PREVENTION AND WELLBEING PROGRAMME
LOCAL PROGRAMME BUSINESS PLAN 2016-2017

District / Borough Council:	Chichester District Council		
Wellbeing Hub Service		£100,000.00	per annum
Additional wrap around projects		£186,013.06	per annum
Total		£286,013.86	per annum

1. Overview

Chichester Wellbeing service consists of two elements, the hub service and a range of wrap around projects which support the work of the Hub and address locally identified need.

Wellbeing Hub
The Wellbeing Hub will operate as an accessible 'one stop' source of information, advice, signposting and support for adults of all ages and older teenagers (16-19) living and working in the Chichester District.

Using motivational interviewing and a range of brief interventions to support behaviour change, Wellbeing Advisors will work one to one with clients for up to 4 appointments where required to understand and support clients. It is frequently found that clients have multiple issues that need exploring and it is important that advisors have the time with clients to discuss their wellbeing needs in order to set realistic goals and achieve effective outcomes for the client. They will signpost and refer to other services where appropriate.

Clients can attend the service for a one to one appointment (extended brief intervention) as above, or an MOT (brief intervention). The MOT is similar to an NHS health check except it does **not** include any of the clinical aspects eg blood pressure / blood cholesterol testing and is offered as an alternative to people who are not eligible for the health checks (under 40 and over 74). Where possible people are sign posted to NHS health checks in the first instance. They are given information on how to make changes to their lifestyle or are sign posted to appropriate services / agencies for further support.

The service will be available face to face and via the telephone on at least 5 days a week, Monday to Friday and 24/7 via the wellbeing website. Wellbeing Advisors will continue to regularly work with clients after 5pm and attend events at weekends where required to suit the needs of the client. The Wellbeing Advisors will use Westgate Leisure Centre as a base for seeing clients. This approach works well as clients are familiar with the centre, they can park easily, it is on a bus route and they are happy to attend a positive / neutral setting. The centre is also open early in the morning and late into the evening so can accommodate out of hours appointments. Other agencies providing wellbeing related services are also able to make use of the rooms eg Stop Smoking Services and the PAT team providing NHS Health Checks. Currently the young people's counselling service uses one of the wellbeing rooms twice a week during the evening to accommodate the needs of young people requiring their support.

Some home visiting has been necessary for clients who are unable to travel to a local venue because of mobility issues. Wellbeing Advisors will continue to provide this service but where local public venues are available these will be preferential. All necessary health and safety procedures are in place to accommodate

remote working / home visits.

The advisors cover the whole district including the rural, coastal and central Chichester areas , particular emphasis is placed on venues in the councils Think Family Neighbourhood area eg Selsey, Chichester East / South, Tangmere and will include the rural areas surrounding Midhurst and Petworth as these are areas where need has been identified in the population and access to services can be limited.

Experience shows that children and family centres and GP surgeries are good venues for engaging with clients. The service will continue to expand and regularly review best use of outreach locations. Particular emphasis is placed on engaging with GP practices and where appropriate organising regular drop in sessions. The GP postcard referral system generates referrals and we will continue to promote this with the practices. We are planning a similar approach with pharmacies and will be working closely with them to encourage increased engagement and referrals.

Countywide campaigns agreed with Wellbeing Hub managers and Public Health team will be promoted at outreach sessions and events. Where required Wellbeing Advisors will organise specific outreach events to promote countywide initiatives.

We will continue to deliver the new pre diabetes programme where people at risk of type 2 diabetes can understand how to prevent the disease through their diet and with regular exercise.

The service will be subject to a comprehensive evaluation process where all clients are telephoned 3 months after they have accessed the service and these outcomes will feed into the quarterly review reports.

Service improvements for 2016/17

In 2016/17 we will be looking for ways to improve engagement with a range of organisations by identifying opportunities to engage with the service.

Following improved engagement with GPs during 2015/16 we will continue to progress this liaison to further increase their understanding of the service and make it easy for them to refer clients for support.

