Health and Wellbeing Board
Thursday 7 June 2018

Developing a Preventative Approach: Priority Status Update

Purpose of the report: Performance Management

To provide the Health and Wellbeing Board (HWBB) with an update on progress against the 'Developing a Preventative Approach' priority in the Joint Health and Wellbeing Strategy since the Board's last update in December 2017.

Recommendations:

The HWBB is asked to:

- Endorse the delivery mechanism of the 'Developing a Preventative Approach' priority through the three emerging Integrated Care Systems.
- Formally agree that the Multiple Disadvantage Steering group including members organisations engagement with this project is accountable to the Health and Wellbeing Board
- Support and advocate the Multiple Disadvantage Steering Group's ambition for a system-wide solution to improving outcomes for people experiencing multiple disadvantage and ensure senior representation from health
- Nominate an executive sponsor from one of the Surrey CCGs to join the executive sponsors from Surrey County Council, the police and the Police and Crime Commissioner for the Multiple Disadvantage Project
- Support the Alcohol Prevention – DrinkCoach launch in their own organisation actively promoting Don't Bottle it Up.
- Endorse Surrey-wide buy-in to the DrinkCoach pilot to ensure all residents can access skype-based alcohol support.

Performance Overview:

1. 'Developing a Preventative Approach' is the second priority in the Joint Health and Wellbeing Strategy (JHWS). The aim of this priority is to prevent ill-health as well as to identify problems as early as possible so that early support can be put in place for people. National and international evidence tells us that there is a clear link between social status, income and health which creates a significant gap in life expectancy. Put simply people are healthy when they have a good start in life; reach their full potential and have control over their lives; have a healthy standard of

living; have good jobs and working conditions; and live in healthy and sustainable communities.

2. The Health and Wellbeing Board last considered the 'Developing a Preventative Approach' priority in December 2017. At that meeting there was an update on Air Quality; Fire as a Health Asset; Prevention of Cardiovascular disease; Tobacco control; and severe and multiple disadvantage.

3. This report will provide an overview of the processes for delivering the prevention outcomes within the Joint Health and Wellbeing Strategy through the Integrated Care Partnerships in Surrey.

4. In addition, this report highlights three key areas where partners are working together to deliver the 'Developing a Preventative Approach' priority:

   - People with multiple disadvantage – Making Every Adult Matter
   - Healthy Lifestyles – Alcohol Prevention in Surrey Heartlands
   - Fire as a health asset – Falls Prevention in Guildford and Waverley

Key Achievements and Outcomes

Delivery of the Health and Wellbeing Strategy prevention outcomes

5. The outcomes we want to see through the delivery of the 'Developing a Preventative Approach' priority are:
   - The gap in healthy life expectancy across Surrey narrows
   - People (children, young people and adults) with multiple needs have better health outcomes
   - People eat and drink healthily, are physically active and stop smoking
   - People travel actively, air quality in Surrey is improved and health is embedded in planning
   - People with Learning Disabilities live independently locally wherever possible

6. The emerging Integrated Care Systems all have a focus on prevention within their plans and aspire to improve health and increase healthy life-expectancy.

7. This whole system, collaborative approach being adopted in Surrey Heartlands, Frimley Health and East Surrey and Sussex provides a useful structure to embed prevention in all plans and effectively deliver the aforementioned outcomes.

8. The delivery mechanism for the Health and Wellbeing prevention outcomes is therefore via these aspiring Integrated Care systems.

Surrey Heartlands Health and Care Partnership

Background

9. Prevention is a central component of the Surrey Heartlands vision for the transformation of the health and social care system.

10. The '**Prevention and the wider determinants of health'** workstream is one of the eleven programme workstreams overseen by a multi-agency Board and reporting to the Surrey Heartlands Delivery Board. The stated vision for this workstream is to increase the numbers of years people live in good health, independent and free from disability, making the biggest changes in those currently experiencing the worst health.

11. The workstream objectives align to the outcomes for Health and Wellbeing Priority 2: Developing a Preventative Approach. The objectives and programmes of work are presented in table 1 overleaf.

