READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE & HEALTH SERVICES

TO:	HEALTH AND WELLBEING BOARD		
DATE:	14 JULY 2017	AGENDA ITEM:	16
TITLE:	UPDATE ON BOB STP PREVENTION WORKSTREAM		
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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report is intended to give the Health and Wellbeing Board an information update on the work of the Prevention Workstream that is part of the Buckinghamshire, Oxfordshire and Berkshire West Sustainability Transformation Plan (BOB STP). The report sets out the 6 themes that are the focus of this work, giving the vision, deliverables and progress to date. The 6 themes are: obesity, physical activity, tobacco, Making Every Contact Count, Digital solutions and Healthy Workforce. The work going on in the BOB STP Prevention Workstream is variable across the themes however there has been considerable progress made and collaboration across the 3 geographical areas within BOB and the different disciplines. The Prevention Workstream is chaired by an Operational Director for the Berkshire West CCGs and there is a presence of Directors of PH and their representatives from Buckinghamshire, Oxfordshire and Berkshire West.

1.2 Appendix 1 – Tiers of weight management interventions
Appendix 2 – London Clinical Senate – Helping smokers quite campaign
Appendix 3 – Making every contact count (MECC) stocktake

2. RECOMMENDED ACTION

2.1 The Board to note progress against delivery of the six STP themes within the BOB STP Prevention Workstream

3. POLICY CONTEXT

3.1 Sustainability and transformation partnerships build on collaborative work that began under the NHS Shared Planning Guidance for 2016/17 – 2020/21, to support implementation of the Five Year Forward View. They are supported by six national health and care bodies: NHS England; NHS Improvement; the Care Quality Commission (CQC); Health Education England (HEE); Public Health England (PHE) and the National Institute for Health and Care Excellence (NICE).

- The development of STPs is driven by Joint Strategic Needs assessments and health and Wellbeing Strategies. Reading is part of the Buckinghamshire, Oxfordshire and Berkshire West STP footprint (BOB STP). *The agreed Council strategy and/or policy within which the decision is being made:*
  Health and Wellbeing Strategy, Joint Strategic Needs Assessment,
- *All relevant past decisions of Council and other decision-making bodies*

4. THE PROPOSAL

The challenges and opportunities facing NHS and care services across Buckinghamshire, Oxfordshire and Berkshire West (BOB) are set out in a five-year Sustainability and Transformation Plan (STP). The plan demonstrates how the NHS will work to improve health and wellbeing within the funds available and also highlights how it will work in partnership with the Local Authorities to address the many challenges that exist including growing populations, higher proportion of older people, inequalities in health, increase in complex and costly treatments etc.
The BOB STP has as its focus the following areas:

- Shifting the focus of care from treatment to **prevention**
- **Ensuring Access** to the highest quality primary, community and urgent care
- Facilitating collaboration of the three acute trusts to deliver **quality and efficiency**
- Maximising value and patient outcomes from **specialised commissioning**
- **Developing Mental health services** to improve the overall value of care provided
- Establishing a flexible and collaborative approach to **workforce**
- **Developing Digital interoperability** to improve information flow and efficiency

The BOB STP Prevention Workstream
Vision
A proactive approach to disease prevention within all that we do, shifting the focus of care from treatment to prevention , addressing unhealthy behaviours that may lead to serious conditions further down the line and thus reducing the burden on the healthcare system. We will take action to motivate people to take ownership of their own health and encourage healthy environments to enhance the quality of life for our population.
There are a wide range of programmes that support the aim of shifting the focus of care from treatment to prevention in all settings. The programmes that have been identified for the BOB STP are:

- Obesity
- Physical activity
- Making Every Contact Count
- Tobacco
- Improving Workforce Health
- Digital self care
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The overall objectives for all of these areas of work are twofold:

1. To embed prevention within the local transformation programmes
2. To collaborate across BOB on areas where there is benefit of working at scale.

There is also an aim to continue working together to identify other BOB wide opportunities, that may include alcohol and social prescribing.
The most appropriate level at which each programme should be led and delivered within the health and care system has been agreed through the STP. This has been based on the partnerships and scale required to best implement the specific programmes. A stocktake of all initiatives was undertaken and schemes were chosen based on the following principles:

1. There is a clear opportunity/ benefit in doing it jointly, to deliver improvement in terms of finance, quality and/or capacity
2. Doing something once is more efficient and offers scale and pace
3. Collective system leadership is required to make the change happen

The case for change in Buckinghamshire, Oxfordshire and Berkshire West

The overall health and wellbeing of the populations across the BOB STP footprint is generally good however areas of deprivation and poor health are often masked. Inequalities in health exist across all three localities. Higher levels of obesity and smoking are more prevalent in certain groups including those on low incomes and living in deprived areas. There is a commitment in the BOB STP Prevention Workstream to focus on developing system wide initiatives to reduce the burden of ill health due to physical inactivity, poor diet and smoking as well as a recognition that this needs to be done in partnership with CCGs, Local Authorities, Public Health, NHS Trusts and The Academic Health Sciences Network (AHSN).

There is a strong evidence base showing that the health and wellbeing of residents can be improved and demand on health and social care services reduced though people changing to healthier lifestyle behaviours, including being more physically active, eating a healthier diet, maintaining a healthy weight and not smoking. Return on investment tools have shown that for the BOB footprint the savings could be as much as £9 million over a 4 year period.

There are already examples of joint commissioning in prevention across Berkshire West for smoking cessation and tier 2 weight management services and these demonstrate the advantages of commissioning at a wider level with multiple partners. There are also examples of joint commissioning with CCGs and LAs through the Better Care Fund. All this can be built upon and extended across the BOB STP.

Update on Progress to date in the five areas of work of the BOB STP Prevention Workstream

Through 2016/17 work has begun including mapping of services already being commissioned, visioning/ planning what might be achieved and setting up subgroups to initiate and take the work forward. Throughout 2017/18 the work is being further developed and plans implemented.

Update for Obesity

Vision: To agree and develop a pathway for commissioning obesity prevention and treatment services which is consistent across the BOB area.