The council has identified priorities for public health that it will be working on during the coming year. These priorities are also linked with those of both the Wellbeing service and the Local Strategic Partnership, Chichester in Partnership (CiP).

Mental health and emotional wellbeing
Planning for healthy communities
Healthy Lifestyles
Dementia Friendly communities (CiP priority)

In order to deliver against planned outcomes we will be working with a wider range of CDC service teams to support their understanding of how their service area impacts on health and wellbeing and how they can ‘make every contact count’ by identifying opportunities to refer people to Wellbeing services.

We will be working in partnership with Chichester in Partnership and the Dementia Action Alliance to embed wellbeing within partnership work in the district to develop Dementia friendly communities. We will engage with Carers through this process.

We will be working to identify additional support that we can provide for Carers through every day engagement with clients and in particular through Careline services and the workplace health project.

All Wellbeing staff will continue to work to promote the service across the district raising awareness of the importance of wellbeing to residents and colleagues / professionals.

In order to support the general promotion of the service a range of promotional activities will be organised during the year covering health related topics but as a minimum and with greater coverage and interventions we will promote the following topic based awareness days during the year;

(Subject to review)

May 2016 – Dementia/ mental health awareness.

June 2016– Diabetes awareness

October 2016– Stress Awareness week

November 2016- Men's Health Week

December / January 2016/ 17– Alcohol awareness / Dry January

February 2017- Healthy Hearts Month

These will be reviewed annually in agreement with commissioners. These campaigns will be delivered by all of the hubs across West Sussex to ensure a consistent message across the area.

Wrap around services to support the work of the Hub and address local need.
A range of services will be delivered 'in house' and commissioned to support the work of the Hub. These services are a referral route for clients of the Hub and they are evaluated to ensure they meet the needs of clients and support behaviour change. They will be required to deliver a series of planned outcomes and address local health and wellbeing priorities.

3. Outcome Delivery

	Public Health Outcomes Framework
Domain 1	**Improving the wider determinants of health** **Objective: Improvements against wider factors that affect health and wellbeing, and health inequalities**
Domain 2	**Health Improvement** Objective: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities
Domain 3	**Health Protection** Objective: The population's health is protected from major incidents and other threats, while reducing health inequalities
Domain 4	**Healthcare, Public Health and Preventing Premature Mortality** Objective: Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

1 - Project Name	**Adult weight management** delivery of a weight management service which is low cost to people on who have a BMI of >25 but <30 (at the leaders discretion)
Domain(s)	**Domain 2**
Proposed Annual Allocation	**£24,400 (0.8 FTE) Sue Crabtree**
Service description	• The service to be available at leisure and community venues in central Chichester, Selsey, Chichester East / South, Petworth and Midhurst and other areas where need is identified across the district. • The service will be targeted to those with a BMI of >25 but < 30 although clients above this level can attend if they wish, if there are no other local services available or at the leaders discretion. • WWW programmes will be delivered in workplaces where need/demand is identified.
Outcome Indicator related to Project ***i.e. from the spec e.g. % of adults meeting the recommended guidelines on physical activity.***	• 16 x 12 week programmes delivered at venues across the District. • Aim for at least 10 – 12 participants at each session. • 30% of attendees to lose 5% of their body weight and 60% will achieve 3% weight loss by the end of 12 weeks and maintain it at 3 months. • People will be expected to attend 75% of the course (9 out of 12 weeks). • 80% Clients will be more physically active and report improved mental wellbeing.
Proposed Method(s) of Data Collection & Evaluation ***Outline the basic plans***	Demographic data collection via a questionnaire Before and after BMI / weight, food diaries, physical activity diaries, Edinburgh / Warwick mental wellbeing scale, GPPAQ Case studies