Progress to date

12. Over the last 18 months and through the workstream Programme Board, senior leaders from across the Heartlands footprint have been engaged in discussions as to how the system can work together to increase healthy life-expectancy through prevention activities to thwart the major causes of ill health and premature death.

13. Three workshops have taken place with a focus on smoking, healthy weight and alcohol prevention that have engaged all of the programme workstreams.

14. A Clinical Academy event was held in February, to challenge the clinical workstream leads to consider the contribution their workstreams could make in preventing ill health resulting in a number of opportunities for collaboration on prevention.

15. Prevention now forms a key part of the work across a number of the workstreams including Women and Children; Diabetes and Mental Health.

16. For example, under the Women and Children's workstream, reducing smoking in pregnancy; breastfeeding; and maternal mental health have all been prioritised. The workstream is also working through how to ensure women and their families requiring additional support are identified early. These priorities fit with the drive from Surrey Heartlands to improve outcomes within the First 1000 Days of life, a concept that is being welcomed by acute trusts and community health providers.

17. Transformation Funding was granted in 2017/18 to take forward three Prevention and wider determinants workstream projects:
    - Social Prescribing – Development of a digital referral system in Primary Care to streamline patient referral to community assets.
    - Making Every Contact Count – Delivery of an organisational development approach to skilling up front line staff to recognise and

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utilise opportunities to raise the issue of healthy lifestyles during each contact with the public.

- Alcohol Prevention – Piloting a digital approach to supporting people to reduce their alcohol consumption (see section 31 below)

18. Further bids for Transformation funding are proposed for 18/19

Table 1. Surrey Heartlands prevention workstream objectives

Objective		**Programmes/ Areas of work**
Healthy Places	Shape the environment in which people live to improve and protect the health and wellbeing of communities	Urban planning for health; Housing Mobilising community assets Air quality
Healthy Lifestyles	Address the major causes of ill health to prevent the future development of long term conditions	Making Every Contact Count; Integrating and improving the support offer for: ○ Smoking cessation; ○ Alcohol reduction; ○ Healthy weight; ○ Mental wellbeing
Staying Independent	Empower citizens to remain independent in their own homes	Social Prescribing; Support for carers
Staying Well	Improve health outcomes for people with existing long term conditions	Early diagnosis of long term conditions; Robust management of care; Self-care; Wrap around support for people experiencing multiple disadvantage
Healthy Workforce	Support our staff to be happy and healthy through the creation of a healthy workplace environment and access to healthy lifestyle support.	Workplace wellbeing strategies; Emotional wellbeing in the workplace

Frimley Health and Care Sustainability and Transformation Partnership[1]

Background

19. The aim of the prevention and self-care workstream across the Frimley footprint is clear. The sustainability of our health and social care system depends on people living healthier for longer. In order to achieve illness prevention at the required scale we will need to transform our approach. In particular, we need to move beyond delivering prevention programmes to our population and start creating prevention programmes with them.

20. Towards this aim, the Frimley STP will be establishing an 'asset based' approach that seeks to fully harness the knowledge, experience and energy of the population to create and maintain preventative work. In 2018/19 the partnership will work to propagate a coherent, evidence-based approach to community development across the STP area. It will also seek to increase the accessibility of community based support via asset mapping, social prescribing and health professional interactions. Finally, it is proposed that focused programmes will be developed that are aimed at helping people find community based support for two key issues facing our area: alcohol related harm and physical inactivity. This will result in programmes that are:
    - A better match to individuals' needs, preferences and values – hence more likely to be accessed and effective
    - Less dependent on commissioning budgets - hence more likely to be sustainable

21. This workstream will not be starting from scratch. The Frimley system footprint already contains many examples of key asset-based work streams including community asset mapping, social prescribing and health improvement programmes run by members of our population for our population. Transformation seed funding has already been allocated to strengthen this work.

22. The aim in 2018-19 will be to align and expand the programmes to make them more than the sum of their parts. Particular attention will be on development that transcends agency and geographical boundaries and creating one system that varies as a function of our population's needs not professional silos.

