Version 11

ABM Public Health Strategic Framework 2014/15

Iechyd Cyhoeddus Cymru
Public Health Wales

Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Abertawe Bro Morgannwg University Health Board

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Contents

SUMMARY

The purpose of the Public Health Strategic Framework (PHSF) is: [*To] set out the services and activity required to meet identified population needs, priority activities, outcomes and milestones agreed with local partnerships' (NHS Guidance 2011)*.

The Framework fulfils the requirement within the Welsh Government's Public Health Strategy *'Our Healthy Future'* (2009) that every NHS Wales organisation shows the contribution they will make to national health improvement priorities.

The ABMU Health Board produced its first PHSF in 2011. This was 'refreshed' in 2012 and again in 2013/14 in the light of developments, including that of the requirement for Local Service Boards to prepare Single Integrated Plans for the health, wellbeing and prosperity of their populations (*Shared Purpose – Shared Delivery* 2012).

For this 2014/15 refresh, the opportunity has been taken to engage Local Service Boards in aligning public health work with their Single Integrated Plans and to ensure that the framework is aligned with the priorities identified in the Strategic Needs Assessment (2014) and the new Integrated Medium Term Plans (IMTPs) developed by the ABMU Health Board.

This new framework makes clear the actions being taken across the area through the work of the ABMU Health Board, the ABM Public Health Team and all the partners of the Local Service Boards in each local authority area.

The PHSF demonstrates how work is prioritised to ensure a strong focus on helping the most vulnerable and disadvantaged individuals, families and groups to address challenges and difficulties and to mitigate the impact of poverty. In seeing how everything we do can contribute to tackling poverty, the Health Board and the Public Health Team will seek opportunities to work with partners and communities to prevent poverty, to strengthen community resilience, to reduce health inequities and to reinforce awareness of good health as a shared goal.

The 'life course approach' has been adopted as a helpful way to consider people's changing needs at different stages of their lives and within the different environments that they live.

The shared outcomes, population indicators, services and activities are presented in the form of 'driver diagrams' which provide a straightforward and powerful way of translating a high level improvement goal into a logical set of underpinning goals and projects. The diagrams capture an entire change programme on a single page and also provide a measurement framework for monitoring progress. The ultimate aim of a driver diagram is to define the range of actions or interventions to be undertaken.

CONTEXT

Strategic Needs Assessment

The PHSF should be based on a clear understanding of the health needs of the local population. To this end, across the ABM area, the three Local Service Boards (LSBs) have used strategic needs analysis to determine priorities for local action in their Single Integrated Plans.

In November 2013, the Health Board published a Strategic Needs Assessment to further help prioritise action to improve health. The Strategic Needs Assessment draws on many data sources which taken together paint a clear picture of what needs to be tackled by ABM University Health Board and its partners.

The major priorities identified include:

- Reducing health inequalities
- Cardiovascular disease, cancers, chronic obstructive pulmonary disease
- Smoking
- Obesity
- Alcohol
- Mental health
- Frail elderly
- Vaccination and immunisation

Meanwhile, at the national level, health improvement priorities have been agreed by Welsh Government and set out by the Chief Medical Officer in *'Our Healthy Future'* (2009). These priorities are to:

• Reduce smoking

• Increase participation rates in physical activity
• Reduce unhealthy eating
• Stop the growth in harm from alcohol and drugs
• Reduce teenage pregnancy rates
• Reduce accident and injury rates
• Improve mental wellbeing
• Improve health at work
• Increase vaccination and immunisation rates to target levels
• Reduce health inequities

Key Delivery Vehicles

Across the ABM area, work on these priorities takes place through the following:

- Local Service Boards and Single Integrated Plans for partnership working across Bridgend, Neath Port Talbot and Swansea
- The ABMU Health Board's Directorates and Locality Teams, Primary Care Services and Community Networks
- ABMU Health Board's Changing for the Better Programme (especially the Staying Healthy and the Women and Child Health Projects)
- Implementation of national immunisation programmes
- Screening and communicable disease control programmes

WHO Healthy Cities and Health 2020

The new WHO policy *'Health 2020'* has been adopted by Wales as a region, and the WHO Healthy Cities network of which ABMU Health Board and the City and County of Swansea are designated partners, is a key vehicle for implementing Health 2020 at the local level. There are two overarching goals for Phase Six of Healthy Cities, namely:

- Improving Health for All and Reducing Health Inequities, and
- Improving Leadership and Participatory Governance for Health

Phase Six will also include a new major focus on building community resilience and promoting health literacy. These programme themes are reflected within this PHSF.

