CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

29 March 2018

Report title	Public Health Transformation Service Consultation	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Wards affected	All	
Accountable director	John Denley, Director of Public health	
Originating service	Public Health	
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Report to be/has been considered by	People Leadership Team Senior Executive Board Health Scrutiny	12 March 2018 13 March 2018 29 March 2018

Recommendation(s) for action or decision:

The Scrutiny Panel is recommended to:

1. Consider the findings of the consultation on the Public Health Service Transformation.
2. Comment on the proposed way forward for the areas considered, making recommendations to the Cabinet Member for Public Health and Wellbeing, as appropriate.

1.0 Purpose

1.1 To advise Health Scrutiny Panel of the outcome of the consultation on Public Health Service Transformation and set out the next phase of the transformational programme based on the feedback received.

2.0 Background

2.1 The Public Health vision is that by 2030 people will live longer, healthier and more active lives; every child will have the best start in life; the gap in healthy life expectancy between Wolverhampton and the England average will close and there will be increased protection from harm, serious incidents and avoidable health threats.

2.2 To prepare for a new approach to delivering public health it is proposed to transform the design of the service by offering expert advice and support to all parts of the Council and external partners, especially the NHS.

2.3 Secondly, there is a re-examination of the right approach to improving the health of residents at a population level. The new approach will involve moving away from providing 'traditional' behaviour change services to individuals and focusing more on making a difference to factors that influence healthy life expectancy at a population level. This change will require reviewing current commissioned services to check that they are aligned to the new public health vision.

2.4 Following Cabinet consideration of the re-examination of the health transformation report on commissioned services, 29 November 2017, the following recommendations were approved:

- An eight-week public consultation on the Public Health commissioning proposals for 2018-2019 onwards to meet the City's public health and wellbeing outcomes.

- Delegate the final decision on the commissioning proposals to meet the reduced grant allocation to the Cabinet Member for Public Health and Wellbeing. The decision to be made in consultation with the Director of Public Health who will provide assurance that the Council has complied with its public-sector equality duty responsibilities.

2.5 The consultation was subsequently initiated to gain views on the vision of public health service delivery going forward. This required insight from the wider public and people affected by public health service changes. From this it was envisioned that the development of an offer to provide a range of approaches for new ways of working to deliver public health outcomes would be developed. The consultation focused on the following aspirations:

- Support women to breastfeed

- Reduce the number of people who smoke
- Increase the number of children with a healthy weight
- Prevent health care acquired infection, particularly in nursing and Care Homes
- Improve young people's emotional and mental wellbeing.

2.6 The consultation approach was ambitious therefore multi-faceted, and the public have been engaged through the following routes:

- Universal public survey as a resident or user of outcomes described above
- Targeted – specifically with service users that will be impacted by the service changes
- Young People – streamlined questions from the original survey to increase participation from young people
- Stakeholder- To allow stakeholders to have their say about how we can work together to meet shared outcomes
- Network promotion - through Councilors, Community Groups, Organisations, Youth Council

2.7 The programme spanned a period of 8 weeks. The consultation started on 21 December 2017 and closed on 19 February 2018. The consultation was promoted through a series of press releases, City People, Social Media and via the corporate communications data base of approximately 1800 contacts. The survey was also publicised through the Council's corporate consultation page and advertised on customer services digital platforms located in the foyer of the Council.

2.8 Customer Services, 'Floor Walkers' were briefed about the consultation, which supported access to the survey for people waiting to be seen in reception. Those who opted to take part were signposted to the computer area located in the Council foyer. In addition, to boost wider public participation external specialist support was recruited and surveys were undertaken in various public buildings across the City.

2.9 The information was also disseminated widely to partners, organisations and forums these included: all Care Homes, Youth Council, Safer Wolverhampton Partnership forums, all Council Equality Forums, internal departments, University, GP's, Pharmacies, Schools, Strengthening Family Hubs, Health Visiting area teams, Maternity, Councillors, Heads of Departments, Children's Outpatient Services, Sexual Health Services, Recovery Near You, and CCG. Organisations were encouraged to engage their service users as appropriate to participate.

2.10 The scope of the consultation covered different ages and groups of the population. A steering group was established at the start of the consultation which included representation from the corporate equality team. This approach supported the prioritisation and monitoring of equality assessments. Targeted groups were then engaged to develop the equality assessments, arranging focus groups as appropriate i.e. counselling services for young people and child weight management. A targeted survey was established for service users so that information could be gathered where focus groups were not appropriate, i.e. Infection Prevention Service, Hospital Youth Service.