Deliverables: A task and finish group of commissioners from CCGs and local authorities will meet in Q4 of 2016-17 to:

1. Agree definitions of "tiers" of weight management treatment (see appendix 1)
2. Map current provision of obesity prevention and weight management services
3. Identify best practice and funding opportunities
4. Discuss opportunities for joint work by CCGs and /or local authorities in commissioning.
5. Agree a further project plan for 2017-18

Progress to date

1. Mapping of current services has been further refined, based on a Stocktake exercise from Sept 16 but with additional input from commissioners in CCGs and Local Authorities
2. The Task and Finish group has met twice (Feb and April 2017) and agreed tier definitions for weight management services
3. Mapping of existing services is complete and gap analysis has demonstrated that tier 3 weight management interventions are a gap for Oxfordshire and Berkshire West.
4. A survey is being completed to map thresholds for access to services
5. A workshop has been planned to take place on July 12th in Reading to explore the joint commissioning of tiers 3 and 4 weight management services across BOB STP. The aims of the workshop are

- To inform BOB level commissioning for Tier 3 and 4. (these are the two levels that we believe might benefit from collaborative commissioning.
- To provide an opportunity to discuss current positive practice and learn from local and national experiences (good or bad) and scope potential pathway

- To provide a safe and informative environment to discuss and seek 'buy in' to vision and direction.

Update for physical activity

Vision: To maximise the use of the IT patient portal, identify through consultations, patients who are physically inactive and use technology and social media approaches to improve their activity levels. To incorporate Physical Activity as a treatment prescription for condition pathways.

Benefits

- Additional resource into the connected care programme
- Focus on a comprehensive/digital programme to encourage the general population to increase activity (focussing on currently inactive residents) and support patients with long term conditions to increase activity
- Align with the stepped approach to care developing through GP and self-care workstreams.

Progress to date

A workshop took place in Oxford in May to agree priorities and the following 4 themes were agreed as priorities:

a. digital solutions
b. communication
c. clinical activity
d. workforce development

Each theme was then identified as being a quick win or a longer term development or needing more definition. Consideration was also given to the cost likely to be incurred for each of the themes.

- The first quick win identified as a priority was the opportunity to make digital apps and local information more immediately available to residents. The following actions will take place: identify a suite of apps to promote physical activity to be promoted across the NHS in BOB; ensure all NHS websites include links to local key physical activity programmes and resources (such as Active Bucks, Go Active Get Healthy); review the physical activity content in the Making Every Contact Count training to ensure it is robust and links to local pathways
- The first developmental action identified as a priority was care pathway work as this offers the potential to integrate promotion of physical activity into core business. Any actions selected will need the appropriate commitment from NHS organisations in order to ensure implementation is possible. The following actions will take place: select one clinical condition and develop a best practice pathway indicating where physical activity can be incorporated as either a preventative or therapeutic input. Pathway to also identify points when patients may be particularly motivated to make changes.

Update for tobacco

Vision : To reduce significantly the number of smokers who have surgical interventions.

Deliverables:

- It is well recognised that smoking cessation is one of the most effective ways to improve health. Whilst most savings are calculated on the medium and long term impact, savings can be delivered in year within health care settings if a focussed and concerted effort is made on reducing significantly the number of smokers who have surgical interventions. This investment would see a new programme run in conjunction with surgical departments within hospitals and primary care to contact and support all surgical elective admissions to stop smoking.

- Acute Trust to support a position prescribing smoking cessation prior to surgical elective admission.

Benefits: In a study by Moller et al, 23% of patients smoking up to the time of surgery had a surgical site infection (SSI). This reduced to 4% among those smokers who quit just a few weeks prior to surgery. A recent study shows that most of the infection risk difference between smokers and non-smokers is mainly observed during the period between surgical procedure and discharge from hospital. So all savings will be in-year
For the BOB STP, the figures show 154,500 elective procedures were carried out last year. If 20% of those procedures are on smokers then we have the chance to make 30,900 offers of quit support. Even if only 5% of those result in setting a quit date – that results in 1545 smokers going into a smoking cessation programme. If there is an achievement of at least a 60% quit rate (which was achieved by Moller and locally exceeded) we will reduce an estimated 355 infections down to just 62. If we assume an average surgery cost of £7000 is doubled to £14,000 if an SSI occur (Broex et al, 2009) then that means a reduced annual cost **of £2,054,917.**

Progress to date
Berkshire West CCG Federation is currently developing a proposal to consider how individuals being referred for elective surgery can be supported and encouraged to make healthy lifestyle changes before their surgery. This will decrease the risks of elective surgery for people who smoke or are obese thus improving patient outcomes and saving valuable resources by decreasing length of stay post operatively.

Another approach being considered is adopting the model of the London Clinical Senate 'Helping Smokers Quit Campaign'. This would include primary prevention with the vision that 'every BOB clinician knows the smoking status of each patient they care for and has the competence and the commitment to encourage and support that patient to quit or reduce their consumption through direct action or referral.' (appendix 2)

Update for Making Every Contact Count (MECC)
Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can help people to reduce their risk of poor health significantly. Making every contact count (MECC) is an approach to behaviour change that utilises the millions of day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations. Making Every Contact Count (MECC)

Vision: The programme of work aims to embed MECC across organisations to enable the workforce to recognise their role in prevention and reducing inequalities to support the sustainability of the health and social care system; building on existing initiatives in place across the BOB STP footprint.

Deliverables: The MECC project will be informed by stages. The focus for the first 6 months will be to develop and implement an agreed MECC strategy across BOB's acute services where significant impact can be made on influencing population health through staff, patients and visitors. The second phase will develop training and implementation across acute services. In parallel to phase 2, the Programme Manager using learning from phase 1, will engage with community and primary care organisations for further MECC roll out.

Progress to date

1. A detailed MECC stocktake is currently being undertaken across BOB STP. This will identify what MECC activity is currently in operation, what level of buy in exists at senior level management, what resources and infrastructure will be needed to fully implement MECC, how can staff be engaged and what training will be required and how will the programme be evaluated? (appendix 3)

2. Michael Mullholland (lead on the Primary Care BOB STP Workstream) will be contacted to discuss how MECC fits in across the 2 workstreams. A Programme Co-ordinator has been appointed to carry out the stock take and set targets and trajectories for MECC in the BOB STP.

Update on Digital self care

Vision:

1. **Supporting general wellbeing through use of digital**
2. **Supporting patients with managing their conditions through digital**
3. **Clinically/social care professional led prioritisation**
4. **Joined up and informed investment around patient facing technology (opposite of as is state)**

Deliverables: Digital Self-Care

- Mapping existing digital approaches and identifying what are the quick wins
- A register of apps that are being recommended for patients
- Identification of patient journeys/scenarios to support with navigation
- Agree priorities of pathways
- Identification of unintended consequences e.g. loneliness if we are removing interactions with care professionals face to face
- Establish a workshop to capture wider professional views.

Progress to date

- Mapping exercise currently being undertaken
    - A 12 month pilot project is being developed in Berkshire involving the NHS and Microsoft. This will involve 400 volunteers who are NHS staff wearing a digital device (Fitbit) 24 hours a day for the period of one year. A number of parameters will be monitored including BP, HR, activity levels and sleep and the aim is to understand if the wearing of an electronic monitoring device can in fact have a positive effect on health and wellbeing.

