barriers to developing evidence based practice and evaluation of impact. Availability of resources is also highlighted as a key factor influencing whether and how evidence bases are used or generated and evaluation of impact undertaken. A number of initiatives are still in progress and are to be evaluated at a later stage; some will be evaluated as part of broader programmes of which they are a part such as health and wellbeing board review cycles.

“An important issue regarding evaluation of an initiative like this is that it may be difficult to undertake but vital that resources are made available to do so.”

Obesity, Gloucestershire

⁴ <http://www.nestainvestments.org.uk/wp-content/uploads/2012/10/Standards-of-Evidence-for-Impact-Investing-v10.pdf>

Case studies

Report on air quality and health in Bath and North East Somerset (B&NES) Council

Bath and North East Somerset

Summary

The report has been compiled by the Public Health and Research and Intelligence teams within B&NES Council to provide information on the health implications of poor air quality. It has three key objectives:

- to summarise the (international) evidence base on the health impacts of poor air quality
- to identify which communities within B&NES air quality management areas (AQMAs) may be more vulnerable to the negative impacts of poor air quality
- identify key learning for the Council based on above objectives

The report was completed incrementally over a period of six months for the Council's environmental protection team. It was intended that the information would be utilised to inform: the Bath Air Quality Action Plan (2011); discussions with other teams whose policies may have implications for air quality including the transport department; and, bids for funding.



Background and context of initiative

B&NES Council is a unitary authority with a resident population of 176,016 (Census, 2011). Public health is located in the People and Communities Directorate of B&NES Council. The public health team is based together in one location and works with colleagues across the council. This is supported by

hot-desking opportunities across different council buildings.

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Demographic information:

- 48.9% of the population is male and 51.1% female
- life expectancy at birth is 80.6 years for men and 84.4 years for women; there is a gap of 7.5 years for men and 4.7 years for women between those living in the most deprived and least deprived areas
- 90.1% of the population is White British
- approximately 23% of the population is aged 19 years or under, 59% are 20-64 years and 18% aged 65 years and over
- deprivation is lower than the national average but 3,700 (13.1%) children live in poverty (PHE Health Profile, 2014)

Rationale

B&NES Council has adopted a target of 30% reduction in their own carbon emissions on 2008 levels by 2014 and 45% for all emissions across the district by 2026. The Councils Air Quality Action Plan (2011) and subsequent progress reports summarise how B&NES Council is taking steps to improve air quality and monitor progress.

Air quality:

- levels of carbon monoxide, benzene and particulate matter in B&NES have not exceeded government air quality objectives
- in 2011 and 2012 levels of nitrogen dioxide at the majority of monitoring sites, exceeded the annual average objective (NO₂ concentration greater than 40 µg/m³); all these sites are within AQMAs
- road traffic in B&NES contributes up to 92% of the total nitrogen dioxide (NO₂) concentration

The aim of the report on air quality and health is to summarise the health impacts of poor air quality, and identify which groups in B&NES may be more vulnerable to the negative impacts of poor air quality.

Working in partnership in the new public health system

The report was commissioned by the Environmental Protection team. The public health team and Research and Intelligence Officer for Policy and Partnerships led the work on producing the report. The NHS Central Southern Commissioning Support Unit supplied local health data. The report is intended to inform discussions with other teams, such as Planning and Transport Development, whose policies may have implications for air quality.

Factors supportive to partnership work

Good collaboration between different departments in the council supports partnership work. An air quality working group was re-established as a result of this work; its current remit is to agree key learning from the report and communicate this to key stakeholders within the council.

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Factors challenging to partnership work

As the report was shared it became apparent that air quality is an issue of interest to many teams and councillors. In hindsight, it would have been helpful to establish the 'working group' at the project initiation stage, rather than after sharing the draft report. This would have ensured all key stakeholders were involved in steering the project from the beginning.

Process

Key actions taken to establish and deliver the work

Stage 1: project initiation involved a meeting between Public Health, Research and Intelligence and the Environmental Protection teams to identify why the project was required, its aims and objectives, outcomes and who would deliver the project.

Stage 2: project scoping. Public health developed a scoping document setting out what the project would achieve and how, to gain agreement on these from the onset.

Stage 3: project delivery. A public health specialty registrar and research and intelligence analyst worked in partnership to produce the report Air Quality and Health in B&NES.

Stage 4: sharing learning. Key learning from the report was shared initially with the Environmental Protection Team through email and a discussion. It was then shared with other members of the Environmental Services Division, a transport representative and councillors.

Stage 5: review and adaptation. Feedback was gained through the above process and the report was adapted.

Stage 6: taking action. A 'working group' has been set up with stakeholders from public health, environmental protection, and Planning and Transport Development. Its objectives are to discuss the report, agree any changes/amendments, agree key learning and identify how it should be used to inform council policy. Learning from the report will inform the consultation for Bath's Transport Strategy (for example, 'Getting Around Bath' <http://www.bathnes.gov.uk/consultations/getting-around-bath-draft-transport-strategy>).

Timescale

The work was undertaken over a period of six months during 2013/14 and completed in July 2014.

Resources

The report was developed by a Public Health Specialty Registrar, and Research and Intelligence Officer, with input from the Environmental Protection Team.

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Structure of initiative

Initial discussions took place on an informal basis. An air quality working group was set up after the first draft of the report was produced and this group has responsibility for making decisions. Work on producing the report was managed and undertaken by staff from the public health and research and intelligence teams.

Key supportive factors:

- good collaboration between the Public Health, Research and Intelligence, and Environmental Protection Teams
- establishing a 'working group' of key council stakeholders helped: gain stakeholder engagement with the project; obtain further comments and feedback; develop a shared understanding of 'key learning' from the report; and enable actions to be agreed regarding how this learning would be utilised to inform council policy

Key challenging factors

Challenges in communicating the risks associated with air pollution were encountered with different views on how this should be done. A number of reiterations of the report were made to ensure that risk was communicated accurately and objectively, and to try and ensure as little misinterpretation of the risks as possible.

Outcomes

A report which:

- summarises the (international) evidence base on air quality and health
- identifies which communities within B&NES air quality management areas (AQMAS) may be more vulnerable to the negative impacts of poor air quality
- shares key learning from the above

Evidence and evaluation of impact

The Air Quality Working Group will consider how the report could be evaluated to ensure that learning from the report has been utilised and made an impact.

Learning

Key messages for people thinking to undertake similar work:

- ensure information about risks to health and the robustness of the data are communicated clearly and are not misleading
- request health data early so that you receive it in a timely way

Key messages regarding working collaboratively in the new public health system

Set up a 'working group' at the beginning of the project (rather than after a draft report has been shared) so that all stakeholders are engaged early on.

Conclusions

It is intended that learning from the report will be used to inform key strategies and plans, including B&NES air quality action plans and B&NES transport strategy ('Getting Around Bath'). More generally a good outcome for the public health team, the council and hopefully the residents of B&NES is that this work has shown that health and wellbeing can be designed into new developments, systematically and within realistic resource constraints.

This support to planning and transport colleagues has been appreciated by officers and councillors alike and has strengthened the profile of the public health team right at the start of its time in the council. Although in theory there was no barrier to such work being done when public health teams worked in the NHS, in practice being in the same organisation has greatly facilitated this work and increased its impact. Finally, of course, while this is indeed good progress, it is but one step on the road to improving the air quality of the hotspots of B&NES.

Further information

Useful reports on air quality:

- Cabinet Office (2009). *The wider costs of transport in English urban areas in 2009* <http://webarchive.nationalarchives.gov.uk/+http://www.cabinetoffice.gov.uk/media/307739/wider-costs-transport.pdf>
- COMEAP Reports: see <http://www.comeap.org.uk/documents/reports>
- Public Health England, CRCE – 010 (2014) *Estimating local mortality burdens associated with particulate air pollution* <http://www.hpa.org.uk/Publications/Environment/PHECRCEReportSeries/PHECRC010>
- World Health Organisation (2013). *Review of evidence on health aspects of air pollution – REVIHAAP Project Technical Report* <http://www.euro.who.int/en/health-topics/environment-and-health/air-quality/publications/2013/review-of-evidence-on-health-aspects-of-air-pollution-revihaap-project-final-technical-report>

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CRUSH: domestic violence and abuse intervention with teenagers

Bristol

Summary

CRUSH is part of a wider initiative called the 'Bristol Ideal' which aims to ensure that all schools in the city develop a whole school approach to preventing domestic and sexual violence in all its forms. The CRUSH programme, developed by West Mercia Women's Aid, is an evidence-based domestic violence and abuse (DVA) intervention aimed at 13-18 year olds. The main focus of this programme is to train facilitators to undertake structured groupwork with young people in their practice settings. The programme aims to raise awareness about DVA, support recovery for victims and facilitate longer term change in values and attitudes regarding DVA.



Background and context of initiative

Bristol City Council is a unitary authority with powers of a non-metropolitan county and district council combined. The resident population is 428,234 (Census, 2011). The public health team is located in the Neighbourhoods Directorate, other Directorates also have public health responsibilities. The DVA team is located within Safer Bristol, a partnership that focuses on tackling crime, domestic abuse, drugs and alcohol.

Demographic information:

- 49.8% of the population is male and 50.2% female.
- life expectancy at birth is 78.3 years for men and 83 years for women; there is a gap in life expectancy of 8.2 years for men and 6.1 years for women between the most deprived and least deprived areas of Bristol
- 77.9% of the population is White British
- approximately 24% of the population is aged 19 years or under, 63% aged 20-64 years and 13% aged 65 years and over
- deprivation is higher than average and 19,600 (25.3%) children live in poverty (PHE Health Profile, 2014)

Rationale

Across Bristol, the Home Office estimates that 14,273 women and girls aged 16-59 have been a victim of domestic abuse in the year 2010/11.⁵ The cost to the local economy is over £40 million per year but the cost to victims and their families is immeasurable. The World Health Organisation describes violence against women as an 'epidemic' and says one in four women will experience it in their lifetime⁶.

The public health team in Bristol was approached by West Mercia Women's Aid to discuss CRUSH and its potential implementation in the city. Public health were confident to support the proposal because the programme is evidence based and deemed safe for use with male and female young people who have experienced DVA, or are at risk of experiencing it. DVA interventions are usually aimed at adult females but because young people experience high rates of DVA themselves and the CRUSH intervention is aimed at both males and females, the programme was something Bristol Public Health felt would fill a gap. This programme was relevant to addressing a key public health issue in Bristol – one that is both part of the Police and Crime Commissioner's and the local health and wellbeing board's targets.

The focus of the programme is on prevention and early intervention with the aim of changing norms and values related to DVA which contribute to its perpetration.

CRUSH is targeted at training facilitators who, in turn, deliver structured groupwork sessions to 13-18 year olds in agreed venues such as schools, youth clubs and other community and voluntary groups.

Working in partnership in the new public health system

Women's Aid, Bristol Public Health, The Domestic Violence Prevention Steering Group and Bristol City Council's Early Help Team were involved in initial discussions. Further partnerships have been developed and formal agreements put in place with organisations wanting to facilitate their staff to receive CRUSH training. In Bristol, participating organisations have included schools, family intervention teams, Brook Advisory Service and Next Link.

Factors supportive to partnership work

Public health in Bristol had already undertaken a significant amount of work to highlight DVA as being everybody's business and it had therefore been incorporated as one of

⁵ Smith K, Osborne S, Lau I et al. (2012) Homicides, firearm offences and intimate violence 2010/11: supplementary volume 2 to Crime in England and Wales 2010/11. London: Home Office

⁶ Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. WHO 2013 http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf and http://www.who.int/mediacentre/news/releases/2013/violence_against_women_20130620/en/

Paths to public health and wellbeing

the areas in the Health and Wellbeing Strategy. As a result, the issue already had some profile in the city and this was helpful in implementing the CRUSH programme. More specifically:

- there was already recognition among key organisations of the high rate of DVA and the need for prevention and early intervention work
- good, strong links were already established with local agencies and professionals who could support and take the programme forward

A dedicated CRUSH coordinator, based at St Mungos oversees and coordinates delivery of the programme in Bristol.

Factors challenging to partnership work

There have been no specific challenges relating to partnership work. One issue that became apparent was that participants attending the CRUSH course were not always able to deliver subsequent groupwork to young people due to other demands. This has been addressed through the formal agreement that all trainees and their managers sign up to, requiring trainees to deliver a minimum of two courses to young people within 18 months of completing CRUSH training; this is monitored by the CRUSH Coordinator.

Process

Key actions taken to establish and deliver the work.

Stage 1: Women's Aid approached Public Health Bristol to discuss potential implementation of the programme in Bristol. The proposal was discussed with the Domestic Violence Prevention Steering Group. Implementation of the programme in Bristol was agreed.

Stage 2: Women's Aid funded and delivered the Crush programme to some organisations in Bristol over two training dates.

Stage 3: Public Health Bristol considered how well the programme could work and whether it could be delivered to more people and decided to support further implementation.

Stage 4: Bristol City Council's Early Help Team and Public Health sourced some funding to enable the next round of training,

Stage 5: Public Health Bristol and partners will reflect on next steps when the current training programme delivery for Facilitators ends in October 2014

Timescale

Roll out of the training programme in Bristol commenced in October 2013 and delivery of courses to young people should be completed by March 2016 with the hope that more might run into the future. Public Health Bristol will then consider evaluation data and decide whether to continue making the programme available and how.

Resources

The initial delivery of the programme in October 2013 was funded by Women's Aid. Funding for the second round of training (3 dates) currently under way, was sourced by public health and the Early Help Team. The Crush Coordinator post is funded by Safer Bristol.

Structure of initiative

Strategic level decisions are made by Public Health Bristol, Safer Bristol, Early Help Team and the Domestic and Sexual Violence Steering Group. The programme is managed by the CRUSH Coordinator and a member of the Violence and Abuse Against Women and Girls (VAAWG) public health team. Women's Aid deliver CRUSH training and collect monitoring and evaluation data. Trained Facilitators deliver groupwork to young people.

Key supportive factors:

- being able to identify and secure funding to enable the programme to be delivered more widely, following the initial delivery funded by Women's Aid
- having an already established Prevention Steering Group on domestic violence which meant there was good understanding of local DVA issues among key players before the approach from Women's Aid
- several years of work on DVA undertaken prior to the introduction of CRUSH and widespread awareness of the issues meant significant numbers of people were keen to support delivery of CRUSH in Bristol

Key challenging factors

Several agencies being in flux resulted in trained trainers being unable to promptly deliver groupwork to young people. This has been addressed by asking Managers to formally agree in a contract that they agree to their staff: participating in CRUSH training; and, to deliver a minimum of two groupwork courses to young people within 18 months of completing training.

There was potential for groupwork to be delivered largely to girls due to the focus on females regarding this issue. This is being addressed by asking trainers to run mixed groups and/ or all male groups.

Outcomes

The programme is still under way and aims to achieve the following outcomes:

- raise young people's awareness of issues relating to DVA and inspire them to advocate the cause to peers
- support recovery for those who are victims of DVA
- address the gap in DVA interventions with a focus on prevention and early intervention
- a longer term change in attitudes to DVA over a period of 5-10 years

Evidence and evaluation of impact

An evaluation of the overall CRUSH programme was conducted by University of Worcester⁷ prior to implementation in Bristol. Ongoing monitoring data for specific training and groupwork courses is collected by Women's Aid from several sources and an evaluation for the Bristol programme is due to be completed in April 2016; this is to allow for the final set of professionals undergoing training in October 2014 to be able to deliver groupwork to young people within the agreed timescale of 18 months. The following data is collected for evaluation purposes:

- professionals receiving training and young people participating in groupwork are asked to complete evaluation forms which are collected by Women's Aid staff and the Crush Coordinator
- practitioners delivering groupwork are asked to build in case studies to capture some of the qualitative aspects that cannot be captured by quantitative analysis

Learning

Key messages for people thinking to undertake similar work:

- this is important work on DVA prevention and early intervention that uses an evidence based programme
- once trained, practitioners should be able to identify the most vulnerable young people in their locality or work context
- engaging and working with schools is good for reaching a large number of young people
- clarify with professionals that they have relevant safeguarding training and groupwork skills to be able to confidently and safely deliver structured groupwork to young people
- obtain signed agreement from Managers, that they agree to the training and related groupwork being part of the job role of their participating staff who will deliver a minimum of two groupwork courses to young people

Key messages regarding working collaboratively in the new public health system:

- ensure that relevant directorates, agencies and professionals are involved from the early stages
- having the relevant people around the table can generate strength, support, funding and knowledge about who the programme should be targeted at
- build and align the work into priorities of other directorates and programmes

⁷ Thiara, R.K. and Ellis, J. (2013) Centralising Young People: An Evaluation of the Crush Programme. University of Worcester

Conclusions

It is too early to reach definitive conclusions because the programme is still being delivered. Professionals receiving the training are required to deliver a minimum of two structured groupwork courses to young people so the work is sustained after participation in training delivered by Women's Aid. The programme will be reviewed after March 2016 to help decide if the facilitator training is to be made available more widely and how this can be achieved.

