Public Health England

Protecting and improving the nation's health

The Prevention Challenge – One Year On

A self-assessment review of progress by NHS Provider Trusts in the East Midlands

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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Foreword – Public Health England

Public Health England (PHE) fulfils the Secretary of State for Health's duties to protect health and address health inequalities, and executes the Secretary of State's power to promote the health and wellbeing of the nation. PHE undertakes a range of evidence-based activities that span the full breadth of public health, working locally, nationally and internationally.

A core function of PHE is to improve population health through sustainable health and care services.

We aim to secure improvements to the public's health, including supporting the system to reduce health inequalities and to deliver the priorities set out in *'From Evidence into Action'* and the NHS Five Year Forward View commitments for a radical upgrade in prevention. We do this through our own actions and by supporting Government, local government, the NHS and the public to secure the greatest gains in physical and mental health, and help achieve a financially sustainable health and care system.

As demand for health and care services continues to rise, our work on prevention and demand management is critically important. Working with the NHS and local government, PHE supports local implementation of the NHS Five Year Forward View prevention agenda - particularly on closing the health, financial and quality gaps - to help reduce avoidable increases in demand on the NHS.

The Prevention Challenge

As set out in *'From Evidence into Action'*, PHE has an ambition: for people of this country to live as well as possible, for as long as possible. This report recognises the challenge we face as a society in tackling the current epidemic of largely preventable long-term diseases. We may be living longer, but we – and future generations – risk spending many of these extra years in poor health. The need to tackle major risks such as obesity, poor diet, physical inactivity, smoking, and excessive alcohol consumption has never been more pressing.

It is simply not feasible to think that the health challenge we face can be solved by spending ever more on hospitals, clinicians and care services treating people who are ill. Resources are scarce and the health and care sectors are under huge pressure from constrained budgets and rising demand. Something else has to change.

In *'Meeting the Prevention Challenge in the East Midlands – A Call to Action'* we set out to provide practical recommendations to NHS organisations about the part they need to play in delivering a radical up-grade in prevention.

In taking forward our Prevention Challenge, we have established a supported self-assessment programme and have demonstrated through this that there are criteria against which the prevention effort of NHS organisations can be assessed. Furthermore, self-assessment can support the identification of progress and next steps within this agenda.

Our findings show positive action is being taken and that NHS Provider organisations are ideally placed to deliver prevention activities but there is still much more to be done if the NHS Five Year Forward View vision is to be achieved.

The work set out in this report aims to support NHS Provider organisations to assess their own progress on prevention activities and to encourage them to adopt systematic prevention policies, plans and programmes. It shines a light on an important area of work and I recommend it to both NHS Provider and NHS Commissioning organisations.

Dr Fu-Meng Khaw
Director, Public Health England East Midlands

Foreword – East Midland Clinical Senate

Clinical Senates have been established to be a source of independent, strategic advice and guidance to local health and care systems, to assist them to make the best decisions about healthcare for the populations they represent.

The Clinical Senate is pleased to endorse this report which has been led by Public Health England. Preventing ill health is the first job of any strategy or plan on healthcare and has been a key East Midlands Clinical Senate line.

This report builds on work previously undertaken to develop a clear understanding of what it would mean for provider and commissioner organisations to deliver the Five Year Forward View's prevention challenge.

It is widely recognised that there needs to be a significant improvement in helping people to live healthier lives as avoidable illness is widespread. We have already begun to see national action on obesity, smoking, alcohol, and other major health risks.

Self-assessment tools developed as part of this work create a robust and consistent methodology for provider and commissioner organisations to evaluate their current position against the original recommendations, and to identify strengths, gaps, and their own next steps.

Work in this important area can only be commended, particularly as we know that the NHS faces a level of unprecedented challenge as demand for services increases.

Dr Neill Hepburn Professor Ashley Dennison

East Midlands Clinical Senate Co-chairs

Executive summary

Public Health England (PHE) in the East Midlands and the East Midlands Clinical Senate jointly published '*Meeting the Prevention Challenge in the East Midlands: A call to action*' in December 2015. Drawing on the NHS Five Year Forward View, this report set out the case for prevention across NHS organisations in the East Midlands, including 10 practical recommendations for NHS Provider Trusts.

To support delivery of prevention action and as part of PHE's system leadership role, a self-assessment tool was developed and PHE sought approval for its use from stakeholders, including Trust CEOs. Directors in NHS Provider Trusts were nominated to lead the self-assessment for their organisation's practice and to plan next steps. The self-assessment tool is based on *The Prevention Challenge* report's recommendations, structured by the World Health Organisation's 'Health Promoting Hospitals' standards on:

- Leadership, Management and Policy
- Patient Contact and Assessment
- Patient and Visitors Information
- Promoting a Healthy Workplace
- Tackling Health Inequalities

The tool consists of 41 questions or statements about prevention practice and enables rating of embeddedness against a 4-point scale; from "cannot demonstrate…" to "systematic across whole organisation" to discern the systematised approach within Trusts.

Between December 2016 and June 2017, supported self-assessments were completed by NHS Trust Directors and their colleagues in 12 out of 15 NHS Trusts in the East Midlands. This use of a self-assessment approach has helped to secure ownership of progress and gaps in prevention activities and set a baseline for future prevention actions by NHS Provider Trusts. Notable progress and gaps are reported in section 5 as 'Strengths' and 'Next Steps' for each organisation while common themes and issues are discussed in section 6 of the report. These include:

1. Three out of 12 Trusts have formally appointed a **board level champion for prevention** with the remaining Trusts considering doing so or considering formalising previous informal arrangements.
2. **Internal Governance** arrangements for prevention vary between Trusts but tend to be more explicitly developed in Trusts with an agreed overarching plan for prevention.

3. With the exception of CQUIN performance, few Trusts reported any meaningful dialogue about their prevention work with their commissioners or through the wider **governance 'machinery' of the NHS.**
4. There is considerable variation about if and where prevention is embedded within NHS Trusts' guiding **strategic documents** and some Trusts intend to strengthen the focus on prevention in the next iterations of various strategies.
5. Harnessing the prevention potential of any organisation requires time, energy and dedicated **capacity for prevention**. This has emerged as an issue for many Trusts with some reporting lack of capacity as a significant issue. As Trusts increasingly embrace their role as significant contributors to the prevention agenda and consider the implications of the move to Accountable Care Systems, more Trusts are seeking to identify and secure suitable capacity for this, including specialist capacity.
6. All Trusts have undertaken work on becoming **completely smoke-free** and although some organisations had not fully implemented smoke free policies at the time of the self-assessments, progress continues in terms of both developing and implementing policy and developing approaches to enforcement.
7. The extent to which Trusts have adopted approaches that embed prevention within **patient contact, assessment and care** seems to vary considerably between Trusts and within Trusts. Self-assessments suggest that further attention is required to ensure that Trusts are consistently **Making Every Contact Count**.
8. Self-assessments suggest that good progress is being made on **staff health and wellbeing**, supported by the CQUIN incentive for staff health and wellbeing in 2016 to 2017.
9. In relation to **health inequalities**, few Trusts reported undertaking work to help them better understand differing health needs in different segments of the population and few Trusts could readily identify examples to illustrate adoption of the principle of *proportionate universalism*.
10. There are opportunities to strengthen **work with external partners** as it was clear that not all Trusts had developed their approaches to prevention in discussion with relevant system partners. Also, some Trusts raised concerns about Local Authority funding cuts resulting in the withdrawal of support for prevention. Although about half of Trusts referred to working with Sustainability and Transformation Plan (STP) partners on aspects of prevention, there is almost certainly an opportunity to strengthen the integration of health, care and other services in the context of STPs and the development of accountable care systems.

Some of these themes are echoed strongly in the recent publication of *'Public Health: Everyone's Business?'* an NHS Providers publication exploring how the health service can respond to the challenges ahead in delivering the 'radical upgrade to prevention and public health' heralded in the NHS Five Year Forward View.

In conclusion, it is encouraging to report a sense of genuine commitment by NHS Providers to play their part in *The Prevention Challenge* and to note that every Trust is

making progress in at least some aspects of prevention. However, progress appears uneven within and between organisations and there is still much potential for NHS Providers to do to more in this space.

The use of CQUIN incentives appears to have been successful in encouraging prevention action and Trusts generally reported good progress on staff health and wellbeing initiatives in response to the 2016 to 2017 CQUIN. Considerably less confidence was generally reported over harnessing the prevention opportunities inherent in patient contact, assessment and care through the delivery of brief interventions, advice and/or referrals of patients whose lifestyles are damaging to their health. These aspects of work were most consistently identified as being in need of attention and this work will undoubtedly be supported by the 2017 to 2019 CQUIN incentive on Preventing Ill health by Risky Behaviours.

Importantly, with the possible exception of CQUIN incentives, prevention activity does not appear to be prioritised and driven consistently across all organisations using the external governance ‘machinery’ of the NHS and there is an opportunity for this to be done more systematically. If the NHS is genuinely going to deliver the “radical upgrade in prevention” required by the NHS Five Year Forward View, much more needs to be done to deliver the necessary scale and consistency of prevention work. Strong leadership, management and specific capacity will be important to deliver change, as will the strengthening and implementing of explicit policies and plans for prevention.

1. Background

1.1 Foundations: The NHS Five Year Forward View

In December 2015, Public Health England (PHE) in the East Midlands and the East Midlands Clinical Senate published a joint report called *'Meeting the Prevention Challenge in the East Midlands – A Call to Action'.* The report followed the national publication in October 2014 of the NHS Five Year Forward View (FYFV) which called for a ***"radical upgrade in prevention and Public Health"*** in the face of the sharply rising burden of avoidable illness threatening the sustainability of the NHS. The NHS Five Year Forward View argued that previous warnings about the rising tide of avoidable illness had not been heeded and the NHS is now on the hook for the consequences. It suggested that the economic after-effects of recent global recession make it implausible to think that NHS budget growth could continue to keep pace with the rising demand for health care for a growing population which is becoming older and sicker. Something else must change.

The NHS Five Year Forward View required NHS organisations to play a more active part in prevention by backing hard-hitting national action to tackle obesity, smoking, alcohol and other major health risks for both patients and the NHS's 1.3 million staff. NHS organisations were therefore required to set a national example as employers, to use NHS influence to advocate for public health measures, to commit NHS organisations to policies with prevention at their heart and to use the combined purchasing power of the NHS to improve health. Many of these themes and issues are re-asserted in the 'Next Steps on the NHS Five Year Forward View' document published in March 2017, albeit under the heading of 'reducing avoidable demand'. Examples include NHS organisations having to ensure appropriate food and drink options for staff, patients and visitors; NHS Provider Trusts being required to screen, deliver brief advice and refer patients who smoke and/or have high alcohol consumption; and all NHS estates becoming completely smoke-free.

1.2 Prevention Matters

In common with much of the rest of the UK, the East Midlands population is both growing and aging with more people living to very old age (ie over 85). However, although more people are living longer, many people are becoming ill younger as a result of smoking, drinking too much alcohol, eating a poor diet and being physically inactive. Whilst ever more effective treatments are helping people to live longer and to survive acute episodes of illness, it is often not possible to undo the underlying damage to health and this means that more people are living for many years with poor health towards the end of their lives.

As well as the human cost to individuals having to endure the limiting and/or unpleasant experience of long-term illness, the societal costs of this are enormous. In terms of the pressure on health and social care services, the King's Fund estimated in 2014 that rising demand for NHS services will lead to a £30 billion funding gap in the NHS by 2020 to 2021.The government committed to providing an additional £8 billion for the NHS over 5 years leaving £22 billion required through the delivery of efficiency savings as set out in the NHS Five Year Forward View. In Social Care, the Local Government Association estimated a £15 billion funding gap over the same period as a result of rising demand for social care services against a backdrop of reduced local government funding.