Update on improving workforce health

Vision: To improve and sustain workforce health and wellbeing and employee confidence to promote healthy lifestyles to others

Deliverables:

- Improve collaboration across BOB to enable the sharing of measures and initiatives
- Using CQUIN as a template, develop new initiatives to further enhance staff wellbeing initiative
- Embed good practice already in place to encourage consistency of wellbeing offer across BOB, disseminate case studies, success, evaluation measures and offer peer support
- Create a culture where staff Health and Wellbeing is used proactively within organisations e.g. during organisational change and is considered in conjunction with other organisational activities e.g. Education and Training, retention programmes etc.
- To engage other employers / providers within the footprint to work collaboratively, including opportunities to use resources at reduced cost e.g. University Gyms, Fire service premises etc.
- Identify further collaborative opportunities over and above local delivery to improve workforce health and wellbeing and additional financial savings, e.g. through NHS employers, National Conferences, Occupational Health and Wellbeing Networks.

- Promote and encourage the role of staff as role models and/or ambassadors for healthier lifestyles
- Making Every Contact Count (MECC) – training staff how to have confident conversations around health and wellbeing and raising awareness of onward signposting opportunities

Progress to date

- Mapping exercise across BOB STP completed and collated on what healthy workforce initiatives are currently happening
- Raising awareness of healthy workforce issues e.g. presented to Bucks Health and Wellbeing Board on healthy workforce mental health initiatives
- Identified achievement of CQUIN (Commissioning for Quality and Innovation) targets for healthy workforce for all NHS Provider Trusts across BOB
- Exploration of a Health and Wellbeing Information Hub for staff and residents (already up and running in Bucks) to identify how this can improve health and wellbeing for NHS staff.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The work being undertaken as part of the BOB STP Prevention Workstream contributes to the following Corporate Plan priority:

Providing the best start in life through education, early help and healthy living;

5.2 The Preventative work within BOB STP contributes to the following Council Strategic Aim:

To promote equality, social inclusion and a safe and healthy environment for all

5.3 There is also contribution to the aims of the Health and Social Care Act (2012) and the Public health Outcomes Framework

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- Under The Health and Social Care Act (2012) local authorities now have a much stronger role in shaping services, and have taken over responsibility for local population health improvement. The Health and wellbeing boards have brought together local commissioners of health and social care, elected representatives and representatives of Healthwatch to agree an integrated way to improving local health and well-being. The aims for each LA are set out in the Health and Wellbeing Strategy that is based on the local JSNA.
- The Public Health Outcomes Framework (PHOF) *Healthy lives, healthy people: Improving outcomes and supporting transparency* sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected
- The BOB STP Prevention workstream will help to improve the health and wellbeing of residents by preventing many long term conditions including diabetes, coronary heart disease, stroke, Chronic obstructive pulmonary disease (COPD), osteoporosis, and some cancers. This will be achieved through helping residents to take responsibility for their own health and wellbeing and adopt healthier lifestyles including being more physically active, not smoking, eating a healthier diet and maintaining a healthy weight. In addition workforce health and digital solutions can also help to improve mental and emotional health and wellbeing of those who live and work in Reading.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 The Berkshire West CCGs have presented the concept of the BOB STP to their residents at a Public Consultation meeting. For North and West Reading and South Reading CCGs these meetings took place in March 2017 in local venues. Details of the Prevention workstream were touched upon only in general terms without details of the work planned.

7. EQUALITY IMPACT ASSESSMENT

7.1 The work of the BOB STP Prevention Workstream will continue to be developed with an awareness of inequalities of health identified through robust local data sets.

8. LEGAL IMPLICATIONS

8.1 We do not anticipate there to be any legal implications at this stage.

9. FINANCIAL IMPLICATIONS

9.1 The work being undertaken by the BOB STP Prevention Workstream is being delivered within existing resources. Some funding may be made available from a variety of sources for specific pieces of work for example the Making Every Contact Count project has been funded through the STP process.

10. BACKGROUND PAPERS

10.1 BOB STP Prevention Workstream Update April 2017.

Appendix 1

Weight Management Tier Definitions

	Appendix 9 Guidance for Clinical Commissioning Groups (CCGs): Service Specification Guidance for Obesity Surgery	**Notes from BOB weight management task and finish group meeting discussion** (21st February 2017)	**Combined definition**
Tier 1	**Preventative programmes:** Public health interventions aimed at prevention and reinforcement of healthy eating and physical activity messages.	• None	**Preventative programmes:** Public health interventions aimed at prevention and reinforcement of healthy eating and physical activity messages.
Tier 2	**Weight management services:** Lifestyle weight management advice. This may be given in primary care as part of on-going personalised care. Weight management services delivered in the community led by a health care professional (e.g. dietician) trained in obesity. This may also include additional support by commercial weight management services. These commercial programmes will be well defined with scientific leadership and with clear protocols.	• It is multi-component .e.g. looking at a range of lifestyle habits (physical activity as well as diet) • It is a structured intervention • Setting/venue is less important than the structured modality of the intervention	**Weight management services:** Multi-component lifestyle weight management structured advice. This may be given in various community settings and venues including, primary care (as part of on-going personalised care) or leisure centres. It is led by a health care professional (e.g. dietician) trained in obesity. This may also include additional support by commercial weight management services. These commercial programmes will be well defined with scientific leadership and with clear protocols.
Tier 3	**Specialist care**: 1:1 management by a medically qualified specialist in obesity. This may be community or hospital based +/- outreach and delivered by a team led by a specialist obesity physician. Patient management will also include specialist dietetic, psychological and physical activity input. This will include group work and access to leisure services. There will be access to a	• Face-to-face component is required but doesn't have to be one-to-one • For further discussion - Tier 2 should be a pre-requisite to being offered tier 3	**Specialist care**: Face-to-face weight management by a medically qualified specialist in obesity. This may include one-to-one support but is not restricted to one-to-one support. This may be community or hospital based +/- outreach and delivered by a team led by a specialist obesity physician. Patient management will also include specialist dietetic, psychological and physical

	full range of medical specialists as required for co-morbidity management.		activity input. This will include group work and access to leisure services. There will be access to a full range of medical specialists as required for co-morbidity management.
Tier 4	**Specialist care:** 1:1 management provided by specialist obesity medical and surgical MDTs with full access to a full range of medical specialists as required. All patients will be referred to Tier 4 by a Tier 3 service. The difference between the medical specialty at tiers 3 and 4 will be a qualitative level of experience in complex patient management. All surgical procedures will take place in tier 4.	• Support has to be offered in preparation for and follow-up after surgery • Is moving to be commissioned by CCG's in 2017	**Specialist care:** 1:1 management provided by specialist obesity medical and surgical MDTs with full access to a full range of medical specialists as required. All patients will be referred to Tier 4 by a Tier 3 service. All patients who go on to have surgery will have support in preparation for the surgery and support in follow-up to the surgery. The difference between the medical specialty at tiers 3 and 4 will be a qualitative level of experience in complex patient management. All surgical procedures will take place in tier 4.