Further information

- Bristol Ideal website - www.bristolideal.org.uk
- Crush Evaluation - http://www.westmerciawomensaid.org/component/docman/doc_download/123-crush-evaluation-report-may-2013
- CRUSH website - <http://www.westmerciawomensaid.org/crush>

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MMR uptake: improving uptake of measles, mumps and rubella (MMR) vaccine in inner city Bristol

Bristol

Summary

Part of the national campaign to increase uptake of the MMR vaccine, this initiative focused on developing an approach that would facilitate uptake of the vaccination in Bristol. A multidisciplinary group involving all sections of the new Bristol health system was convened to develop a project targeting inner city Bristol. This area historically has low MMR uptake rates, is ethnically diverse and has high levels of deprivation suggesting that barriers exist to MMR uptake in inner city Bristol. Immunisation uptake data in Bristol was validated by comparing the General Practice records for 10-16 year old children with the records held on the Child Health Information System.

The ethnic and language characteristics of individuals with the lowest MMR uptakes were identified using the software package Onomap, and then by hand searching of General Practice records. This enabled specialist Black and Minority Ethnic (BME) locality Health Link Workers to be appropriately allocated to facilitate access for these families into primary care immunisation clinics.



Background and context of initiative

The Bristol local authority public health team is located in the Neighbourhoods Directorate, other Directorates also have public health responsibilities.

Bristol City Council is a unitary authority with powers of a non-metropolitan county and district council combined. The resident population is 428,234 (Census, 2011).

Paths to public health and wellbeing

Demographic information:

- 49.8% of the population is male and 50.2% female
- life expectancy at birth is 78.3 years for men and 83 years for women. There is a gap in life expectancy of 8.2 years for men and 6.1 years for women between the most and least deprived areas of Bristol
- 78% of the population is White British
- approximately 24% of the population is aged 19 years or under, 63% aged 20-64 years and 13% aged 65 years and over
- deprivation is higher than average and 19,600 (25.3%) children live in poverty (PHE Health Profile, 2014)

Rationale

In April 2013, a national MMR catch up campaign was announced to improve immunisation rates in 10-16 year old children in England; it was recognised that this was an important opportunity to improve take up locally. National and local data on uptake identified that there was a particular risk of outbreaks in inner city Bristol due to the particularly low uptake.

The aim of the initiative was to increase uptake of the vaccine and protect the population against measles. It was targeted to areas where there was low uptake. These areas had a high BME population, including a large Somali community.

Working in partnership in the new public health system

The initiative was a partnership based approach. A steering group was set up and included: NHS England/Public Health England Screening and Immunisation Team; local authority public health team; Health Protection Unit; Bristol Clinical Commissioning Group; Health Link Workers; Health Improvement Locality Teams; GPs; community provider services; PHE Field Epidemiology Team; and, several others. There had been a prior campaign as part of the national initiative, therefore many of the relevant key professionals, agencies and groups were already known which made it easier to identify and invite people to join the steering group.

Most people on the steering group joined from the start; the few that joined later on were people who could potentially provide funding and other resources needed to progress the initiative. Roles and responsibilities were discussed and agreed in the steering group and set out in an action plan.

Factors supportive to partnership work:

- shared commitment from the outset from all members to progress this work
- a shared belief that this work was necessary
- the opportunity to pilot this approach in the newly reformed public health system
- support and backing from the director of public health, it was important to have this high level endorsement

Paths to public health and wellbeing

Factors challenging to partnership work

A lack of clarity regarding some responsibilities, such as, how, and who, should fund elements of the initiative from within the newly established public health system. This was resolved by inviting potential funders/resource owners to join the steering group.

Process

A Consultant in Public Health – Screening and Immunisation Lead – led on the initial work. Once the steering group was up and running, this group decided on allocation of tasks and responsibilities, both within and outside the steering group.

Stage 1: the issue of low uptake in Bristol was already recognised, the national drive was seen as an opportunity to address this.

Stage 2: a steering group was set up bringing together a wide range of partners

Stage 3: a scoping exercise was undertaken.

Stage 4: an action plan and options for undertaking the work were developed by the steering group.

Stage 5: a data cleansing exercise was undertaken to deal with the lack of reliable information to identify individuals in the targeted communities.

Stage 6: GP Practices worked with Health Link Workers to invite identified children and to facilitate access to appointments, following up where parents did not attend.

Stage 7: outreach work was undertaken to highlight the importance of this vaccination and individuals were vaccinated by eight inner city practices.

Stage 8: evaluation was undertaken with significant input from Public Health England Field Epidemiology Team and completed in May 2014.

Timescale

The project was set up in September 2013; patient contact for vaccination took place between December 2013 and January 2014. A project evaluation report was completed in May 2014.

Resources

No national monies were available so it was necessary to locate a Commissioner in the new public health system locally who could fund the work. Ultimately, some funding came from NHS England and some agreements were reached within the group to provide resources in kind. Members of the steering group contributed skills, knowledge and expertise as part of their work programmes.

Structure of initiative

The Screening and Immunisation Team provided leadership and the steering group made decisions. Managerial and operational elements of the campaign were overseen by the Screening and Immunisation Team and Public Health Bristol.

Key supportive factors:

- a national imperative which gave a sense of importance to the need to support local improvement
- local commitment – people were committed because of the national campaign and saw it as an opportunity not to be missed for making local improvements
- transferable learning – uptake was low for other initiatives before the measles campaign, and it was felt the work undertaken on this campaign may have valuable learning and messages that could be applied to other work in future
- access to the national Field Epidemiology Team at Public Health England was important; specialist skills were needed, for example for data analysis, making sense of the data would not have been possible without access to the right expertise
- Health Link Workers – played a vital role as they knew who to contact, whether it was individual patients or key community leaders and whether contact needed to be made by Health Link Workers or could be made by administrative staff in the practices. This was very important and something the public health team could not have done alone because they do not hold all the relevant knowledge or contacts

Key challenging factors

Poor data was a recognised challenging factor. Anomalies in the data and its poor quality meant there were difficulties identifying who had and had not received the vaccination; it was also difficult to identify patient ethnicity from Onamap or GP records and initially people tried to identify by names that were recognised by Health Link Workers as potentially belonging to a person of BME origin; later it was discovered that BME children could have been identified through school records held by the local authority. It was also found that data held by GPs did not always match the data held by the child health system; the issue is now recognised nationally. Competing priorities in the new system and insufficient capacity to take on extra tasks such as locating and securing necessary funding were also significant challenges.

The challenges were resolved through commitment and persistence of members of the steering group to find solutions and by having someone identified to lead on and coordinate efforts

Outcomes:

- uptake of the vaccine increased significantly (from 59% to 74%) and is higher than was demonstrated nationally
- an established role and contribution of the Screening and Immunisation Team in the local public health system
- increased understanding of the new public health system through working in partnership with a wide range of professionals and agencies
- good links built and relationships established which will have enduring benefits for future work on other issues and topics

Paths to public health and wellbeing

- information about uptake has been cleansed and highlighted that more individuals had in fact been immunised than indicated by the data obtained early on; it is now possible to break down the uptake by specific localities in the city and uptake is continuing to improve
- it has become apparent through this work that uptake was low in the White British population as well as the BME population this knowledge confirms that the issue of low uptake related to geographic areas of significant deprivation as well as ethnicity and that the initiative to improve support to BME populations also had benefits for the wider population
- contribution from the Screening and Immunisation Team to the national MMR campaign evaluation as a member of the steering group

Evidence and evaluation of impact

The initiative was evaluated by the field epidemiology team at Public Health England and concludes that Phase 1 of the campaign demonstrated that the single biggest intervention to improve MMR uptake rates was to cleanse the data. Whilst this led to a significant increase, a small but substantial cohort of unvaccinated children remained. Overall, phase 2 of the campaign (to improve uptake in this cohort), had good outcomes in that it resulted in the vaccination of 82 children.

The percentage of children vaccinated with at least one measles containing vaccine increased from 85.9% at the end of Phase 1 to 91.7% at the end of Phase 2. Even though 82 children vaccinated from a cohort of over 1,000 is small, only a small increase in uptake may be required to prevent outbreaks. A large amount of time and resource went into planning and delivering this campaign. Whilst there were lessons learnt that can be applied to future catch-up campaigns, a better approach would be to implement the recommendations now to prevent the need for a catch up campaign in the future.

Learning

Key messages for people thinking to undertake similar work:

- identify and bring on board relevant stakeholders from as early as possible, ensuring that the right knowledge, skills and expertise are represented on the group
- listen to the priorities of stakeholders, this is important in order to align priorities across several organisations and projects; aligning of priorities across stakeholders is very important and should not be underestimated
- involve key partners such as the director of public health from the outset and facilitate continued involvement by teleconference if necessary; this is important because their overall feedback, contribution to design of the project and to troubleshooting is valuable and made easier if they have ongoing involvement and are kept updated

Key messages regarding working collaboratively in the new public health system:

- it can be difficult to articulate the new PH system to people who don't directly work in it – even to GPs
- it is important to establish, at the start of the project, what the key players in the new public health system can offer; in this project for example, it was necessary to: a) identify who would fund the work at a crucial stage in the project; b) undertake significant work on identifying BME children and young people before it emerged this information was held by the local authority for school age children
- there can be a lack of agreement between stakeholders about how the public health system should work; it is important to focus on and work towards a shared perspective in relation to the specific initiative for which people have come together
- public health needs to develop a shared vision with partners or it may not progress sufficiently

Conclusions

The Screening and Immunisation Team who have been involved in the ongoing national evaluation of this campaign are also members of the national MMR Campaign Evaluation steering group. Locally, as a result of the work undertaken for this initiative, there is now improved data to inform future work.

Lessons learned from undertaking this campaign will continue to inform other areas of screening and immunisation work and have been built in to the current routine work programme. Further action is planned to develop a strategy to inform and support future work on needs analysis and immunisation uptake.

Further information

- <https://www.gov.uk/government/publications/evaluation-of-vaccine-uptake-during-the-2013-mmr-catch-up-campaign-in-england>
- <https://www.gov.uk/government/publications/mmr-vaccine-dispelling-myths>

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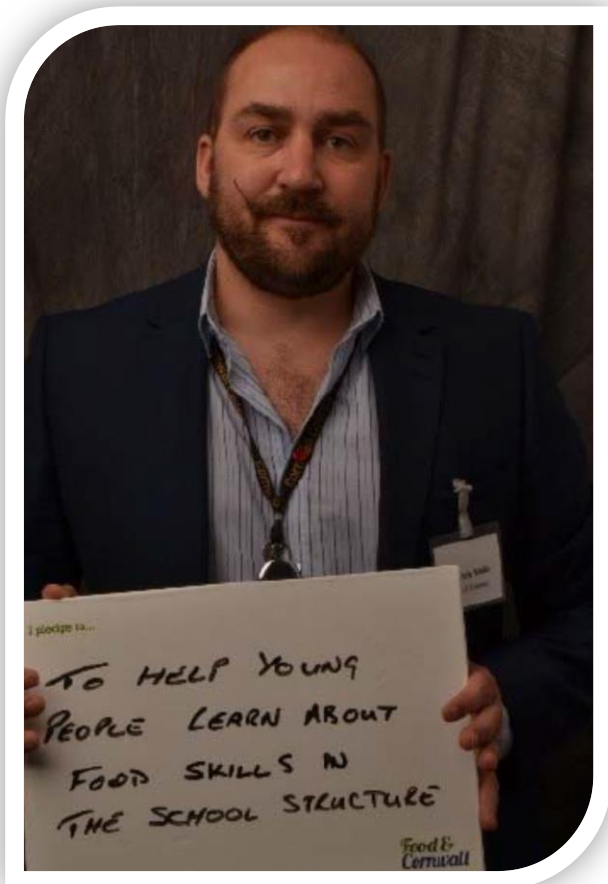
Food and Cornwall: creating food wealth so that no one in Cornwall is hungry

Cornwall

Summary

Cornwall was selected by the national System Leadership Programme to develop its innovative Food and Cornwall programme as a national example of good practice. The Food and Cornwall programme works to tackle food poverty using economic, environmental, social and political systems in Cornwall by engaging leaders and key local champions on increasing access to good nutritious food across the population.

The programme emphasises the involvement of communities, drawing on local assets and listening to local voices. Work is based around social movement theory, mobilising commitment to action and developing networks between communities, organisations and individuals. The programme has a number of interconnected project workstreams which have identified clear priorities to implement action addressing food poverty and health inequalities.



Background and context of initiative

Cornwall Council is a unitary authority with a population of 532,273 (Census, 2011). Public health is located in the Education, Health and Social Care Directorate and provides the strategic lead for development and action in health improvement, healthcare and health protection public health across Cornwall.

Paths to public health and wellbeing

Demographic information:

- 48.4% of the population is male and 51.6% is female
- life expectancy at birth is 79.5 years for men and 83.5 years for women; there is a gap of 4.3 years for men and 3.9 years for women between the most deprived and least deprived areas of Cornwall
- 95.7% of the population is White British
- approximately 21.7% of the population is aged 19 years or under, 56.7% aged 20-64 years and 21.6% aged 65 years and over
- deprivation is lower than average but 16,200 (18.1%) children live in poverty (PHE Health Profile 2014)

Rationale

The impetus for this work came from evidence of the rising number of individuals and families in Cornwall using foodbanks and the indication that food poverty was becoming a significant issue. Levels of childhood obesity are significantly higher in areas of deprivation. Taking a whole systems approach was deemed appropriate to address inequalities in access to good nutritious food. Initial work was undertaken to look at what was working well and identify gaps. A definition of food poverty was formulated which included the poverty of skills and knowledge for growing, buying, preparing and cooking as well as knowledge about the nutritional value of food in addition to inadequate supply and barriers to access. The programme includes wider issues of poverty in communities, families and individuals. Several sources of data were used to build a picture regarding the impact of food on health in Cornwall, including: the Joint Strategic Needs Assessment (JSNA) related to diet, obesity, diabetes and other long term conditions; Public Health Outcomes Framework indicators on excess weight, diet and dental health; National Child Measurement programme data; and, a range of other indicators regarding the health and wellbeing of people in Cornwall. This included information on the impact of social connectedness on health and wellbeing.

The overall aim of Food and Cornwall is to create food 'wealth' so that nobody in Cornwall goes hungry. The work is targeted at vulnerable groups and communities reached through place based approaches that bring together families, community groups, charities and people using and providing emergency food provision and support.

Working in partnership in the new public health system

The bid to the System Leadership Programme was submitted by public health on behalf of the Cornwall Health and Wellbeing Board, local nature partnership and local economic partnership. Developing workstreams and action priorities was co-produced by all partners. Partners include: the health and wellbeing board; local economic partnership; local nature partnership; Cornwall Council Cabinet; Cornwall foodbank representatives; senior leaders of voluntary and community organisations; faith group representatives, Cornwall College Food Production Department; and others.

Paths to public health and wellbeing

Factors supportive to partnership work:

- shared understanding and values around issues of inequality and food – spending time to understand each other's core values has enabled finding common ground and shared values
- collective leadership and a move from a hierarchical style to a different way of working in which partners lead on areas in which they have specific expertise
- distributive leadership whereby power is allocated where the expertise sits, not just one person or group taking the lead all the time
- characteristics of system leaders, driven by values and outcomes

Factors challenging to partnership work:

- embracing uncertainty presented by a new way of working
- it can be challenging to ensure that evidence forms a key component within dynamic and creative processes led across partnerships

Process

Key actions taken to establish and deliver the work.