1.3 What can be done?

Improving the health of the population and increasing the number of years people can expect to live in good health (healthy life expectancy) is clearly not something that the NHS can deliver on its own. It requires support and action across government, from employers, business and many agencies as well as from all of us as individuals taking action in our own lives. However, the NHS is well placed to make a difference. Indeed, sometimes the NHS is uniquely well-placed to offer advice and support or to influence the lifestyle decisions that will shape the habits and health of a lifetime for individual patients and staff members.

The report '*Meeting the Prevention Challenge in the East Midlands – A Call to Action'* set out to stimulate and support action on prevention by NHS organisations in the East Midlands. It highlighted the projected rises in demand for health and care services and described an expanding 'window of need' for health and care services as the population's healthy life expectancy falls further behind total life expectancy. The report provided a framework for prevention action by identifying areas for intervention and highlighting case studies of local good practice. Implicitly targeted towards the NHS, the requirements of the NHS Five Year Forward View were incorporated into sets of **'Prevention Top Ten'** recommendations for both NHS Commissioning organisations and NHS Provider organisations respectively. These recommendations aimed to provide practical support to enable organisations to deliver their part of the required radical shift towards prevention.

1.4 Prevention Top Ten recommendations for NHS Providers

The full report '*Meeting the Prevention Challenge in the East Midlands – A Call to Action'* is available as a resource on the website of the East Midlands Clinical Senate and can be accessed by following the link below:
http://emsenate.nhs.uk/resources/2016-02-23-09-57-37/421-clinical-senate-resources

The report's recommendations for NHS Providers are set out below and these remain relevant as broad recommendations of good practice:

1. To embed *Prevention* within corporate governance structures, appoint a board level *champion* for Prevention and Public Health and develop *Prevention Impact Assessment* for all policies, plans and programmes.
2. To systematically adopt a *Making Every Contact Count (MECC)* approach within the delivery of all services supported by necessary staff training and IT infrastructure to record activity and outcomes.
3. To develop holistic approaches to history taking to address lifestyle and other risk factors and use this information in care planning and include in discharge summaries.
4. To share information on clinical and lifestyle risks in referral and discharge summaries to ensure that prevention is addressed at all points in pathways and that patients are included on relevant disease registers as early as possible.
5. To ensure healthy food provision within all premises, removing sugary snacks and beverages from vending machines in public sector buildings.
6. To develop estates management and transport policies with prevention at their heart, reducing the impact on local communities and promoting active travel and providing high quality infrastructure to support this.
7. To maximise the organisations impact on the health of staff and their families by ensuring a living wage and implementing occupational health and workforce wellbeing strategies that meet best practice.
8. To adopt a comprehensive Corporate Social Responsibility strategy maximising the positive prevention impact of the organisation within the local economy.
9. To consider how service delivery can support the prevention agenda and how adoption of a *proportionate universalism* approach can maximise the impact amongst communities with the greatest need.
10. To consider system, scale and consistency in the organisation's approach to prevention to ensure delivery of an equitable population level impact.

The report '*Meeting the Prevention Challenge in the East Midlands – A Call to Action'* was shared widely across the health and care system during 2016 and its influence was evident within each of the 5 Sustainability and Transformation Plans (STPs) in the East Midlands. As part of the dissemination strategy, the report was shared with NHS Provider Trust Chief Executives in the East Midlands, all Directors of Public Health, Clinical Commissioning Groups (CCGs) and was presented at the Acute Trust Chief Executives forum. Clinicians from across the East Midlands' Trusts also attended East Midlands Clinical Senate 'Prevention' events in April 2016 at which the report was presented along with practical examples of the delivery of its recommendations. However, there was little evidence beyond this of the report's influence within the NHS provider landscape.

1.5 One Year On

In October 2016, the Clinical Senate Council agreed to support a piece of follow-up work to assess the impact of the report and its recommendations within the East Midlands system and to encourage further progress. This follow-up work became known as '*The Prevention Challenge: One Year On*'.

The proposed objectives of the follow-up work with NHS Provider Trusts were to:

- Develop suitable self-assessment tools to facilitate supported self-assessment of progress by NHS organisations against the Prevention Top Ten recommendations
- Engage with each NHS Provider Trust in the East Midlands and based on each Trust's own self-assessment, support a review of progress against the Prevention Top Ten recommendations for Provider organisations.
- In doing this, to (a) identify any opportunities or barriers to further prevention work; (b) provide or facilitate support as appropriate (c) develop appropriate connections with and between the NHS Providers and the wider Public Health system and (d) identify areas of good practice for potential dissemination.
- Analyse and write up key findings from the supported self-assessments and issues arising from discussions, including identifying further actions agreed and/or recommendations
- Disseminate findings to audiences as agreed with key stakeholders

The purpose of undertaking a review of progress was to increase the usefulness and influence of the original report on '*The Prevention Challenge'* and further harness the preventative potential of NHS organisations. As well as 'holding up a mirror' to help Trusts identify their own progress, it was intended to generate discussion about the prevention agenda with and within each NHS Provider Trust, to stimulate further prevention action, to share good practice and to offer encouragement and support.

The remainder of this report provides details about this work, including self-assessed strengths and next steps for each organisation together with a discussion of key themes, some conclusions and reflections.

2. The East Midlands Population – Health Issues

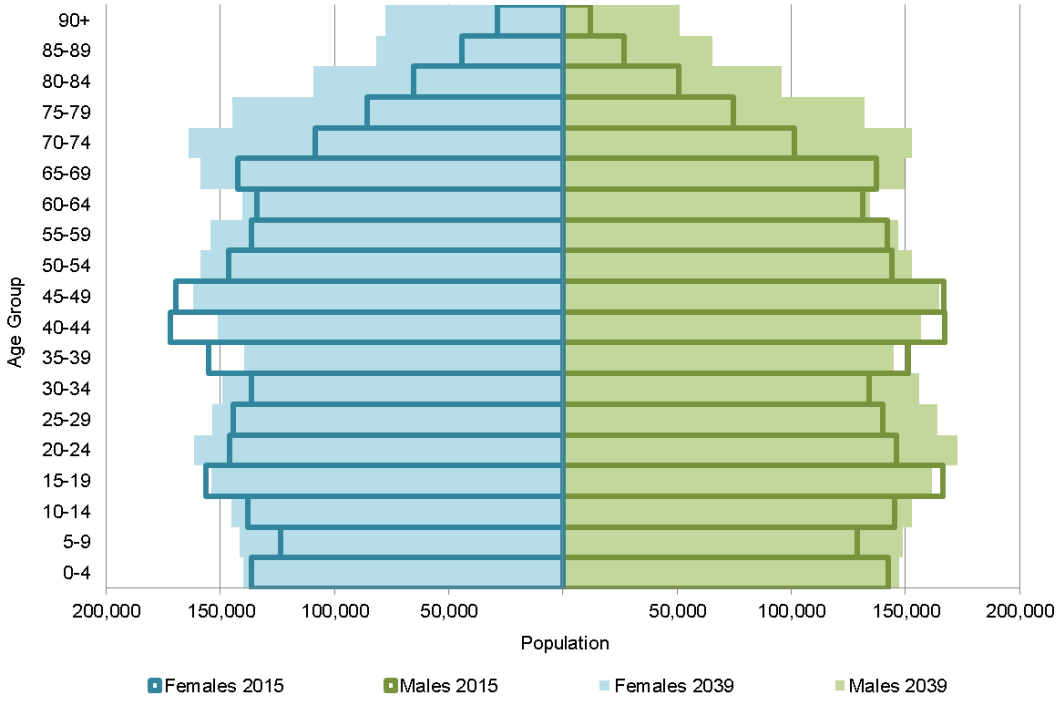
2.1 Summary

In the East Midlands, the population is both growing and ageing. People are living longer in ill health and this is particularly true for those in the more deprived groups who are likely to have more complex needs. The most common causes of ill health in the East Midlands are due to lifestyle factors such as diet, smoking and alcohol or obesity and this means that ill health is largely preventable ie by adopting healthier lifestyle habits; many people could avoid or delay the onset of illness to later in life. Although preventable deaths in the East Midlands have decreased in recent years, indicators for 'unhealthy' lifestyle factors are stabilising across the region and in general show little improvement over time. This means that, without significant action to change this trajectory, we can expect to see the most common causes of ill health continuing to result in more people living longer but in poor health.

2.2 The ageing population

In 2015, the population of the East Midlands was estimated to be 4,677,038 people; of these, 877,557 were aged over 65, corresponding to 18.7% of the population (Figure 1). By 2039, the population is projected to have risen to 5,338,800 people, of whom 1,382,600 will be aged over 65. This will equate to approximately 25% of the East Midlands population.

Figure 1: Mid-2015 population estimates and 2039 population projections by age group and sex for the East Midlands. Source: ONS



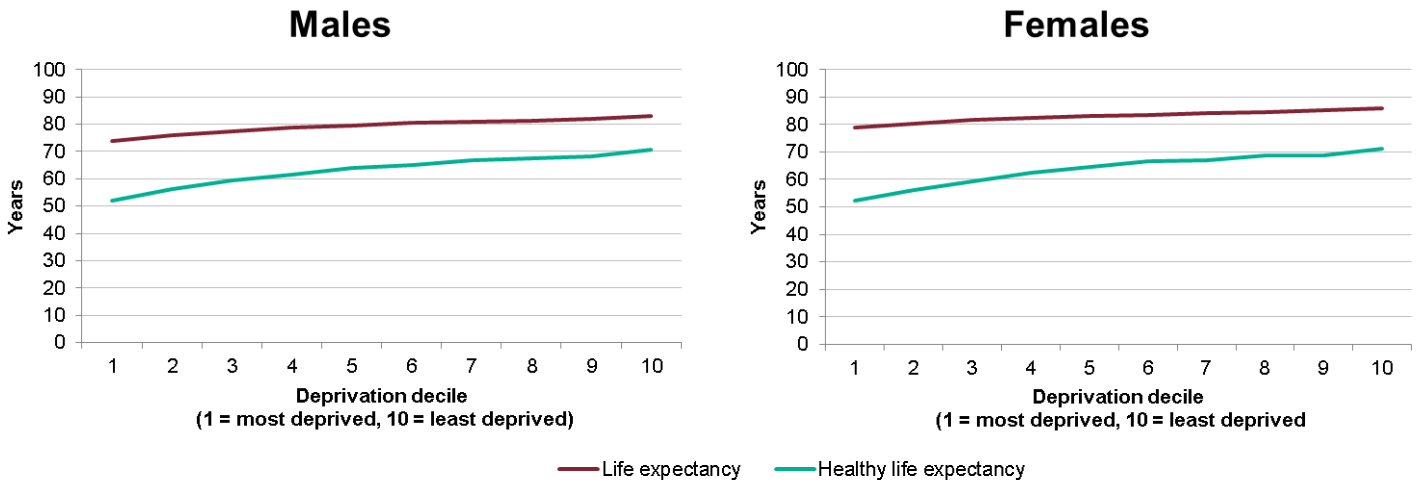
2.3 Life expectancy and 'the window of need'

Life expectancy at birth has gradually increased since 2001 to 2003 in the East Midlands. In 2013 to 2015, the highest life expectancy at birth was in Rutland for both males and females at 81.8 years and 85.2 years respectively, while the lowest were in Nottingham at 76.8 years and 81.4 years respectively. The average life expectancy at birth across the East Midlands as a whole is 79.3 years for males and 82.9 years for females, both significantly lower than the national average.

Healthy life expectancy, which is the number of years lived in good health, has remained stable since 2009 to 2011, with the highest in Rutland and the lowest in Nottingham for both males and females. In the East Midlands in 2013 to 2015, the healthy life expectancy was 62.5 years for males (significantly worse than the national average) and 63.5 years for females (similar to the national average).

