APPENDIX A: DESCRIPTION OF THE NEW COMMISSIONING MODEL

The model

In summary the new model for the service does four things:

1) Develops infrastructure and capacity for people in Essex to support each other in their wellbeing, to enable both delivery of outcomes at much larger scale than traditional services, and to focus professional service support where it is really needed.
2) Bring together previously separate contracts into a single care pathway so that wellbeing is looked at holistically across all risk factors, not just weight management or smoking in isolation for example, which also enables agencies referring into the service to have a single rather than multiple referral in routes.
3) Delivers better value and lower unit cost at the same time increasing the scale of wellbeing support offered.
4) Attempts to build our service population's individual resilience by looking at the things that risk their resilience, as a foundation on which to build work on modifying individual lifestyle risk factors.

How we have arrived at this

Public health strategic thinking has evolved over the past three years to consider how best to support people in their wellbeing. The position has moved from looking at individual lifestyle risk factors in isolation, delivered exclusively by professional services, to looking at the real drivers of overall wellbeing in a collective sense. This better reflects how people live their lives and is a significant change from how we have historically commissioned services focused on individual outcomes such as smoking cessation or weight management. Individual lifestyle risk factors are still very important and have not been compromised in this new model. However, the evidence suggests that commissioning individual risk factor services focused on a single risk factor outcome does not have as significant an impact and do not reflect what people need in order to be supported in their wellbeing.

Whilst certain areas of work have been developed within existing contracts, our ability to realise this new commissioning approach strategically and at scale has been limited by the constraints of previous contracts, which have now been brought into alignment. Over the past 15 months of the Covid pandemic, we have developed very local community infrastructure using digital approaches and social media, and harnessing the capability, capacity and desire of the people of Essex to support each other. This has had very significant benefits, such as supporting vulnerable groups who were shielding during lockdown with shopping and other daily tasks, and also identifying previously hidden and unmet need. There is a strong indication that the level of support that the people of Essex want to give to each other is increasing, and a determination that we should not return to old ways of doing things. The challenge the new model seeks to achieve is to convert the community wellbeing support offered to date, including the considerable support offered during Covid, into a sustainable community support offer for wellbeing going forward. This is a new approach, but is

what is needed to achieve outcomes at scale. Sir Derek Wanless, independently commissioned by the Dept of Health to review nationally what it would take to get the population engaged in their wellbeing, asserted that “more of the same (public health practice) won’t work”. In Essex we are responding to this challenge.

Work over the past two years in both weight management and strengthening communities has shown that more really can be achieved with less. Weight management services were reconfigured two years ago to include a light touch model using community delivery partners, such as the Councils for Voluntary Service, who were not highly trained professionals and provided basic social support for people in their weight management journey. Our proposal based on public health experience was very simple: that local people want to support their neighbours and others in their community, and in doing so they gain considerable benefit as well as the people they help and support.

The strengthening communities’ model has used digital community campaigns to digitally support many more people who are socially isolated, and has surfaced unmet need. Three recent key digital campaigns that support wellbeing themes are United in Kind, Essex Coronavirus Action and Never too Late Mate which supported mental health awareness. 45,000 Essex residents were trained in mental health first aid and suicide prevention, compared with 976 residents being trained using traditional commissioned nondigital mechanisms.

Evidence of effectiveness

To date the evidence shows that our new model works. Weight management results showed that this light touch model still produced clinically significant weight loss. Within 12 months a 30% increase in the number supported to lose weight was achieved as well as a 50% saving in contract value, compared with a traditional service baseline.

For the digital campaigns, 90% of those who reported back on the Mental Health First Aid training have stated that they have used the training within their own communities, on themselves or from a parenting perspective. Everyone reported that the training was beneficial to them. In addition the new strengthening communities model generated 7000 volunteers who were mobilised on wellbeing activities from March 14th to March 21st, and 3651 volunteers were mobilised to support an NHS Trust over 3 weeks, 80% of whom had not volunteered before, compared to traditional recruitment of 476 volunteers across 12 organisations within 3 months. In addition, during 2020/21 the Social Isolation model transformed to become the Essex Wellbeing Service and has supported 207,000 people with a range of needs from daily living tasks through to supporting a range of cohorts of vulnerable people within our community during the Covid pandemic.

Risks of the new model and associated mitigation

The greatest risk is posed by continuing the status quo of mainly commissioning a traditional service model. This will not deliver the required outcomes at the scale needed, particularly in the context of the greater need of the population for wellbeing caused by Covid.

Risk: direct measurement of outcomes at scale through use of a light touch support model - our proposed approach does not fit neatly into the traditional service performance management model where professionals intervene more directly in evaluating outcomes, such as direct measurement of weight for example.

*Mitigation: t*his risk has been mitigated by directly measuring a sample of the overall population, as well as corroboration through self-report measures. This is standard and accepted methodology within the public health and academic and research community and does not risk meaningful reporting of outcomes at scale.

Risk: trying a new approach which goes beyond the evidence base of traditional services - the existing evidence base for some lifestyle interventions is well-established, but these interventions are not replicable at scale in their current form. We are incorporating the traditional evidence base but operating beyond it.

Mitigation: we will add to the traditional evidence base by prospectively generating new evidence. Whilst we have developed exploratory new performance measures to test a new approach, we have not confused innovation and flexibility with lack of clarity about what we expect from a provider or clear contractual accountability. Forensic clarity on individual performance measures as well as contractual terms which require action against any underperforming areas limit the risk to ECC, whilst giving the provider (and ECC as commissioner) the necessary agility to continue the developmental journey required to achieve the transformation we need towards achieving outcomes at scale.

Risk: commissioning this new model at a point when the new ECC administration has only just begun to define priorities and strategic plans - it is early days, both for the new administration and its strategic plans, and for the development of the Essex 4 year strategic public health plan which could impact on commissioning priorities.

Mitigation: the new commissioning model allows for early manifestation of the new public health strategic approach, and early testing of the key question: how do we improve outcomes at scale across the wider Essex population? This key question will remain in any public health strategy and the new administration's plans going forward. However, the contract and specification still retain flexibility in what will be needed to be a developmental journey, in both strategic policy and operational delivery.

Risk: not achieving wellbeing outcomes because we have not worked sufficiently with other parts of the system - multiple factors impact on wellbeing and not working well with other partners, such as the NHS risking not only delivery of the outcomes in this ECC specification, but the wellbeing outcomes that other system partners also seek to achieve.

Mitigation: Appendix A of the specification clearly describes services in scope, as well as out of scope. The successful provider will be expected to develop strong relationships with out of scope services commissioned by others, such as the NHS, in order to secure joined up overall care plans for our residents. This will involve alignment of services and pathways optimised to residents. It is essential to build on the opportunities for systems working with Primary and Secondary Care catalysed by Covid. EWS is currently supporting 53 practices across Essex to understand vaccine

hesitancy; this has seen the system come together to put information sharing agreements in place in a way that would not have been possible prior to Covid. The model is supported by both CCGS and the ICS systems with pathway work rolling out to assist those held on elective waiting lists within Secondary and Primary Care.