Stage 1: discussions took place between members of the Council Cabinet and Chairs of partner groups about developing priority areas; nine workstreams were identified to take the work forward, with clear outputs and outcomes.

Stage 2: the Senior Leader Group that developed and submitted the bid was expanded to form a Development Group to engage more stakeholders, build a shared public narrative and generate commitment to action.

Stage 3: a Food and Cornwall conference was held, a website launched and Food Activists across the system pledged to action.

Stage 4: workstream projects progressed their specific areas of work – these included the broad areas of emergency food provision & sustainable approaches, skills and learning, good food across the life course, longer term planning for food security; evidence was given by the Food and Cornwall Programme to the All Party Parliamentary Inquiry into Hunger and Food Poverty.

Stage 5: discussions and planning begins on taking forward an embedded implementation phase with an action plan to 2016.

Timescale

Work on strategy development commenced in September 2013 and this phase of the work was completed in March 2014. Work to be done on strategy implementation is currently under discussion and due to be completed in 2016.

Resources

Some funding was made available by the System Leadership Programme for the strategy development phase and was match funded by the health and wellbeing board. Partners have made contributions in kind of time, expertise and commitment to future action. Cornwall College Media Department worked with local charities to facilitate community engagement to develop the work to produce 'Local Voices' films.

Structure of initiative

Following senior leader engagement, the expanded development group was established and meets on a regular basis to monitor action across workstreams and develop forward plans. Public health provides support for the key elements of the System Leadership Programme and approach; strategic partnerships, social media and marketing, monitoring, evaluation evidence building. Otherwise there is no hierarchy or singular leadership within the ethos of the System Leadership Programme whereby individuals lead on the areas in which they can offer expertise.

Key supportive factors:

- engagement with senior political, economic and environmental leaders
- developing shared understandings of health, inequality and well being
- commitment, enthusiasm and determination of the partners involved
- leaders across the system connecting to form strategic partnerships
- combining resources so that a little contribution from many people can result in a significant resource when combined

Key challenging factors:

- limited resources including time constraints
- focusing an extremely wide health and wellbeing agenda around food poverty into priorities for action

Outcomes

Whilst the programme will evaluate longer term outcomes in due course, early outputs from Food and Cornwall suggest the System Leadership approach has already had an impact on place based asset building for health and wellbeing;

Local Voices: listening to local voices and community participation has influenced the direction of the programme and project workstreams. A short film 'Telling it like it is', has been produced, it was created and developed by local people sharing their stories of experiences of food poverty. See www.foodandcornwall.org.uk/fac-conference/food-poverty---telling-it-like-it-is/

Paths to public health and wellbeing

Food in Schools: strategic collaborative work with schools has led to a number of schools now working on Good Food for All and Plot to Plate approaches to transform whole school food culture.

Distribution and Surplus: in collaboration with a cross county charity, a new pilot site has been developed to redistribute surplus food in Cornwall to those in most need. During this early stage it will map need and test models of distribution in Cornwall to explore the most effective design and delivery.

Growing, Cooking and Eating Skills: cooking skills demonstrations have been delivered in communities, health and social care, education and business. This has led to ongoing collaborations across the system.

Emergency Food & Sustainable Support: support for emergency food assistance in Cornwall to better meet both immediate and long-term needs. The work has engaged with community kitchens, local food charities and foodbanks to support the development of models based on providing wider ongoing support to people in food poverty crisis to provide longer term solutions.

Food and Older People: strategic collaborations between public health and protection and adult social care have led to pilot lunch clubs to improve the quality of food supplied to older people.

Good Food Across Settings: this workstream is supporting catering standards and good food culture in Hospitals, Care Homes, Schools & Early Years Settings. Including effective procurement of local/quality food, catering skills, peer learning, effective employer led skills development.

Evidence and evaluation of impact

Under the programme, a systematic review of published literature was conducted and identified insufficient systematic evidence in the UK in specific areas of community food intervention. It is important to develop an evidence base to inform strategic actions to promote food security. The programme will develop research questions as proposals for a bid for European funding on System Leadership food poverty interventions to build the evidence base.

A learning history was conducted via interviews with key partners which has documented the views of people involved in the early stage of the programme. Evaluation pilots are collecting monitoring information from the workstream projects.

Learning

Key messages for people thinking to undertake similar work:

- engage with local communities, listen to them and to those who work with them

Paths to public health and wellbeing

- value and interpret what has happened before and build learning into new ways of working
- bring technical public health skills into the mix of creative innovation and social movement

Key messages regarding working collaboratively in the new public health system:

- draw on skills from across the system to inform wider wellbeing and associated aims
- work with key partners to highlight the economic and industry case for action alongside health, social, environmental and community case
- enable distributed leadership across the system

Conclusions

There are profound health and wellbeing challenges facing the population in Cornwall. To make a really significant impact in reducing health inequalities, food poverty was seen as a focus for a System Leadership approach. The Food and Cornwall programme brought together leaders with diverse backgrounds from across the boundaries of different organisations and from across the environmental, economic, political, social and community systems.

Leaders worked together and focused small resource towards building shared commitment and agreeing a clear set of objectives. Collaborative actions are focused on reducing food poverty via a set of interconnected project work streams. There is much more to do and the system leaders will continue to work to create food wealth so that no one in Cornwall is hungry

Further information

- Food and Cornwall website - <http://www.foodandcornwall.org.uk/>

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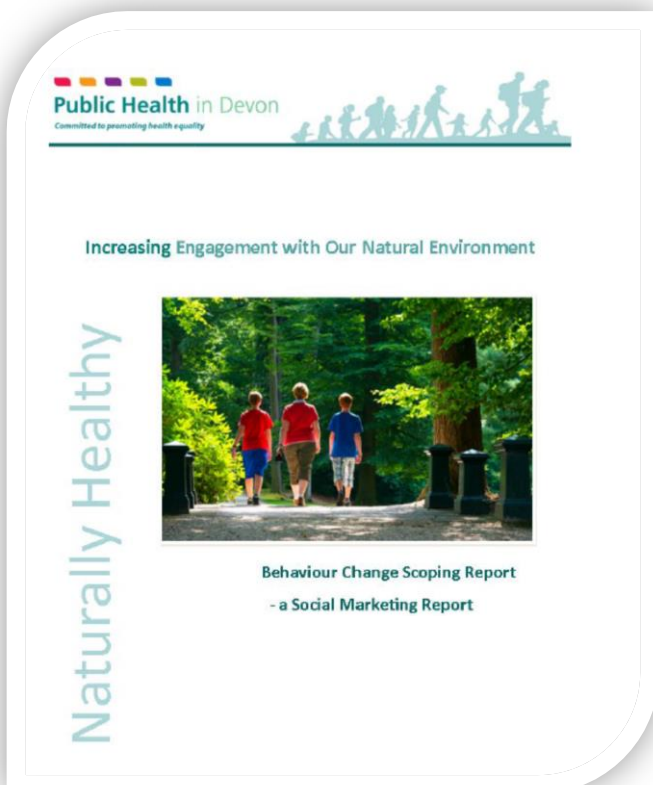
Naturally Healthy: a partnership between public health and the Devon Local Nature Partnership to promote health equality and improve health

Devon

Summary

Public Health Devon and the Devon Local Nature Partnership (LNP) have established a partnership to champion Devon's natural environment as a way of securing good health and wellbeing for Devon's population. A Naturally Healthy Task and Finish Group has brought together several partners from the health, public, voluntary and environmental sectors to oversee delivery of the LNP's Naturally Healthy Priority.

The group has decided to focus on encouraging access to the natural environment by those not currently accessing. To direct energies into the right elements, a social marketing behaviour change scoping review has been undertaken that will provide an evidence based practical resource. The scoping exercise and report are the means for providing intelligence needed to design an effective intervention and communications campaign that will be taken forward by local organisations.



Background and context of initiative

Devon County Council is 2-tier local authority, in addition to the county council there are 8 non-metropolitan districts with their own district, borough or city council. Devon has a population of 746,399 people (Census, 2011).

Public health is located in its own directorate in Devon County Council and works closely with other directorates. The core offer provision from public health is delivered in partnership with Plymouth and Torbay public health for the North Eastern and Western Devon CCG and the South Devon and Torbay CCG.

Paths to public health and wellbeing

Demographic information:

- 48.5% of the population is male and 51.5% female
- life expectancy at birth is 80.4 years for men and 84.1 years for women; there is a gap of 4.9 years for men and 3.2 years for women between the most deprived and least deprived areas
- 94.9% of the population is White British
- approximately 21% of the population is aged 0-19 years, 56% aged 20-64 years and 23% aged 65 years and over
- deprivation is said to be lower than the national average but 16,800 (13.6%) children live in poverty (PHE Health Profile 2014)

Rationale

Devon has a huge number of natural resources that have a potential benefit for both physical and mental health. Public health and the LNP share similar goals in relation to improving access to green spaces and increasing physical activity levels; setting up a Naturally Healthy Task and Finish Group was seen as a means for taking forward the Naturally Healthy Priority of the LNP. Making the link between natural resources and their potential health benefits was facilitated by the director of public health sitting on the LNP Board alongside the chair of the Devon Health and Wellbeing Board (the county councillor portfolio holder for health and wellbeing).

The initiative aims to support the environmental sector to embed health benefits of the natural environment into their strategic priorities and to improve access for members of the public. People not accessing the natural environment, such as those living in areas of deprivation or with long term health conditions, are specific target groups for the initiative alongside children and young people with their families and schools.

Working in partnership in the new public health system

The LNP initially approached public health to discuss improving access to the natural environment and related health benefits. Broader partnerships were subsequently established through setting up the Naturally Healthy Task and Finish Group whose membership includes several organisations including: public health, clinical commissioning group, Devon County Council, Community Council of Devon, Devon Wildlife Trust, Dartmoor National Park and several others including community and voluntary organisations.

Membership of the group has fluctuated with the range of partners joining at different stages, the partnership is being strengthened by linking health benefits with the strategic priorities of partners. The group has been chaired by public health with a view that the Chair will rotate in future.

Factors supportive to partnership work:

- the environment sector wanted to establish and demonstrate the links between the natural environment and health; this was an advantage for public health to work with a sector already interested in exploring potential partnership work
- location of public health in the local authority has provided a good opportunity for developing this initiative jointly

Paths to public health and wellbeing

- high level sign up and the director of public health sitting on the LNP Board has been important to establishing a wider partnership and providing necessary impetus and profile to get the initiative under way
- high level sign up with the chair of the Devon health and wellbeing board sitting on the LNP board has led to the signing of a compact between the two boards in March 2014 to align their priorities
- linking the work with the strategic priorities of partners has helped to create a shared vision

Factors challenging to partnership work:

- initially it was a challenge to develop common understanding of the issues between professionals from a range of health and non-health working environments
- capacity for public health to undertake this work over and above existing priorities

The challenges have been addressed by conveying that the work was achievable but may take time to set up and develop as a partnership approach. Taking an evidence and process based approach has been valued by partners, in particular those from non-health based working environments, who have appreciated the need to undertake necessary groundwork first to inform future actions.

Process

Key actions taken to establish and deliver the work.

Stage 1: the LNP approached public health Devon to discuss potential links and partnership work to improve access to the natural environment.

Stage 2: a Naturally Healthy Task and Finish Group was set up, bringing together a range of partners from different sectors.

Stage 3: the group discussed and agreed that more intelligence was needed to support development of effective interventions and a communications campaign; agreement was reached that this was to be achieved by undertaking a Social Marketing behaviour change scoping exercise and producing a report.

Stage 4: a literature review was undertaken on the 'Benefits to Health of Engagement with the Natural Environment'; alongside this, facilitators were appointed to undertake focus groups with people living in a rural area and an urban area of Devon to establish their views regarding barriers and motivators to accessing the natural environment for health benefits.

Stage 5: a behaviour change scoping review was written by public health and is a practical resource for those interested in encouraging people to secure the health benefits of the natural environment; future next steps are to disseminate the review widely amongst partners of the LNP to encourage providers of existing and future initiatives to effectively communicate the benefits of accessing the natural environment and to support increased access by those groups not currently accessing.

Step 6: a compact was signed between the Devon LNP and the Devon Health and Wellbeing Board, with a joint aim to maximise the health and wellbeing impact of the natural environment in Devon through shared strategic approaches.

Paths to public health and wellbeing

Timescale

The Naturally Healthy Task and Finish Group was set up in September 2013 to take the Naturally Healthy Priority forward. The scoping report is due to be completed in July 2014 and ongoing work will be taken forward under the LNP umbrella with local organisations.

Resources

Public health contributed manpower by allocating staff to Chair the Naturally Healthy Task and Finish Group and to drive forward the work. Some funding was made available by public health and the Environment Sector to enable primary qualitative research to be undertaken, including three focus groups with people living in one rural and one urban area of Devon.

Partners contributed a range of skills, knowledge and expertise through their membership of the Naturally Healthy Task and Finish Group.

Structure of initiative

Strategic level decisions have been made through the director of public health's input to the LNP Board, a Councillor holding the portfolio for Health and Wellbeing and a Public Health Specialist. The Naturally Healthy Task and Finish Group have overseen and agreed actions to progress the initiative. Research and consultation work have been undertaken by staff from the public health team and specially appointed facilitators, the final report has been written by the public health team.

Key supportive factors:

- public health allocating resources to get the work started
- high level support and sign up from the director of public health, LNP Board and the chair of the Devon health and wellbeing board (a Councillor holding the Portfolio for Health and Wellbeing although she sits on the health and wellbeing board as a director of Exmoor National Park), have enabled the work to be prioritised and resources allocated to get the initiative moving
- accepting that this work would take time to develop and undertaking the necessary groundwork first to establish an evidence base and undertake primary research to identify barriers and motivators to public access

Key challenging factors:

- the LNP is an umbrella organisation with no access to its own funding for this initiative
- establishing effective working relationships and new ways of working; this is being addressed by facilitating all partners to own the work and drive it forward together

Outcomes

The immediate outcome from this first phase of work was to produce an evidence based resource to inform the future work of partners and future sustainability. Longer term outcomes are to increase public access to the natural environment and for the environment sector to be actively engaged in considering health within its strategic priorities.

Evidence and evaluation of impact

A full literature review has been undertaken and provides an evidence base which, together with qualitative data generated from focus groups, will inform ongoing future developments. Some monitoring of outcomes will be done through reviews of the Public Health Outcomes Framework (1.16% of people using outdoor space for exercise/health reasons) and any future local initiatives will include evaluation.

Public health has contributed to development and production of the Devon State of the Environment Report which now forms part of the suite of documents contributing to the JSNA. The report looks at trends in data indicating future condition of, as well as identifying the current and likely future pressures on, the environment that are important to decision making. This can be found on the Natural Devon website.

Assessment of cost–benefit and contribution to a future evidence base may be possible but it is unclear at this stage how this can be done. The primary objective has been to undertake robust groundwork to inform further development and action.

Learning

Key messages for people thinking to undertake similar work:

- secure high level sign-up, especially from people who can influence the deployment of resources
- allow freedom to be creative
- establish links with as broad a range of partners as possible

Key messages regarding working collaboratively in the new public health system

It has been a very positive experience for public health to work with colleagues from another directorate and this has been facilitated by location within the council. It has been beneficial to the local authority to have public health expertise in linking health and wellbeing to the work of other directorates.

Conclusions

A specification has been created to support future work on linking health and the environment for health benefits. Links have been made with two national parks and projects are in development to establish links with health and social care organisations and environmental organisations operating in national parks; the aim is to promote activities for the benefit of physical and mental health, in particular for those who would not normally consider visiting a national park. The language and content of the Explore Devon website has been influenced by the report to make it more accessible and user friendly.

The Naturally Healthy Task and Finish Group will continue to link with other LNP priorities 'Green Connections' and 'Outdoor Learning' to facilitate integration of health outcomes and priorities into the environmental sector. Public health will continue to provide input to the LNP structure and local organisations will take the work forward on improving access to the natural environment.