Appendix 2

London Clinical Senate 'Helping Smokers Quit' Campaign

The London Clinical Senate established a 'Helping Smokers Quit Programme' to run from September 2014 until May 2016, chaired by Dr Mike Gill. The values underpinning this work are:

- Reduce the harm caused by tobacco.
- Reduce health inequalities.
- Champion value-based care because treating tobacco dependence is THE value proposition for the NHS.

The vision is that every London clinician knows the smoking status of each patient they care for and has the competence and the commitment to encourage and support that patient to quit or reduce their consumption through direct action or referral.

All London clinicians should complete the Very Brief Advice Training from NCSCT. It has deliberately moved to a different language which explicitly recognises that smoking is not a "lifestyle choice" but a sign of tobacco dependency, a long term relapsing condition that usually starts in childhood and 'treating it is the highest value intervention for today's NHS and Public Health system, saving and increasing healthy lives at an affordable cost.' People who are tobacco dependent deserve to have the same access to high quality, integrated, person-centred, and evidence based services as people with other long term conditions.

The Clinical Senate is asking all London's health organisations to commit to CO4:

- The 'right' **CO**nversation for every patient and staff member who smokes that gives him or her a chance to quit, referring if necessary.
- Make routine near-patient (i.e. desk-top, bed-side and home) exhaled carbon monoxide (**CO**) monitoring by clinicians possible: "Would you like to know your level?"
- **CO**de smoking status and the intervention so we can evaluate effectiveness – including death certification.
- **CO**mmission the system to do this right: so the right behaviours are incentivised systematically.

Three key messages for developing STP's:

1. Tobacco dependence is a major problem for the NHS.
2. Helping people stop smoking is the single highest value contribution to health that any clinician can make.
3. Effective diagnosis and treatment of tobacco dependence requires an urgent improvement in clinical training, use of carbon monoxide monitoring and medicines optimisation.

Examples of best practice:

- Royal Free – In-house hospital stop smoking service. Smoke free Steering Group. Clinical leads take responsibility for ensuring that the programme is at the heart of the Trust's clinical strategy. Also leadership within the respiratory, infection and HIV teams.

- Kings College - Taking CO levels are a standard part of respiratory assessment in the lung function lab and oxygen assessments.
- Whittington – Two specialist advisors join the daily ward round and train all staff.
- Barking and Dagenham – Funds the maternity service to deliver the BabyClear model.
- CNWL - Made level 2 training 'Essential to role' for Clinicians, and Level 1/VBA for all other staff.
- UCL – Include 'treating tobacco dependence' in the first year of training to medical students.
- Oxleas – Use of CO monitors on all wards, CO4 used as a CQUIN.

Recommendations from the report:

- CO monitors are cheap (£130) and should be made available to all clinicians.
- Every NHS organisation should have a clear pathway for people who are tobacco dependent, which ensures access to local specialised services.
- Sustainability and Transformation Plans offer a real opportunity for a step change and should clearly set out responsibilities and actions for addressing tobacco dependence agreed by all partners.
- Every NHS Trust should have a board level clinician responsible for addressing tobacco dependence and Clinical leads should be identified in each area to support this action.
- All London's health organisations should commit to CO4, a four pronged approach to identifying and treating tobacco dependence.
- All formularies should include a full range of Nicotine Replacement Therapy products as well as Varenicline.
- All patients should be offered a combination of interventions, with combined behavioural support and pharmacotherapy being most effective.
- The smoking status of all NHS patients should be established, recorded and updated as necessary at every patient contact, with appropriate referral to stop smoking services as required. Both the smoking status and intervention should be coded so the effectiveness can be evaluated.
- All NHS organisations should make VBA part of all health professionals 'mandatory training requirements.

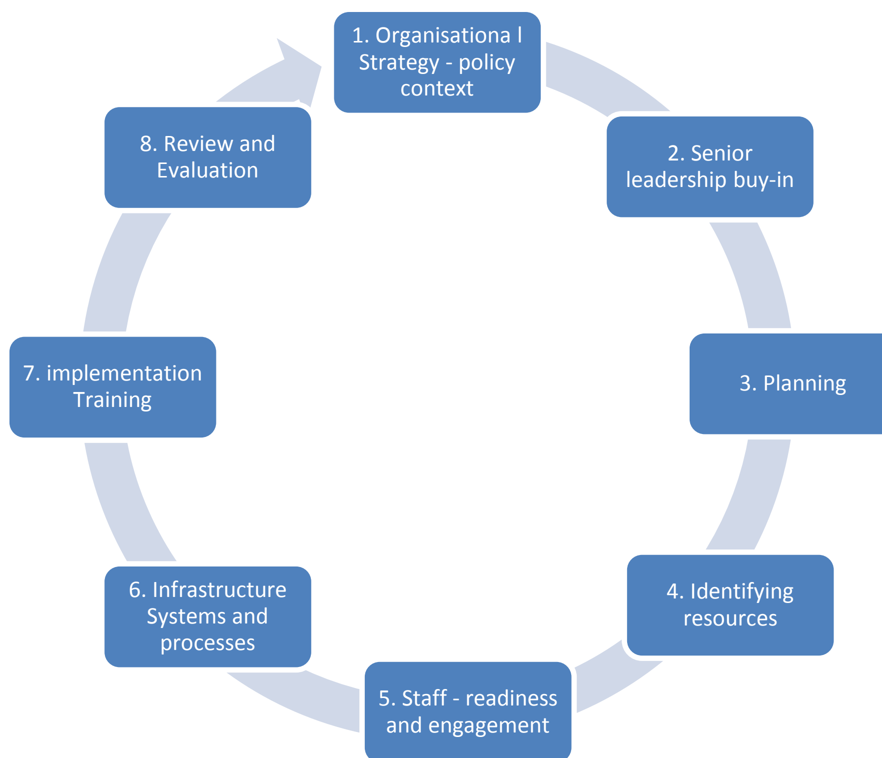
Useful Links:
http://www.londonsenate.nhs.uk/helping-smokers-quit/

Appendix 3

BOB STP Making Every Contact Count

Eight Steps diagram: for planning and implementing MECC across BOB

The diagram below illustrates the steps involved in scoping, planning and implementing a BOB MECC initiative. In addition to these steps, there is a backdrop of encouraging staff to take responsibility for the own health and wellbeing.