There is a correlation between life expectancy and deprivation and between healthy life expectancy and deprivation. As shown in Figure 2, people in the least deprived deciles of the population have a higher life expectancy and live a greater number of years in good health than people in the most deprived deciles.

Figure 2: Life expectancy and healthy life expectancy at birth for males and females, East Midlands, England, 2013 to 2015. Source: PHOF

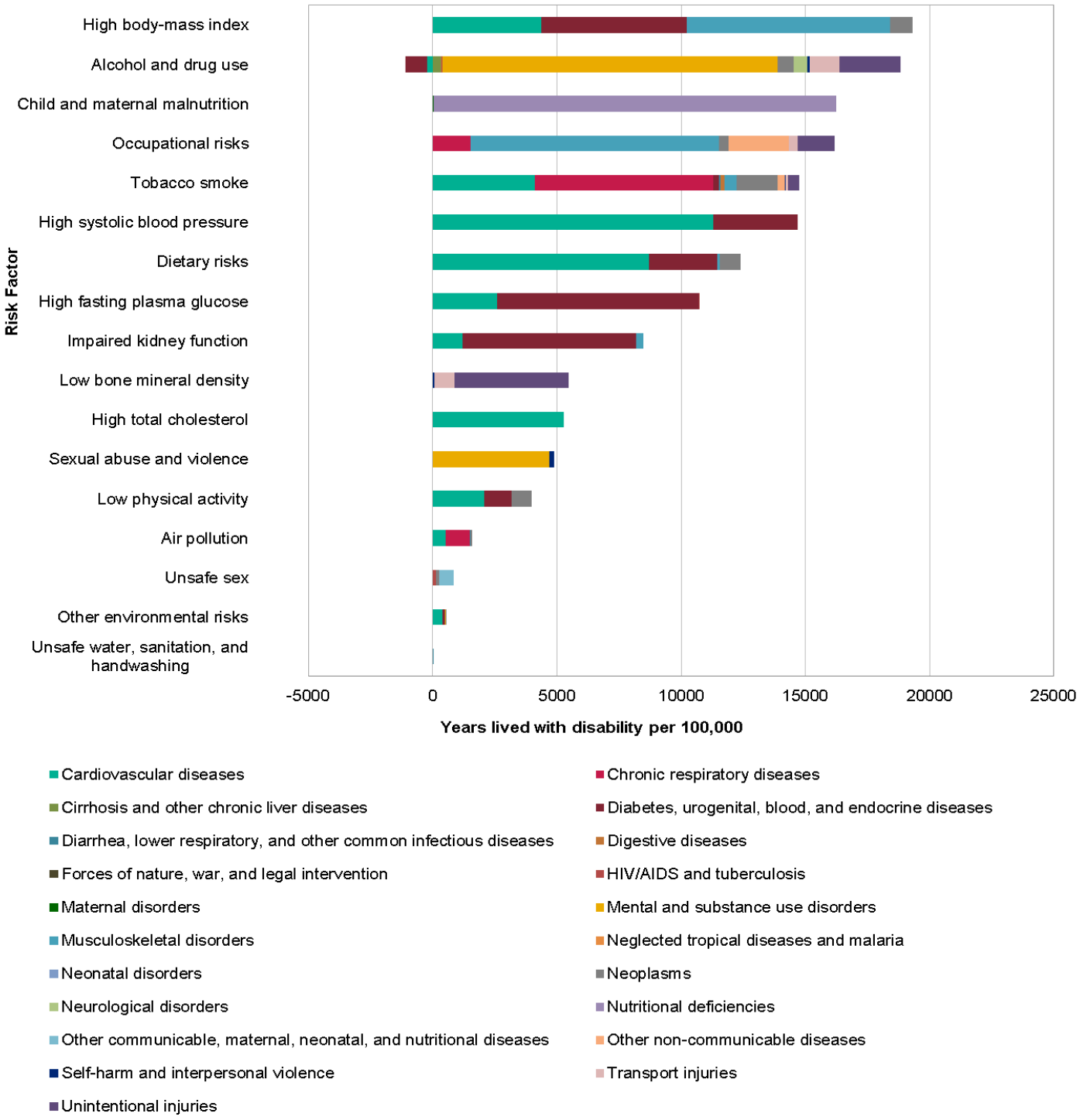


The gap between life expectancy and healthy life expectancy is referred to as 'the window of need', and is the number of years that an individual can expect to live in ill health, almost certainly with the support of health and care services. In England, a male living in the most deprived areas will live for 22.1 years in ill health, while a male in the least deprived areas will live for 12.5 years in ill health. Similarly, females in the most deprived areas will live for 26.7 years in ill health, compared with females in the least deprived areas who will live in ill health for 14.7 years.

2.4 Risks to health and causes of disability

The WHO Global Burden of Disease Study highlights the most common risk factors that lead to years lived in disability. In the East Midlands, the top 5 risk factors leading to years lived in disability are obesity, alcohol and drug use, poor diet, occupational risks and smoking, as shown in Figure 3. Many of the risk factors identified in the region lead to disability through cardiovascular diseases and diabetes, urogenital, blood and endocrine diseases.

Figure 3: Years lived with disability per 100,000 population by risk factor and cause of injury, East Midlands. Source: WHO Global Burden of Disease Study 2015



3. Methodology

3.1 Approach

The approach to this work sought to be generally collaborative, recognising that many colleagues were and are actively engaged in leading, delivering or supporting practical prevention initiatives through NHS Provider Trusts. Many leaders in NHS provider organisations are already committed to influencing the public's health via their prevention work as well as through their role as providers of treatment and care. The advent of Accountable Care Systems and Accountable Care Organisations can be expected to deepen this commitment. This review sought to add impetus, clarity and support to existing prevention efforts without cutting across existing processes or relationships.

Also, whilst Public Health England (PHE) has a role to provide system leadership to protect and improve the public's health, PHE does not have any mandate to develop direct local public health interventions or to measure or manage the performance of NHS Trusts. In light of this, it was important to seek and secure system-wide support for this review at the outset.

3.2 Securing System-wide Support

At the East Midlands Clinical Senate Council meeting on 4th October 2016 there was strong support for undertaking a collaborative review of progress including support for the development of a self-assessment tool. It was noted that this should encourage Trusts to draw from current activity on prevention and align it with *The Prevention Challenge* recommendations and should seek to ensure future-proofing and delivery of STP priorities. Subject to introductory discussions with stakeholder groups, it was agreed that a self-assessment tool should be developed to enable supported self-assessment by NHS Provider Trusts. Discussions with nominated contacts in each organisation could then then take place to more fully explore progress, opportunities and/or barriers in each NHS Provider Trust and to stimulate further action.

Proposals for a review of prevention progress 'One Year On' were discussed and agreed with the East Midlands Directors of Public Health and with the East Midlands Acute Trust Chief Executives through their respective fora towards the end of 2016. Following an introductory e-mail from Dr Peter Miller, CEO of Leicestershire Partnership NHS Trust, Community and Mental Health NHS Trusts were contacted individually to seek the support of their Chief Executives for this work to take place with their respective organisations. Alongside this, the approach was discussed with the East Midlands CCG Congress on 18th November 2016 where CCGs supported the proposed

review and also agreed to participate in a self-assessment of their own progress towards delivering the 'Commissioner Top Ten' recommendations of *the Prevention Challenge* report.

These contacts and discussions with organisational and system leaders provided the mandate and necessary high level support to take the work forward with both NHS Provider Trusts and CCGs in the East Midlands.

3.3 Self-Assessment Tool

A self-assessment tool was developed specifically for use by NHS Provider Trusts. This was based on the key recommendations of the Prevention Challenge report, sub-divided where this might be helpful. Other relevant guidance such as Public Health guidance from the National Institute for Health and Care Excellence (NICE) was also used to inform the development of the tool and existing standards such as the World Health Organisation's Standards for Health Promotion in Hospitals were also used. Links to all supporting documents and guidance were provided within the self-assessment tool.

The self-assessment tool was developed as an excel spreadsheet consisting of 41 questions or statements about prevention practice as detailed in appendix 1. The tool enables rating of embeddedness against a 4-point scale; from "cannot demonstrate…" to "systematic across whole organisation" within the following 5 domains:

- Leadership, Management and Policy
- Patient Contact and Assessment
- Patient and Visitors Information and Intervention
- Promoting a Healthy Workplace
- Tackling Health Inequalities

Completion of the tool required each NHS Trust to apply a self-assessment score to the organisation's practice on each question or issue. As far as possible, Lead Directors and other participants were encouraged to use the discipline of applying a score to help them to reach a judgement about the extent to which good practice has become systematic.

3.4 Scope

The scope of the review included all NHS Provider Trusts located in the East Midlands. On this basis, the following organisations were approached and invited to participate:

Acute Hospital Trusts

- Chesterfield Royal Hospital NHS Foundation Trust
- Derby Hospitals NHS Foundation Trust
- Kettering General Hospital NHS Foundation Trust
- Northampton General Hospital NHS Trust
- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- University Hospitals of Leicester NHS Trust
- **Community and/or Mental Health Services Trusts**
- Derbyshire Community Health Services NHS Trust
- Derbyshire Healthcare NHS Foundation Trust
- Leicestershire Partnership NHS Trust
- Lincolnshire Community Health Services NHs Trust
- Lincolnshire Partnership NHS Foundation Trust
- Northamptonshire Healthcare NHS Foundation Trust
- Nottinghamshire Healthcare NHS Trust

We also made contact with East Midlands Ambulance Service (EMAS) to promote the report and self-assessment approach. However there was not sufficient capacity to support further adaptation or application of the self-assessment tool with EMAS.

3.5 Supported Self-Assessments

The first point of contact in each Trust was the Chief Executive and in most cases the first substantive discussion about the content and timing of the review was held with each organisation's Chief Executive. In most cases, Chief Executives nominated a Director to lead the self-assessment process for their organisation. Following an introductory telephone conversation with the nominated lead Director, the self-assessment tool was provided so that they could consider how best to facilitate the self-assessment process in their respective organisation. Arrangements were made to gather the necessary information prior to a supported self-assessment meeting with Deb Watson, Consultant in Healthcare public Health employed by Public Health England. In a small number of cases, other Public Health colleagues also attended self-assessment meetings, either to observe or to offer additional support or both.

Some Trusts gathered self-assessment information and evidence to enable them to complete the tool in advance of a self-assessment meeting. In other Trusts, lead Directors simply invited relevant colleagues to participate in a workshop-style supported self-assessment discussion in which the tool was completed 'live' on the basis of the collective knowledge and judgements of the participants. Self-assessment meetings

lasted between one hour and 2 and a half hours, involving between one and eight participants with arrangements at the discretion of the Trust's nominated Lead Director. In several organisations, the constraints of time and very busy diaries meant that some key colleagues were not able to participate in these discussions or that there was insufficient time to complete the process. As far as possible, details were picked up with individuals after the meeting but the practical constraints meant that some gaps in self-assessments were inevitable.

Where time allowed at the end of the self-assessment conversations, Lead Directors and their colleagues were asked to reflect on the self-assessment and to identify a few key strengths in their organisation's practice or progress as well as to identify next steps for the organisation's work on prevention. Where time did not allow for this, these reflections were captured as far as possible by telephone or by e-mail at a later date. The 'strengths' and 'next steps' set out for each organisation in section 5 below were those that were identified at or close to the time of each Trust's self-assessment.