Paths to public health and wellbeing

Further information

- Link to LNP website: <http://www.naturaldevon.org.uk/>
- Link to Primary research findings: <http://www.naturaldevon.org.uk/wp-content/uploads/2013/11/Getting-Naturally-Healthy-research-presentation.pdf>
- Link to final report: <http://www.naturaldevon.org.uk/priorities-and-projects/naturally-healthy/naturally-healthy-documents-and-links/>

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Breaking the intergenerational cycle of obesity: System Leadership Programme

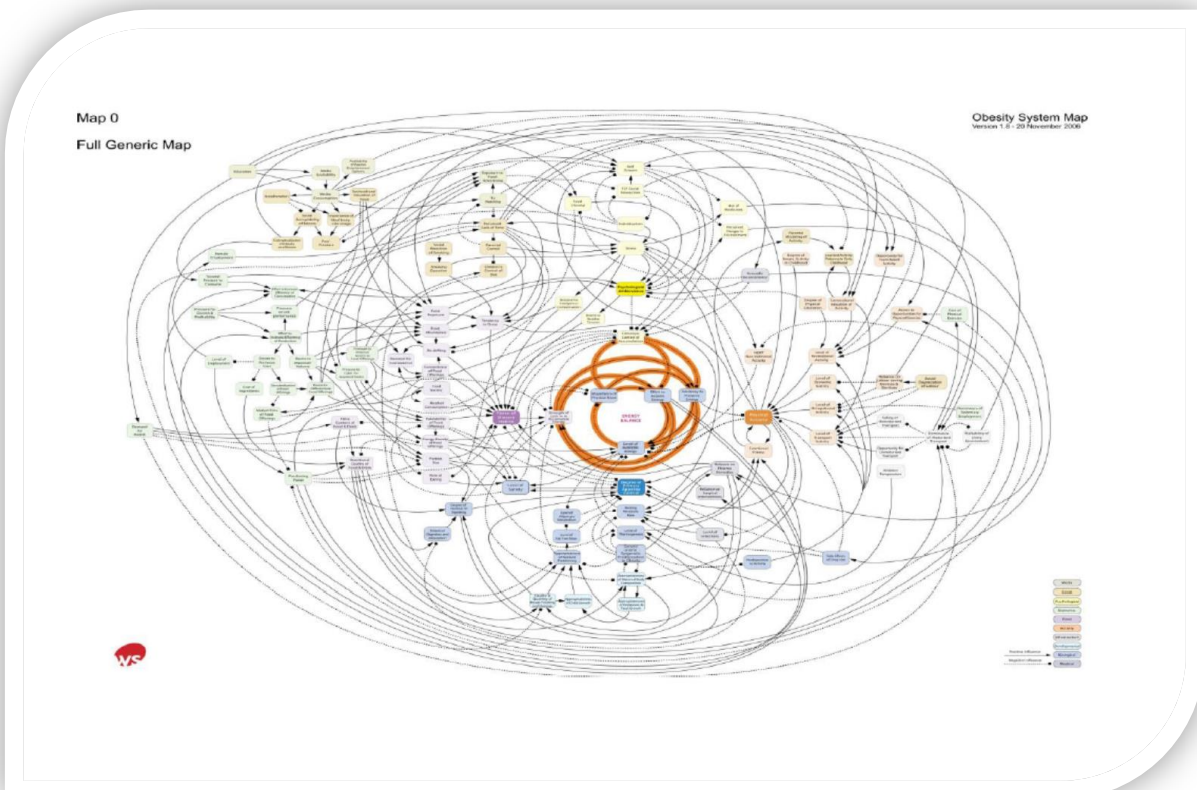
Gloucestershire

Summary

Gloucestershire Health and Wellbeing Board (GHWB) decided to use the national System Leadership Programme as an opportunity to review their local approach to reducing intergenerational obesity. The Board submitted a successful bid to the programme for facilitator support to develop this initiative. The overall objective is to work at three different levels: community level to enable behaviour change; operational level to identify and work with relevant systems to develop a shared plan for healthier lifestyle behaviours; and, strategic level to develop system leadership capacity across the GHWB's partner agencies and apply the learning to other strategic priorities. The projects' initial focus was on three local communities, all with high levels of child obesity.

Background and context of initiative

Gloucestershire county council is a 2-tier authority with a population of 596,984 (Census 2011). Public health is located in the Health and Social Care Directorate, reporting to the Council Chief Executive and Director of Adult Social Care.



Paths to public health and wellbeing

Demographic information:

- 49% of the population is male and 51% female
- life expectancy at birth is 80.0 years for men and 84.1 years for women; there is a gap of 7.9 years for men and 5.8 years for women between the most deprived and least deprived areas
- 91.6% of the population is White British
- approximately 23% of the population is aged 19 years or under, 58% 20-64 years and 19% aged 65 years and over
- deprivation is lower than the national average but 15,500 (14.7%) children live in poverty and some urban and rural areas experience deep deprivation (PHE Health Profile 2014)

Rationale

Tackling obesity is a key priority for GHWB. Indications from available data are that while obesity levels among local children are lower than the average for England, in some communities the rates are among the worst in England with a strong correlation between childhood obesity and deprivation. GHWB were keen to explore how system leadership and place-based approaches could be applied to the local obesity agenda. The project first aimed to develop a clearer understanding of the local 'obesity system' by engaging with local communities.

The aims of the initiative are to: develop solutions to a local priority area through leadership development; build leadership capacity in GHWB; apply system leadership lessons to address other local issues.

Working in partnership in the new public health system

A wide range of partners contributed to developing the bid and supporting implementation, including: clinical commissioning group (CCG); local authority public health commissioners; a councillor and community development manager from the council; frontline staff including volunteers.

A Project Board, set up after the bid was secured, oversees the work and agrees roles and responsibilities of partners.

Factors supportive to partnership work

Initially, partners had differing ideas about an effective way forward; part of the system leadership process was to identify these differences in order to work towards developing a more appropriate and cohesive system. Specific factors that supported developing the partnership and effective collaboration are:

- backing and support of GHWB
- willingness of members of the Project Board to adopt an experimental approach and not be bound by a rigid process

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- external facilitators able to be objective and challenge established views or ways of working
- willingness of communities to engage in the process of talking about a sensitive topic such as obesity
- community led conversations that started by looking at wellbeing in general terms, gradually making the link with obesity
- recognition and acceptance that the initiative would take time and may require revision of initial aims and timescales

Factors challenging to partnership work

Two main challenges for partnership working include:

- establishing a balance between working towards pre-stated targets and outputs versus the time and flexibility necessary to support organic development and to allow for innovation; the words of one GP summed up the dilemma well, “We might hit a target but completely miss the point”
- allocation of dedicated project management and administrative support is recommended to manage communications and maintain the momentum of the project alongside the day-to-day workload

Process

Key actions taken to establish and deliver the work.

Stage 1: bid development and submission to the national System Leadership Programme.

Stage 2: a Project Board was set up to oversee and take the work forward, including a rapid review of evidence on obesity.

Stage 3: undertake stakeholder and asset mapping to understand the local ‘obesity system’.

Stage 4: appoint facilitators to engage communities and facilitate communication of conversations to the Project Board; including challenging established views and ways of working that could potentially undermine achieving intended aims.

Stage 5: process the learning and apply to planning future activities to reduce obesity.

Stage 6: link the learning into broader priorities and programmes of the GHWB to inform future work.

Stage 7: inform commissioning framework and strategies regarding how lifestyle support is offered in future.

Currently the initiative is at stage 4. There is a concerted effort to move away from a service driven model of working to an approach that connects more with community assets.

Paths to public health and wellbeing

Timescale

Work on stage 2 commenced in late September/early October 2013 and the intention is to work towards developing a coherent commissioning framework for encouraging and enabling healthy lifestyles by December 2014.

Resources

A small budget was received from the national System Leadership Programme, this was match funded by public health to pay for facilitators. Some resources in kind were made available by community groups and other partners. Otherwise partners contributed time and expertise as part of their work programmes. It should be noted that expertise in System Leadership and knowledge of the local community are at least as important a resource as expertise on obesity.

Structure of initiative

The Chair of the health and wellbeing board is also Chair of the Project Board which operates as a learning set as well as setting a direction. Facilitators were brought in and this was crucial to effectively engaging with communities and to challenging the Project Board. Management of the project is undertaken by partners as part of their work programme; however, it is clear that a project such as this requires dedicated time and should not be an add-on to existing workloads.

Key supportive factors:

- independent facilitators who can engage with communities as well as challenge Board members
- high level sign up and backing for the initiative
- taking calculated risks; monitoring and making necessary adjustments, but being prepared to take risks
- enthusiasm, commitment and energy of stakeholders
- individual willingness and buy in to learn and be challenged
- organisational willingness, in this case the CCG and public health, to embed System Leadership capacity building

Members of the Project Board want to continue to be in place beyond the timescale of this initiative, to carry on as a learning set and challenge group on System Leadership.

Key challenging factors

Keeping the project moving with limited resources was a key challenge, it was overcome by people's enthusiasm and motivation to take the work forward.

Outcomes

The work is currently ongoing so it is too early to focus on longer term outcomes. However, some early tangible benefits and learning are apparent, including:

Paths to public health and wellbeing

- community – direct engagement with the community has helped progress a series of activities including removing barriers to local walking and cycling, and supporting communities to help themselves which includes plans to support the development of a Community Food Co-operative
- operational – the initiative has demonstrated ways of working proactively and confidently with communities and partners across the system; the relationships and trust built can continue to be a resource for ongoing engagement and coproduction of interventions
- strategic – the learning about systems leadership can be applied across a range of other issues and GHWB priorities, such as development of a domestic abuse strategy and implementation of the Better Care Fund

Evidence and evaluation of impact

The initiative is not being formally evaluated but the process is being recorded. The next phase of the work will have an element of performance monitoring built in. A review of evidence on obesity was undertaken early on to inform the development of this initiative.

An important issue regarding evaluation of an initiative like this is that it may be difficult to undertake but vital that resources are made available to do so.

Learning

Key messages for people thinking to undertake similar work

The most powerful learning from this project is said to have been achieved through direct engagement with residents of the three participating communities. Other learning points are:

- the importance of sign up from senior people across relevant health and social care agencies
- manage expectations well and be realistic
- refrain from developing an initiative like this as an ‘add on’ to existing workloads and consider dedicated resources to oversee and coordinate tasks
- engage openly with local communities and recognise their capabilities and resourcefulness. Sustained change is more likely with communities that feel involved in the development and delivery of interventions. Solutions need to be developed on a very local level
- facilitation is very important to engaging communities and challenging established ways of working; finding out and framing an issue such as obesity in a way that resonates with communities is key
- the first priority should be learning, the second to achieve outputs and outcomes which should be informed by learning
- be humble, have an open mind and be willing to change or modify the original workplan if necessary; follow where the work takes you

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- take the time to establish good working relationships that engender trust and openness
- the approach is cost effective, requests from communities participating in this initiative related more to practical and advocacy support than large amounts of funding
- recognise that coproduction takes time and requires long-term commitment, each community is different and solutions need to be developed at a very local level

Key messages regarding working collaboratively in the new public health system:

- recognise that it takes time to establish good working relationships that engender trust and openness
- be open to understanding other perspectives, it is important to walk in other people's shoes
- there can be great scope in the new integrated system to really understand broader perspectives and links with different directorates and departments

Conclusions

Participating in the development and implementation of this initiative has resulted in significant shifts in partners' attitudes and behaviours. As one Board member observed, it is unrealistic to expect people to respond to healthy eating messages when there is no access to healthy food where they live. There is a better understanding of community needs, circumstances and what could really help in moving forward effectively. Connections between various agencies in the public health system are improving.

In terms of sustainability, the capacity building and learning will continue. There is a shift towards enabling communities and building on local assets. Next steps are for the GHWB to apply lessons learned from this initiative to other areas of the Board's business, and to build on the obesity work to develop a comprehensive commissioning framework for health behaviours.

Further information

- Information on the System Leadership Programme - <http://www.leadershipacademy.nhs.uk/support/system-leadership/>

Contact

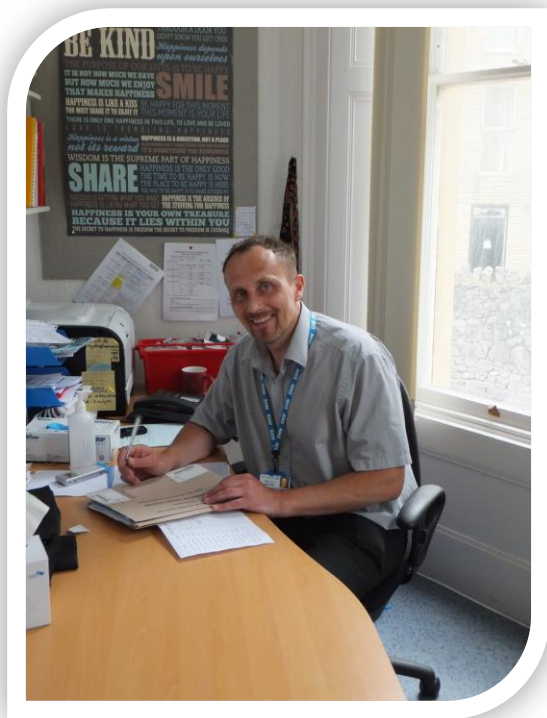
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Setting up Hepatitis C outreach and treatment services in drug treatment provider facilities

North Somerset

Summary

A satellite treatment service has been set up in Weston-Super-Mare to address patient dropout and non-attendance for Hepatitis C treatment. Geographic access was identified as a significant barrier because patients had to travel over 23 miles to Bristol Royal Infirmary for treatment. In order to increase uptake, an NHS satellite Hepatitis C treatment service has been developed and is provided by Bristol Royal Infirmary through the premises of a charitable organisation providing specialist drug treatment. Access to treatment is said to have increased with the introduction of the satellite service and it is now mainstreamed into NHS provision. The satellite clinic was initially provided at a recovery centre in a less accessible location. Moving the service to be co-located with a drug treatment provider proved helpful in ensuring good attendance. The provider had located to new larger premises which allowed them to offer the service on site.



Background and context of initiative

North Somerset Council is a unitary authority with a population of approximately 202,566 (Census 2011). Public health is located in the People and Communities Directorate of North Somerset Council and there is alignment of public health priorities across all Council Directorates.

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Demographic information:

- 48.6% of the population is male and 51.4% female
- life expectancy at birth is 79.6 years for men and 83.5 years for women; there is a gap of 9.8 years for men and 6.6 years for women between the most deprived and least deprived areas
- 94.1% of the population is White British
- approximately 23% of the population is aged 0-19 years, 56% aged 20-64 years and 21% aged 65 years and over
- deprivation is lower than the national average but 5,500 (14.9%) children live in poverty (PHE Health Profile 2014)

Rationale

Public health was initially approached by a GP with concerns that patients with Hepatitis C were not continuing with their treatment, a significant barrier was the fact that patients had to travel to Bristol for treatment. There was an overall perception among local services and professionals that this was an accurate picture, though not possible to verify due to lack of accurate data regarding attendance at GP and other services. However, anecdotal evidence was strong with significant concerns expressed about attrition and non-attendance. Outreach work, through provision of satellite services locally, was considered a potential good option to address identified barriers to access and the decision was made to set up this service.

The aim of the initiative is to improve access to all phases of Hepatitis C screening through to treatment. The satellite service is targeted at intravenous drug users from the specialist drug treatment service; GPs may refer patients to the satellite service through the drug treatment service. Currently the service is only available in North Somerset to ensure it is fit for purpose and there is a manageable caseload for the clinician and nurse.

Working in partnership in the new public health system

Initial discussions took place with several agencies and professionals after the issues of low access and dropout were raised by the GP. A project working group was set up three months after the matter was raised and included: a nurse, the Lead Consultant, a representative from a private drugs company, a community based specialist drugs treatment charity, a charity providing residential treatment and rehabilitation and a Public Health Consultant. Roles and responsibilities were agreed by the working group through regular meetings and teleconferencing.