2.11 Methods of consultation have been careful to record the equalities profile of responses so that any diversity responses can be understood and can inform the future direction of service and policy.

2.12 The young person's survey was specifically streamlined to increase the response rate from young people which was marketed in schools and youth venues like The Way. We engaged with members of Wolverhampton Youth Council who also completed the young person's survey.

2.13 The survey had a separate tab that supported stakeholders to respond and have their say about Public Health Transformation and how joint outcomes could be met. This will allow partnership planning as to how outcomes can be achieved collaboratively and address any potential challenges.

3.0 Consultation Outcomes

3.1 The consultation received 1,239 responses across all four survey areas. This comprised 861 of the public, 72 targeted, 203 Young People and 103 Stakeholders. Given the public health outcomes being consulted on, affecting all ages but most specifically younger people, it is helpful that there is good representation from across all age groups, but particularly those aged 25 – 44 years.

3.2 The demographic analysis indicates that women are over represented in the responses, which is quite usual and is hard to counter-balance. However, there has been a high response rate overall so the male view has been considered. Those from a white ethnic back ground are slightly higher in the response rate than the general population. This translates to 69% identifying as female, 82% identified as heterosexual, 73% identified as white, 9.8% identified as disabled.

3.3 Smoking Cessation and Tobacco Control

3.3.1 Respondents who were smokers said they would most likely try and quit on their own or use online information. Non-smokers however, expressed a greater support for GP and pharmacy services. Smokers found national campaigns helped them think about quitting smoking. The vast majority of current/ex-smokers felt it was essential to create smoke free environments, especially around children. Most smokers would not consider vaping to stop smoking however there was a significant minority who were not aware of vaping or e-cigarettes.

3.3.2 In relation to children and young people and smoking, schools were often identified as the place were prevention work could be undertaken and having a role in it, by users, residents and stakeholders. Respondents mentioned a wide range of things that could be done to prevent or stop smoking in adults and children and, thus a wide range of partners and organisations could potentially have a role in supporting this agenda. For example, smokers as well as non-smokers thought there should be more enforcement around

where smoking can take place, specifically in public areas and health sites, as well the need to increase the price of cigarettes/tobacco.

3.3.3 **Proposed way forward**: With these findings in mind, public health will work with partners to develop smoke-free health and social care systems, make more public areas smoke free, and enhance the schools-based education plans, with emphasis on prevention. Considering new evidence around the safety and effectiveness of e cigarettes we will explore ways to promote and encourage smokers to consider e cigarettes as a harm reduction approach.

3.4 Child Weight Management

3.4.1 Where there was concern about a child's weight, the survey highlighted that for advice or information most participants said they would look online or visit the GP. Most respondents would do free activities such as walking, running or think carefully about shopping habits, and consider the availability of after school clubs. A notable suggestion made for how children's weight could be managed was the need for the creation of appropriate environments which enabled people to take part in physical activities.

3.4.2 Evidence from the consultation questionnaires indicates that there is demand for self-help services. There is a very strong preference by members of the public for accessing information online. Furthermore, in addressing weight concerns, respondents to the main consultation indicated a preference for lifestyle adjustments through self-help techniques, such as changing shopping habits and engaging in no-cost low-cost activities with their families (such as walking and cycling).

3.4.3 **Proposed way forward:** In response to and in mitigation to these considerations, Public Health could support the current child weight management provider (PASS) in accessing alternative funding for their programme. We will signpost families to reliable sources of online support and ensure that staff in GP practices are trained, this would also include promoting free activities across the city and within communities that are accessible for families, promote national campaigns, which are based on good evidence and develop a stronger link with planning policy.

3.4.4 We also know that preventing children from becoming overweight in the first place is essential. To achieve this, we will continue with our obesity prevention plan in primary schools; develop further our prevention plans in secondary schools and develop a 0-4 obesity prevention strategy to include all partners working with children in the early years.

3.5 Healthcare Acquired Infection Prevention

3.5.1 Overall all respondents supported care homes to have measures in place that would address the spread of infections. Stakeholders health partners, felt that this is a critical service that prevents onward transmission of infection and reduces hospital admission.