Changing for the Better – Staying Healthy

This Public Health Strategic Framework forms an integral part of Changing for the Better – the Health Board's vision for future NHS care in ABMU.

The Changing for the Better Programme Board has established a 'Staying Healthy' Project Group to take forward health improvement priorities and this forms a major vehicle for the delivery of this overarching framework by the Health Board. The other delivery vehicles include work undertaken through the Health Board's Locality Teams and the Primary Care Community Networks and partnership work through the Local Service Boards in the three counties.

The Staying Healthy Project has adopted a life course approach and plans to develop initiatives for:

- early years (maternity and newborns)
- children and young people
- working age adults and
- older adults (including frail elderly)

The Project Group's priorities include developing initiatives to reduce smoking, tackle obesity (to increase physical activity and reduce unhealthy eating), to increase the uptake of vaccination and immunisations, to prevent harm from alcohol and drugs, to improve sexual health and reduce teenage conceptions and to improve mental health and emotional wellbeing.

The Project will target health improvement initiatives for vulnerable groups and people with long term conditions. The project aims to reduce health inequalities and inequities, to raise the profile of public health and embed public health objectives in directorate, locality and partnership plans, to increase the level of integrated working and to increase staff knowledge and skills in health improvement (for example, through the implementation of 'Making Every Contact Count').

DRIVER DIAGRAMS

Driver diagrams are structured logic charts that describe the link between a goal and the project activities that will be undertaken to deliver it. Typically simple driver diagrams have three or more levels that include:

- A goal or vision

- The high-level factors that you need to influence in order to achieve this goal - called 'primary drivers'
- Specific projects and activities that would act upon these factors – 'secondary drivers'

The primary drivers set out our hypothesis of the factors that we should focus on in order to achieve our goals. In each case these 'drivers' are stated as goals in their own right. These goals are clearly defined and measurable. In this way a driver diagram can become a measurement framework for tracking progress towards a goal.

This first set of underpinning goals are referred to as 'primary drivers' because they 'drive' the achievement of our main goal. These drivers may act independently or in concert to achieve the overall goal.

The secondary drivers then show the factors that support the achievement of each primary driver, again expressed as goals (e.g. 'reduce falls').

The complete driver diagram would include the projects that underpin each of these secondary drivers. For example, 'reduce falls' might be linked to a range of projects such as introducing a falls risk checklist or a falls prevention programme to raise staff awareness about how to prevent falls. Using a driver diagram in this way creates a clear connection between our goals and specific actions to achieve them.

The ultimate aim of a driver diagram is to define the range of actions or interventions that we may want to undertake.

Driver diagrams can fulfil a range of functions. They can:

- help us explore the factors we believe need to be addressed in order to achieve a specific overall goal
- show how the factors are connected
- act as a communication tool for explaining a change strategy, and
- provide the basis for a measurement framework

Driver diagrams are therefore best used when partners need to come together to determine the range of actions they need to undertake to achieve a goal. They are especially suited to complex goals like where it is important for a team to explore many factors and undertake multiple reinforcing actions.

PERFORMANCE FRAMEWORK

Progress towards achieving the population outcomes will be monitored through the use of a Performance Framework which is intended to reflect the impact of action taken by the NHS and also by all partners in the three local authorities, the third sector, business and communities.

To avoid duplication, and to ensure consistency, it is intended that the Performance Framework will include the same measures that need reporting through different routes, including the Health Board and *Changing for the Better*, the Single Integrated Partnership Plans (with agreement of partners) and the Standards for Health Services in Wales.