Factors supportive to partnership work:

- shared commitment and agreement by all members of the working group to address access to treatment

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- the Bristol clinical team had developed a prison in-reach service, so they were familiar with some of the issues that needed addressing; people were therefore confident that the model could work and were supportive of it
- clinicians genuinely wanted to address non-attendance for treatment and help people, they were therefore keen to make the initiative happen and address any presenting challenges
- the drugs company representative on the working group was able to make a strong case for the need for this provision, by highlighting the risks associated with inadequate treatment; this was a powerful message that contributed significantly to securing the backing of key people at Bristol Royal Infirmary

Factors challenging to partnership work:

- insufficient capacity in the clinical team to drive forward the work over and above existing workloads; some of the tasks could only be undertaken by a lead clinician or nurse and therefore difficult to delegate
- there were several issues regarding remote working in the first setting, including: unreliable IT connections; difficulties accessing patient records remotely; and, flow of samples to and from laboratories

Process

Key actions taken to establish and deliver the work.

Stage 1: the issue of low access and dropout from treatment was raised with public health by a GP.

Stage 2: a Public Health Consultant sought to identify best available evidence of Hepatitis C prevalence in North Somerset and data from Bristol Royal Infirmary hepatology department about dropout rates.

Stage 3: a working group was set up bringing together key people from the NHS, a private pharmaceutical company and providers from the voluntary & community sector.

Stage 4: discussions took place between the working group and other NHS personnel to look at and agree financing and practicalities of setting up the initiative.

Stage 5: a pilot service was set up in Weston -Super -Mare. This was problematic in terms of remote access to records and other practical difficulties.

Stage 6: the pilot was relocated to be provided from the premises of a community based drug and alcohol project.

Stage 7: the service was mainstreamed into NHS provision.

Stage 8: an evaluation of the service was undertaken.

Timescale

The pilot service ran from April to October 2013 and has since been mainstreamed into NHS provision.

Paths to public health and wellbeing

Resources

Some funding was made available by public health to increase capacity as this was a priority area that was unlikely to be progressed without increasing capacity. This funding also contributed to purchasing IT equipment and kit to support remote working.

Members of the working group contributed a range of relevant skills, knowledge and expertise as part of their work programmes or as contribution in kind.

Structure of initiative

The working group oversaw development and implementation of the service; they looked at treatment pathways, considered the minute details of developing and implementing the service and participated in reviewing the pilot. Delivery of treatment was overseen and managed by a clinician and nurse.

Key supportive factors:

- a strong, shared commitment in the working group to support clients in need of treatment
- treatment adherence and a shared understanding that local outreach work was needed
- being able to make a strong case to the Bristol Royal Infirmary that a satellite service would contribute to improving efficiencies
- taking stock after encountering difficulties with delivery of the satellite service from the first location and being prepared to review and relocate

Key challenging factors:

- the setting for the first satellite service presented difficulties in terms of geographic access and other practical difficulties such as remote access to patient records; this was addressed by defining a target population and location from which the satellite service would be provided
- insufficient clinical capacity resulted in significant increase of work load for the clinician and nurse; this was addressed eventually by securing resources to increase clinical capacity
- lack of accurate data from services such as client attendance and contact details, prior to setting up the satellite service; there was insufficient recording which hampered analysis of need, some work was undertaken to address this with services as part of the task of setting up the satellite service

Outcomes

There are four broad outcomes to be achieved now through the mainstreamed service:

- increased access to treatment
- improved data collection by services on attendance at clinics
- better treatment initiation, adherence and outcome
- fewer people who are Hepatitis C positive

Evidence and evaluation of impact

An evaluation was carried out by North Somerset council to compare uptake of Hepatitis C services before and after the implementation of the satellite service. The report concludes that while the analysis did not cover a long enough period of time to assess whether increased numbers of people are going through the satellite service, the service has taken on a large number of individuals who were not prepared to travel to Bristol. The evaluation also demonstrates that co-locating Hepatitis C services in the community based drug and alcohol service, appears to increase detection of Hepatitis C compared to primary and secondary care services on their own.

Learning

Key messages for people thinking to undertake similar work:

- identifying and resolving practical issues promptly is of utmost importance as they can have an adverse effect on initiatives and potentially contribute to failure
- co-location with a community based treatment service can facilitate access because the service is already known to clients, there is an element of established trust and ongoing contact that enables the service to successfully encourage and support clients to attend appointments
- consider necessary resources such as funding needed to increase capacity and ensure they are in place
- finance is important both in terms of availability as well as arrangements for how and when it can be used; money that needs to be spent within a specified time period can be problematic if it needs to be carried over for good reason; in this case to revise the initial location of the pilot and to relocate and start again

Key messages regarding working collaboratively in the new public health system

- it is crucial that all partners agree the initiative is worthwhile and needed
- shared strategic priorities are helpful
- reach agreement about necessary resources and who will provide them as early as possible

Conclusions

The initiative has been mainstreamed into NHS provision and will continue to be provided. The working group will continue to operate via teleconferencing in order to monitor care pathways.

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Reducing the strength: restricting the availability of high strength alcohol products in Plymouth

Plymouth

Summary

This is a voluntary scheme that invites alcohol retailers in Plymouth to stop selling low cost high strength alcohol with an alcohol volume of 6.5% or over. The scheme is part of the Strategic Alcohol Plan for Plymouth 2013/18 – ‘Promote Responsibility, Minimise Harm’. This is a whole systems approach to addressing alcohol related concerns across the city that includes: action to enhance prevention approaches; improving identification and early intervention; building capacity for specialist treatment; and, using enforcement and legislation to control and manage the sale and use of alcohol. The Strategic Alcohol Plan includes a commitment to developing an evidence based approach to reducing the retailing of low cost super strength lager and cider.

Background and context of initiative

Plymouth City Council is a unitary authority with a resident population of 256,834 (Census, 2011). Public health is located in its own directorate in the council and the

director of public health works to influence policy and initiatives across the local authority, using the Public Health Grant to improve health and wellbeing and reduce inequalities.



Demographic information:

- 49.4% of the population is male and 50.6% female
- life expectancy at birth is 78.3 years for men and 82.1 years for women; there is a gap of 7.9 years for men and 5.8 years for women between the most affluent and least affluent areas
- 93% of the population is White British

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- approximately 23% of the population is aged 19 years or under, 61% are aged 20-64 years and 16% aged 65 years and over
- deprivation is higher than the national average and 10,100 (22.4%) children live in Poverty (PHE Health Profile 2014)

Rationale

A significant number of people in Plymouth are drinking at dangerous levels, the issue is not confined to a particular population group or geographical area and binge drinking is a key feature of the night time economy. In 2012/13 there were 5451 admission episodes due to alcohol. Between 2002/03 and 2009/10 alcohol attributable hospital admissions increased by 71%. Rates of hospital admissions are significantly higher in more deprived areas. In 2012/13 there were 2,073 alcohol related crimes recorded in Plymouth and it is estimated that violence accounts for 70% of all alcohol related crime. There is a strong correlation between alcohol, domestic violence & abuse and sexual assault. The estimated annual cost of alcohol to the health economy in Plymouth is over £9.5 million, and the estimated annual cost of alcohol related crime is around £27m.

The specific aims of this project are to address alcohol related health harms, including the disproportionate impact on the most deprived individuals and communities and to address crime, disorder and public nuisance in certain areas of the city. The project is aimed at alcohol retailers and presents an opportunity to engage them as key partners in the overall delivery of the Strategic Alcohol Plan.

Working in partnership in the new public health system

A number of local organisations have worked in partnership to develop and implement this scheme; they had already worked together on the development of the Strategic Alcohol Plan. The organisations include: Shekinah, a charity addressing the complex issues of homelessness, substance misuse and social exclusion; Harbour Drug and Alcohol Service, a charity offering support to people affected by drug and alcohol misuse; Public Protection; Police Licensing; Community Safety; and, public health. The overall project is co-ordinated by public health.

Factors supportive to partnership work:

- involving all partners in all stages of development and implementation of the Strategic Plan
- adopting a whole systems approach in which all partners have ownership of the Strategic Plan

Factors challenging to partnership work:

All partners have a commitment to improving the impact of alcohol in Plymouth so this helps drive the project forward, as does the fact that partners already knew each other through working on the Strategic Alcohol Plan and good working relationships were

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already established. The challenge for all partners is in dedicating sufficient time and resources to the project.

Process

Key actions taken to establish and deliver the work.

Stage 1: the need for the scheme was identified at the planning stage of the Strategic Alcohol Plan and agreed by all partners as a priority for action.

Stage 2: evidence from other areas was gathered and links made to areas that have implemented similar approaches.

Stage 3: An audit of local small shops and supermarkets was undertaken by the licensing department to identify how many products were being sold and at what cost.

Stage 4: Engagement with local stakeholders was undertaken through the partners who have their own networks and therefore a wide reach could be achieved in informing and encouraging others to understand and support the work.

Stage 5: All partners contributed to the development of marketing materials.

Stage 6: Retailers from two local areas were invited to sign up to the scheme.

Stage 7: A full launch of the scheme is planned for October 2014 where all retailers across the city will be invited to sign up through a general call to action.

Timescale

The scheme is part of the Strategic Alcohol Plan which was published in September 2013 and several discussions regarding the scheme had taken place in the lead up to its publication. Engaging with retailers is a two stage approach with targeted engagement during August and September 2014 and a wider call to action in October 2014. The project work will continue for the foreseeable future and the scheme will be embedded in local authority and police licensing policy and process.

Resources

The scheme is built into the work programmes of all partners and they have contributed towards the costs of marketing resources and the launch event. Members of the partnership bring wide ranging knowledge and experience of prevention, licensing and enforcement, treatment and recovery work. This is one of the benefits of having cross-agency involvement.

Structure of initiative

The Strategic Plan has been signed off by the health and wellbeing board (HWB) and there is a specific working group that meets regularly to oversee this project. All other aspects of managerial and operational work are overseen by the Senior Public Health Commissioning and Policy Manager.

Key supportive factors

A positive aspect of having a range of individuals involved is that the project can be linked across organisations and departments. Various partners have their own networks and this presents potential for having a significant reach. Supportive factors include:

- strong partnerships with established good working relationships
- clarity of purpose for each partner agency regarding the scheme and their role/contribution to it
- the scheme being part of a strategic plan already in place
- sign off by the HWB
- shared understanding of the issues and their wide ranging impact on public health and personal and community safety
- public health portfolio holder in the council engaged and signed up
- engaging many organisations from across the city, generating wide-ranging support and enabling a wide reach through their networks; it is worth putting work into engaging relevant agencies and having them on board

Key challenging factors

The main challenge is insufficient time and capacity to undertake the necessary work. All partners have managed to prioritise this work and there is a commitment from a broad range of agencies which is helpful to spreading the workload.

Outcomes

The overall aims stated in the Strategic Alcohol Plan are to reduce:

- alcohol related hospital admissions
- levels of harmful drinking by adults and young people
- alcohol related violence
- alcohol related anti-social behaviour
- the number of children affected by parental alcohol misuse

Additionally this project aims to:

- contribute to a change in attitudes regarding harmful drinking
- encourage responsible retailing of alcohol
- ensure alcohol plays a positive and proportionate role in the city
- engage local retailers in the whole systems approach to addressing alcohol in Plymouth

Evidence and evaluation of impact

The work already undertaken in Ipswich and other local authority areas provided useful information about the structure of the scheme and potential outcomes. The scheme will be subject to overall performance review as part of the wider Strategic Alcohol Plan reporting. It is important to note that one of the main aims of this project has been to enhance a whole systems approach to addressing alcohol. It is also part of work to support cultural change.

Learning

Key messages for people thinking to undertake similar work:

- engage with other areas who have experience of similar work and share resources and experiences
- a whole system approach is a good model for engaging broader partnerships – an engagement tool in itself
- this is a good approach to challenge public perceptions about alcohol
- it is good to develop and have a strategic plan in place that is jointly owned

Key messages regarding working collaboratively in the new public health system

The location of public health in the local authority supports engagement and influence over a broad range of public policy and decision making. It is not a case of public health telling people what to do but public health being part of shared solutions to complex challenges.

Conclusions

Work on the project is still in progress. It has benefited from being part of the Strategic Plan for the city that has sign up from all key partners. The project will be embedded into local authority and Police licensing frameworks & approaches so there is good potential for sustainability of the scheme. The project is one of a number in Plymouth aiming to change attitudes and behaviours toward alcohol. The campaigning work and work to engage retailers will continue for the foreseeable future.

Further information

- Shekinah building lives and futures - <http://www.shekinahmission.co.uk/>
- Harbour drug and alcohol service - <http://www.harbour.org.uk/>
- Thamesreach - <http://www.thamesreach.org.uk/news-and-views/campaigns/super-strength-drinks/>

Contact

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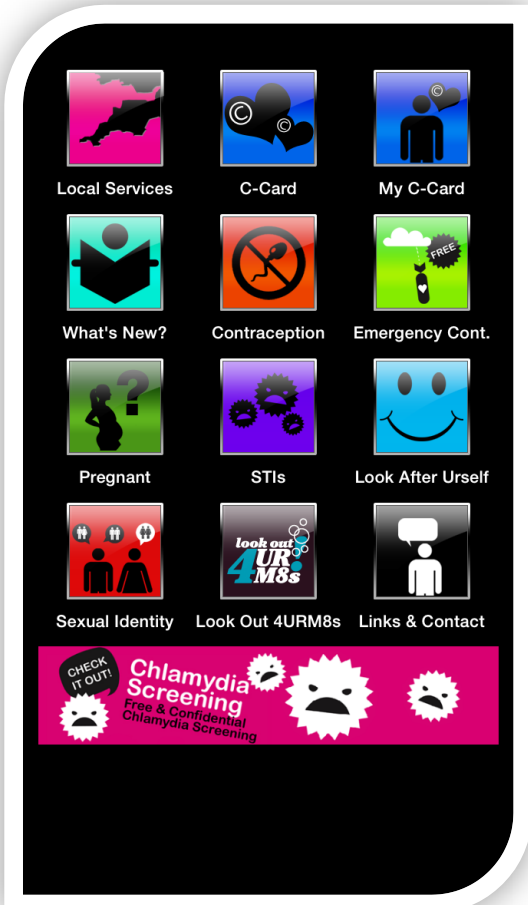
Contraception and sexual health app – more than your average app!

Somerset

Summary

Somerset has launched a smartphone app, designed especially for young people in Somerset to enable access to contraceptive and sexual health information whenever and wherever they need it, with additional useful features. A range of information can be accessed, including the location of: C-Card issue points (a scheme where young people can access free condoms following a registration process with a trained adult); contraception and sexual health (CASH) clinics; genitourinary medicine (GUM) clinics; pharmacists who provide Emergency Hormonal Contraception (EHC); school nurse clinics; and the ability to order a chlamydia screening kit with one click.

The app identifies the location of services nearest to the geographic area where the young person is located. Sometimes this may be close to their home; or at other times, from a different location, such as after a night out. The app can also be set to provide reminders for taking or renewing contraception. A virtual C-Card is included, enabling young people to privately and discreetly compile a list of items to access from a C-Card issue point.



The app is compatible for use on Apple and Android phones. In addition to the app, information can be accessed via a responsive website that displays and functions like an app on a smartphone for young people who have other devices that do not use the Apple or Android platforms; this ensures all smartphone users can access the same information. The UK Youth Parliament Somerset members have given the app the thumbs up and have been really impressed with the variety of features and benefits offered to young people, including lesbian, gay, bisexual and transgender young people.

Background and context of initiative

Somerset County Council is a two-tier authority with a resident population of 529,972 (2011 census). Public health is one of four commissioning teams within Somerset County Council and the Director of Public Health is a member of the council's senior leadership team.

Demographic information:

- 48.8% of the population is male and 51.2% female
- life expectancy at birth is 80.6 years for men and 84.1 years for women; there is a gap in life expectancy of 5.9 years for men and 3.7 years for women between the most deprived and least deprived areas
- 94.7% of the population is White British
- approximately 23% of the population is aged 19 years or under, 56% aged 20 to 64 years and 21% aged 65 years and over
- deprivation is lower than the national average but 13,800 (14.9%) children live in poverty (PHE Health Profile 2014)

Rationale

In 2012, the rate of conception for young people aged under 18 years was 24.4 per 1000 for 15 to 17 year olds and 4.4 per 1000 for those aged under 16 years. Repeat abortions in those aged under 25 years were 22.7% in 2013 and the rate of chlamydia diagnoses in the same year was approximately 1,450 per 100,000 15-24 year olds.