1 - Project Name	**Pre Diabetes Programme**
Domain(s)	**Domain 2**
Proposed Annual Allocation	**£5,600 (0.2 FTE) Sue Crabtree**
Service description	• The service to be available at leisure and community venues in central Chichester, Selsey, Chichester East / South, Petworth and Midhurst and other areas where need is identified across the district. • 10 pre diabetes courses are delivered at local venues in the District
Outcome Indicator related to Project ***i.e. from the spec e.g. % of adults meeting the recommended guidelines on physical activity.***	• 80% of clients report improved knowledge of how to reduce the risk of developing type 2 diabetes • 80% demonstrate increased confident that they will be able to make changes to their lifestyle • 80% of clients completing a follow up appointment with a Wellbeing Advisor • 50% of clients report a sustained positive lifestyle behaviour change at 3 months
Proposed Method(s) of Data Collection & Evaluation ***Outline the basic plans***	Details recorded on database Clients are phoned at 3 months and outcomes recorded on database Case studies

2 - Project Name	**Family weight Management -** A bespoke service in place for families with a child who is above their ideal weight. Those families that need it are offered a series of pre course sessions.
Domain(s)	**Domain 1, 2, 4**
Proposed Annual Allocation	**£ 30,000**
Service description	A commissioned service designed to meet the needs of individual families with a child aged over 5yrs. The project aims to educate children and their parents or carers in the basics of nutrition and physical activity using a variety of methods. The approach is to be positive and enthusiastic, making the sessions interactive and fun in order for them to learn using memorable learning aids and experiences. Physical activity sessions are designed to be energetic, motivational and cater for all needs and abilities; in order to increase physical fitness. The course also provides interactive

	cookery demonstrations with cost effective and nutritious meals for families to use at home. Sessions are carried out in the optimum venue for effectiveness for each family, and may include school, community setting, leisure centre or family home.
Outcome Indicator related to Project ***i.e. from the spec e.g. % of adults meeting the recommended guidelines on physical activity.*** **)**	• 36 families are recruited to a course (subject to funding and complexity of cases) • 50% of children completing a minimum of 12 weeks whose weight is stabilised (eg have grown into their weight) at the end of the course • 75% of children completing a minimum of 12 weeks whose weight stabilisation is maintained/improved three months following the end of the course • 75% Self-reported /Improved emotional wellbeing • 75% of children completing a minimum of 12 weeks who have improved their cardiovascular fitness at end of course. • 75% of adults accompanying the children in 4 above, who achieve a weight loss equal to or more than 5% three months after the end of the course • 75% Self-reported Improvement in eating behaviour/quality of family diet
Proposed Method(s) of Data Collection & Evaluation ***Outline the basic plans***	Demographic data collection via a questionnaire Before and after BMI / weight, food diaries, achievement of weekly goals, pre and post programme evaluation. Case studies are included.

3 - Project Name	**Healthy Workplaces -** local businesses are supported to introduce health improvement activities into the workplace.
Domain(s)	**Domain 2**
Proposed Annual Allocation	**£30,000**
Service description	This project uses a setting approach to reach the working age population and encourage employers to support the health and wellbeing of their staff. It is an opportunity to deliver MOTs, NHS health checks, weight management courses, health campaign information as appropriate to address the needs of staff. This project has developed over the last 3 years. During 2016/17 we will work with existing businesses to further embed their commitment to the health and wellbeing of staff and engage with new businesses focusing on low income / manual workers and employers located in Think Family Neighbourhoods.
Outcome Indicator related to Project ***i.e. from the spec e.g. % of adults meeting the recommended guidelines on physical activity.***	• The programme will engage with 12 new businesses including at least 1 industrial estate in the district. • 8 of these businesses will be SMEs and /or employ manual workers • 7 of the new businesses will have a second intervention eg MOTs/NHS health checks • The project will continue to work with at least 10 of the existing businesses on a more in depth basis to embed health and wellbeing within the organisation eg WWW programme, pre diabetes course, healthy lifestyle talk or other workshop
Proposed Method(s) of Data Collection & Evaluation ***Outline the basic plans***	Type / location of business recorded Number of employees All actions initiated with businesses recorded Second intervention outcomes and evaluation are recorded within other projects eg WWW data, MOT data recorded within HUB outcomes Case studies