3.6. Completed Self-Assessments

Self-assessments were completed by the following NHS Trusts and meetings were held to discuss them between December 2016 and June 2017:

Acute Hospital Trusts

- Chesterfield Royal Hospital NHS Foundation Trust - 13th February 2017
- Derby Hospitals NHS Foundation Trust - 8th February 2017
- Northampton General Hospital NHS Trust - 9th March 2017
- Nottingham University Hospitals NHS Trust - 9th May 2017
- Sherwood Forest Hospitals NHS Foundation Trust - 21st March 2017
- United Lincolnshire Hospitals NHS Trust - 23rd June 2017
- University Hospitals of Leicester NHS Trust - 28th March 2017

Community and/or Mental Health Trusts

- Derbyshire Community Health Services NHS Trust - 22nd February 2017
- Derbyshire Healthcare NHS Foundation Trust - 22nd March 2017
- Leicestershire Partnership NHS Trust - 6th February 2017
- Northamptonshire Healthcare NHS Foundation Trust - 7th March 2017
- Nottinghamshire Healthcare NHS Foundation Trust - 15th December 2016

For a variety of reasons, it was not possible to include self-assessments with the 3 other NHS Provider Trusts in the East Midlands. This was mainly due to issues of capacity and/or the timing of this work clashing with other priorities such as CQC visits, winter/bed pressures or significant changes in key leadership roles.

The use of a supported self-assessment approach was designed to enable genuine engagement by participants and importantly to help to ensure ownership of the assessment and next steps. It was agreed with each Trust at the outset that their completed self-assessments would simply be theirs to use in whatever way might further support the prevention agenda within the organisation. It was agreed that PHE would not publish or share the self-assessments, enabling Trusts to treat the process as an internal 'warts and all' opportunity to genuinely understand their progress and determine next steps through a process of continuous improvement. It was agreed however that PHE would publish the self-assessed 'strengths' for each organisation as well as their 'next steps' on prevention. PHE has encouraged Trusts to share their self-assessments as appropriate with other partners in their local Sustainability and Transformation Plans to support system wide approaches to prevention.

4. Self-Assessed Strengths and Next Steps

This section details the 'strengths' and 'next steps' identified and/or agreed by each organisation following their engagement in the self-assessment process. Whilst progress has since moved on in many Trusts, the details below provide a snapshot taken at or close to the time of each Trust's self-assessment.

4.1 Acute Hospital Trusts

4.1.1 Chesterfield Royal Hospital NHS Foundation Trust

Strengths

1. The Trust has identified a Board Level Champion for Prevention and has developed a Strategic Plan for Prevention setting out how the Trust will deliver against the agenda of ill-health prevention for staff, patients and the wider population of North Derbyshire. This '*Five Year Forward View for Prevention - Framework for Action'* has been agreed by the Trust Board and it is in line with the ambitions of the Derbyshire STP as well as aligned with the recommendations of the Prevention Challenge report.
2. The Trust has an established Health and Wellbeing Committee and has made good progress on initiatives to improve staff Health and Wellbeing, supported by the CQUIN incentive for staff health and wellbeing in 2016/17. This includes staff uptake of flu vaccine above 75% this year.
3. A staff health needs assessment has recently been undertaken by the Trust and analysis of this will be used to inform future work.
4. The Trust has developed a Multi-disciplinary Admission and Discharge proforma booklet which incorporates brief assessments on alcohol and substance use as

well as recording smoking status and prompts about offering brief advice to patients. At the time of the self-assessment, this was in draft and planned to be launched in April 2017.

5. The Trust relaunched as a smoke free site in July 2016, raised the profile of smoking cessation support services for staff and implemented measures to support staff to feel able to approach anyone smoking on site.

Next Steps

1. To develop a SMART action plan to implement the trust's 'Five Year Forward View Plan for Prevention - Framework for Action', enabling the Hospital Leadership Team and the People Committee of the Board to both manage the implementation of agreed actions on Prevention and to provide assurance to the Board.
2. As part of the above, to adopt a 'Making Every Contact Count' (MECC) approach within the delivery of all services, supported by necessary staff training, the details of which are to be identified within a training needs assessment.
3. To review leaflets to ensure consistent signposting to support services within outpatient clinics.
4. To relaunch Chesterfield Royal Hospital as a 'no-smoking' site with new signage in October 2017.

4.1.2 Derby Hospitals NHS Foundation Trust

Strengths

1. The Trust has as developed an approach to holistic patient history taking which includes lifestyle and other risk factors. An example of this is used by the Frail Elderly Assessment Team (FEAT). This approach is being rolled out to other parts of the hospital eg with elective surgical patients with the intention that it becomes standardised.
2. The Trust has an established Workplace Health Group and an existing Health and Wellbeing for Work Strategy. Through these, the Trust has made good progress on initiatives to improve staff Health and Wellbeing, supported by the CQUIN incentive for staff health and wellbeing in 2016/17. This includes staff uptake of flu vaccine of 75.2% this year.
3. The Trust won an NHS Sustainability Award for its Travel Plan and was commended for its efforts to engage staff in this, including encouraging walking and cycling.
4. The Trust has launched a Health and Wellbeing App offering guidance and support for staff working in the hospital. The App contains info about Trust policies, processes and support available in the workplace as well as advice on improving health and wellbeing.

5. The Trust has successfully implemented the CQUIN recommendations for healthy eating.

Next Steps

1. To consider the nomination of a Board level Champion for Prevention
2. To consider other ways in which the governance of Prevention work might be strengthened, particularly to consider the incorporation of Prevention as an explicit strand within the new People Strategy which was in the early stages of development at the time of the self-assessment.
3. To strengthen the audit and evaluation of approaches to health and wellbeing for both staff and patients. This may include undertaking an audit to establish the extent to which holistic history taking is embedded across the hospital and/or an evaluation of provision of brief interventions relating to lifestyle factors such as smoking and alcohol.
   In doing this, the Trust has identified that one of the biggest challenges to overcome in the next period will be to ensure that its IT systems can capture the necessary data about activity and then interface with external providers of services to see if patients actually follow their referral through.

4.1.3 Northampton General Hospital NHS Trust

Strengths

1. Considerable progress on staff Health and Wellbeing, (driven through the Health and Wellbeing Sub-Group) and supported by the CQUIN incentive for staff health and wellbeing in 2016/17. Progress includes 79.3% uptake of the flu vaccine this year.
2. The Trust has a Sustainability Strategy in place which includes a number of measures of progress on relevant issues such as carbon reduction. These are reported annually to the Board. The Trust is one of the top 39 Trusts nationally in terms of NHS reporting on sustainability
3. The Trust has a Bronze Award from the Soil Association in recognition of progress made towards the procurement, preparation and provision of healthy foods
4. The Trust has a Food Policy in place covering food for both staff and patients.

Next Steps

1. To consider the nomination of a Board level Champion for Prevention
2. To incorporate Prevention explicitly in the next Clinical Services Strategy which is due to be re-developed in April 2018

3. To develop and implement a plan to reinvigorate the Trust's approach to 'Making Every Contact Count' (MECC), recognising that further practical actions are required to support and embed this across the organisation
4. As part of the above, to re-consider the Trust's approach to MECC staff training, seeking to ensure that all clinical staff have the knowledge and confidence to talk to patients appropriately about the impact of their lifestyle choices on their health and to deliver brief interventions and/or make referrals to support services as appropriate.

4.1.4 Nottingham University Hospitals NHS Trust

Strengths

1. Considerable progress has been made on staff Health and Wellbeing including NUH being identified by NHS England as an exemplar site for its Healthy Workforce Programme in 2016/17. Well-developed work in this area includes taking action based on staff health needs assessments and the analysis of NHS Healthy Workforce Survey results for the Trust, benchmarked against other exemplar sites.
2. The Trust was highly commended by NHS Employers in the 2016/17 Innovative 'Flu Fighter' awards after its campaign increased the uptake of staff flu vaccination to 66.2% in 2016/17 from 42.87% in the previous year. As part of this, NUH developed a bespoke Flu App, used by its large cohort of peer vaccinators to capture data on uptake in real time.
3. The Trust has well-developed work on smoking prevention as part of Nottingham City's Tobacco Control Strategy and has committed to an increased strategic focus on this work to fully implement NICE Public Health Guideline on Smoking for acute, maternity and mental health services (PH48).
4. The Trust has a strong focus on prevention embedded in some areas of clinical practice, appropriately targeted towards high risk populations.
5. The Trust has a strong patient and public focus which is a key part of its prevention model.

Next Steps

1. To consider the nomination of a Board level Champion for Prevention
2. To develop a concept and framework for Prevention/Public Health for the Trust, bringing together current responsibilities and new efforts on prevention into a coherent plan. This will enable the Trust to link the various work streams around the STP, MECC, and CQUIN rather than thinking of these as separate components. It will also include up-dating the Trust's plan for improving staff health and well-being

3. To develop and implement a plan to reinvigorate the Trust's approach to 'Making Every Contact Count' (MECC), recognising that further practical actions are required to fully adopt and embed this philosophy across all areas of clinical practice.
4. As part of the above, to re-consider the Trust's approach to MECC staff training, seeking to ensure that all clinical staff have the knowledge and confidence to talk to patients appropriately about the impact of their lifestyle choices on their health conditions, to deliver brief interventions and advice and/or make referrals to support services as appropriate. This work will underpin delivery of the new CQUIN incentive on Preventing Ill health by Risky Behaviours, focusing on smoking and alcohol.
5. The Trust will review the extent to which the organisation has implemented NICE guidance on workplace health and will address any identified gaps as part of up-dating the plan for staff health and wellbeing.

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4.1.5 Sherwood Forest Hospitals NHS Foundation Trust

Strengths

1. The Trust has made considerable progress on staff Health and Wellbeing, working through the Health and Wellbeing Committee and supported by the CQUIN incentive for staff health and wellbeing in 2016/17. Progress includes uptake of the flu vaccine by over 75% of frontline staff this year.
2. The Trust maintains a comprehensive Library and Information service at Kings Mill Hospital which provides information and evidence to support clinicians, managers, patients and visitors via book loans, leaflets and other resources, literature searching and outreach services. This service supports the prevention agenda in a number of ways and it is free and open to all SFH staff plus staff working for the CCGs and Public Health Team in Nottinghamshire.
3. The Trust is a partner in Mid-Nottinghamshire's Better Together Vanguard Alliance which is seeking to focus on prevention of ill-health as well as joining up health and social care more effectively in future.

Next Steps

1. To consider the formal nomination of a Board level Champion for Prevention
2. To consider other ways in which the leadership and governance of Prevention work might be strengthened, including developing an explicit Trust plan for prevention and/or incorporation of regular items about prevention issues on relevant Committee agendas and/or embedding prevention within the Trust's Quality and Assurance programme

3. To review the progress and effectiveness of the Trust's work on 'Making Every Contact Count' (MECC) and to develop a plan to revise and strengthen this as necessary
4. To actively consider how to embed and build on the positive momentum created through the current CQUIN measures, for example by undertaking an audit of current practice against NICE guidance on workplace health

4.1.6 United Lincolnshire Hospitals NHS Trust

Strengths

1. The Trust's role in promoting health, wellbeing and the prevention agenda is explicitly recognised within several of ULHT's key strategic documents. An approved 'People Strategy' includes an objective about 'keeping people well and healthy' and includes a measure to enable performance to be assessed for the outcome 'Having real concern for the health and wellbeing of staff, recognising the part they play in the prevention and self-care agenda'. The strategy sets out a number of actions to support staff health and wellbeing over the next 4-5 years.
2. The Trust has made progress in relation to staff health and wellbeing, supported by the CQUIN incentive for staff health and wellbeing in 2016/17. This includes the provision of healthy food options and as well as strengthening support for physical activity. In 2016/17, the Trust increased the up-take flu vaccine among frontline staff and extended the range of initiatives to respond to the main causes of sickness absence with a particular focus on supporting mental health
3. The Trust has an approved Staff Engagement Strategy and action plan. A Staff Engagement Group meets bi-monthly, is chaired by the Chief Executive and considers issues relating to staff wellbeing as part of its work
4. The Trust has developed a Green Transport Plan and has an approved Sustainable Development Management Plan which includes among its objectives to (a) create a healthier environment in which care is delivered for both patients and staff; and (b) to ensure that among our working practices, "Every opportunity contributes to healthy lives, healthy communities and healthy environments".