BOB STP MECC Stocktake

Action point	Stocktake response	Indicate: Achieved Part Achieved or Development area (RAG – red, amber, green)	Action required for BOB STP to implement
1. Organisational strategy **To shape why MECC should be taken forward** • What is your organisation's vision? • How does MECC fit the organisational goals? • Are there shared goals? • What are other organisations within your area or region doing in relation to MECC? • Have you identified where MECC activity can fit into wider health improvement plans or activity across your area or region? • Have the benefits for patients / clients and staff been identified?			
2. Senior leadership **Senior leadership buy-in is crucial to the successful implementation of MECC** • Is the organisation's senior leadership aware of MECC?			
Action point	**Stocktake response**	**Indicate: Achieved**	**Action required for BOB STP to implement**

		Part Achieved or Development area (RAG – red, amber, green)	
• Is there an opportunity to increase senior leadership involvement? If so, who needs to be involved and how?			
3. Planning **To implement MEXX, a team of people is needed to lead and champion the approach. This section will assist you to identify key individuals to support implementation.** • Who will lead the MECC implementation (developing, reviewing, and monitoring an action plan) in the organisation and teams? • Do you need to form a MECC implementation team from across the organisation to lead the programme? • Who are the key stakeholders who should be involved? • Who will be the MECC champions? • How will you identify and engage them? • Do you need MECC meetings? Should they be face to face or virtual? Who will attend and how often do meetings need to happen?			
Action point	**Stocktake response**	**Indicate: Achieved**	**Action required for BOB STP to implement**

		Part Achieved or Development area (RAG – red, amber, green)	
4. Identifying resources **What resources are needed and available to support implementation? For example:** • Time • Budget • Staff capacity for training • How will training be delivered? (e.g. delivery using a train-the-trainer model; at face-face-face workshops, or distance learning) • Facilities and equipment needed e.g. rooms, laptops, etc. • Physical areas where staff work e.g. are there any barriers to holding healthy conversations?			
Action point	**Stocktake response**	**Indicate:** **Achieved** **Part Achieved or**	**Action required for BOB STP to implement**

		Development area (RAG – red, amber, green)	
5. **Infrastructure – systems and processes** **Consider what systems and processes are required to embed MECC and whether existing infrastructure can be modified to support staff. How can MECC be embedded and sustained long term?** Issues to consider include: • Activity and outcome monitoring – how will you know how many healthy conversations have taken place? • Can you integrate monitoring forms into existing systems? If so, how? • How will the referrals and signposting to other services be managed? Who will be responsible for collating the information on services signpost to? How will you monitor signposting / referrals? • Will MECC be an agenda item at team meetings or at one-to-one meetings with staff? How can support be made available to staff when required e.g. via information displayed in organisational surroundings and staff intranet?			
Action point	**Stocktake response**	**Indicate: Achieved Part Achieved or**	**Action required for BOB STP to implement**

		Development area (RAG – red, amber, green)	
• Can MECC be written into organisational policies, processes and procedures? Can MECC link with or build on existing projects or initiatives within the organisation? • Can reporting on MECC activity be incorporated into existing core annual reports? • Can all new staff be trained in MECC? Can MECC training be part of an induction programme? • Can MECC be included in job descriptions, person specifications or as part of organisational codes of practice, or outlines of professional duties? • Consider how MECC activity can be captured and reflected during staff appraisals, e.g. via a MECC KPI. Can your organisation consider role modelling with a MECC champion? • Consider activity to support self-wellbeing for all staff			
Action point	**Stocktake response**	**Indicate: Achieved Part Achieved or**	**Action required for BOB STP to implement**

		Development area (RAG – red, amber, green)	
6. Staff readiness and engagement **Consider how staff can be engaged, empowered and their inside knowledge used to maximise opportunities to promote health and wellbeing** • Which workforces will be identified to be trained and engaged in MECC delivery? • What criteria will be used to determine which teams / groups / departments are selected? • How will teams / groups / departments be recruited? • How can staff be engaged from the beginning to support the implementation and to sustain MECC? • What can staff do to support the process of implementing MECC? E.g. questionnaires for staff / suggestion boxes or input into forms and systems / processes • How can staff assist with the identification and understanding of departmental pressures / barriers and the opportunities to embed MECC?			
Action point	**Stocktake response**	**Indicate:** **Achieved** **Part Achieved or** **Development area**	**Action required for BOB STP to implement**

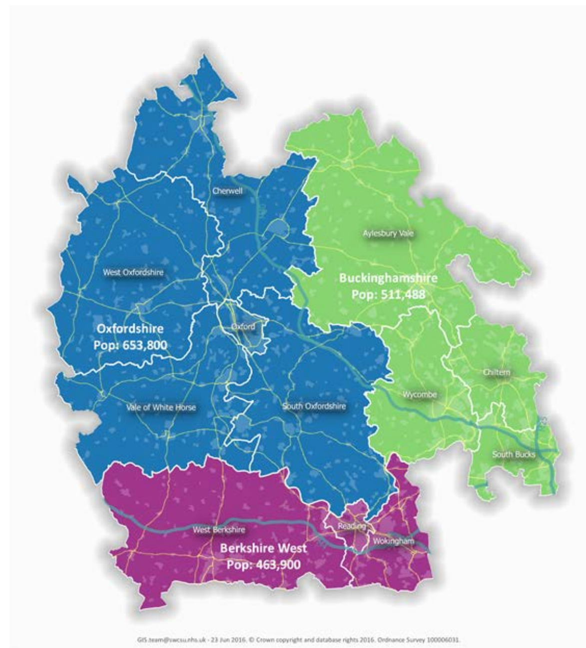
		(RAG – red, amber, green)	
• Is a facility available for staff to share their challenges and learning from providing healthy conversations?			
7. Implementation – training **MECC is about organisational change and workforce development. Use this section to plan to prepare staff to MECC.** • What knowledge and skills do staff have already? How will you identify these and any gaps? • How will the training be implemented? How will you accommodate roles / shift patterns, etc.? • Training the trainers – who will become the trainers? • How will staff be introduced to MECC? • How will staff be trained? E-learning for knowledge and face to face healthy conversation skills delivery. How will it be contextualised to fit with staff roles? • How will training be evaluated? • In addition to the initial training is subsequent skills practice or training opportunities identified for staff?			
Action point	**Stocktake response**	**Indicate: Achieved Part Achieved or Development area (RAG – red, amber, green)**	**Action required for BOB STP to implement**

8. Review and evaluation **To ensure that MECC implementation has been effective, it is essential to monitor and review the process, outcomes and impact of activity in order to improve future delivery.** • How will you know whether the systems for monitoring progress are effective? • How will you provide evidence of impact? • Will you capture outcomes from patients/ clients where possible? • Will this include assessing the impact of MECC on patients / clients' levels of motivation and outlook for health related behaviour change? E.g. what action did they take following the MECC intervention / healthy conversation? • Have you considered using the friends and family test to capture feedback on MECC? • How will you capture feedback on uptake of referrals?			
Action point	**Stocktake response**	**Indicate: Achieved Part Achieved or Development area**	**Action required for BOB STP to implement**

		(RAG – red, amber, green)	

• Are there wider benefits beyond helping service users / patients / clients?
  ○ Staff health and wellbeing, staff sickness levels
  ○ Staff feedback
  ○ Cost savings, monitoring of outcomes
  ○ Credibility of the benefits
• Who do you need to keep informed, of what and how? How will you report and share the benefits and findings with others?
WHAT NEXT?
• How will you further cascade MECC
• Which other teams within and outside your organisation could take MECC forward?			