4 - Project Name	**Home Energy Visitor (shared with Arun DC)**
Domain(s)	**Domain 1,2 and 4**
Proposed Annual Allocation	**£16,800 (0.4 FTE)**
Service Description	Home visits to home owners or private rented tenants are carried out and clients are supported to heat their homes in the most economical way. The project is targeted to areas where fuel poverty rates are higher; include both urban and rural areas of both districts. Identified by JSNA data sources

	Simple hard measures installed in all homes where required
Outcome Indicator related to Project ***i.e. from the spec e.g. % of adults meeting the recommended guidelines on physical activity.***	95% reporting satisfaction with the service provided 80% reporting service has helped them change behaviour X (TBC) signposting and referrals to other energy efficiency/fuel poverty schemes and to other services/agencies eg Wellbeing Adviser or Citizens Advice Bureau X (TBC) promotional/information sessions delivered to other agencies X (TBC) training sessions (minimum 25 front line staff in each session) across the two districts As part of the visit the client receives relevant local information leaflets and details where further information can be obtained, eg websites.
Proposed Method(s) of Data Collection & Evaluation ***Outline the basic plans***	Demographic data collected via a questionnaire Eligibility questionnaire identifies current behaviour Database developed to record information There will be a requirement to follow up visits by telephone or email, generally after three months, but with an option to contact earlier if considered appropriate. Case studies

5 - Project Name	**First Steps to fitness. A programme to support sedentary / inactive adults to become more active.**
Domain(s)	**Domain 2**
Proposed Annual Allocation	**£35,000**
Service description	Inactive adults are supported to start and maintain regular physical activity in their daily life using goal setting, motivational interviewing and behaviour change techniques. Inactive people aged 18+ (16 – 17yr olds can access the programme at the leaders discretion) are supported to become more active by providing support to access local leisure facilities / classes in Chichester District. Monitor and evaluate each client's progress through the scheme.
Outcome Indicator related to Project ***i.e. from the spec e.g. % of adults meeting the recommended guidelines on physical activity.***	At least 120 clients will engage with the project (eligibility criteria: clients are inactive eg <30 mins per week or sedentary no more than 1 x 30 per week and looking to increase) 0% (72) clients will be active to 30 minutes a week and sustain for 3 months 90% (65) clients will feel improved mental wellbeing
Proposed Method(s) of Data Collection & Evaluation ***Outline the basic plans***	Initial screening uses GPPAQ measurement tool / physical activity diaries Database used to record all data Demographic data gathered via a questionnaire Case studies

6 - Project Name	**Cook and Eat**
Domain(s)	Domain 1 , 2, 4
Proposed Annual Allocation	**£18,000**
Service description	Plan and deliver 12x 6 week Healthy Food For Life courses with at least 5 people attending each course. Target= 60 people attending courses. Clients should be from Think Family Neighbourhoods and aim to complete 5/6 weeks of the course
Outcome Indicator related to Project ***i.e. from the spec e.g. % of adults meeting the recommended guidelines on physical activity.***	90% of participants should demonstrate improved understanding of the components of a healthy diet. Eg reducing fat, salt and sugar and increasing fruit and vegetables in their diet. 90% of participants should demonstrate improved skills and confidence to prepare and cook healthy food.

	90% of participants should report improved skills for shopping for food on a budget. 90% of clients demonstrate increased understanding of portion sizes and cooking in bulk. 70% of participants should report continued use of cooking skills and healthy eating choices 3 months after completing the programme.
Proposed Method(s) of Data Collection & Evaluation Outline the basic plans	All client demographic information should be gathered eg age, gender, postcode Case studies of individual success stories Pre and post questionnaires Feedback during sessions Evaluation via phone Customer satisfaction forms

4. Links with Partners

Provide details of the key local interdependencies and plans for developing relationships with partners in order to achieve the Programme outcomes. These can be broad across the Programme or link specifically to the outcomes or projects above.