Current measures relating to public health priorities have been drawn from the range of plans used to inform the Driver Diagrams. These measures have been reviewed using criteria to establish a small number where routine data are available and which are most helpful to the Health Board and partners in understanding the delivery of public health services and progress towards system outcomes.

The proposed Performance Framework will follow a Results Based Accountability (RBA) approach, with indicators that relate to overall population outcomes (referred to as population accountability) and indicators which relate to specific services e.g. Stop Smoking Wales (referred to as performance accountability).

IMPLEMENTATION

This Public Health Strategic Framework will be circulated to all partners through the Local Service Boards and the Health Board's 'Changing for the Better' Staying Healthy Project Group. The activities agreed and the indicators to be used to measure progress will also be communicated to all partners through these forums.

Successful implementation will rely on the governance by all partners of the activities they have agreed to undertake and on partners identifying when and where they can add value to one another's efforts. Our overall progress will be reviewed and the Framework refreshed again in April 2015.

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Driver Diagram ~ Improving Maternal Health so that Babies are Born Healthy

Outcomes and Indicators

Outcomes

Babies are born healthy and child birth is a safe and positive experience for women in the ABM Area

Indicators:

- % of low birth weight rate
- Uptake of influenza vaccination by pregnant women
- Under 18 conception rates
- % of babies breast fed at birth and six weeks.

Under Consideration:

- Perinatal Mortality Rate
- Infant Mortality Rate
- % of pregnant women giving up smoking
- Pre and post pregnancy drug use
- % of women booked by 10 completed weeks of pregnancy
- Numbers of mental health conditions in pregnancy.
- Planned pregnancy rate

Primary Drivers

- Pregnant women are 18 years of age and older
- Pregnant women have direct access to a midwife in early pregnancy
- Pregnant women receive care from the same midwife for most of their pregnancy
- Pregnant women can make informed choices about their birthing options.

- Pregnant women do not smoke, drink alcohol or misuse drugs
- Women are at a healthy and safe weight for pregnancy, and eat a healthy balanced diet
- Pregnant women feel safe, supported and experience good mental health and well-being throughout their pregnancy and following the birth of their child
- Pregnant women make an informed choice whether to accept / decline antenatal screening tests

- Pregnant women and their partners are equipped with parenting skills
- Pregnant women have financial security and are able to access the appropriate financial support available to them
- Pregnant women and parents are able to access a range of local support groups, for advice and to socialise.

Secondary Drivers (ABMU, LA & Partnership Commitments)

- Develop and implement a systematic approach to **preconception care**
- Provide high quality **antenatal care** to all women including consistent midwifery care, nutrition throughout pregnancy, smoking cessation, weight management and emotional wellbeing
- Develop Women's and Children's Services as set out in the **C4B Women, Children & Families Project** for co-dependent services, including maternity, neonates, gynaecology & inpatient and community paediatrics
- Provide supportive environments and encourage healthy behaviours for pregnant women across the ABMU HB area through the **C4B Staying Healthy Project**
- Provide a systematic and co-ordinated approach to increase the number of babies who are breast fed at birth
- Focus services and engagement on pregnant women in **hard to reach and deprived communities**
- Further develop partnership work to reduce the rate of **teenage pregnancy** (e.g. through implementation of 'Empower to Choose' programme)
- Ensure equitable access to contraceptive and **sexual health services**
- Deliver **sex and relationships education and advice** services in schools, colleges and local community settings and increase the number of staff in these settings who are trained to deliver it
- Provide **alcohol** brief advice in primary and secondary healthcare
- Improve the accessibility of **substance misuse** services
- Improve levels of support for **emotional wellbeing** to families and parents at an early stage to prevent problems becoming critical
- Implement **Communities First Healthy Living Projects**
- Deliver maternity services in line with the Welsh Government's Strategic vision for maternity Services in Wales (2011).