Next Steps

1. To consider the nomination of a Board level Champion for Prevention
2. The Trust is currently implementing a 'smoking-free' policy on all of its hospital sites. As part of this implementation, the Trust will consider appropriate ways in which enforcement of this policy can be further facilitated and staff further supported.
3. To further strengthen delivery of initiatives to improve the health and wellbeing of staff, including implementing a comprehensive plan for the 2017/18 flu campaign.

4. To consider how best to re-establish and embed policy and procedures relating to holistic patient history taking and the appropriate delivery of brief interventions, advice and referrals. This will build on the foundations of previous work at ULHT to deliver the CQUIN on Making Every Contact Count (MECC) as well as on existing good practice within the Trust which is not yet systematic. It will also underpin delivery of the new CQUIN incentive on' Preventing Ill Health by Risky Behaviours', which focuses on smoking and alcohol issues.
5. To work with partners in the Lincolnshire STP to develop a system-wide approach to the prevention agenda, identifying the particular actions which are the responsibility of ULHT and its staff.

4.1.7 University Hospitals of Leicester NHS Trust

Strengths

1. The Trust has developed 'Looking after UHL', a Health and Wellbeing Strategy 2016 to 2019 which has 3 ambitions and sets out a delivery plan of actions for them. The ambitions are: that every employee will be supported to maintain and improve their health; every patient contact will count for promoting health and wellbeing and the wider community will benefit through UHL's involvement in broader health and wellbeing agendas.
2. Good progress has been made on staff Health and Wellbeing in 2016 to 2017, including arrangements to ensure access to healthy food, supported by the CQUIN incentive for staff health and wellbeing in 2016 to 2017. Also, in 2016 to 2017, there was a key focus on stress management and emotional resilience training for staff in response to continued high demands on services and a large number of staff comments about high levels of demand reported in UHL's quarterly Pulse Check Survey of staff engagement.
3. In 2016 to 2017, UHL achieved over 75% uptake of flu vaccine by frontline staff members which represented considerable improvement on uptake in 2015 to 2016 of 63%.
4. The Trust's Occupational Health service delivers strong performance in terms of helping people return to work quickly after a period of sickness absence.

Next Steps

1. To consider the formal nomination of a Board level Champion for Prevention
2. To refresh and further strengthen the 'Looking after UHL' Strategy to ensure that there is a single plan for the Trust's Prevention activities that can be realistically enacted over the next 3 years. The plan will bring together the following: the full implementation of NICE Public Health Guideline PH48 on smoking for acute, maternity and mental health Trusts; delivery of the 2017 to 2019 CQUIN including the new incentive on Preventing Ill health by Risky Behaviours focusing on

smoking and alcohol; prevention activities planned as part of wider STP Prevention workstream; and lessons learned from a stocktake of prevention progress so far.
3. As part of the above, to develop and implement a plan to reinvigorate the Trust's approach to 'Making Every Contact Count' (MECC), recognising that further practical actions including further staff training will be required for UHL to fully adopt and embed this approach across all areas of clinical practice.
4. UHL will support staff-led change to deliver on the prevention agenda using 'Listening into Action' and other staff engagement mechanisms to shape practical implementation.

4.2 Community and Mental Health Trusts

4.2.1 Derbyshire Community Health Services NHS Trust

Strengths

1. The DCHS Clinical Strategy and Operational Plans are explicitly based on a commitment to prevention and promoting public health. DCHS describes itself as a Public Health Organisation 'Getting Serious about Prevention' with commitments to action on: Healthcare Public Health, Improving the wider determinants of health, health improvement and Health protection.
2. The Trusts has appointed a Consultant in Public Health as an explicit commitment to the organisation's Public Health ambitions. This is seen by the Trust as a key step in building the organisations capacity to further define its Public Health ambitions and to deliver on them. This capacity has enabled the Trust to be proactive in developing discussions around 'place' within the context of STP delivery.
3. Good progress has been made on staff Health and Wellbeing, supported by the CQUIN incentive for staff health and wellbeing in 2016 to 2017. DCHS is currently conducting a needs assessment relating to staff Health and wellbeing.
4. The Trust has a Sustainable Development Management Plan in place which identifies how the organisation will meet its corporate and social responsibilities. This includes targets and measures of progress based on the NHS Sustainable Development Unit's Good Corporate Citizen Assessment Model which are reported to the Board. The Trust already has a good track record in relation to carbon reduction and green travel and has recognised the areas of procurement and workforce as key area to focus on in future.

Next Steps

1. To consider the formal nomination of a Board level Champion for Prevention
2. To implement the public health ambitions of the organisations Clinical Strategy and Operational Plan
3. To develop an over-arching plan for staff well-being, in light of the findings of the current staff health needs assessment
4. To review the Trust's approach to the delivery of MECC staff training, once the commissioned service is transferred in November 2017, to improve the confidence of staff to draw on the principles of MECC by engaging in difficult conversations when appropriate.
5. To develop a Food Policy covering food for both staff and patients.

4.2.2 Derbyshire Healthcare NHS Foundation Trust

Strengths

1. Prevention is an explicit strand within the Trust's Corporate Strategy 2016 to 2021.
2. The Trust has maintained its approach and commitment to Making Every Contact Count (MECC)
3. The Trust is a member of the Carers Trust's 'Triangle of Care' Scheme having completed a self-assessment for Stage One and undertaking Stage Two. Membership of the Triangle of Care Scheme signals the Trust's commitment to ensuring the culture of the Trust is one that is inclusive and supportive for Carers.
4. The Trust has taken a proactive approach to promoting healthy eating. This has been further supported and embedded through work on the CQUIN incentive for staff health and wellbeing in 2016 to 2017 and 2017 to 2018.
5. The Trust works proactively with wider partners to support preventative work for example, work to facilitate GPs Annual Health Checks for people with serious mental Illness and for people with a learning disability.
6. The Trust promotes the prevention agenda amongst staff eg access to smoking cessation, employee assistance, healthy eating at work.

Next Steps

1. To consider formalising the current designation of the Trust's Board level Champion for Prevention
2. To consider additional ways in which arrangements for the leadership and governance of Prevention work might be strengthened.
3. To review the progress and effectiveness of the Trust's work to promote the uptake of seasonal flu vaccine by frontline staff members and to develop a plan in order to improve uptake in future years

4. To actively consider undertaking audit work to confirm the extent of embeddedness of the MECC approach and more use of existing data to evaluate the effectiveness of Making Every Contact Count (MECC)
5. To more actively promote the availability of health checks to staff over 40 years of age.

4.2.3 Leicestershire Partnership NHS Trust

Strengths

1. The Trust has developed a Strategic Approach to Staff Health and Wellbeing 2017 to 2020 and has made good progress on initiatives to improve staff Health and Wellbeing, supported by the CQUIN incentive for staff health and wellbeing in 2016 to 2017. This includes the use of an online Wellbeing Zone to help staff take control of their own health.
2. The Trust has a Corporate Social Responsibility Strategy in place which sets out how Leicestershire Partnership Trust will contribute to the local community and the wider environment in terms of transport, community building, procurement and estates. This includes encouraging staff to volunteer as 'Good LPT Citizens' in the local community by providing 2 paid days per year for volunteering.
3. The Trust's Clinical Strategy includes a Strategic aim of 'Helping People to Stay Healthy and Well' and this sets out the ways in which LPT will seek to do this, including using staff as health promoting partners through the 'Making Every Contact Count' (MECC) initiative
4. The Trust has taken a systematic approach to ensuring that the staff voice is incorporated into decisions. A variety of arrangements are in place for listening to and engaging staff, including a recent 7th cohort of staff engaged in a 'Listening into Action' (LiA) programme.

Next Steps

1. To consider the nomination of a Board level Champion for Prevention
2. To consider further strengthening the Trust's approach to 'Making Every Contact Count' (MECC), recognising that further practical actions may be required to embed this across the organisation, including using data about the delivery of brief interventions and advice to patients in order to evaluate and inform further progress on MECC
3. To develop specific actions relating to reducing alcohol-related harm, encouraging those staff that drink alcohol to do so only within recommended limits.

4.2.4 Northamptonshire Healthcare NHS Foundation Trust

Strengths

1. The Trust is an active formal partner in First for Wellbeing; a Community Interest Company focused on managing and improving the health of the Northamptonshire population and has also acquired a share in a GP Federation enabling the Trust to actively strengthen the preventative work of Primary Care.
2. Considerable progress has been made on staff Health and Wellbeing, supported by the CQUIN incentive for staff health and wellbeing in 2016 to 2017 on staff health and wellbeing. Progress includes 77.2% uptake of the flu vaccine in 2016 to 2017.
3. The Trust has regular discussions with commissioners about issues relating to Prevention, including being constructively challenged in relation to this agenda. The Trust actively welcomes the encouragement and support of commissioners in relation to its work on Prevention and Public Health
4. The Trust has robust processes in place for Quality and Equality Impact Assessments and these assessments include elements (such as impact on staff wellbeing and impact on disadvantaged groups) that help to support the Prevention agenda.

Next Steps

1. To re-consider the Trust's approach to mandatory 'Making Every Contact Count' (MECC) training for staff and specifically to consider re-introducing an actively taught session on MECC as part of induction training. The Trust is seeking to ensure that all clinical staff have the knowledge and confidence to talk to patients appropriately about the impact of their lifestyle choices on their health conditions and to deliver brief interventions and/or make referrals to support services as appropriate.
2. To actively consider how to embed and build on the positive momentum created through the CQUIN incentive for staff health and wellbeing in 2016 to 2017.
3. To develop and implement a communications plan relating to reducing alcohol-related harm, including recognition of the recommended limits of alcohol consumption.
4. To implement measures to ensure that all Trust sites become completely smoke-free from 1st April 2017, including strategies to support staff to feel able to approach anyone smoking on site.
5. As part of the Trust's commitment to Prevention, to explore how to improve the use of data to evaluate and continuously improve.

4.2.5 Nottinghamshire Healthcare NHS Foundation Trust

Strengths

1. The Trust has an over-arching Strategic Public Health Framework which incorporates the 3 domains of Public Health practice (Health Protection; Health Improvement; and Improving services) through the work of the Trust. The implementation of the Strategy is driven by a senior clinician with specialist Public Health skills, including in the systematic use of data to analyse health needs, to target services and to track progress across population segments.
2. The Trust has well-developed governance arrangements for its Prevention work, including the Deputy Trust Chair's role as a Prevention Champion and the requirement for regular reporting to the Board on progress against the Public Health Strategy.
3. The Trust has a strong and successful on-going programme of work on smoking and tobacco control, including a specific programme of staff training on smoking cessation which is of benefit to both staff and patients. The Trust now supports the use of e-cigarettes as a route for Nicotine Replacement Therapy (NRT).
4. Working with others, the Trust has a plan to enable data to be extracted on improving physical health, including tracking the delivery of brief interventions on lifestyle. This work includes the Trust having linked access to data on prevention in Primary Care supported by the NHS IT Portal work in Nottinghamshire.
5. The Trust is actively engaged with partners in the development and implementation of the Nottinghamshire Sustainability and Transformation Plan (STP), with a particular role in driving innovative work on mental health and prevention as part of the Rushcliffe CCG's 'Vanguard' development of a multispecialty community provider. Specific projects aimed at Parity of Esteem for people with serious mental illness are included in the work of the Vanguard.