The wellbeing programme links with Chichester in Partnership for information and signposting to and from partner organisations and delivery of actions related to Dementia Friendly communities and mental health and emotional wellbeing

GPs are key partners and support the delivery of MOTs and drop in sessions. In 2016/17 we will work to improve the relationship with GPs and pharmacists and look for opportunities to improve referral rates.

Key partners are the weight management centre for referrals to weight loss services for people with a BMI of 30+, NHS health check providers, Solutions for Health (quit smoking services), CGL (care Grow Live) for support with alcohol related issues.

Carers Support and other voluntary groups refer clients for support and are signposting sources for wellbeing advisors.

Children and Family centres are particularly linked with joint priority of healthy weight, smoking cessation, adult mental health and reducing alcohol misuse. We work with them to recruit adults and families for general wellbeing and weight management support.

The Wellbeing advisors work with partners to deliver outreach sessions at venues across the District e.g. Children and Families Centres, library service, GPs and other NHS providers etc.

The family weight management coordinator works with the Think Family and Intensive Support teams at WSCC to support families referred for weight management.

5. Marketing and Communications

Describe how the programme and individual projects will be marketed.

Provide a provisional list of the Public Health campaigns to run until March 2017 (agreement between districts/boroughs on common countywide campaigns would be favoured, where appropriate)

The marketing of the Wellbeing programme as a whole will be carried out via a countywide coordinated approach of leaflets, posters, website, regular press releases etc. A local communications plan will be developed to ensure coordination of communication of health messages.

Individual programmes / projects will be marketed according to the target group and the specific requirements of the project.

Hub marketing
Marketing plan in place for 2016/17
Chichester Observer press releases for key events / times / awareness days
Radio where appropriate
Social media posts
All publicity must include the wellbeing logo and contact details
Branded goods made available at events
V-logging now being piloted

Wellbeing Website
The website will be updated weekly to include
All events
Drop in activity
MOTs sessions
NHS health check sessions
Monthly campaigns
Publicity photographs and testimonials
Information relating to wraparound projects.
Workplace challenges – linking to campaign websites
Voluntary sector events and activity that is relevant to wellbeing
Other Council events and activities relevant to wellbeing

Targeted campaigns to address national and local wellbeing issues (subject to review)

May 2016 – Cancer awareness (including Skin Cancer, Chichester has higher than the England average (19.4 v 13.6) for malignant melanoma, this rate has increased in recent years.

June 2016– Diabetes awareness

October 2016– Stress Awareness week

November 2016- Mens Health Week

December / January 2016/ 17– Alcohol awareness / Dry January

February 2017- Healthy Hearts Month

Individual campaign materials will be ordered via websites to promote each campaign at public events and during drop in sessions.

Wraparound projects
Individual marketing plans
All literature must be wellbeing branded
Posters/flyers designed along same theme/branding as wellbeing hub
Radio and press releases where appropriate
Social media used when possible

6. Resources

Provide information on the staffing levels and team structure that will be commissioning and delivering (if applicable) the programme.

Wellbeing funded team
0.8 FTE wellbeing officer
0.6 monitoring officer
1.4x FTE wellbeing advisors (increasing to 1.6Fte in September)
1 FTE workplace health advisor
1 FTE adult weight management / PDP coordinator
Casual staff hours for evaluation process

Chichester District Council funded support for programme
1 x 0.4 FTE wellbeing manager
Further support from Head of Community Services, HR, IT, PR and other support services.

7. Governance and Accountability

Provide details of the accountability and governance arrangements for the programme and the projects commissioned.

Chichester District Council (CDC) is accountable for the overall delivery of the Wellbeing Programme and the projects delivered through the commissioning process.

Internally, the Overview and Scrutiny Committee will monitor and scrutinise the outcomes of the Wellbeing Programme annually.

CDC will meet quarterly with West Sussex County Council Public Health to review the budget plan and finances aligned with monitoring requirements.

Projects commissioned by the programme will be subject to the councils internal audit requirements and financial standing orders.