Driver Diagram ~ Pre-school Children

Outcomes and Indicators (ABMU, LA & Partnership Commitments)

Outcomes:

Preschool children in the ABM area are safe, healthy and develop to their full potential.

Indicators:

- Uptake of scheduled vaccinations of children to age 4
- % of babies breastfed at birth and six weeks
- % of children aged 4 to 5 who are overweight or obese
- Oral Health (DMFT age 5)

Under consideration:

- Childhood mortality under 5 years
- School readiness – (WG developing)

Primary Drivers

- Children are breastfed
- Children are protected against illness by immunisation
- Children experience good mental health and well being

- Children are physically active and eat a healthy balanced diet
- Children live in smoke free environments
- Children do not live in poverty

- Children are safe from harm (including injury and abuse)
- Parents possess good parenting skills

Secondary Drivers

- Provide **health visiting services** which deliver interventions to support breast feeding, infant feeding, whole family nutrition, immunisation, reduction in parental and whole family smoking, injury prevention, reduction in parental drug and alcohol abuse and early recognition and treatment of post natal depression.
- Target enhanced services in areas of deprivation and to the most vulnerable families through the **Flying Start and Families First Programmes**
- Provide a systematic and co-ordinated partnership approach to increasing breastfeeding rates
- Secure full participation in the **'Designed to Smile' oral health** programme
- Implement **immunisation programmes** to meet national targets
- Ensure involvement of Therapy Services in the co-ordination of pathways, for example, preschool language pathways
- Develop Women's and Children's Services as set out in the **C4B Women, Children & Families Project** for co-dependent services, including maternity, neonates, gynaecology & inpatient and community paediatrics
- Provide supportive environments and encourage healthy behaviours across the area through the **C4B Staying Healthy Project** including priority plans for tackling obesity, smoking and vaccinations & immunisations)
- Embed priorities into SIPs and other relevant plans and policies including regeneration and environmental strategies
- Maintain support for the Healthy and Sustainable **Pre-school Scheme**
- Develop **walking and cycling** routes
- Implement **Communities First Health Action Plans**
- Support the reduction in exposure to second hand smoke through **smoke free** homes, cars and playgrounds
- Refresh **Child Care Sufficiency Assessments and Play Sufficiency Assessments** and produce action plans to improve existing arrangements
- Provide opportunities for all children to experience **developmental play**
- Support the **reduction of poverty** in families through provision of debt management / financial literacy, increased benefits uptake, by promoting access to education, training and employment and through the provision of high quality accessible and affordable childcare
- Provide **effective child protection services** and continue to embed child protection in all services
- Ensure that **planning arrangements** for children and young people are aligned to achieve pre-school outcomes
- Support environmental health through **food safety programmes**

Driver Diagram ~ School Age Children and Young People

Outcomes and Indicators

Outcome: School aged children and young people in ABM area are safe, healthy and equipped for adulthood

Indicators:

- % of children aged 4 to 5 who are overweight or obese
- % of children aged 11-15 who smoke
- Oral health (DMFT age 12)
- Child Poverty: %of children in households with less than 60% median income
- Teenage Conceptions < 18 years
- % 15 year olds achieving 5 GCSEs (A* to C)
- HBSC Survey - % who drink alcohol

Under consideration:

- Mental health / emotional health indicators
- Sports Wales indicators – physical activity levels
- Chlamydia diagnosis rates (15-24)

Primary Drivers

- Children and young people are physically active and eat a healthy balanced diet
- Children and young people do not smoke, drink alcohol or misuse drugs

- Children and young people are protected against illness by immunisation
- Children and young people do not engage in underage sexual activity and have good sexual health
- Children and young people have good mental health and wellbeing

- Children and young people are safe from harm (including from injury, unwanted pregnancy, self-harm or abuse)
- Children and young people receive good parenting
- Children and young people live in suitable housing and are socially connected
- Children and young people live in environments that are free from poverty

Secondary Drivers (ABMU, LA & Partnership Commitments)