Project descriptions

23. **Community Asset Toolkits & Maps**
    Why? The success of an STP wide approach will depend on a common set of evidence based methods being employed across the system. **What?** Extensive collaboration across agencies and resident groups will take place to generate a set of online tools aimed at guiding asset based work. These will include a toolkit for engaging people in behaviour change,

[1] Information on Frimley STP Prevention workstream taken from Frimley STP 2018-19 System Operating Plan and March 2018 prevention and self-care workstream highlight report

a ‘bank’ of positive case studies for use in promotional campaigns and interactive digital maps of community based groups.

24. **Social Prescribing**

Why? Social prescribing services help residents find and access community based health improvement opportunities.

What? Work will be undertaken to expand and embed existing social prescribing programmes across the Frimley system (Slough, North East Hampshire & Farnham, Windsor Ascot & Maidenhead) and develop new programmes where they do not currently exist (e.g. Bracknell Forest, Surrey Heath). Referral will be via professionals (especially primary care) as well as by self-referral.

25. **Making Every Contact Count (MECC)**

Why? Evidence suggests that brief advice from health professionals and implementing nudge theory techniques significantly increases the likelihood of health behaviour change.

What? Training will be rolled out for staff across the Frimley system in behavioural change techniques, as well as improving their understanding of lifestyle risks and the community based support available. Using nudge theory techniques (e.g. healthy hospital initiative) and a focussed approach to digital platforms (e.g. apps) to enable residents to support behaviour change themselves.

26. **Hospital Based Alcohol Services**

Why? There are around 13,000 admissions each year across the STP footprint. Evidence shows brief advice in hospital can reduce admissions.

What? Behavioural advice and support is offered when patients are in hospital for alcohol related reasons. An additional 4 alcohol liaison nurses will enable the extension of the service at Frimley Park Hospital and introduce a new service at Wexham Park Hospital, enabling the service to run 7 days a week between 8am and 8pm

27. **Physical Activity Initiatives**

Why? Nearly a quarter of adults in the STP footprint are active for less than 30 minutes a week, increasing their risk of long term health problems.

What? A range of accessible opportunities for activity will be developed and promoted with a particular focus on community programmes that have proven health benefits (e.g. walking groups). Work will take place to ensure opportunities are accessible through Community Sports Partnerships to people with mental health problems – who often are at greater risk of physical inactivity. Pilot scheme using wearable technology to encourage activity.

Progress to date

28. Asset based community development: Agreement from the Prevention and Self-Care working group to look at progressing the three outputs from an initial workshop in February. Plans are currently being drawn up to progress. These will be discussed at next working group meeting.

29. Surrey Heath and Bracknell Forest are preparing their go-live in April. This will then mean that social prescribing is available across the STP. The Number of GP practices with social prescribing has increased in Slough and Windsor & Maidenhead.

30. The Frimley Local Workforce Action Board has approved funding to extend the roll out of MECC training and continue the MECC co-ordinator role. This means delivering more accessible routes into to MECC training (including e-learning) and expanding the work in social care and the voluntary sector. The aim will be to embed the work in local systems.

31. Hospital Based Alcohol Services: Agreement from East Berkshire CCG to fund initial administration support, this will enable the alignment of hospital based alcohol services across Frimley Health.

32. Physical Activity: Proposal for media campaigns is taking shape with input from Get Berkshire Active, will be discussed at the next working group meeting.

Sussex and East Surrey Sustainability and Transformation Partnership

Background

31 To support the prevention agenda within the Sussex and East Surrey STP, a system-wide approach to prevention will be taken forward in East Surrey through a Place-Based Prevention Plan.

32 The ambition is to embed a preventative approach across local health, public health and local authority services in East Surrey in order to reduce premature mortality and health inequalities.

33 Five key prevention priorities have been identified, which map to the Surrey Health and Wellbeing Strategy:

- Support a good start in life, including delivering a whole systems approach to healthy weight and promoting emotional wellbeing and good mental health in children
- Improve the health and wellbeing of working people through the development of workplace health and wellbeing programmes
- Prevent the development of long term conditions (LTCs) through primary prevention programmes focused on the major causes of ill health, including smoking, poor diet, lack of physical activity, alcohol, mental health and loneliness
- Improve health outcomes for people with LTCs, including cancer
- Empower citizens to remain independent in their own homes, taking an asset based approach to support carers, strengthen social networks and communities