Somerset is a rural county where the geography can present a challenge to accessing services. Prior to the introduction of the app, contraceptive and sexual health information was made available to young people in pocket-sized paper directories, which required annual updating and reprinting. Another consideration was to enable access to information about clinics from different locations depending on where young people live or socialise. The idea behind developing the app was to enable young people to identify a service whenever and from wherever needed, including phone numbers, opening times, directions and the ability to rate their experience, which young people believed contributed to a service being young-people friendly. Furthermore, the app was considered to be more environmentally friendly, reducing the need for printed directories, which many young people felt was important.

It was vital to build in features that young people would like and use regularly; these would help as an anchor to keep the app on their phones. Young people stated they felt 'My Virtual C-Card' and 'My Contraception' (a function on the app that enables them to set a reminder to take their pill or change their patch) were really good features that they could use.

Paths to public health and wellbeing

Working in partnership in the new public health system

Those involved in early discussions continued to contribute to the development of the app and website; a web developer was employed at a later stage. Between them, the partners involved brought a combination of specialist health, public health, youth work and technical expertise. They included:

- young people
- CASH clinic nurses
- members of the young people's sexual health reference group
- targeted youth support workers and the boys and men's development worker

Factors supportive to partnership work

Having a clear rationale for the project and ensuring the work was in line with the agendas of all partners with an identified lead for the work.

Factors challenging to partnership work

No specific challenges were encountered. This was due to good working relationships, already established prior to working on the app.

Process

Key actions taken to establish and deliver the work.

Stage 1: partners, including young people, were brought together to discuss ideas for the app and its content.

Stage 2: the Commissioner responsible for sexual health was approached to make a case for funding the development of the app.

Stage 3: a web design company was identified and employed to develop the app and website.

Stage 4: negotiations were set up with Apple; the Apple app was the first to be developed followed by the android app.

Stage 5: both apps were launched at a conference on contraception.

Stage 6: some work undertaken to market the app in schools and colleges.

The app and website are updated regularly with information and additional features have already been added, such as an alcohol calculator.

Timescale

The app was developed within six months of the idea being generated.

Resources

Partners contributed their time and expertise as part of their programmes of work, between them contributing clinical, young people, public health and health promotion expertise. Funding was provided through the public health grant to pay for input from the web design company.

Paths to public health and wellbeing

Access to further resources would enable evaluation of the initiative and to add additional features to the app and website as required.

Structure of initiative

All partners worked together to make decisions collectively and this was helped by having key local people around the table. The Health Promotion Manager coordinated work with partners, led on work with the web design company and on the launch.

Key supportive factors

Three broad factors are identified as being fundamental to facilitating development and delivery of this initiative:

- established, good partnerships with relevant professionals and stakeholders around the table
- being able to justify the need for funding, simply and convincingly particularly in terms of sustainability, longer term efficiency and increased use and accessibility of an electronic resource; young people's use of smartphones, social media and apps increases year on year and more people access the internet via a smart device than conventional PCs
- a good working relationship with the web design company, enabling the commissioner to be involved throughout the process and not just at key stages of development

Key challenging factors

Marketing the app and monitoring downloads have been the key challenging factors; there was one major launch event and the majority of marketing of the app has been in colleges at all the fresher's fairs. School nurses have been made aware of the app but they only go into schools for a limited amount of time and see some, not all, young people; consequently, this limits how many and which young people they can market to. It is necessary to have an ongoing plan for marketing, so that new starters at school and college can be reached.

The app is free to download and as such, monitoring its use is more challenging. Work is being undertaken with the web design company to address this, as well as additional data being collected from the newly commissioned schools' survey.

Outcomes

While publicising the app at fresher's fairs, it has become apparent that many young people have already downloaded the app and used it regularly. Feedback from young people has been extremely positive. In addition, there has been good feedback from GPs, nurses and sexual health workers, who have found it a useful resource to point young people towards.

Links have been established with the Drug and Alcohol Action Team (DAAT) as the app has relevance in the context of alcohol and sex. The app now features a section on alcohol with an alcohol calculator and other useful information.

All services that feature on the app now have a 'Rate this service' feature that enables young people to review their experience through three short questions. The questions are answered using a five-star rating system and there is also an option to include text. This feature helps services demonstrate their young people's participation and voice in relation to becoming accredited as a 'young people friendly service'.

Evidence and evaluation of impact

The app developers are currently adding a feature to capture data on the number of young people using the app, the devices used, pages visited and features used. This will improve future evaluation and its impact. In addition, a new Schools Survey which has been commissioned in Somerset will gather data on young people's knowledge about the app and if they have it. It is possible to track numbers of young people ordering chlamydia screening kits through the app. This will also enable further insight to be gained about young people's use of the app.

An additional benefit of the app has been the number of staff, including GPs and pharmacists, who themselves now use the app as their first point of access to gain information for signposting young people to services beyond their own.

Learning

Key messages for people thinking to undertake similar work:

- consider if an app is what is really needed for the local context. Consider all options that may do the same job; for example, a responsive website
- consider and put in place a relevant marketing strategy from early on, to ensure the widest possible reach
- ensure a good working relationship is established with all partners around the table, this will provide a sound basis for progressing the work and addressing challenges

Paths to public health and wellbeing

- consider necessary funding, both in terms of what can be saved if an app/website replaces existing products and the costs of developing, marketing and evaluating new products
- put in place a plan for ongoing marketing, tweaking and updating of the product

Key messages regarding working collaboratively in the new public health system:

- establish good working relationships; this is key to effective partnership working
- identify and bring key players on board from the start; this can be easier in the new integrated public health system
- encourage word of mouth recommendations and promotion

Conclusions

Anecdotal evidence suggests people and staff working with young people have downloaded the app and found it really useful. The number of paper-based directories printed has been more than halved from 32,000 to 15,000. There is no significant cost other than a hosting fee and for making updates so the initiative can be sustainable at relatively low cost. In the longer term it is anticipated that the paper-based directories will be entirely replaced by the app.

Further information

- Link to C&SH app on i-Tunes - <https://itunes.apple.com/gb/app/c-sh-somerset/id507419928?mt=8>
- Link to C&SH website - <http://www.somersetcsh.co.uk/>

Contact

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Public health system response to flooding

Somerset and Public Health England

Summary

The unprecedented rainfall during the winter of 2013/2014 and related flooding prompted a major incident to be declared and an emergency response put in place. The Somerset Levels were extremely badly affected, Public Health England (PHE) and Somerset County Council were part of the partnership response to the emergency in Somerset co-ordinated by Avon and Somerset Local Resilience Forum.

At Somerset County Council the Director of Public Health and public health team worked jointly with PHE to provide support to the emergency response effort. Operating jointly as a public health system worked well and involved agreeing who would lead on key tasks such as:

responding to media queries; giving support to specific geographic areas; providing advice to the public and a range of agencies; and so on.



Public Health England provided: information to local partners on potential health impacts before, during and after the flooding; a web-page to provide information to the public and professionals; timely advice to the public, media and kept the Department of Health informed through the PHE Centre covering Devon, Cornwall and Somerset.

The local team provided feet on the ground, maintained day to day relationships with partner agencies and provided continuity into the recovery phase, supported by on-going expert advice from PHE.

Background and context of initiative

Somerset County Council is a two-tier authority with five districts and a resident population of around 529,972 (2011 census). Public health is one of four commissioning teams within Somerset County Council and the Director of Public Health is a member of the council's Senior Leadership Team.

Paths to public health and wellbeing

Demographic information:

- 48.8% of the population is male and 51.2% female
- life expectancy at birth is 80.6 years for men and 84.1 years for women; there is a gap in life expectancy of 5.9 years for men and 3.7 years for women between the most deprived and least deprived areas
- 94.7% of the population is White British
- approximately 23% of the population is aged 19 years or under, 56% aged 20-64 years and 21% aged 65 years and over
- deprivation is lower than the national average but 13,800 children live in poverty (PHE Health Profile 2014)

The county has a joint civil contingencies unit between all local authorities, which is well established and forms part of the Local Health Protection Forum, chaired by the Director of Public Health.

The Somerset Levels are a flat landscape covering around 170,000 acres; approximately 10% of the Levels are said to have been underwater. Several homes were affected with some people having to evacuate their properties and other homes and communities being cut off.

A sub-plan for responding to emergencies was already in place as part of the Local Resilience Forum (LRF). LRFs are strategic multi-agency partnerships that bring together local agencies to effectively deliver statutory duties under the Civil Contingencies Act 2004. More information on LRF's and category 1 and 2 responders is available at: <https://www.gov.uk/local-resilience-forums-contact-details>

Detailed knowledge about the local communities was already in place such as who lives where, location of particularly vulnerable people and so on; this was important in providing ready access to essential information about communities during the emergency response.

From a public health perspective, the aims were to:

- minimise adverse impacts on the public's health as a result of flooding
- ensure the new integrated health system arrangements worked effectively

The sub-plan, previous experience of dealing with local flooding and access to national expertise informed the response and the provision of evidence based advice to the public and professionals.

Working in partnership in the new public health system

In the event of flooding, or other emergencies, PHE works with local agencies including NHS, Police, Local Government and the Environment Agency to provide expert advice on protecting the health of local communities; in particular, from microbiological and chemical hazards. Key partners were brought together by the Avon and Somerset LRF, around 35-40 agencies.

Paths to public health and wellbeing

Partners in the Avon and Somerset LRF can be found at <https://www.avonandsomersetprepared.org/>

Factors supportive to partnership work:

- trust between partners
- commitment to the new integrated public health system
- being able to negotiate quickly and effectively
- good communication systems in place to keep relevant agencies and partners regularly informed and up to date
- an established LRF with a relevant infrastructure in place

Factors challenging to partnership work

During an emergency response such as this there is no time to disagree – any differences have to be put on hold in order to proceed with providing an effective response.

A key longer term challenge has been the protracted scale of the emergency requiring three months of intensive input at response level. Public health do not have resilient capacity for involvement over such a long period of time, over and above the regular workplan and priorities. Mutual aid for PHE was secured from other areas but this is more difficult for public health in local government if processes are not yet set up for this.

Another challenge was dealing with considerable national and local media attention, alongside providing the emergency response. This required being sensitive to both the practical and the political dimension of the public health response.

Process

The work undertaken to respond to this emergency can be summarised in four broad stages:

Stage 1: relevant components need to be in place prior to the emergency occurring such as: information about local communities and their locations; relevant infrastructure to support partnership working; and, good communication systems to provide relevant updates and advice to a range of people.

Stage 2: swift mobilisation of resources and support during the emergency.

Stage 3: continue to provide relevant support during the recovery period.

Stage 4: ensure that community engagement runs through all stages; the Public Health approach in Somerset has been to actively listen to people's anger, concerns and suggestions and be proactive in advocating on behalf of local communities to wider decision making structures.

An emergency response such as this is a complex operation and therefore not possible to summarise all activities undertaken by the various agencies, individually or in partnership. A key piece of advice would be to have an overall plan in place for such emergencies and ensure there is swift co-ordination and communication when an emergency arises.

Timescale

The multi-agency response through the Local Resilience Forum commenced in January 2014, moving into the recovery phase by April 2014. The recovery phase has been led by Somerset County Council, which includes the director of public health and local authority public health team who have led the multi-agency workstream on Health and Housing. This has covered a range of issues including on-going advice about managing waste and clear up, emotional and mental health, insurance and grants.

Resources

When dealing with a public health emergency such as this there is no time to worry about funding and who is going to pay for what, it is necessary to just get on and focus on resolving the emergency. In this particular situation public health contributed extra staff and hours, for example more staff were allocated to on-call duties; the extra work was undertaken as part of people's work programmes and a certain amount of goodwill.

The Scientific and Technical Advice Cell (STAC) coordinated a range of knowledge, skills and expertise at the local, national and international levels. This includes tasks such as accessing equipment to pump water and coordinating evacuation. STAC brings together experts from all agencies to provide advice to the Gold Commander, more information about STAC is available at: https://www.avonandsomersetprepared.org/Documents/stac_plan.aspx

Structure of initiative

The LRF's structure was followed in relation to strategic, managerial and operational activities. The public health team contributed to all levels of activity.

Key supportive factors:

- access to tried and tested systems relevant to dealing with this emergency
- an established level of trust is vital in relation to getting things moving quickly and, on this occasion, working in a newly reformed public health system

Key challenging factors:

- the duration of the response requiring three months of intensive investment from PHE followed by the ongoing involvement of the local authority public health team in the long recovery period, in addition to the regular programme of work and priorities
- insufficient capacity and time in a situation such as this emergency to deliver the emergency response, contribute to the Strategic Co-ordinating Groups and the Tactical Co-ordinating Groups and set up and run local STACs; it would be worth looking at possibilities for setting up a national STAC process to coordinate local and national advice

Outcomes

Several positive outcomes have been observed, including:

- people were kept safe through an effective emergency response
- there was effective overall partnership working
- both the new and the tried and tested old systems worked which is encouraging because they had not been deployed for this level of emergency response before
- the response was timely
- most people have been able to return to their own homes
- confidence in the new public health system was secured with local partners and national government
- the local authority public health team provided continuity of response into and throughout the recovery phase, with a particular focus on longer term impacts such as emotional and mental health
- this work is currently informing the future 5-year Flood Plan

Evidence and evaluation of impact

Evidence based advice was given to the public and professionals and robust information about local communities was already in place to inform the emergency response. Three further pieces of work are planned and which will provide further insights:

- a population review and cohort study looking at the impact of flooding on mental health led by PHE's field epidemiology service working together with Somerset County Council and the director of public health
- the LRF will be writing up a structured debrief report
- in addition The Diocese of Bath and Wells have produced an impact report on the flood and Exeter and Birmingham Universities are engaged in research studies
- the local authority public health team have convened a research coordination group to minimise the impact of the research on local communities

Learning

Key messages for people thinking to undertake similar work:

- put in place a plan, have key meetings and discussions before an emergency occurs
- recognise the importance of the recovery phase and of long term planning in supporting recovery

Key messages regarding working collaboratively in the new public health system

Ensure on-going, good relationships and trust are in place between partners and be clear about roles and responsibilities of all partners.

Conclusions

Public health will consider debrief documents, LRF report and outcome of cohort studies to look at areas that can be further enhanced. The debrief documents will also be used to amend the emergency plan as necessary. The South West Network of Directors of Public Health will be sent debrief reports to keep them informed.

Further information

- PHE publications providing advice to the public and professionals can be accessed via this link.
<http://www.hpa.org.uk/Topics/EmergencyResponse/ExtremeWeatherEventsAndNaturalDisasters/EffectsOfFlooding/>

Contact

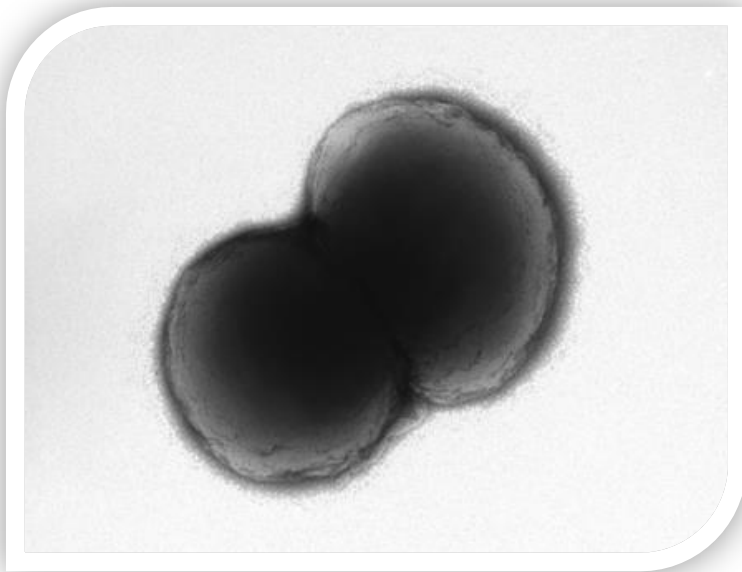
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Managing a meningococcal outbreak in a care home

South Gloucestershire

Summary

In November 2013 there was an outbreak of meningococcal infection in a care home. The outbreak started over the weekend and was initially dealt with by the Public Health England out of hours team who undertook a risk assessment and set up an incident team. A decision was made to offer the antibiotic chemoprophylaxis to close contacts, identified as all residents and staff of the care home, 110 people in total. Subsequently, the vaccine quadrivalent MenACWY was offered to all who had received chemoprophylaxis. The response to this outbreak required rapid authorisation, supply and administration of chemoprophylaxis and subsequent vaccination in a recently reformed public health system.