NHS



DRAFT

BOB
Sustainability & Transformational Plan

Prevention Workstream Update

April 2017

V1.1

Initiative map

Our approach

There are a wide range of programmes that support our aim of shifting focus of care form treatment to prevention in all that we do. These our outlined in our narrative plan for BOB We have agreed through the STP the most appropriate level at which each programme should be led and delivered within the health and care system., We have done this based on the partnerships and scale required to best implement the specific programmes. A stocktake of all initiative was undertaken and schemes were chosen based on

1. There is a clear opportunity/ benefit in doing it jointly, to deliver improvement in terms of finance, quality and/or capacity
2. Doing something once is more efficient and offers scale and pace
3. Collective system leadership is required to make the change happen

We have set out below the results of the stocktake as it related to this delivery plan and the BOB STP level programme

BOB STP LEVEL

- Obesity
- Physical Inactivity
- Workforce health
- 'Make every contact count'
- Digital Self Care
- Development of other initiatives including; Tobacco, Alcohol
- Embeding digital self care
- Embed prevention throughout our transformation plans

LOCALITY LEVEL

- Diabetes – BOB – wide coverage of the NDPP
- Implementation of element of the STP Level plan may be delivery at a locality area level where appropriate
- Reducing avoidable admissions through secondary prevention, falls, alcohol, AF, hypertension, smoking

CCG/BOURGH LEVEL

- Health and Wellbeing Board Strategies in each of the 6 boroughs,
- Prevention priorities identified in each borough
- Self care management
- Social prescribing
- Obesity
- Physical health
- Suicide prevention intervention
- Diabetes
- Screening
-

BOB Prevention Delivery Plan on a Page

Vision

A proactive approach to disease prevention within all that we do, shifting the focus of care from treatment to prevention , addressing unhealthy behaviours that may lead to serious conditions further down the line and thus reducing the burden on the healthcare system. We will take action to motivate people to take ownership of their own health and encourage healthy environments to enhance the quality of life for our population.

Priorities and Objectives

1.To embed prevention within our local transformation programmes

3.To collaborate across BOB on areas where there is benefit of working at scale. Initially these have been identified as:

- Obesity
- Making Every Contact Count
- Tobacco
- Improving Workforce Health
- Digital self care

4.To continue working together to identify other BOB wide opportunities, which may include alcohol and social prescribing

Background and Case for Change

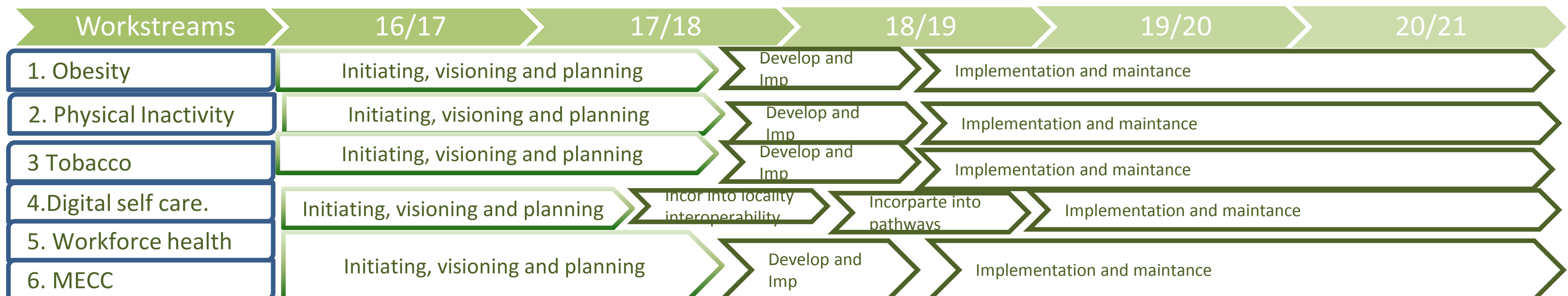
- Our plans seek to encourage people to help themselves and take control of their lives. Overall BOB good health status mask variation and inequalities
- Child and adult obesity has doubled

•We are committed to working across the three localities of BOB focusing on system wide initiatives to reduce the burden of obesity and physical inactivity., working in partnership with Public Health, CCGs, AHSN, and NHS Trusts

Research that suggests we can improve the lives of residents and reduce demand on services through enabling people to change their behaviours. This is especially true with smoking, drinking and physical activity. Evidence suggests we could save up to £10M.

•BOB is unique in have three distinct localities , Berkshire West , Oxfordshire, and Buckinghamshire. We will build on our existing local health and wellbeing strategies and public health initiatives, as well and integrated care services to ensure services wrap around and support neighbourhoods,

•To support this, we are identifying where there is benefit of working at scale to develop new models of care, focused on prevention. These currently include obesity, physical inactivity and workforce health and we are also developing other initiatives, including strengthening prevention across our STP. This includes systematic approaches to ensure we '*Make Every Contact Count*' across all our interactions with the public.