Progress so far

34. To support delivery of the five key priorities, progress so far includes:

- The Wellbeing Prescription service operates out of all East Surrey GP surgeries. The Wellbeing Advisors to date have helped over 2,500 people, which includes support to lose weight; improve their mental and emotional wellbeing; getting more active; eat healthier; drink less alcohol; stop smoking; and support/advice with housing, debt and social care issues
- Newly diagnosed Type 2 diabetics are supported through the Wellbeing Prescription service around diet and lifestyle information and advice prior to enrolling onto the DESMOND programme, which provides self-management education for patients with Type 2 diabetes
- A STP wide bid to the British Heart Foundation was submitted for a 2 year project for SECAMB clinicians to assess at least 5000 people each year for hypertension through pop up tents in key areas of deprivation across the STP area
- The All Together Better approach in East Surrey is supporting citizens to: build their knowledge, resilience and confident to achieve their potential; become engaged, involved and active citizens; and communities to share their skills and expertise, improving their own health and the health of others

People with multiple disadvantage

Background

35. It has been previously recognised by the Health and Wellbeing Board that for individuals, whose needs fall across health, social and criminal justice, the current complex systems makes it difficult to achieve improved outcomes. As a result of this local partners including Public Health were requested to work together to develop practical approaches to address this challenge.

36. Representatives from Surrey Police, the Police and Crime Commissioners Office for Surrey and Public Health Surrey are working together to identify ways in which current models of support could be aligned in order to reduce the complexity of support services and improve access for individuals facing multiple disadvantage. Executive sponsors have been identified from each of these lead organisations to champion this agenda.

37. Surrey's successful application to become a Making Every Adult Matter (MEAM) area, enables the county to access support from the national team. Their support will draw on expertise from across the MEAM coalition to ensure cross-sector insight. The primary aim of working with the MEAM programme is to provide support to see how existing projects can work together better in order to provide an improved response to the small but severely disadvantaged proportion of people who fall into a chaotic cycle of

homelessness, substance misuse, offending behaviours and mental ill-health.

Progress

38. Since the last update a Multiple Disadvantage Steering Group has been formed. This includes representatives from a range of organisations across Surrey including Police, Public Health, Adult Social Care, CCG, Homelessness and Housing, Ambulance, Mental Health, Probation, Dept for Work and Pensions and people with lived experience.

39. The Steering Group has been involved in discussions on current service provision; effective practice and the identification of areas requiring improvement. The Steering Group are passionate about achieving an ambitious solution that better meets the needs of this cohort of people.

40. The ideal solution that the group are working towards is one in which:
    - The service user is at the centre with the care around them being tailored to their needs,
    - There is one assessment process with information that moves with the person,
    - There is one support worker who helps the person to navigate the health, social care, criminal justice and housing systems,
    - There is a single commissioning strategy which reflects the objectives of MEAM and ensures sustainability,
    - There is no exclusion criteria,
    - There is agreement for joint working and information sharing.

41. The Steering Group has successfully secured the support of a Darzi Fellow for a year who will begin work on this project from May 2018. Within this year it is proposed that a thorough landscape review is completed in order to fully understand existing models for people with multiple disadvantage, their funding streams, the resources attached, their strengths and weaknesses. By the end of the Darzi Fellows placement, it is anticipated that there will be a clear plan for taking the project forward that has been developed with service users, and is supported by both strategic partners and practitioners.

42. A workshop was help with the Health and Wellbeing Workshop on 2nd May, where it was agreed that the Board would be appropriate to provide governance of the Multiple Disadvantage Steering group and hold partners to account for their engagement.

Next steps

43. Identify an Executive sponsor from health to join sponsors from Surrey Police, The Police and Crime Commissioner Office and Surrey County Council in influencing the adoption of the recommendations within their organisations.

44. The Darzi fellow with support from the Steering group will be conducting the following activities over the next 12 months:

- Establish methods to engage with people with complex needs (experts by experience), ensuring their experience informs the project.
- Understand demand and its causes across the system, including demand on individual organisations, and recurring themes across the partnership related to those with complex needs.
- Identify and implement solutions (including technological) to address difficulties of understanding demand and joining data held in separate organisations.
- Complete a landscape review, identifying a range of solutions for Surrey, whilst critically appraising current approaches.
- Secure multi-agency agreement on pathways representing an improved response for these residents.