3.5.2 **Proposed way forward**: The consultation has identified that this is a key service with shared outcomes, therefore we propose to work collaboratively with Royal Wolverhampton Trust (RWT) and the Clinical Commissioning Group (CCG), to support a joined-up approach to the delivery of infection prevention across the city.

3.6 **Breastfeeding**

3.6.1 Midwives and breastfeeding support groups in the community were considered the best ways to support women to breastfeed by women who have experience of breastfeeding, those who had supported their partners to breastfeed, and by those who had no experience.

3.6.2 The overall feedback received showed there was a demand for face to face support, whether it is through voluntary support groups, or professional support, as well as the need to normalise breastfeeding in public.

3.6.3 Respondents would like or had welcomed and valued the experience, advice and support of women who had breast fed their baby. One of the places where people could get initial advice/support about breast feeding was immediately after birth and before they were discharged from maternity. However, on the whole respondents were not positive about their experiences and did not feel that staff had time to provide support required.

3.6.4 **Proposed way forward:** Public Health will work closely with The Royal Wolverhampton Hospital Trust (RWT) to enhance ways in which peer support groups could be developed and available to the women who need them most, in a timely manner. Public Health will also work closely with Children's Services and family support, to ensure the most vulnerable children in our City are given the best start in life. We will work to ensure all front-line staff make every contact count, by being able to offer breastfeeding advice. We will continue to achieve UNICEF baby friendly status by working through our partners.

3.7 **Young People's Emotional Health and Wellbeing**

3.7.1 To help improve Young People's emotional health and wellbeing, respondents suggested they would or be highly likely to seek advice from all the options provided (Young People's Service (such as The Way, Base 25, Believe to Achieve), online, school, GP surgery. Very few respondents would do nothing. 96.6% (424) of respondents think it is important that there is support available in hospital settings for Young People who have presented at A&E who have experienced violence, or have mental health concerns/harmful behaviors, and are identified to health and social care staff and can access on-going support.

3.7.2 It was suggested that this support could be provided through; faith centres, youth groups, hospital youth service, mental health teams, schools, Headstart/other charities, as resources to support the needs of young people's emotional health and wellbeing.

3.7.3 **Proposed way forward:** A new contract has been awarded to commence on 1 April 2018 to provide Emotional Health and Wellbeing Services to Young People and Families,

funded by the Clinical Commissioning Group (CCG), CWC and Headstart for young people up to the age of 18. The service will operate a single point of access and will be delivered through a range of different settings based on the needs of the child's and family. Public Health will consider business partnering arrangements that will support newly commissioned services for children and young people and work directly with schools to enhance the school offer. Public Health will also work with Children's Social Care and RWT to reassess how services in the hospital could be developed.

4.0 System Feedback: Health Partners

4.1 Feedback from RWT to the consultation supported the commitment of all stakeholders to work in partnership to deliver effective services. Their response highlighted the importance of face to face contact for breast feeding support and Making Every Contact Count (MECC) to support lifestyle choices. It was felt that a Tier 2 service was required to support a weight management offer which includes psychological and physical support. RWT are concerned about infection prevention risks and the wider impact on acute admissions and increased infections in care homes. In addition, the withdrawal of young people services was viewed as a reduction in the options for support to young people and a potential risk to the increase of A&E waiting times including demand on the Paediatric Assessment unit.

4.2 The CCG supported "the initiative to change to ensure that services have the widest impact, are evidence based and makes use of advances into technology". They highlighted that a targeted approach is required with pregnant smokers given the problem with infant mortality. It was felt that there are significant risks of stopping the infection prevention service about increased outbreaks in care homes. It was highlighted that the young people's counselling service has a good reputation with exemplary feedback. The Hospital service was recognised as critical for young people presenting at A&E who are not meeting the thresholds for entry into Child Adolescent Mental Health Services (CAMHS) but can who receive support through this service.

4.3 Public Health England (PHE) were concerned that health improvement gains from the personal support provided by local community infection prevention would be undermined, however, they agreed with making infection prevention control everyone's business. In terms of breastfeeding they commented that the way of working should include implementing the UNICEF UK Baby Friendly Initiative standards. Reliance on digital and online tools for women who want to breastfeed, smokers and families looking for weight management help and support were not felt to be equally available in more deprived groups. Those with additional needs, such as physical, sensory or learning disabilities, and people who do not speak or read English need to be considered.