Return of Investment (ROI) opportunities

Our financial requirements includes a £3m saving. We plan to deliver this by scaling up our combined effort across a range of prevention intervention. The figures below have been reached from Public Health Resource modelling produced to support STP Planning. The below table set out an intervention level view of how we believe a significant portion of those saving can be delivered

Programme	Intervention	Outcomes	Investment – over the 4 years - total	Recurrent Gross savings	Recurrent Net savings
Diabetes	Roll out of NDPP across BOB	X% of diabetic to have good glucose control		£1.03m	£1.03m
Physical Inactivity	Promotion of digital self care	X% of exercise more than 30 minutes per day	£200k	£430k	£230k
Obesity	NHS referrals to evidence based weight management service BOB mapping of service	To expand the tier 2 services to focus on patients with obesity and existing long term conditions by x%	£1.2m	-£900k	- £ £340k
MECC	Requires further development	Requires further development	£200k		
Workforce health	Requires further development	Requires further development			
Tobacco		Reduce smoking prevalence to X% Reduction in average LOS for smokers undergoing elective surgery	£1.28m	£10.25m	£8.65m
Total costs/savings identified to date			**£2.68m**	**£10.81 m**	**£ 9.57m**

NHS

Activity and Performance report

- Currently under development with support from Public Health England and CSU

Detailed plans and monthly status reports

Detailed plan, Workstream: Reducing the burden of Obesity

SRO	• Jackie Wilderspin, Public Health Specialist Oxfordshire County Council
Delivery Lead	

Vision

- To agree and develop a pathway for commissioning obesity prevention and treatment services which is consistent across the BOB area.

Deliverables

A task and finish group of commissioners from CCGs and local authorities meet in Q4 of 2016-17 to:

1. **Agree definitions of "tiers" of treatment**
2. **Map current provision of obesity prevention and weight management services**
3. **Identify best practice and funding opportunities**
4. **Discuss opportunities for joint work by CCGs and /or local authorities in commissioning**
5. **Agree a further project plan for 2017-18**

Benefits

1. Services of consistent quality across BOB
2. Improved access to self care and appropriate behaviour change services
3. Financial savings in preventing diabetes, reducing the number of overweight and obese adults, reducing the number of people who are physically inactive.

Timeline

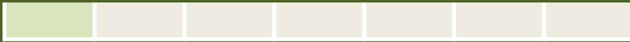
- Available to:-

Q4 2017	Initiation
Q4 2017	Visioning
	Planning
TBC	Design
TBC	Implementation
TBC	Maintenance

Key enabler

Reducing the burden of Obesity
Status Report: April/ 2017

Status



Summary of where we are:

1. A project brief was agreed at the BOB prevention group

Recent Achievements

What has happened since last update:

2. Mapping of current services was further developed, based on the Stocktake exercise from Sept 16 but with additional input from commissioners from CCGs and local authorities
3. The Task and Finish group has met once (21st Feb 2017) and agreed tier definitions.
4. Mapping of existing services is complete and gap analysis has started.
5. A survey is being completed to map thresholds for access to services

Challenges/Roadblocks

Any outstanding actions or roadblocks that require board input:

Information on funding availability for CCGs to commission services for obesity (tier 3)

Next Steps

Plan and action for activity over the next month:

Further meeting of Task and Finish group to be held in early April. This will complete the current tasks and prepare recommendations for action in 2017-18 for consideration by the BOB prevention group in April 2017.

Detailed plan, Workstream:
Reducing the burden of physical inactivity

SRO	• Tracey Ironmonger, Public Health Specialist , Buckingham County Council
Delivery Lead	• Brett Nicholls CEO, Get Berkshire Active

Vision

The approach that is anticipated will be to maximise the use of the IT patient portal , identify through consultations patients who are physically inactive and use technology and social media approach to improve their activity levels

Incorporate Physical Activity as a treatment presciption for pathways

BENEIFITS

- additional resource into the connected care programme
- focus on a comprehensive / digital programme to encourage the general population to increase activity (focussing on currently inactive residents), and support patient with long term conditions to increase activity
- align with the stepped approach to care developing through GP and self care workstreams.

Benefits

	Percentage inactive	Number inactive	To reduce to 20%	% reduction	Cost saving
Oxon	23.4	124347	-18067	3.4%	£203,705
Bucks	22	88660	-8060	2%	£93,275
Reading	29.7	37125	-12125	Total for W Berks - 18631/367300 = 5%	£133,723
Wokingham	21	25662	-1222		
West Berks	24.4	29304	-5284		
total		305,098	-44758		£430,703

Timeline

27/3/17	Initiation
2/5/17	Visioning
Q1	Planning
TBC	Design
TBC	Implement
TBC	Review
TBC	Maintenance

Key enabler

Reducing the Burden of Physical Inactivity
Status report April 2017

Status
A proposal for a workshop and key invitees were discussed at the February STP Prevetion meeting

Recent Achievements
Date for workshop set for 2 May with Oxford Venue
Invite produced to be circulated to the STP group and wider networks w/c 27th March

Challenges/Roadblocks
Will be key to get clinical input into the workshop. STP Prevention workstream are requested to follow up specifically with any clinical staff they would like to be targeted for attendance

Next Steps
Workshop to generate proposed priorities for STP prevention workstream
Proposals to come to STP meeting for discussion and final actions to be agreed.

Detailed Plan, Workstream Tobacco

SRO	• Katie Summers, Director of Operations, NHS Wokingham CCG
Delivery Lead	

Vision

To Be

reducing significantly the number of smokers who have surgical interventions. This investment would see a new programme run in conjunction with surgical departments within hospitals and primary care to contact and support all surgical elective admissions to stop smoking.

Deliverables

- It is well recognised that tobacco cessation is one of the most effective ways to improve health. Whilst most savings are calculated on the medium and long term impact, savings can be delivered in year within health care settings if a focussed and concerted effort is made on reducing significantly the number of smokers who have surgical interventions. This investment would see a new programme run in conjunction with surgical departments within hospitals and primary care to contact and support all surgical elective admissions to stop smoking
- Acute Trust to support a position prescribing smoking cessation prior to surgical elective admission

Benefits

In a study by Moller et al, 23% of patients smoking up to the time of surgery had an surgical site infection (SSI). This reduced to 4% among those smokers quit just a few weeks prior to surgery. A recent study on this shows that most of the infection risk difference between smokers and non-smokers is mainly observed during the period between surgical procedure and discharge from hospital. So all savings will be in-year (or indeed in-month!)

For the BOB STP, the figures show 154503 elective procedures were carried out last year. If 20% of those procedures are on smokers then we have the chance to make 30,901 offers of quit support. Even if only 5% of those result in a quit date – that makes 1541 smokers into the programme. If we then achieve at least a 60% quit rate (which was achieved by Moller and locally exceeded) we will reduce an estimated 355 infections down to just 62. If we assume an average surgery cost of £7000 is doubled to £14,000 if an SSI occur (Broex et al, 2009) then that means a reduced annual cost **of £2,054,917**

Timeline

TBC	Initiation
TBD	Visioning
TBD	Planning
TBD	Design
TBD	Implementation
TBD	Maintenance

Tobacco
Status report. April 2017

Status

Summary of where we are:

- Berkshire West Locality is consulting on a Tobacco safe Surgery Proposal during April

Recent Achievements

Berkshire West had led a review of positions across the NHS on Safe Surgery approaches

Berkshire West currently within consultation

Challenges/Roadblocks

Any outstanding actions or roadblocks that require board input:

Next Steps

To share consultation with Oxford and Bucks Locality :

Status Takeaway Message- On track, significant progress, etc.