Healthy Lifestyles - Alcohol Prevention in Surrey Heartlands 2018/19

Background

45. Smoking and harmful use of alcohol are amongst the most significant risk factors in the global burden of disease in England.[2] This is recognised in the NHS Five Year Forward View (5YFV) which identifies the need for a "radical upgrade in prevention". Preventing excess alcohol consumption can significantly reduce the burden on the NHS and help to address alcohol-related health inequalities.

46. Improving detection and intervention of alcohol misuse is known to avert both alcohol-related admissions and A&E attendances through reduced morbidity and mortality. Alcohol Identification and Brief Advice (IBA) and Extended Brief Interventions (EBI) are recommended by NICE for people aged 15yrs and over, and are aimed at reducing alcohol consumption to lower risk levels.

47. The national 'Preventing ill health' CQUIN (2017-19) focuses on the identification of smoking and alcohol misuse, provision of brief advice and referral to specialist services as appropriate, for all inpatients in community, mental health and acute trusts. Surrey Public Health Team has been supporting trusts to prepare for delivery of the CQUIN through a series of meetings and workshops. A key aspect of this has been to ensure that the CQUIN requirements are understood and that trusts are aware of the training which is available for staff undertaking alcohol interventions. In March 2018, a new e-learning module to support training needs for the CQUIN was made available via e-Learning for Healthcare. This can be accessed at the following link: https://www.e-lfh.org.uk/programmes/alcohol-and-tobacco-brief-interventions/. In addition, there four other alcohol IBA e-learning courses are available to access for different settings: primary care, community pharmacy, hospitals and dental teams: https://www.e-lfh.org.uk/programmes/alcohol.

[2] Newton, John N., et al. "Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013." *The Lancet* 386.10010 (2015): 2257-2274.

48. In Surrey, Don't Bottle It Up (DBIU) has been commissioned by Public Health since 2015 and is the primary means for delivering alcohol screening and brief advice. DBIU is an evidence-based online alcohol screening tool which allows people to find out if they are drinking at risky levels and to access personalised feedback and advice. DBIU has been highly successful in reaching risky drinkers within the county; 5 out of 6 people who complete the alcohol screen are drinking above recommended levels.

49. To support the alcohol prevention agenda, transformation funding has been approved in Surrey Heartlands. This funding will be used to:

- Pilot skype-based EBI for increasing and higher risk drinkers using the DrinkCoach platform.
- Commission an independent, countywide evaluation on the effectiveness/impact, acceptability and economic return on investment associated with skype-based EBI.

50. In addition to the DrinkCoach pilot, Surrey Public Health Department will be undertaking a scoping activity with partners to identify key opportunities in clinical pathways where the delivery of face-to-face alcohol brief advice and EBI would be most impactful and feasible. This will inform a business case for expanding the alcohol prevention approach.

51. What is IBA and EBI?

Simple alcohol IBA is aimed at increasing risk drinkers and typically lasts between 30 seconds and 5 minutes, whereas EBI is aimed at higher risk drinkers and tends to involve up to four 30-40 minute motivational interviewing sessions. These sessions focus on increasing an individual's desire to stop drinking, planning strategies to cut down and monitoring progress. Increasing risk drinkers who receive IBA but do not respond (ie reduce their drinking to lower risk levels) may be offered additional support by way of EBI. There is strong evidence that IBA and EBI in community settings have a high degree of efficacy and cost-effectiveness. IBA can reduce weekly drinking by between 13% and 34%, resulting in 2.9 – 8.7 fewer drinks per week. This will reduce relative risk of alcohol-related conditions by c14%, and absolute risk of lifetime alcohol-related death by c20%.

52. What is DrinkCoach?

DrinkCoach consists of 4-6 forty minute coaching sessions delivered risky drinkers over Skype by an alcohol specialist. The sessions use standard motivational interviewing techniques to support individuals to reduce their drinking to lower risk levels. The sessions focus on reviewing the person's drinking levels; exploring their relationship with alcohol; setting desired goals; and supporting them to achieve them.