Background and context of initiative

South Gloucestershire Council is a unitary authority with a resident population of approximately 262,767 (Census, 2011). Public health and social services form one Children, Adults and Health Directorate in the council. Public health is developing new ways of working with colleagues in the council including the Emergency Planning Unit.

Demographic information:

- 49.6% of the population is male and 50.4% female
- life expectancy at birth is 81.0 years for men and 84.6 years for women; there is a gap of 5.2 years for men and 4.2 years for women between the most deprived and least deprived areas
- 92% of the population is White British
- approximately 24% of the population is aged 0-19 years, 59% are aged 20-64 years and 17% are 65 years and over

Paths to public health and wellbeing

- deprivation is lower than average but 5,800 (11.9%) children live in poverty (PHE Health Profile 2014)

Rationale

This was a response to an incident involving two confirmed cases of invasive meningococcal disease in a care home. The aim of the response was to effectively deal with the outbreak and protect individuals identified as close contacts; that is, those who had prolonged close contact in a household type setting during the seven days before the onset of illness.

Working in partnership in the new public health system

Public Health England set up an incident team that included the local authority director of public health, NHS England Area Team, local GP practice and the care home. Once convened, members of the team participated in teleconferences to decide on action, agree and allocate responsibilities. Co-ordination of the response and problem solving was conducted by email communication.

Factors supportive to partnership working

Excellent collaborative working was enabled by established, good personal relationships which trumped systems and bureaucracy. This was crucial to co-ordinating a swift response that required organising immunisation on similar principles to those for mass vaccination.

Factors that challenged/ hindered partnership working

Not a challenge as such but there was lack of clarity very early on about who would fund the process. The director of public health acted as an enabler by offering to provide funding for delivery of the vaccine; thereby taking the issue of payment out of the equation so that the Incident Team could focus on responding to the outbreak.

Process

Stage 1: the incident was reported to Public Health England's out of hours team who undertook a risk assessment and set up an Incident Team. The team kept in regular communication through teleconferencing and email.

Stage 2: a Patient Group Directive (PGD) was developed to allow the antibiotic chemoprophylaxis to be administered to a large number of people.

Stage 3: informed consent was obtained where necessary, such as for care home residents with dementia.

Stage 4: vaccines were sourced from national stockpiles.

Stage 5: all care home residents were registered with the same GP and this was helpful, particularly in terms of checking any contraindications; the director of public health was also able to source excellent staffing support through agencies used by the GP practice.

Paths to public health and wellbeing

Stage 6: vaccines were sourced by the Screening and Immunisation Lead, transported by the Council Emergency Planning Team and stored in refrigeration at the GP surgery.

Stage 7: further testing resulted in identifying the need to offer quadrivalent MenACWY vaccine to all who had received chemoprophylaxis.

Stage 8: a Patient Specific Directive was developed by Public Health England and signed by the director of public health to enable vaccination to proceed.

Stage 9: a structured debrief session was held after the incident was successfully addressed to enable review of what worked well and lessons for the future.

Timescale

The time between decision to vaccinate and actual vaccination of the majority was less than one week. The incident was closed one month after being declared.

Resources

The operational response to the incident was co-funded by Public Health England and South Gloucestershire Council. Funding was initially offered by the director of public health to address the immediate lack of clarity regarding responsibility for funding the process; this enabled the Incident Team to focus on dealing with the task in hand.

Knowledge, skills and expertise were provided by the Incident Team led by Public Health England. The local GP Practice offered significant support, the director of public health was also able to secure excellent staffing support from the local District Nursing team and organise additional nursing capacity, at short notice, from a list of agencies used by the GP Practice.

Vaccines were sourced, free of charge, by the local Screening and Immunisation Lead from national stockpiles. Cool storage was made available by the GP Practice which had recently completed a measles catch-up campaign and consequently had storage space in their vaccine refrigerator; otherwise vaccine storage could have presented some challenges.

Swift transportation of the vaccine was enabled by engaging the local authority Emergency Planning Unit.

Structure of initiative

Public Health England initially led on decision making with the Incident Team taking on this role once it was set up. Members of the Incident Team sourced other relevant support such as from the Screening and Immunisation Lead, GP practice, agency nursing staff and local authority Emergency Planning Team.

Key supportive factors:

- excellent multi-agency working with good collaboration, swift cooperation and flexibility of multi-agency partners was critical to the success of the response
- outstanding organisational skills, a can do attitude and focus on the task in hand were important, especially to addressing immediate challenges such as lack of clarity regarding who would fund the process in the newly established public health system
- good communication with many of the right people participating in teleconferences enabled high level decisions to be made quickly, such as supporting development of the Patient Specific Directive; regular teleconference and email communication facilitated timely coordination of the response and problem solving
- swift sourcing of the vaccine and transportation to GP practice for cold storage
- all care home residents being registered with one GP and one GP practice
- less media coverage than expected, therefore management and handling of the media response was less challenging than anticipated

Key challenging factors:

- initial lack of clarity regarding who would pay for the process; this was addressed by the director of public health offering to pay for delivery of the vaccine and suggesting the issue of funding be addressed at a later stage in order to focus on the task in hand
- obtaining consent from relatives of some clients due to insufficient/incorrect contact details held by the care home
- contacting relevant care home staff for vaccination due to their being on leave or otherwise off duty and unavailable
- lack of clarity regarding roles and responsibilities following the relatively recent reorganisation of the NHS and public health in April 2013
- gaps in awareness such as the availability of vaccines free of charge; it was noted that the participation of a pharmacist in discussions would be useful in future responses of this nature
- lack of a clear plan/procedure regarding use of medicines in a care home outbreak and in particular the need for PGD's.
- logistics of vaccine delivery, storage and administration; in this case the GP practice had capacity for cold storage and was supportive of the response, had they not been then this would have posed a challenge

Outcomes

No further cases of meningococcal infection were reported. The different health organisations worked effectively under pressure to protect the public's health.

Paths to public health and wellbeing

Evidence and evaluation of impact

A structured debriefing and report have reviewed the response, established points for learning and ideas for the future.

Learning

Key messages for people about undertaking similar work:

- good working relationships are a necessity to addressing an emergency such as this and dealing with any presenting challenges promptly; in this emergency response, effective partnership work is said to have played a crucial role in enabling the outbreak to be dealt with successfully
- planning, policy and procedures should be considered regarding what needs to be in place in the event that mass vaccination, or similar, is required; such vaccination can be incorporated into organisational policies, PGDs can be arranged prior to an event and PGD guidelines can include emergency supply; sources of vaccines, their transportation and storage can be identified in advance of an outbreak
- staffing and resources can be considered and terms agreed with a number of agencies regarding supply of agency staff, in advance of an outbreak occurring; confidentiality clauses can be considered in advance with GPs and nurses; extra vaccines should be sourced to allow for wastage. Everyone involved should be acknowledged for a job well done
- communication should ensure all partners are involved from the start and maintain communication throughout with everyone; consent forms can be devised and put in place on admission of individuals to facilities such as care homes

Key messages regarding working collaboratively in the new public health system:

Clarify and agree organisational roles, responsibilities and arrangements for funding, especially in the context of the new local public health arrangements following the reforms that came into force in 2013.

Conclusions

A structured debrief session after the successful handling of the outbreak identified what worked well and what could be done differently. A paper on the handling of the incident is being prepared for publication.

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Development of a domestic violence and abuse joint strategic needs assessment (JSNA)

Swindon

Summary

This JSNA, led by Public Health, was undertaken to establish intelligence and information regarding the needs of children and young people affected by domestic violence and abuse (DA). Swindon Health and Wellbeing Board commissioned the JSNA; it takes a whole family approach but the main focus is children and young people exposed to DA within their families and young people who are themselves within abusive teenage relationships. Development of the JSNA was guided by a working group of local expert practitioners and involved:

- gathering national and local data
- mapping the range of agencies working with all aspects of DA in Swindon
- undertaking focus groups with children and women in Swindon affected by DA

This initiative focuses on the process of developing and undertaking the JSNA; the Local Authority has a JSNA steering group that oversees development of all JSNA's and each JSNA has an eight-page bulletin summarising the key points. The aim of the

health and wellbeing board is to produce JSNA's that are accessible and can be used by all agencies working to promote health and wellbeing.

Background and context of initiative

Swindon Borough Council is a unitary authority with a resident population of 209,156 (2011 census). Public health is located in the Corporate Commissioning Directorate and there is an integrated approach to public health across other directorates.



Paths to public health and wellbeing

Demographic information:

- 50% of the population is male and 50% female
- life expectancy at birth is 79.3 years for men and 82.7 years for women; there is a gap of 7.2 years for men and 3.7 years for women between the most deprived and least deprived areas
- 84.6% of the population is White British
- approximately 24% of the population is aged 19 years or under, 62% aged 20-64 years and 14% aged 65 years and over
- deprivation is lower than the national average but 7,200 (17.3%) children live in poverty (PHE Health Profile 2014)

Rationale

The Local Children's Safeguarding Board raised concerns with public health regarding the impact of DA on children and young people. Subsequently, the Public Health Intelligence and Analysis Team identified that a more strategic process was needed to understand the issue of DA in Swindon and inform a plan for moving forward. A range of data sources were used to establish an initial picture including the Crime Survey for England, local data held by the police and courts, information communicated by Swindon police to Social Services and anecdotal evidence from local providers.

The aim of this initiative was to establish the scale of the problem in Swindon and its impact on children and young people. As such, the main focus was on developing a strategic process that would provide necessary information to inform future work on addressing the needs of children and young people affected by DA.

Working in partnership in the new public health system

A JSNA Steering Group was established to oversee development of all JSNAs, membership includes: Director of Public Health; Public Health Intelligence and Analysis Team; Accountable Officer of the CCG; Board Director Commissioning (Director of Children's Services/Director of Adult Social Services); voluntary and community sector organisations; and, Healthwatch. The JSNA steering group requested that a domestic violence working group be established to take forward the work on this JSNA; a Domestic Violence Task and Finish Group was set up and was led by a Senior Public Health Manager with support from other colleagues in the public health team. Consultations with mothers, children and young people affected by DA were undertaken by the Public Health Lead and made possible by Swindon Women's Refuge and Swindon Ten to Eighteen Project (STEP).

Some partners were involved in developing the process from the start and others joined later. Roles and responsibilities were agreed by the Domestic Violence Task and Finish Group.

Paths to public health and wellbeing

Factors supportive to partnership work:

- good collaborative relationships that recognised DA as everyone's business
- a shared view that DA has an impact on several agencies including those working in health, social care, criminal justice, substance misuse and others
- an already established domestic violence forum that was able to provide insights into key issues relating to DA

Factors challenging to partnership work

The main challenge was an initial lack of awareness about the link between DA, public health and the wider determinants of health. This was addressed by facilitating a broader understanding and recognition of the wide ranging impact of DA and links across all local authority directorates.

Process

Key actions taken to establish and deliver the work.

Stage 1: concerns about the impact of DA on children and young people were raised by the Local Safeguarding Children's Board to public health and the JSNA steering group.

Stage 2: the issues were discussed by the health and wellbeing board who commissioned the JSNA.

Stage 3: a Domestic Violence JSNA Task and Finish Group, led by public health, was set up as a sub-group of the JSNA steering group.

Stage 4: national and local data was gathered to establish a picture of the scale and nature of the problem in Swindon including mapping of relevant local agencies.

Stage 5: consultations were undertaken with three groups: mother's affected by DA and living in a refuge; children aged 5-10 years affected by DA; young people aged 10-15 years affected by DA.

Stage 6: a detailed JSNA on DA was produced along with an 8 page bulletin summarising the key points and recommendations and was signed off by the health and wellbeing board.

The Domestic Violence Steering Group will continue to monitor progress on implementation of the JSNA.

Timescale

The JSNA was commissioned by the health and wellbeing board in early 2013 and published in January 2014.

Resources

There were no specific financial resources allocated, the work was undertaken as part of people's regular work programmes and responsibilities to support production of

Paths to public health and wellbeing

JSNAs. A range of agencies contributed knowledge skills and expertise through the Domestic Violence Working Group.

Structure of initiative

Strategic level decisions were made by the JSNA Steering Group and the JSNA was formally presented to the health and wellbeing board for sign-off. Members of the public health team led on managerial and operational tasks, supported by the Domestic Violence Task and Finish Group.

Key supportive factors:

- high level strategic sign up was very important to giving the issue profile and progress the JSNA
- willingness of a wide range of agencies to come together and address the issue
- the overall JSNA process established in Swindon which aims to be transparent inclusive and accessible to all agencies working to promote health and wellbeing
- location of public health in the local authority has been supportive to working with colleagues in other directorates

Key challenging factors

There were no specific challenges encountered overall, it was possible to establish a shared understanding and commitment which was supportive to taking the initiative forward.

Outcomes

A shared understanding has been developed regarding the link between domestic violence and public health which will continue to be important in informing future work on this issue. A better understanding has been established about the nature and extent of DA in Swindon and its impact on children and young people. The JSNA has been published and makes recommendations for preventing DA, dealing with the impact on victims and working with perpetrators who are willing to change behaviours.

Evidence and evaluation of impact

The national and international evidence base regarding programmes that work to reduce prevalence of DA is developing but remains ambiguous and contested. The Swindon JSNA process that has been developed ensured that the DA issues identified and raised through the DA JSNA and bulletin have been incorporated into a DA action plan that will be monitored and reviewed through the health and wellbeing board, as for all JSNA's. One of the recommendations from the JSNA was to improve the identification of DA and pathways to support during consultations with health professionals. This has now been actioned with additional DA provision (an Independent Domestic Violence Advisor) linked to healthcare settings.

Learning

Key messages for people thinking to undertake similar work:

- take the time necessary to develop and undertake the needs assessment, it is important not to rush this process
- manage expectations of all partners regarding the overall time frame needed to undertake this work effectively

Key messages regarding working collaboratively in the new public health system

The new integrated system of public health presents good opportunities for:

- understanding and demonstrating links between public health and the objectives of other directorates in the local authority
- developing collaborative work
- influencing the agenda of other directorates from a public health perspective

Conclusions

Undertaking and publishing the JSNA is the first step in addressing the impact of DA on children and young people. Addressing domestic violence is now part of the work programme and will be taken forward by the health and wellbeing board in the longer term. The JSNA makes several recommendations for future action.

Further information

- Domestic Violence and Abuse Needs Assessment - <http://www.swindon.gov.uk/sc/sc-healthmedicaladvice/jsna/Pages/sc-jsna-Domestic-Violence-and-Abuse-Needs-Assessment.aspx>
- Domestic Violence and Abuse Needs Assessment Bulletin - <http://www.swindon.gov.uk/sc/Health%20Document%20Library/Information%20-%20Domestic%20Violence%20and%20Abuse%20Needs%20Assessment%20Bulletin%20Children.pdf>
- Health and Wellbeing Board minutes – <https://ww5.swindon.gov.uk/moderngov/documents/g5971/Printed%20minutes%2008th-Jan-2014%2014.00%20Health%20and%20Wellbeing%20Board.pdf?T=1>

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Embedding public health in redesign groups

Torbay

Summary

A key focus of this work is to embed public health, prevention and early intervention into the redesign of health and social care. Torbay and South Devon was one of fourteen sites awarded Pioneer status to work across local health and social care systems to achieve and demonstrate the scale of change required in order to establish an integrated way of working. In Torbay and South Devon public health are supporting this by:

- working in partnership with the CCG to jointly deliver the strategic plan
- working with colleagues from the local integrated care organisation (ICO) on drug and alcohol treatment pathways
- talking with colleagues in the council to look at embedding initiatives and ways of working which promote well-being
- discussions with Adult Social Care, Children's Services and Community Safety to agree strategic direction and priorities.