Detailed Plan, Workstream MECC

SRO	•Juliet Anderson Assistant Director HHE
Delivery Lead	

Vision

The programme of work aims to embed MECC across organisations to enable the workforce to recognise their role in prevention and reducing inequalities to support the sustainability of the health and social care system; building on existing initiatives in place across the BOB STP footprint

Deliverables

The MECC project will be informed by stages. The focus for the first 6 months will be to develop and implement an agreed MECC strategy across BOB's acute services where significant impact can be made on influencing population health through staff, patients and visitors. The second phase will develop training and implementation across acute services. In parallel to phase 2, the Programme Manager using learning from phase 1, will engage with community and primary care organisations for further MECC roll out

Benefits

Activity	Who is responsible	Start Date	End Date
Establishment of strategic steering group to provide leadership and guidance to MECC Strategy	Prevention Board, LWAB representation	April 2017	End March
Recruitment of Programme Manager who understands the NHS acute sector and can influence engagement from senior andmiddle managers	CCG	March 2017	April 2017
Scoping of current MECC initiatives across acute sector and build in evaluation model	Programme Manager	April 2017	2 weeks
'Winning hearts and minds' across acute services	PM with support from Board and LWAB to identify trust board lead, and trust MECC operational lead to implement MECC strategy in conjunction with PM	April	July
Establishment of operational steering group	Steering group representing trust MECC leads co-ordinated by PM	April	July

Key enabler for all 5 STP priorities

MECC
Status report: April 2017

Status

Summary of where we are

Recent Achievements

- **LWAB agreed MECC project bid for £140k**

Challenges/Roadblocks

- **Issues with recruiting PM. Initial proposal of support from RBFS, was unfortunately not supported due to restructure at RBFS**

Next Steps

- **Recruitment of PM with support from HEE**
- **Identification on a Clinical SRO to oversee leadership of MECC working with NHS executive teams**

Status Takeaway Message- On track, significant progress, etc.

Detailed Plan, Workstream Digital – Self care

SRO	• Lise Llewllyn, Strategic Director of Public Health
Delivery Lead	• Mark Sellman, Associate Director Digital Transformation SCWCSU

Vision

As Is

- Organisations investing in patient facing technology in isolation
- No standards, security dubious, not joined up, limited support for organisations.
- Pockets of good practice not being shared.
- Patients are already engaging with digital for health in isolation of the NHS/social care.

To Be

Agreed definition of digital self-care:

1. Supporting general wellbeing through use of digital
2. Supporting patients with managing their conditions through digital

- Clinically/social care professional led prioritisation
- Joined up and informed investment around patient facing technology (opposite of as is state)

Deliverables

Digital Self-Care

- What have we got/what are we doing- Mapping existing digital approaches and identifying what are the quick wins
- Register of apps that are being recommended for patients
- Patient journeys/scenarios to support with navigation
- Agree priorities of pathways
- Identifying unintended consequences- loneliness if we are removing interactions with care professionals face to face
- Establish a workshop to capture wider professional views.

Workforce

TBD

Prevention (Public Health)

TBD

Benefits

- Act as an advisory group for organisations looking to invest in patient facing technology
- Share best practice across BOB and Frimley STP's
- Support broader STP and local transformation plans

Timeline

To have a baseline and workshop delivered within the next 6 months

Key enabler for all 5 STP priorities

March 2017

Digital Self Care

Status

Summary of where we are

Visioning- Generating baseline and developing future state aspirations.

Recent Achievements

What has happened since last update

- Kick off meeting with key digital representatives from BOB and Frimley
- Agreed to baseline existing projects and to continue to meet monthly

Challenges/Roadblocks

Any outstanding actions or roadblocks that require board input

Next Steps

Follow up meeting in late April

Status Takeaway Message- On track

Detailed Plan Workstream
Improving workforce health

SRO	• Karon Hart, Buck Helah
Delivery Lead	• Paul Durrand, Amy Sherman

Vision

To improve and sustain workforce health and wellbeing and employee confidence to promote healthy lifestyles to others

Benefits

Improved Health and Wellbeing within the workforce in scope of this paper

Anticipated correlated reduction in sickness absence levels, without raising levels of presenteeism

Deliverables

- Improve collaboration across BOB to enable the sharing of measures and initiatives
- Using CQUIN as a template, develop new initiatives to further enhance staff wellbeing initiative
- Embed good practice already in place to encourage consistency of wellbeing offer across BOB, disseminate case studies, success, evaluation measures and offer peer support
- Create a culture where staff Health and Wellbeing is used proactively within organisations e.g. during organisational change and is considered in conjunction with other organisational activities e.g. Education and Training, retention programmes etc.
- To engage other employers / providers within the footprint to work collaboratively, including opportunities to use resources at reduced cost e.g. University Gyms, Fire service premises etc.
- Identify further collaborative opportunities over and above local delivery to improve workforce health and wellbeing and additional financial savings, e.g. through NHS employers, National Conferences, Occupational Health and Wellbeing Networks.
- Promote and encourage the role of staff as role models and/or ambassadors for healthier lifestyles
- Making Every Contact Count (MECC) – training staff how to have confident conversations around health and wellbeing and raising awareness of onward signposting opportunities

Key enabler for all 5 STP priorities

Improving workforce health

Status

- Workforce PID approved by STP Prevention Group
- BOB Healthy workforce group established – 1st meeting held to clarify understanding, agree direction and clarify learning points
- Mapping exercise - 1st exercise completed and been collated – further information requested

Recent Achievements

- BHT Health and Wellbeing CQUIN targets achieved
- Meetings with STP members re workforce wellbeing initiatives
- Raising awareness of Workforce wellbeing via;
  - Presentation to Health and Wellbeing Board (Bucks) on Healthy Workplace mental health
  - Presented at AHSN road show re Healthy Workplaces
  - Represented Healthy Workforce Stream at Workforce STP meeting

Challenges/Roadblocks

- **Review membership of BOB healthy workforce group – need higher level representation from some areas.**
- **AHSN going through internal transformation process so limited resource available (Now resolved)**
- **SRO change of role (now incorporated into new role)**

Next Steps

- **CQUIN update from all BOB NHS Trusts (end of year reports for 16/17)**
- **Collate new mapping information and publish**
- **BOB Healthy Workforce meeting 9th June to agree actions. Also focus on improving Mental Health/Stress initiatives (As requested by group)**
- **Further meetings with STP members re implementing good practice in workforce wellbeing**

Status Takeaway Message- On track, significant progress, etc.