Next Steps

1. To up-date the Trust's Public Health Strategy and associated action plan and to continue to systematically implement this.
2. To refresh the Trust's plans for improving physical healthcare, including further action on food and nutrition, as part of the Trust's commitment to the principle of parity of esteem.
3. To further develop the Trust's approach to Making Every Contact Count (MECC), particularly to meet the requirement of the 2017 to 2019 CQUIN on 'Preventing ill health by risky behaviours – alcohol and tobacco'.
4. Building on the Trust's smoke-free programme and mental wellbeing programme for staff, in 2017 the Trust plans to develop specific actions to encourage increased staff physical activity.

5. Utilising the Trust's recently established Clinical Development Unit, the Trust plans to increase the use of population healthcare data and building population healthcare capacity and competence in a wider group of staff across a range of disciplines, including establishing a base as a training location for PH registrars and Foundation doctors with a special emphasis on population healthcare/healthcare public health.
6. Development of a bespoke offer to improve access to the regional diabetes prevention programme for patients with SMI

5. Themes

5.1 Leadership, Management and Policy for Prevention

Board-Level Champions for Prevention
Three out of the 12 NHS Trusts have formally appointed a board-level Champion for Prevention. All of the remaining Trusts are considering appointing a board level Champion or formalising existing informal arrangements as one of their next steps. Some Trusts that have not yet appointed a board-level Champion for Prevention were keen to stress that they have suitable informal arrangements in place which are widely recognised and/or that they have a board-level champion for other activity that is strongly related to prevention such as staff health and wellbeing. Where Champions have already been formally appointed, the role is held by either an executive Director or a non-executive Director and one trust has appointed both an executive and a Non-Executive Champion. There is considerable variation with respect to where leadership for prevention sits within Trusts with Directors who have a range of different portfolios being identified as Prevention Champions or taking this role informally. There was discussion with some Trusts about the possibility of appointing both Clinical and Non-clinical Champions.

Governance of Prevention within Trusts
The extent to which the boards of NHS Trusts explicitly delegate various powers and manage responsibilities relating to prevention seems to differ considerably from one organisation to another. However, most Trusts have clear arrangements for overseeing the delivery of CQUIN incentives, including their staff Health and Wellbeing CQUIN performance in 2016 to 2017. Governance arrangements relating to wider aspects of prevention tend to be more explicitly developed in Trusts where an overarching plan for prevention activity has been set out. Governance arrangements seem to be clearer in relation to staff health and wellbeing than other aspects of prevention. As well as Workforce Sub-Committees, many Trusts have well-established Staff Health and Wellbeing groups overseeing and reporting on the delivery of plans and initiatives for staff health and wellbeing. These have become the natural delivery vehicles for action relating to the 2016 to 2017 CQUIN with progress often being reported to sub-committees of Trust Boards. There was less evidence of this type of arrangement or rigor in relation to the governance of prevention activities within patient contacts.

Commissioner Input and wider NHS Governance
With the possible exception of staff Health and Wellbeing CQUIN performance, only a few Trusts reported any meaningful dialogue with CCG commissioners seeking assurance about the Trust's prevention activity or with other external NHS bodies with an interest in the implementation of the NHS Five Year Forward View. One Trust cited their regular discussions with commissioners about prevention as one of their strengths

and 2 others reported their Trust taking a proactive role with commissioning colleagues over some aspects of STP discussions and developments. This suggests that while the NHS Five Year Forward View requires the NHS to deliver "a radical upgrade in prevention", the governance machinery of the NHS is not systematically prioritising this issue or regularly seeking assurance about the progress being made on prevention actions by NHS Providers eg through commissioning relationships.

In addition, one Trust commented that commissioning arrangements can themselves present a challenge to a provider Trust's work on prevention if they restrict the ability of Trusts to develop prevention work in a patient pathway. Prescriptive service specifications (for example linking payment to only one specific type of activity or target measurement) might inadvertently inhibit the ability of Providers to develop and embed other useful and evidence based prevention activity. Competing incentives within different commissioning specifications was also mentioned as something which can set Providers at odds with each other. It was suggested that system-wide work to address these issues would be helpful.

Strategic documents for Prevention

There is considerable variation about if and where prevention is embedded within NHS Trust's strategic documents. Only a few Trusts have an agreed Strategic Framework for Prevention or a high level Public Health Strategy document although 3 Trusts intend to develop a framework or long-term plan of this nature as part of their next steps.

Some Trusts already articulate some of their prevention ambitions through documents such as a Corporate Social Responsibility Strategy and/or have a clear prevention focus within their Corporate Strategies or workforce strategy and/or within their clinical strategy. Some Trusts reported their intention to strengthen the focus on prevention within the next iteration of various strategy documents. In most Trusts, different aspects of prevention are led and managed in different parts of organisation but there seemed to be better co-ordination and a firmer 'grip' on prevention progress in Trusts that have pulled this work together into over-arching plans. However, few Trusts believed that they already have a clear prevention 'golden thread' running through all key strategic documents. One Lead Director put it this way… "Is Prevention part of the organisation's DNA? No, I don't think so".

Capacity for prevention

Issues of limited resources and capacity were mentioned by a number of Trusts, with some Trusts reporting that this is a very significant issue, particularly in the face of rising demand for NHS care and heavy workloads in frontline services. In this context, it is clear that harnessing the prevention potential of any organisation does require time, energy and someone to plan, drive and organise the necessary activities. Discussions in this self-assessment process suggests that provider Trusts are increasingly embracing their role as a significant contributor to improving the public's health and they

are seeking to secure capacity and to formally identify people to lead, co-ordinate and help them deliver their part.

One Trust reported that the prevention agenda does not feature in the Trust's top priorities for the year due to limitations in both the capacity to lead and the capacity of the organisation to engage in this agenda amid more immediately pressing issues about the quality and safety of services and financial recovery. None-the-less, the Trust in question remains committed to doing more when capacity allows and will return to this agenda in 2018 to 2019.

Discussions between PHE and Directors of Public Health and with the East Midlands Public Health Training Network indicate a willingness on the part of the Public Health system to try to support Trusts in this work (eg through short term placements in Trusts of public health staff members or Public Health Specialty Registrars). *The Prevention Challenge: One Year On* has provided some opportunities to strengthen links between Trusts and public health partners, although local arrangements inevitably tend to be opportunistic and short term unless Trusts decide to invest in specialist capacity. One Trust was in the process of making arrangements for a Public Health Specialty Registrar to be placed with their occupational health services one day per week and 3 other Trusts were intending to seek similar arrangements as a result of this process.

Three Trusts were identified which currently employ or 'buy in' dedicated Public Health Consultant capacity. Where this capacity is focused on leading and supporting all of the domains of public health practice (ie health improvement, health protection and health services) across the Trust, it is clear that this has helped Trusts to understand the issues and opportunities and to make progress across a range of prevention priorities. One Community Trust noted that the appointment of Public Health Consultant was a very explicit commitment to the organisation's Public Health ambitions and a key step in building the capacity needed to define and deliver on these ambitions. This type of capacity may become more important as NHS Providers begin to take wider responsibility for the health of populations in emerging Accountable Care Organisations.

Prevention Impact Assessments

None of the Trusts have developed a systematic approach to considering how to maximise prevention impact as part of major decision-making. Several Trusts felt that some aspects of prevention are already included in their Equality Impact Assessment or Quality Impact Assessments which are embedded in the organisation's decision-making processes. One Trust reported that they are working up a prevention governance challenge into the Trust's Board and its 3 direct sub-committee papers for Quality Business, Quality Service and Quality People sub-committees, to ensure that decision making has included consideration of the specific public health impact of any proposals detailed in papers.

Smoke Free Sites

In light of the very considerable damage to health caused by cigarette smoking, the adoption of Smoke-Free policies by Trusts has been seen by many as a 'touchstone' issue indicating a Trust's appetite for its prevention role. As such, although this was not an explicit question in the self-assessment tool, the issue of smoke free policy was frequently discussed. All Trusts have undertaken work on becoming Smoke Free with all but 3 Trusts having policies in place at the time of their Prevention Challenge self-assessments that require all their buildings, grounds and vehicles to be completely smoke-free. Two Trusts had plans in place to become completely Smoke Free in the early part of 2017 to 2018.

One Trust currently has a policy of retaining smoking shelters in its grounds for use by patients in exceptional circumstances. This Trust does have a non-smoking policy in place but the policy allows for circumstances where staff might feel they need to make an assessment about a patient being permitted to smoke. In such circumstances a patient would be directed to the smoking shelters and permission to smoke in an outdoor area would only be given by the Matron or site manager. The Trust in question is developing a plan to fully implement the Public Health NICE guidelines (PH 48) on *Smoking: acute, maternity and mental health services* and as part of this, has been encouraged to consider its current policy position on retaining smoking shelters and giving permission for their use to patients in exceptional circumstances.

The approach taken by Trusts to securing Smoke Free status has varied, with some Trusts reporting considerable resistance to this change and staff reporting not feeling confident about discussing the Trust's Smoke Free status with people who are observed smoking on site. Additional measures have been taken by several Trusts, including delaying full implementation of smoke free status to allow time for additional staff training to be provided (eg on rapid provision of Nicotine Replacement Therapy for inpatients) and to enable other measures to increase staff confidence.

However, several Trusts referred to on-going concerns about the enforcement of their smoke free policies with one Trust describing their position as having "hit a wall" with people "not taking it as seriously as they should". This Trust is re-energising their campaign and trying some innovative ways of influencing people and a variety of approaches are being taken by other Trusts. One Trust has had a smoke-free policy in place since 2007 and is now teaming up with Protection Officers from the local council to patrol the site and help to enforce the ban on smoking anywhere in the grounds. In addition to smoke free signage, the best Trusts have taken a broad approach, listening to concerns and providing support for staff and patients in order to maximise the benefits of the policy.

Sustainability
The NHS standard contract includes a clause requiring Trusts to have a Sustainable Development Management Plan (SDMP) and to report annually on sustainability. In the context of discussions about prevention, some Trusts reported having these sustainability plans and/or policies in place and made appropriate connections between elements of these and the prevention agenda. Where these were discussed, it was noted that progress against targets for sustainability indicators do tend to be reported annually to the Board or a sub-committee of the Board. One Trust in the East Midlands reported its ranking as one of the top 39 Trusts nationally in terms of NHS reporting on sustainability.

5.2 Patient Contact and Assessment

The extent to which organisations have adopted approaches that embed holistic history-taking seems to vary considerably between Trusts and within Trusts. In some Trusts, lifestyle factors are systematically included in all inpatient history-taking at initial contact and assessment. In some places, key data fields and prompts relating to smoking and/or alcohol and/or weight and/or physical activity are included as mandatory in admission proformas such as multi-disciplinary admission and discharge booklets. In some Trusts, the approach to this differs between departments or specialties and a greater focus on lifestyle factors tended to be reported in relation to patients with cancer or respiratory illness and in midwifery.

Wider determinants of health including factors such as housing, debt, employment, and other social circumstances such as loneliness and isolation do not seem to be systematically assessed and were generally described as being most likely to be discussed as part of discharge planning, but only where this seemed relevant to facilitate discharge.

Information about patients' lifestyle and other risk factors does not seem to be reported consistently to GPs in discharge summaries Whilst some clinicians were confident about good practice in their own teams, they were less confident about this being systematic everywhere or were aware that these elements of discharge summaries are often not completed due to time pressures.

5.3 Patient and visitor information and intervention

Making Every Contact Count (MECC)
Arrangements relating to Making Every Contact Count (MECC) seem to vary considerably between Trusts and the self-assessment scores attributed to this aspect of prevention suggest that this is an area in which Trusts are less confident that they are acting systematically or effectively. In general, discussions only scratched the surface and no work was done as part of this process to confirm the extent to which MECC

practices were embedded, but the importance of this work was generally recognised by Trusts and reinforced by the publication of the 2017 to 2019 CQUIN incentive on Preventing Ill Health by Risky Behaviours.