Sessions are completely confidential and free to all those who meet the inclusion criteria (below) who are residents of Surrey Heartlands. DrinkCoach sessions are available at evenings and weekends allowing those in employment, housebound, and/or with caring or parental responsibilities access to the service.

53. **Who is DrinkCoach for?**

The DrinkCoach service tackles health inequalities by extending alcohol services into communities who do not typically access treatment. Table 2 identifies the inclusion and exclusion criteria for the service. At present, DrinkCoach will only be available to Surrey Heartlands residents, however Surrey Heath and East Surrey CCG have the opportunity to buy into the service and ensure provision is available for residents in their area. Both CCGs are currently exporing if this is possible.

Table 2 DrinkCoach inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
• Increasing and Higher Risk Drinkers • Service-users who are willing to work on reducing their alcohol intake • Service-users agreeable to interventions based on Motivational interviewing, including EBI or Brief Treatment • Accepted the Terms and Conditions of the HAGA Online Brief Treatment service, including confidentiality agreement	• Aged seventeen years or younger • Have been assessed in need of alcohol detoxification • Have been assessed to have significant physical health problems, such as a history of alcohol-related liver disease, seizures etc. • Without sufficient IT and Internet connection. • Do not agree to the Terms and Conditions, including confidentiality agreement

54. **How is DrinkCoach Accessed?**

DrinkCoach was developed, and is delivered by Blenheim (formerly known as HAGA) – the existing provider of Surrey's DBIU website. Individuals can access DrinkCoach by completing the DBIU alcohol assessment. Other referral routes include via self, NHS health checks, GPs and primary care, Alcohol Liaison services and substance misuse service providers.

55. **Evaluation**

To assess the effectiveness of the pilot service, an independent evaluation of DrinkCoach is being commissioned by Public Health. This will consider the impact of DrinkCoach on drinking behaviour, alcohol consumption, level of risk and self-reported physical and mental health. It will also consider service user experience and satisfaction, including service acceptability and accessibility. Additionally, Public Health will undertake an economic evaluation to identify Return on Investment and value for money.

56. Fire as a Health Asset

Key Challenges

57. The national reduction in Public Health funding continues to place pressure on public health commissioned services and public health lead activities. Reduction in public health capacity and public health service provision including public mental health; substance misuse and healthy lifestyle services represents a significant challenge to the achievement

of the Boards prevention priority. It is imperative that public health services and programmes are prioritised and plans put in place to mitigate the impact of budget pressures.

58. There remains a challenge for Public Health to ensure equitable provision of support across the whole of the Surrey while taking advantage of opportunities to improve public health as these arise within individual ICP footprints. PH are looking the way in which we organise our work and our relationship with CCGs to ensure that we can deliver as appropriate.

Conclusions:

59. The three emerging integrated health and care partnerships across Surrey each have prevention at their core. It is acknowledged that the sustainability of Surrey's health and social care system depends on people living healthier for longer and in order to achieve a preventative approach at scale we need to transform our system. These systems therefore provide the framework for the delivery of the Health and Wellbeing Board Prevention Priority.

60. There are a number of good practice examples already underway as highlighted in this report. However, this requires a sustained, collaborative approach and strong leadership across all member organisations.

Next steps:

61. Identify future actions and plans for the strategy to build on successes and address challenges

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Report contact:
Please see the contacts below for more information on:

- **Fire as a Health Asset**: Bryn Strudwick, Group Commander - Fire and Rescue Service, bryn.strudwick@surreycc.gov.uk
- **Alcohol Prevention:** Gail Hughes, Public Health Lead, gail.hughes@surreycc.gov.uk
- **Severe and Multiple Disadvantage (Complex Needs):** Amy McLeod, Surrey Safeguarding Adults Board Manager, amy.mcleod@surreycc.gov.uk
- **Surrey Heartlands Health and Care Partnership prevention overview:** Helen Harrison, Public Health Consultant, h.harrison@surreycc.gov.uk
- **Frimley Health and Care Partnership prevention overview:** Catherine Croucher, Public Health Consultant, catherine.croucher@surreycc.gov.uk
- **Sussex and East Surrey Health and Care Partnership prevention overview:** Rachel Gill, Public Health Consultant, rachel.gill@surreycc.gov.uk

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