Consideration is being given to matrix working as an approach to increase inter-departmental and inter-organisational work.



Background and context of initiative

Torbay council is a unitary authority having the powers of a non-metropolitan county and district council combined. The resident population is around 130,959 (2011 census). Public health is located in its own directorate in Torbay council and is

developing work with other directorates. The public health team act as relationship managers between the local authority, NHS providers and CCGs.

Paths to public health and wellbeing

Demographic information:

- 48.2% of the population is male and 51.8% female
- life expectancy at birth is 79.1 years for men and 82.4 years for women; there is a gap in life expectancy of 8.3 years for men and 6.3 years for women between those living in the most deprived and least deprived areas
- 94.8% of the population is White British
- approximately 21% of the population is aged 19 years or under, 55% aged 20-64 years and 24% aged 65 years and over
- deprivation is lower than the national average but 5300 (23.5%) children live in poverty (PHE Health Profile, 2014)

More information about the area covered by the South Devon and Torbay CCG, including work on the Pioneer programme, can be accessed via this link

<http://www.southdevonandtorbayccg.nhs.uk/pioneer-joinedup/Pages/default.aspx>.

Rationale

Work on integration was already under way prior to the public health reforms of 2013. As a Pioneer site Torbay and South Devon are using the System Leadership approach to build on the integration work already in progress.

The aim of the work is to put public health on the agenda of all agencies in the new integrated system. This is being achieved by aligning priorities across several organisations and structures to support integration of public health across the council. Of specific interest is embedding preventive work into the plans of several partners.

Working in partnership in the new public health system

The System Leadership model is being applied to develop partnership work between a wide range of organisations and structures, including: Children's Services, Adult Social Care, CCG, Sports Development, Community Safety, Voluntary and Community Sector, Health and Well Being Board and several others. At this early stage the work is being overseen by the director of public health who assigns tasks. All partners contribute to undertaking relevant work.

Factors supportive to partnership work

Of central importance is taking sufficient time to build trust, develop good working relationships and agree a common purpose. These features are essential to progressing partnership work productively and with confidence.

Factors challenging to partnership work

Nothing specific at present, it is important to recognise that aspects such as agreeing a common purpose and building trust take time and effort to build.

Paths to public health and wellbeing

Process

Key actions taken to establish and deliver the work.

Stage 1: focused on building a case for the need to embed prevention work in the redesign of public health, led by the director of public health and the public health team.

Stage 2: brought together partners to work on establishing a common purpose and agreeing priorities for partnership work.

Stage 3: will be to embed agreed priorities and action into the work plans of partners.

Stage 4: will be the implementation and delivery of agreed priorities and plans, this final stage is currently scheduled to commence in 2014/15.

Timescale

The work commenced in June 2014 and is currently at stage 2, an update paper is being prepared. The process will continue to evolve and is described as a jigsaw that is gradually falling into place.

Resources

There are no specific resource allocations, partners are developing the process of integration as part of their work programmes.

Structure of initiative

The early stages of work are being led by the director of public health and public health team. Within the ethos of the System Leadership approach, partners will lead on areas in which they have specific interest and expertise. Establishing leadership across all agencies will be important to keep the issue alive and progressing.

Key supportive factors

Developing a common purpose has been essential, establishing and agreeing shared aims and objectives and working collectively towards common goals.

Key challenging factors

The challenges so far have been to address different ways of working including language used, lack of common understanding and shared goals. Addressing these challenges has been helped by open and transparent dialogues with partners.

Outcomes

There are four broad intended outcomes:

- better integrated working
- better care for the public
- stronger focus on prevention and early intervention
- address health inequalities and work towards reducing them

Paths to public health and wellbeing

Evidence and evaluation of impact

The work being undertaken on integration will, in due course, be assessed against other evaluations such as those looking at whether health inequalities have reduced and integrated working has improved. Progress on outcomes will be reviewed and considered in other processes such as the JSNA and activities of the health and wellbeing board.

Learning

Key messages for people thinking to undertake similar work

Develop a common purpose and shared narrative, this is a strong basis from which to build future partnerships, develop joint working and integrated care.

Key messages regarding working collaboratively in the new public health system

Be a System Leader, be courageous, have a candid outlook and approach.

Conclusions

The work is still in the early stages of development and working towards achieving outcomes. The current initiative will continue to work towards: integrating public health within the plans of partners; encouraging the CCG and adult social care to actively engage in prevention work; writing an integrated prevention strategy.

In relation to sustainability, the intention is that integrated health and social care becomes an embedded way of working. The health and wellbeing board and other structures will oversee and review progress in future as part of their work.

Further information

- Pioneer programme - <https://www.gov.uk/government/news/integration-pioneers-leading-the-way-for-health-and-care-reform--2>

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Diabetes: summit and work with clinical commissioning group

Wiltshire

Summary

Discussions between a GP in public health with special interest in obesity and diabetes and public health acknowledged a shared agenda and a potential way to address these concerns. Work on developing obesity related support material and referral pathways was undertaken by the GP who then also undertook a review of diabetes care in Wiltshire. After the review a public health consultant and the GP in Public Health collaborated to: develop links with the clinical commissioning group (CCG) regarding diabetes; set up and hold an annual diabetes summit; and, deliver a multimedia awareness raising campaign in partnership with other organisations including Diabetes UK. The diabetes summits have contributed significantly to building links between local hospitals and the CCG; public health has been responsible for taking forward outcomes from the summit discussions and this has resulted in the CCG taking on diabetes as a priority long term condition. Furthermore, public health is now represented on the CCG steering group meetings for diabetes and obesity. The multimedia campaign is being delivered through: roadshows; a website; development of a patient hand held record (Blue Book); and, a radio campaign. The aims of the multimedia campaign are to broaden public awareness of the risks of obesity for type 2 diabetes and to identify the estimated 7,000 undiagnosed diabetics in Wiltshire.

Background and context of initiative

Wiltshire Council is a unitary authority with a resident population of 470,981 (Census,

2011). The council has adopted a 'One Council', 'One Wiltshire' approach to public health as part of a strategic, place-based approach to all public services. The Director of Public Health and Public Protection is one of three corporate directors, with additional local authority responsibilities covering 150 frontline services.



Demographic information:

- 49.2% of the population is male and 50.8% female
- life expectancy at birth is 80.4 years for men and 83.9 years for women; there is a gap of 5.7 years for men and 2.4 years for women between the most deprived and least deprived areas
- 93.4% of the population is White British
- approximately 24% of the population is aged 19 years or under, 58% aged 20-64 years and 18% are aged 65 years and over
- deprivation is said to be lower than average but 10,300 (11.9%) children live in poverty (PHE Health Profile 2014)

Rationale

The initial impetus for this work came from a GP who raised concerns about obesity levels in patients and was looking for interventions that did not involve medication but focused more on raising awareness through education. In considering the issue of obesity it became apparent that diabetes was a far bigger problem; the link between obesity and type 2 diabetes indicated a potentially massive public health issue was likely to present in the future and action was needed to address this.

A review of diabetes care in Wiltshire highlighted that, based on the National APHO Diabetes Prevalence Model for England 2010, the prevalence of diabetes in Wiltshire was projected to increase from 6.9% to 7.4% by 2015. Of the nine key care processes identified by NICE for comprehensive diabetes service provision, the National Diabetes Audit 2010-2011 review found that only 46% of diabetics in Wiltshire received all nine processes over 2009/10, placing it in the second lowest national quintile.

The aim of the diabetes summits, work with CCG and awareness campaign is to: prevent or diagnose early type 2 diabetes through awareness raising and health checks; reduce type 2 diabetes or at the very least prevent the predicted rise and if possible reverse the trend across all agencies in the NHS and public health.

The initiative is targeted at two groups: members of the public to raise awareness and encourage healthy living; NHS and public health agencies to discuss and agree future actions.

Working in partnership in the new public health system

A range of agencies and professionals have been brought together to participate in the annual summit and act as a steering group for progressing work on diabetes in Wiltshire. They include: Wiltshire council; Wiltshire CCG; Diabetes UK; GPs and secondary care Consultants; Diabetes Specialist Nurses; patients; and, a range of other health and social care organisations.

Paths to public health and wellbeing

Some contacts had been built up through the initial focus on obesity and there was a dedicated drive to bring others on board to work on addressing the diabetes challenge. The work is overseen by the Diabetes Lead in public health and key discussions/agreements are reached during the annual summit that is attended by partner agencies. Participation by the CCG in the summit has been a key enabler for the CCG to recognise diabetes as a priority long term condition.

Factors supportive to partnership work:

- the GP and public health role have been significant; a GP communicated knowledge gained from frontline healthcare to public health and the issue is now being taken forward as part of the public health agenda in Wiltshire
- the independence of public health can support issues to be progressed with a range of agencies and avoid being seen as empire builders which could act as a barrier to effective work
- bringing together a wide range of agencies that can offer diverse perspectives and knowledge; this is helpful to building a comprehensive picture and look at related actions
- reaching a shared understanding and agreements with partners regarding actions to be taken
- support from public health to progress the work and overcome barriers

Factors challenging to partnership work:

The main challenge is a lack of motivation arising from previous failed attempts to effectively address the issue. This can result in an “Its been tried before” attitude that requires extra effort to motivate people and push for things to be done differently.

Process

Key actions taken to establish and deliver the work:

Stage 1: a GP working within and on behalf of public health pursued this public health agenda and undertook initial work on developing obesity related support material and referral pathway; subsequently, the link with diabetes highlighted that diabetes was likely to present as a significant health issue in future.

Stage 2: a review of diabetes care in Wiltshire was undertaken by the GP, examining the extent to which Wiltshire achieved the nine NICE care processes and six other standards of ‘good care’ identified by Diabetes UK

Stage 3: the annual summits were introduced bringing together key agencies and professionals to discuss and agree actions regarding diabetes prevention and care in Wiltshire

Stage 4: the CCG recognised diabetes as a priority long term condition and public health became members of the CCG steering groups for obesity and diabetes

Stage 5: roadshows were developed and delivered in partnership with Diabetes UK to raise public awareness

Paths to public health and wellbeing

Stage 6: radio campaigns, associated website and a patient hand held care plan (blue book) were introduced

Timescale

After some initial work on obesity, dedicated work on diabetes began in 2012. The work is ongoing with a second summit and roadshow to be delivered this year. A review will be conducted at the end of 2014 and an action plan put in place for the next phase of activity.

Resources

Public health funds the roadshow, radio campaign and associated website, summit organisation and event and GP time (1 day a week).

Partners contribute their time, knowledge and expertise as part of their programme of work.

Structure of initiative

The annual summit, chaired by the Wiltshire Councillor Cabinet Member for Public Health, is a meeting of all interested parties to agree the way forward. GPs also reach decisions through the CCG. The GP and Consultant in Public Health who developed the initiative oversee delivery of the actions agreed by the Summit and they created the awareness raising campaign with Diabetes UK. The public health team contribute and provide support as and when needed.

Key supportive factors:

- public health supporting the work financially and giving it some priority
- enthusiasm and engagement across agencies in Wiltshire to address this issue
- the summit has helped bring people together, especially as individual professionals and clinical teams are spread across three hospital locations which makes it difficult for all to come together and work on a specific issue
- the CCG taking diabetes on as a priority long term condition has contributed to raising the profile and potential future scale of the problem if it remains unaddressed

Key challenging factors:

- identifying and accessing necessary funding
- reaching people in rural areas
- maintaining communications across GP practices
- having three hospital bases serving the Wiltshire population can mean people bring different approaches so it can take time to reach shared understanding and agreement about the best way to proceed

The challenges will be addressed through the CCG and public health will work with them to address challenges and finance future work.

Outcomes

There are four key outcomes to be achieved:

- prevent type 2 diabetes through better awareness
- reduce obesity
- more patients have annual diabetes care checks done
- increased engagement with diverse communities and groups

Evidence and evaluation of impact

The National Diabetes Audit was used to inform initial developments and will be used to ascertain future progress. Local obesity rates will be checked through Quality and Outcomes Framework (QOF) data and Health Survey England for overall figures.

Learning

Key messages for people thinking to undertake similar work:

- it is useful to have public health look at the National Diabetes Audit and have a local GP undertake a review for the region or locality
- a GP undertaking the work is important because it brings knowledge of the locality and its community and can tap into various clinical links already in place
- bring relevant people together in a summit to develop a shared agenda and set clear outcomes
- continue to push for recognition of the issue on an ongoing basis
- recognise that this work can take years so have in place long term plans and resources
- invite the CCG to participate and encourage them to take this on as a priority – diabetes and obesity are national concerns
- consider IT equipment to be used because if different systems are used by primary and secondary care professionals this can result in some programs not being compatible for use on some computers

Key messages regarding working collaboratively in the new public health system

Allow time for partnerships to develop, this work can take several years and it is helpful to have the same people attending meetings on a long term basis. It takes time to develop an agreed understanding and commitment which is not helped if there is a high turnover of participants.

Conclusions

It is difficult to comment on outcomes of the initiative as these will take some years to realise. The CCG will take forward this work so it will be sustained through that route. Future action planned includes:

- roadshows will continue to be delivered
- a schools awareness campaign is being developed for delivery in primary schools
- a Blue Book has been produced for patients so they can keep a track of checks done
- a computer template is being developed for primary care nurses so they can link this into the Blue Book

Further information

- State of the Nation 2012 – Diabetes UK report on the current diabetes landscape in the UK. http://uk.sitestat.com/diabetes/website-uk/s?state-of-the-nation-2012&ns_type=pdf
- NICE Type II Diabetes National clinical guideline for management in primary and secondary care (update) (2008). <http://www.nice.org.uk/nicemedia/live/11983/40803.pdf>
- YHPHO – Diabetes A to Z – comprehensive list of diabetes resources, and links to both national and local data sources. <http://www.yhpho.org.uk/default.aspx?RID=91596>

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Appendix 1

Information sent to respondents ahead of telephone discussion

Case Study - topics for discussion and data collection

This document is intended to give an indication of the broad areas to be discussed for each case study. The key aim of data collection is to highlight each initiative in the context of its delivery in the new integrated public health system. The intention of the final document is to provide the reader with a brief overview of the initiative and details of where to access further information.

Please note:

- Allow minimum 45 minutes for the telephone discussion on your case study.
- Each case study written up will be approximately (specify number of words).

1. Title of initiative.

2. Background:

Brief summary: of initiative (Eg aim, target population/agencies, timescales).

Rationale: reason for embarking on the initiative, any data highlighting need for it (evidence base, anecdotal, needs assessment and so on).

Demography of local authority: population groups, life expectancy, deprivation, health inequalities.

Configuration: of new integrated public health system in the local authority.

- 3. Partnerships:** agencies involved in developing and/or delivering the initiative.
- 4. Process:** key actions taken to establish and deliver the work.
- 5. Resources:** relevant to developing, implementing, evaluating and sustaining the initiative.
- 6. Programme Structure:** key components of the initiative: strategic, managerial, operational.
- 7. Key supportive factors:** those that facilitated work to be undertaken.
- 8. Key challenging factors:** those that presented and how they were addressed.
- 9. Outcomes:** the results achieved or to be achieved.
- 10. Evaluation:** undertaken or under way to measure outcomes/impact, including rating the standard of evidence according to the *'NESTA' rating scale below.
- 11. Learning:** key messages for people thinking to set up/undertake similar work.
- 12. Conclusions:** changes made as a result of the initiative, sustainability, further action planned.
- 13. Other information:** useful links to other organisations/resources.
- 14. Contact details:** for this initiative to be included in final document.

***NESTA rating scale:**

Level 1 (Promising): The project can describe what they are doing and why it matters, logically, coherently and convincingly.

Level 2 (Promising): The project can capture data that shows positive change, but cannot demonstrate causality link.

Level 3 (Good): The project can demonstrate causality using a case control comparison group.

Level 4 (Good): The project has one (or more) independent replication evaluations that confirms the causality and outcome conclusions.

Level 5 (Good): The project has manuals, systems and procedures to ensure consistent replication and positive impact.

<http://www.nestainvestments.org.uk/wp-content/uploads/2012/10/Standards-of-Evidence-for-Impact-Investing-v10>