The majority of Trusts have undertaken work on MECC over recent years, mainly driven by MECC CQUIN incentives in previous years. Although MECC requirements became embedded within a standard clause of NHS contracts following the previous CQIUN incentive, there is variation with respect to how well this has been maintained or developed by different organisations and this has framed the current level of emphasis since the CQUIN incentive was removed. Trusts who had continued to take forward MECC approaches were in a better position to talk about numbers or percentage of staff currently trained in MECC and their expected brief intervention skills. However, even where Trusts had maintained an emphasis on this work (eg retaining mandatory training on MECC) they were unsure about the level of staff confidence and were unable to point to evidence of the impact of training on the delivery of patient care.

Few, if any, Trusts had mechanisms to measure the volume or quality of activity generated by their MECC approach, eg the provision of brief interventions by clinicians or the number of referrals made to further lifestyle support. Several Trusts reported that IT infrastructure did not support the recording of activity relating to MECC and no Trusts are yet in a position to demonstrate the impact of this work in terms of numbers of people attempting to quit smoking or reducing alcohol consumption following advice or referral by a hospital clinician. Some Trusts reported that their IT systems did not support the necessary collection and collation of data and/or reported planned developments in IT systems which may be helpful in future. One Trust felt that one of their biggest challenges was to ensure that the Trust's IT systems can capture the data they need and then interface with other providers.

This aspect of the prevention agenda was most consistently assessed as the being in need of attention as part organisations' next steps, with every trust identifying action relating to either patient contact and assessment or the provision of brief advice or referral to Make Every Contact Count. In most cases, next steps involve reviewing, revising, re-considering and reinvigorating MECC approaches, often including renewing or reviewing staff training and its effectiveness. In a small number of Trusts, the clinicians involved in self-assessment discussions had experience of both providing and/or witnessing exemplary practice within their own specialty but felt that it might be beneficial to carry out audit work across the organisation to confirm or establish the level of embeddedness of MECC approaches elsewhere.

Health Promotion and Information for patients and visitors

All trusts provide health promotion information for patients and visitors, often through displays and printed information on wards and in public areas of building. One trust maintains a comprehensive library and information service which provides information

and evidence to support clinicians and managers as well as patients and visitors. It provides leaflets and other prevention resources for patients through an outreach service.

5.4 Promoting a Healthy Workplace

Most Trusts have made good progress in terms of staff health and wellbeing and in general, this was an area of strength with several Trusts having long-standing arrangements in place to support staff wellbeing and the majority of Trusts have well-developed policies, plans and delivery arrangements to support staff well-being. A range of good practice examples were identified with regard to staff health and wellbeing covering occupational health, health checks and health promotion, staff support services, active travel, smoking cessation, healthcare worker flu vaccination and vending and food offers. One trust was identified by NHS England as an exemplar site for its Healthy Workforce programme in 2016 to 2017. Four Trusts reported having carried out staff health needs assessments and others were in the process of doing so. Several Trusts had existing staff wellbeing strategies, but many would benefit further from a more holistic approach in this area, informed by their assessment of staff health needs.

Efforts in this area do appear to have been strengthened by the national CQUIN incentive on NHS Staff Health and Wellbeing in 2016 to 2017. This CQUIN was equivalent to £450 million nationally in incentive payments to Trusts and was designed to see improvement in the following areas:

- Improving the range of support across musculoskeletal, mental health and physical activities;
- Improving the up-take of flu vaccinations by frontline healthcare workers (with a target to achieve 75% coverage by December 2016); and
- Taking action on food and drink sold on NHS premises to ensure that these are as healthy as possible for staff, visitor and patients

In some cases, Trusts have stand-alone occupational health and wellbeing policies and plans while in other Trusts health and well-being is embedded within wider workforce or ‘People’ policies or plans. Most Trusts have teams or individuals dedicated to improving staff health and wellbeing through the development of policy, training and health promotion campaigns as well as through the provision of rapid access to appropriate support for staff experiencing ill-health eg rapid access physiotherapy for staff with musculoskeletal problems or mental health support for staff experiencing mental health problems such as stress, anxiety or depression.

Several Trusts mentioned their concerns about the impact on staff of managing high demand and unrelenting workload on the frontline of services, exacerbated in some

areas by difficulties with recruitment and retention. Several Trusts highlighted their efforts to engage and listen to staff, to understand their experience and to provide appropriate measure to support and increase resilience.

Staff Flu Vaccination
In relation to specific indicators of progress relating to staff wellbeing, 6 Trusts (5 acute hospitals and one Community and Mental Health Trust) had achieved the staff flu vaccination coverage of 75% required by the CQUIN. The highest uptake by staff within an acute trust was 79.2% and the lowest uptake was 66.2%. The highest uptake by staff in a Community or Mental Health Trust was 77.4% and the lowest was 38.4%.

Of the Trusts that did not achieve the target of 75% in 2016 to 2017, all had made progress compared to their coverage in 2015 to 2016 with some making very considerable progress egone acute Trust increased coverage from 42.8% to 66.2% and was highly commended for these efforts by NHS Employers in the 2016 to 2017 Innovative Flu Fighter awards; one community and mental health Trust increased from 47% to 66.2% and one mental health and learning disability Trust increased from 22.7 % to 38.4%. The range of outcomes across both acute and community/mental health Trusts suggests that this might be an area that would be suitable for peer-to-peer learning and support between Trusts.

Food Policy and Access to Healthy Food
During 2016 to 2017, all Trusts have made progress in terms of their provision of access to healthy food and this activity has clearly been supported by the staff health and wellbeing CQUIN in 2016 to 2017, including improving healthy options in vending machines. Some have developed new Food Policies as part of this work and other organisations intend to do so. One Trust has received a Bronze Award from the Soil Association in recognition of progress made towards the procurement, preparation and provision of healthy foods.

Transport Policies/Travel plans
Many Trusts have developed transport or travel policies which support walking or cycling. Some have developed Green Transport policies and salary sacrifice for purchase of bicycles is very common. Some Trusts have developed parking policies which exclude staff from parking on-site if they live within a designated distance (eg 2 miles) from their base and some Trusts reported that they pay mileage allowances for work-related travel by bicycle. One Trust has won an NHS Sustainability Award for its Travel Plan.

5.5 Tackling Health Inequalities

Some self-assessment participants were aware that Joint Strategic Needs Assessments are produced and published and there had been presentations about these in some

Trusts. However, this type of analysis and information does not seem to routinely provide a strategic sign-post for NHS Provider Trusts. This will be increasingly important as we move towards the development of Accountable Care Organisations. Although most Trusts recognised that their organisation probably had the capacity to analyse Hospital Episode Statistics data in a segmented way to enable them to better understand the differing health needs in different population groups, few organisations reported doing so and most reported that they did not have the capacity to do this.

Whilst it is mainly the job of NHS Commissioners to understand health needs and to disproportionately commission services to meet the higher health needs of some groups, it was notable that few Trusts were able to identify examples to illustrate the adoption of proportionate universalism (ie the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need), particularly in relation to their prevention activities.

Working with External Partners

Prevention work within some Trusts seems to be developed in relative isolation with few linkages to external partners being evident or discussed. There were one or two striking examples of Trusts having developed substantial organisational plans for prevention with little if any dialogue with relevant partners. While about half of Trusts referred to working with STP partners among their strengths or next steps, few Trusts seem to actively use the local Joint Strategic Needs Assessment (JSNA) or Health and Wellbeing Strategy to drive their focus. One Trust noted that the STP offers opportunities to synchronise prevention with wider partners to ensure that the prevention focus is seamless for patients and to ensure consistency and continuity of messages across the system.

Most Trusts were in contact with local lifestyle support services, particularly in relation to smoking cessation, although fewer Trusts seemed to have links to other types of lifestyle support or to have a systematic approach to ensuring that these services are taken up by people who would benefit from them. In some Trusts, concern was expressed about actual or potential reductions in the capacity or availability of lifestyle support services commissioned by local authorities who are facing significant cuts in their revenue support grant and Public Health Grant funding. Reductions in lifestyle support services are likely to coincide with increases in referrals as NHS Provider Trusts are increasing their identification of people who would benefit from support.

Some Trusts also mentioned other impacts and implications for Trusts of the financial pressure in Local Authorities, particularly Public Health Grant reductions. One Trust offered a specific example about their Local Authority Public Health team having to withdraw a seconded smoking cessation trainer from the Trust in response to Public Health Grant reductions. In response to this, the Trust in question agreed to invest its own resources into a training post combining smoking cessation and wider physical

health issues. The advertised post is intended to focus on staff training but will also offer support to patients on the wards. The Trust acknowledged that this investment would help towards their performance against the 2017 to 2019 CQUIN although the decision to invest was not specifically aimed at this.

Some of these themes are echoed in the October 2017 publication *'Public Health: Everyone's Business?'* produced as part of the *Provider Voices* series by NHS Providers, exploring how the health service can respond to the challenges ahead in delivering the 'radical upgrade to prevention and public health' heralded in the NHS Five Year Forward View.

6. Conclusions and reflections

6.1 Conclusions

Progress is being made but it is patchy. Every organisation is making progress and it is encouraging to note considerable progress in some Trusts and on some issues but the 'shape' of progress is different in each organisation. With the possible exception of CQUIN incentives, prevention does not appear to be driven consistently across all organisations using the governance and performance management architecture of the NHS. Rather prevention work seems to be driven from within each trust and is therefore subject to various organisational idiosyncrasies, resulting in uneven prioritisation of relevant actions. Good practice or high achievement in one aspect of prevention in an organisation does not necessarily mean good progress in other aspects, probably because prevention is often led and managed in a dispersed way and is afforded different level of priority in different parts of each organisation. Indeed, it seems likely that different Trusts have given different levels of priority to prevention activity in the past but it was encouraging that senior staff in all Trusts understood and articulated the importance of the NHS contribution to the prevention agenda, particularly in light of delivering the sustainability and transformation required by the NHS Five Year Forward View.

Leadership and capacity are important. Developments generally appear to be more systematic and embedded in some organisations than others, particularly where there has been and continues to be strong leadership and dedicated capacity to deliver work on various aspects of the prevention agenda. This is based on current leadership for prevention as well as on historic leadership, policies, practices and resources. Capacity for prevention is clearly a significant factor and was raised as an issue by several Trusts. Governance and strategies for prevention would benefit from further strengthening in many organisations, particularly as we move towards the establishment of NHS Accountable Care Organisations responsible for the health of whole populations.

There is a genuine commitment to prevention. It is difficult to accurately judge the level of organisational ownership of the prevention agenda from a relatively brief self-assessment process and a self-assessment meeting but all organisations demonstrated an active willingness to engage in this process and some key staff demonstrated considerable knowledge and personal enthusiasm for prevention and public health. Whilst there was almost no work done to 'evidence' the progress outlined in discussions, the impression was that progress is real and there is a genuine commitment by NHS Providers in the East Midlands to play their part in delivering the Prevention Challenge. The 'next steps' will help to solidify that commitment and set a baseline agenda against which further progress can be assessed.

Plans and Policies In terms of corporate policies and plans for prevention, it is encouraging to see more organisations adopting strategic approaches to prevention through the development of Strategic Frameworks for Public Health or Corporate Social responsibility Strategies or similar corporate plans. It is also encouraging to note that prevention is being explicitly included in other corporate plans such as clinical strategies or workforce strategies.

Considerable progress on staff Health and Wellbeing The highest overall self-assessment scores in this process were attributed by Trusts to their work on staff health and wellbeing. It was encouraging to note that all Trusts were continuing to develop their staff wellbeing initiatives and were keen to provide information about their plans and programmes, with considerable evidence of good practice.