- Develop Women's and Children's Services as set out in the **C4B Women, Children & Families Project** for co-dependent services, including maternity, neonates, gynaecology & inpatient and community paediatrics
- Provide supportive environments and encourage healthy behaviours across the area through the **C4B Staying Healthy Project** including priority plans for tackling obesity, smoking and vaccinations & immunisations
- Implement **immunisation programmes** to meet national targets
- Reduce the number of children and young people accessing **alcohol** inappropriately and provide alcohol brief advice
- Continue to roll out **substance misuse** information and targeted health promotion interventions in partnership with the Substance Misuse Area Planning Board
- Continue to implement local **Emotional Wellbeing Strategies** and to develop wellbeing services and counselling in schools, colleges and communities
- Implement the 'Empower to Choose' programme to reduce the proportion of **unplanned conceptions** among young people under 18 year olds.
- Support schools in developing **whole school approaches** to support physical and mental well being and in achieving Healthy School Scheme national standards
- Develop and implement **parenting programmes**
- Embed **tobacco control initiatives & healthy eating messages** within children and young people's settings, including schools, colleges, youth clubs, etc
- Embed priorities into SIPs and other relevant plans and policies including regeneration and environmental strategies
- Implement **Communities First Healthy Living Projects**
- Develop multi-agency integrated **family support services** for vulnerable and 'at risk' children and young people, and to support young carers and disabled children through the **Early Support and Families First Programmes**
- Target early intervention services to the most vulnerable families through the **Intensive Family Support Service**
- Provide accessible **sexual health and contraceptive services** including C-card schemes and school-based services
- Encourage more children and young people, including those from low income families, to be **physically active** through delivery of high quality local sports, play, arts and dance facilities
- Develop and encourage the use of **walking and cycling** routes
- Secure full participation in the 'Designed to Smile Programme'
- Develop programmes for young people who are 'Not in Education, Employment or Training' (NEET)

Driver Diagram ~ Working Age Adults

Outcomes and Indicators

Outcomes: Working age adults in ABM area live healthier lives for longer

Indicators:

- % of adults who are overweight or obese
- % of adults meeting physical activity guidelines
- % of adults eating 5+ fruit and vegetables
- % of adults who smoke
- % of adult smokers treated through smoking cessation services
- % of adults drinking above alcohol guidelines
- % of adults binge drinking
- % of working age adults employed
- Breast screening: % of eligible women screened
- Life expectancy gap
- No. of referrals to NERS
- Update of influenza vaccination: under 65 at risk
- Update of influenza vaccination: healthcare workers

Under consideration:

- Rate of alcohol specific hospital admissions
- Diagnosis of selected STIs
- Proportion of population with mental health inventory score of over 60
- Incidence, survival and mortality rates for cancer, coronary heart, circulatory, respiratory and liver diseases

Primary Drivers

Individual

- People take responsibility for their own health and wellbeing
- People are health literate and have access to information which allows them to make informed decision
- People do not smoke or misuse alcohol or drugs
- People are active and eat a healthy diet
- People are a healthy weight for their height.
- People experience good mental health and wellbeing
- People enjoy physical, emotional, mental and social well-being in relation to their sexuality and sexual relationships

Community

- People live in resilient and sustainable communities

Environments

- All people have access to a living wage
- People have access to meaningful work
- People have access to reliable & affordable public transport
- People live in good quality housing

Secondary Drivers (ABMU, LA & Partnership Commitments)