8. Key Milestones

Provide key milestones for the programme (and individual projects where known).

Mar 2016	• Complete and agree business plan and funding agreement • Complete evaluations for additional projects to year end • Review on going additional projects and amend project specifications • Draft new project specifications for commissioning in April
Apr 2016	• Finalise budget plan for 2016 - 2017 • Q4 review meeting / agree business plan for 2016 – 2017 with public health • Commission new projects
May 2016	• Dementia/ mental health awareness • Continue to establish new partnerships to deliver MOTs and outreach sessions • Liaise with pharmacies to establish referral routes
Jun 2016	• Diabetes awareness activity

	• Future service planning with other hubs and WSCC PH
Jul 2016	• Q1 review of commissioned and internally delivered projects • Q1 review meeting with public health • Future service planning with other hubs and WSCC PH
Aug 2016	• Summer wellbeing activity • Future service planning with other hubs and WSCC PH
September	• Future service planning with other hubs and WSCC PH • Promote the service at events
Oct 2016	• Stress awareness campaign • Q2 review of commissioned and internally delivered projects • Q2 review with Public Health • Future service planning with other hubs and WSCC PH
Nov 2016	• Mens Health week activity • Alcohol awareness week activity
Dec 2016	• Xmas / new year promotion • Dry January promotion
Jan 2017	• Q3 review of commissioned and internally delivered projects • Q3 review meeting with Public Health • Business planning or exit strategy dependent on funding • Promote Dry January
Feb 2017	• Healthy heart month • Review business plan and confirm funding for 2017/18
Mar 2017	• Q4 review with Public Health • Review business plan and confirm funding for 2017/18

9. Financial Breakdown

Attached separately.

10. Overall programme risk assessment

- What could stop the programme, or key projects within the programme, taking place and what are the chances of that happening? How can the risk be reduced?

Threat	Consequences	Ways to remove or reduce the threat	Risk Red – high Amber – medium Green – low
Partners do not refer clients to the programme, lack of support from partners.	Low number of clients receiving wellbeing support., outcomes may not be met	Engage with partners continually throughout the year	Impact = high Likelihood = low Overall risk = medium
Clients do not engage with the programme	Low number of clients receiving wellbeing support, outcomes not achieved.	Ensure advisors are working in the right settings to engage with clients and can follow up with people who are referred but don't attend.	Impact = high Likelihood = medium Overall risk = high
Wellbeing staff unable to achieve outcomes due to illness, maternity or resignation	Break in provision of services. Increased pressure on other staff to cover role.	Ensure all Wellbeing advisors can cover for each other in case of illness. Replace staff who resign asap, backfill maternity leave. Regular 1-2-1 sessions so any work-related issues can be identified and addressed.	Impact = medium Likelihood = Low Overall risk = Low
Provider does not meet project specification requirements	Outcomes not achieved	Control measures incorporated into contract. Regular monitoring.	Impact - High Likelihood – Low Overall Risk - Medium
Services referred to fail to provide suitable or appropriate information to clients.	Service becomes discredited	All staff receives training on key topic areas. Services referred to are credible. Disclaimer included on website	Impact - High Likelihood – Low Overall Risk - Medium
Loss of key CDC staff eg manager / coordinator	Gap in management of programme / loss of experienced staff	CDC has contractual obligation to manage the programme. Good communication within existing team to ensure information is shared.	Impact - High Likelihood – Low Overall Risk - Medium
Reduction in funding	Staff are made redundant, service is unable to continue or continues in a reduced form.	WSCC Public health are contractually obliged to provide 6 months notice of any reductions in funding, redundancy costs are	Impact - High Likelihood – Low

		not included in the budget plan. CDC has budget for redundancy payments	Overall Risk – Medium
CDC Members decide not to accept the funding.	Staff are made redundant Service will cease	Work with Members to support their understanding of the role Wellbeing plays in supporting the community and delivering Corporate Objectives.	Impact – High Likelihood – low Overall risk – medium