Patient Contact & Assessment and Making Every Contact Count The self-assessment scores attributed to this aspect of prevention suggest that this is an area in which Trusts are less confident that they are acting systematically or effectively. This aspect of the prevention agenda was most consistently assessed as the being in need of attention as part of organisations' next steps, with every Trust identifying actions relating to either patient contact and assessment or the provision of brief advice or referral in order to 'Make Every Contact Count'. This work would almost certainly benefit from further shared learning opportunities across the East Midlands or other structured peer-to-peer support over the next year as Trusts implement the 2017 to 2019 CQUIN on 'Preventing ill health by risky behaviours – alcohol and tobacco'.

CQUIN Incentives This self-assessment process suggests that the use of CQUIN incentives has been successful in encouraging and strengthening action and improvement in prevention work (eg on staff health and wellbeing) but it has also highlighted the risk of developments not continuing to be actively supported in all Trusts once CQUIN incentives are removed (eg Making Every Contact Count) unless wider NHS governance arrangements ensure that efforts continue. The 2017 to 2019 CQUIN on 'Preventing ill health by risky behaviours – alcohol and tobacco' represents both

challenge and an opportunity for Trusts to step up their prevention efforts with patients over the next period.

Other Specific policy areas In terms of specific policies, differing aspects of good practice were identified across the East Midlands on issues such as food policies, sustainability and green transport. Smoke-free status has been something of a touchstone issue in terms of leadership for prevention and it is good to see steady progress in this area of policy although some organisations had not fully implemented smoke free policies at the time of the self-assessments and others continue to find it difficult to enforce their smoke-free policies.

Next Steps It is important that Trusts maintain the momentum created by the FYFV and *The Prevention Challenge* in the East Midlands, harnessing the enthusiasm of key players and embedding prevention in the DNA of every part of NHS organisations. Whilst this self-assessment process has identified progress, the 'next steps' indicate that substantial further development work is planned to help deliver the scale and consistency of prevention work likely to be necessary.

6.2 Reflections

This work was undertaken to understand, encourage and support progress on all aspects of work relevant to the prevention agenda and not to 'audit' against a gold standard or to collect/report data in order to benchmark organisations. Those involved in self-assessments frequently said that they had found the process helpful to them in assessing their position and developing next steps. Some staff reported finding it helpful to have a mirror held up for them and found the process of dialogue encouraging as well as informative. One new staff member who attended a self-assessment meeting found it invaluable to her in gaining an oversight of the Trust's processes and activities. It was also heartening to see the strengthening of understanding, engagement and resolve among colleagues participating in some self-assessments.

It is important to note that, during self-assessment conversations, the questions in the framework were answered in slightly different ways in different Trusts and issues were explored to differing degrees, shaped by backgrounds and knowledge of those involved in the self-assessment process. This means that in most aspects it is not possible to directly compare one organisation against another and this report is therefore rather impressionistic. However, the strengths and next steps by organisation provide some insight into where one organisation might be well-placed to help or support others.

It was important to obtain system-wide support for this work at the outset because without this, it is unlikely that it would have been possible to engage Trusts. Key people in NHS Trusts are extremely busy and it was very difficult to secure suitable times in busy diaries for phone calls and meetings, particularly over the winter period. If further

work of this nature is undertaken, it will be important to allow a longer time period to secure engagement. The fact that so many Trusts prioritised participation in this self-assessment is a testimony to the commitment to prevention of people in leadership roles.

It seems likely that the provision of practical recommendations in *The Prevention Challenge* report and supported self-assessments have raised the profile of prevention within NHS Provider Trusts, helping Trusts to recognise the prevention activity already being delivered in different parts of organisations and develop further plans as part of STPs.

7. Future Developments

In response to the NHS Five Year Forward View and to support the development of Sustainability and Transformation Plans (STPs), Public Health England published a 'Menu of Preventative Interventions' and NHS England has published an 'STP aide-mémoire: Prevention', both of which provide guidance, support and recommendations about prevention action. Both documents should continue to be used by STP partnerships to further develop and strengthen local prevention action.

This self-assessment by NHS Providers was intended as a one-off exercise to understand, encourage and support prevention actions following the publication of the report on *'Meeting the Prevention Challenge in the East Midlands – A Call to Action'*. A similar process is now underway with CCGs who have been offered a supported self-assessment of their own organisational progress on prevention. Having completed it, each organisation will be able to use their self-assessment as a baseline against which to review and monitor their own progress in future and we would encourage Trusts to use the self-assessment tool to re-assess their progress another year on.

In the more immediate future, this work suggests that there are a number of areas where good practice in one trust might be transferred to others and where workshop events or some other forms of peer-to-peer support would be beneficial. Future developments might include:

1. Development of a support package, bringing together all NICE Guidance and Quality Standards linked to the domains of the Prevention Self-Assessment tools along with related good practice examples observed through our interactions within the East Midlands. This would be intended to support Trusts in progressing their agreed Next Steps, implementing the related CQUINs and provide a resource for commissioners and providers in support of STP plans and aspirations to progress Accountable Care System models.

2. Delivery of a prevention-focused facilitated learning event(s), to bring together key leads from Trusts across the East Midlands to support the sharing of good practice
3. The development of networks to facilitate on-going collaboration and peer-to-peer support between Trusts
4. Building on the direct engagement between PHE and the East Midlands Trusts through the self-assessment process with more regular contact between senior members of PHE's Healthcare Public Health team and the Trust lead directors.

8. Acknowledgements

The work by NHS Provider Trusts towards meeting *The Prevention Challenge* and this review of progress would not have been possible without the willing engagement of Trusts in the East Midlands. Thanks to the Chief Executives, Prevention Champions and/or nominated Lead Directors and staff members in NHS Provider Trusts for their time, enthusiasm and invaluable insights. Particular thanks to the following people who convened, enabled and participated in supported self-assessments for their Trust:

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9. References

The original report '*Meeting the Prevention Challenge in the East Midlands – A Call to Action'* provided extensive references and links to useful documents. This is available as a resource on the website of the East Midlands Clinical Senate and can be accessed by following the link below:
http://emsenate.nhs.uk/resources/2016-02-23-09-57-37/421-clinical-senate-resources

Since the original report was published, the following helpful resources have also become available:

- NHS Providers Public *Health: Everyone's Business?* http://nhsproviders.org/provider-voices-public-health
- 'Menu of Preventative Interventions' Public Health England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565944/Local_health_and_care_planning_menu_of_preventative_interventions.pdf
- an 'STP aide-mémoire: Prevention', NHS England https://www.england.nhs.uk/wp-content/uploads/2016/05/stp-aide-memoire-prevention.pdf

Appendix 1 – Self Assessment Toolkit Questions

The self-assessment tool included the following questions about prevention practice:

1. Leadership, Management and Policy

1.1 Do you have a board level champion for prevention and public health? Who holds this role?

1.2 Have you embedded prevention within corporate governance structures? What gaps have been identified?

1.3 Has the board developed and implemented an approach to undertaking Prevention Impact Assessments? What is this approach?

1.4 Is the group confident that prevention is translated into;
a) Policies
b) Plans
c) Programmes

1.5 Is prevention addressed in the following:?
a) Estates management strategies
b) Transport policies
c) Occupational health and wellbeing strategies
d) Food policies

1.6 Are staff made aware of these policies?

1.7 Do you have a comprehensive corporate social responsibility/ corporate public health strategy that maximises the role of prevention in both the organisation and local economy?

1.8 Are there mechanisms in place to monitor progress and effect of prevention in policy documents? How do you measure the impact of the corporate social responsibility strategy within the local economy?

2. Patient contact and assessment

2.1 Have approaches been adopted that embed holistic patient history taking ie one that addresses lifestyle and other risk factors? Do you have examples of how this is being achieved?

2.2 If gaps have been identified in embedding holistic patient history taking, are plans in place to develop this area of prevention?

2.3 Has a Making Every Contact Count ('MECC') approach [4] been adopted to ensure all staff have the knowledge and confidence to improve patients' health and wellbeing?

2.4 Are all staff who come into contact with patients and their relatives (both clinical and non-clinical) trained to deliver the 'MECC' standard? Is this a mandatory requirement?

2.5 Is the delivery of brief interventions and advice to patients recorded and reported as part of 'MECC'? How is this reporting used to evaluate and inform further activity?

2.6 If gaps have been identified in the process of embedding the 'MECC' approach, do have you a plan in place to address them?

2.7 Is your approach to MECC supported by your local IT infrastructure? Eg for patients- recording of advice given related to lifestyle factors. For staff- register of accredited MECC training?

2.8 Is there a plan in place to develop necessary IT infrastructures?

3. Patient and Visitor Information and Intervention

3.1 Do you have a standardised pathway for referring patient(s) who demonstrate or report lifestyle and other risk factors into relevant intervention programmes?

3.2 Do you provide information to enable people to refer themselves or advise GP led referral into relevant intervention or support programmes?

3.3 Are patients given clear, understandable and appropriate information about the impact of their lifestyle choices on their health condition(s)? What tools are used (eg electronic apps or paper based leaflets) to deliver this?

3.4 Do you offer general information on factors influencing health and prevention advice to all visitors in the organisation? (whether these are relatives, visitors from other organisations or contractors)

3.5 Is information about an individual patient's lifestyle and other risk factors shared between the MDT working within the provider organisation? (eg across relevant departments)

3.6 Is information about an individual patient's lifestyle and other risk factors shared with the wider health and social care colleagues, those working outside but alongside the provider organisation (eg primary care practices, third sector services)?

3.7 Do you ensure that patients with new diagnoses are included on the relevant disease registers? How do you achieve these?

4.0 Promoting a Healthy Workplace

4.1 Do you have a strategy towards implementing a living wage [5] for all staff working on site?

4.2 What progress has been made against the Health and Wellbeing CQUIN [6] priorities? In particular, do you…

- 4.21 … provide NHS health checks at work to staff members over the age of 40 years?
- 4.22 … ensure year on year improvements in uptake of flu vaccines by staff members?
- 4.23 … have specific initiatives in place to respond to the main causes of sickness absence? (eg for stress and musculoskeletal problems)
- 4.24 … have a local physical activity and mental health offer for staff?

4.3 Do what extent have you implemented NICE guidelines on workplace health [7]?
4.4 Have you signed up to/ implemented the NHS Statement of Support for Tobacco Control [8]?

4.5 Do you have any specific strategies to encourage staff members to quit smoking or drink within recommended limits?

4.6 Do what extent to you ensure healthy food provision within all premises?

- 4.61 What progress has been made to remove sugary snacks and beverages from vending machines?

4.7 Do you promote active travel? What infrastructure has or will be needed to support this?

4.8 Do you have an approach/ forum to ensure that the staff voice is incorporated in decisions impacting on their working environment?

5.0 Tackling Health Inequalities

5.1 Do you communicate the findings from the most recent JSNA to department or service leads? How do you ensure that the needs of the local community are embedded into service delivery plans?

5.2 Do you have the ability to track organisation access rates by different segments of the local population?

5.3 Do you adapt the health services you offer to reflect the different needs of individuals who use the trust? eg text reminders for appointments for certain groups (etc.)

5.4 Do you adapt the occupational health services you offer to reflect the different needs of your workforce? eg appointment times that fit with shifts (etc.)

5.5 Do you ensure that the health services you provide are equitable for all?

5.6 Do you have a process in place to review prevention challenges in collaboration with other health services, institutions and sectors on an ongoing basis?

Each question within the toolkit had space to enter a self-assessed score. The system used for scoring answers was as follows:

Blank or 0 = We **can not** demonstrate this practice/ haven't made any progress in our organisation
1 = We can demonstate **some relevant practice** in our organisation but can identify room for improvement
2 = We can demonstrate that this practice is **systematic in some departments or teams in our organisation** and have evidence to demonstrate this
3 = We can demonstrate that this practice is **systematic across the whole organisation** and have evidence to demonstrate this

For further information or a copy of the toolkit, please contact the report authors