- Provide supportive environments and encourage healthy behaviours across the area through the **C4B Staying Healthy Project** including plans for tackling obesity, smoking and vaccinations & immunisations
- Align all activity with other **disease specific prevention** and health improvement initiatives and implement **clinical management pathways** for obesity, hypertension, diabetes and raised cholesterol
- **Embed priorities** into Single Integrated Plans and all other relevant plans and policies including economic regeneration and environmental strategies and the Local Development Plan
- Implement **Communities First Action Plans**
- Promote **Making Every Contact Count** (MECC) to improve lifestyles and reduce health inequalities
- Support employers to maintain an **active and healthy workforce** by developing best practice and through **workplace health awards**
- Encourage more people to be **physically active** by aligning local physical activity plans (LAPAs) with *Creating An Active Wales*
- Develop **walking and cycling** routes
- Develop **substance misuse** services through strategic commissioning
- Provide **alcohol** brief advice in primary and secondary healthcare
- Further develop multi-agency approaches to **tobacco control**
- Promote **smoke-free environments** and reduce uptake and access to **illicit tobacco** as part of the wider tobacco control plan**.**
- Increase uptake of **flu vaccination**
- Increase the participation of women in **breast cancer screening services**
- Encourage uptake of **annual health checks** for those aged 50
- Increase the participation of people aged 50+ in **bowel cancer screening** programmes
- Deliver the '**Hearty Lives Project'** to improve the health of people at greatest risk of heart disease
- Develop 'Tier 0' services to **promote better mental wellbeing** and to prevent mental health problems
- Develop programmes for young people who are **'Not in Education, Employment or Training**' (NEETs)
- Develop reliable, affordable and sustainable **transport** system through the Transport Consortium and the Regional Transport Plan
- Improve and ensure equitable access to good quality **sexual health services** and reduce the number of unintended pregnancies

Driver Diagram ~ Older People 65+

Outcomes and Indicators

Outcome: Older people in the ABM area age well into their retirement

Indicators:

- Rate of emergency hospital admissions for hip fractures (aged 65+)
- Uptake of influenza vaccination (aged 65+)

Under consideration:

- Mortality rates (associated with long term exposure to air pollutants)
- Welsh Health Survey for wellbeing?
- % of adults aged 70+ who report participating in physical activity twice a week
- % of cancers
- % of older people in receipt of S/S
- % of people who die with a will
- % of people who die in their place of choice

Please note – several of the working age indicators may also be relevant to Older People 65+

Primary Drivers

- Older people take responsibility for their own health and wellbeing
- Older people are health literate and have access to information which allows them to make informed choices
- Older people experience good mental health and wellbeing

- Older people are active, maintain a healthy weight and are well nourished
- Older people do not smoke, misuse alcohol or abuse drugs
- Older people are protected through vaccinated against influenza and shingles

- Older people do not fall
- Older people have available to them accessible transport services
- Older people live in suitable housing and are able to live as independently as possible
- Older people live in safe and sustainable communities

Secondary Drivers (ABMU, LA & Partnership Commitments)

- Strengthen community based services to meet older people's needs out of hospital – **Western Bay Community Services Project**
- Provide supportive environments and encourage healthy behaviours across the area through the **C4B Staying Healthy Project** including plans for tackling obesity, smoking and vaccinations & immunisations
- **Embed priorities** into Single Integrated Plans and other relevant plans and policies including economic regeneration and environmental strategies
- Provide older people who are frail and those with long term conditions with the opportunities and support to be independent, to take care of themselves and to maintain healthy foot care, oral health, nutrition and continence
- Provide **supported discharge** for older people
- Provide appropriate support and respite for **carers**
- Implement **Community Nutrition Pathway** and develop **community weight management initiatives**
- Align activity with other **disease specific prevention** and health improvement initiatives and implement systems for early intervention in **chronic conditions**
- Implement **clinical management pathways** for obesity, hypertension, diabetes and raised cholesterol
- Promote **immunisation** programmes to maximise uptake in seasonal influenza and pneumococcal vaccination
- Further develop multi-agency approach to **tobacco control**
- Provide **alcohol brief advice** in primary and secondary healthcare
- Encourage older people to be **physically active** and implement falls prevention programmes
- Implement **Communities First Action Plans** and support communities to **improve mental wellbeing**
- Provide **housing** tailored to meet the specific needs of older people
- Increase the participation of women in breast cancer **screening services**
- Increase the participation of people aged 50+ in **bowel cancer screening** programmes
- Encourage uptake of **annual health checks** for those aged 50
- Provide **neighbourhood policing** schemes to respond to communities' needs
- Develop accessible public **transport** system and community transport schemes