4.4 PHE response stated that Wolverhampton is identified as already experiencing the implications of obesity and its associated health conditions. Investing in effective, evidence-based services to help people achieve and maintain a healthier weight can provide a return on investment. Finally, there was concern that without a dedicated stop smoking service in place inequalities between different parts of the city might increase.

The continuation of work to deliver smoke free messages through schools was supported with consideration about how to reach all those who need advice and support.

5.0 Next Steps

5.1 The response rate and the information received from the public and stakeholders demonstrates that the public are engaged and want to have a say about health approaches. This gives a solid platform to start discussions, to develop those concepts that the public have supported which will further build the Public Health offers. The process has also shown that there is immense value in having a robust consultation strategy.

5.2 The end of the consultation marks the start of on-going conversations with partners and public, strengthening relationships and maximising health outcomes. New ways of working take time to plan, develop and implement. It is an iterative process which needs to be worked through with partners and stakeholders. In order to start this, task and finish groups will work up the offers further based on the consultation findings, best practice guidance, research evidence and equalities, to ensure that there is a joined-up offer fit for the needs of our population.

6.0 Financial implications

6.1 Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The total allocation for 2018-2019 is £20.8 million. Any costs associated with the delivery of these services will be contained within this overall allocation.
[MI/06032018/X]

7.0 Legal implications

7.1 The Council has a duty to improve the health and well-being of its population. There is a legal requirement to conduct a formal 8-week consultation based on potential changes.
RB/28022018/A

8.0 Equalities implications

8.1 To support this process working together with colleagues from the Equalities Team was undertaken from the onset of the Public Health transformation programme. An equality analysis was undertaken on each of the services affected and these focused on the equality impacts as understood using relevant data and research then available. A formal consultation on the actual and or likely impact of proposals was undertaken where gaps in knowledge were seen to be relevant and were required to be closed.

8.2 To support an approach that focused on those individuals who were more adversely impacted by the changes a targeted approach was developed, 72 people responded to the targeted survey and where appropriate focus groups were undertaken. In addition, and importantly, all methods of consultation used were supported by questions asking respondents to identify their equalities identities.

8.3 In summary, the equality analyses conducted so far have provided outline intelligence that services that were being provided, supported only small numbers of the population, for example those provided to help people stop smoking and those to support breastfeeding. Therefore, services may not be delivered as they have been traditionally, since evidence, local research and the consultation has highlighted that residents want different options for accessing lifestyle advice and support including self-help.

8.4 These findings indicate that any adverse impacts will be limited in number and scope. With any mitigating actions resulting from the study of feedback from diverse respondents finally developed, access to groups of the population with protected characteristics can be expected to improve. Monitoring will be in place to check that actions intended and outcomes worked for actually materialise.

8.5 Equality analysis of services like infection prevention and the counselling service highlighted that all groups benefited from the services, with BME over-represented for the counselling service. From all the data, we have been able to assess up to this point, negative or positive impacts or importantly, gaps in our knowledge about likely impacts on individuals or on particular groups in the community have been considered. The findings will be addressed and mitigated (where required) as part the public health offer going forward.

8.6 However, there are some instances of potential differential impact i.e. a service ending would disproportionately affect one group of people. The completed equalities assessments will be built into each area affected to ensure that any gaps are addressed through the next phase of the transformation and that these disproportionate impacts are mitigated, for example by working with local libraries to ensure that people who do not have access to a computer at home can be supported to access online information or printed copies.

8.7 A final suite of equality analyses will be completed by service managers prior to, and in support of Executive decisions. These will incorporate and respond to the diversity data collected. Consequently, those interventions developed by the transformation programme will be directly informed by the findings from specifically targeted consultation and supported by other relevant data and research held previously. In this way, these final decisions will be those that the Council can be confident are the best that resources permit to be provided to support the diversity of Wolverhampton's Public Health requirements.

9.0 Environmental implications

9.1 No environmental implications have been identified relating to the consultation and engagement process.

10.0 Human resources implications

10.1 Public Health funding supports the Hospital Youth Link Service through Children's services therefore there are human resource implications in relation to the two posts that will need to be considered and managed in line with human resource procedures.

11.0 Corporate landlord implications

11.1 No corporate landlord implications have been identified relating to the consultation and engagement process

12.0 Schedule of background papers

12.1 Cabinet paper dated 29 November 2017 on Public Health Commissioning Proposals for 2018-2019 onwards.