SYB ICS Prevention Work Stream Update
and
Prevention Within the NHS Long Term Plan

SOUTH YORKSHIRE AND BASSETLAW
COLLABORATIVE PARTNERSHIP BOARD

10 May 2019

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Is your report for Approval / Consideration / Noting

Consideration

Links to the STP (please tick)

☑ **Reduce inequalities**	☑ **Join up health and care**	☑ **Invest and grow primary and community care**	☑ **Treat the whole person, mental and physical**
☐ **Standardise acute hospital care**	☐ **Simplify urgent and emergency care**	☑ **Develop our workforce**	☐ **Use the best technology**
☑ **Create financial sustainability**	☑ **Work with patients and the public to do this**		

Are there any resource implications (including Financial, Staffing etc)?

A business case for QUIT is under development.

Summary of key issues

This paper:

A. Provides an update on progress of the three agreed priority areas within the ICS Prevention Work Stream:

- **Embedding the treatment of tobacco dependence in secondary care – the QUIT programme**
- To **increase access for a wider range of residents of SY&B to social prescribing** as a gate way to accessing non-medical forms of support and to empower clients to enhance their own well being
- **Systematic quality improvement in the identification and management of clinical**

risk factors for cardiovascular disease (AF, hypertension and cholesterol)

B. **Highlights the possibility of some funding to support QUIT funding from Yorkshire Cancer Research – as long as we can demonstrate in the business case a commitment from all partners to also contribute to the costs.**

C. **Summarises the key prevention priorities within the NHS Long Term Plan**

D. **Notes the key risks associated with the prevention programme**

Recommendations

To:

- Note the **progress on the three prevention priorities** and the relationship of these programmes to both the Long Term Plan and Primary Care Networks
- Note the **ongoing development of a QUIT business case** and the possibility of some **funding from Yorkshire Cancer Research**
- Note the **key prevention priorities within the LTP** and that:
    - Several of them relate to Trusts and hence the suggestion of having a **Healthy Hospital Programme**
    - Many other prevention priorities are scattered throughout the LTP and link with **other ICS work streams**
- Note and consider the **risks** associated with the current prevention priorities and more broadly with the implementation of the Long Term Plan prevention priorities

SYB ICS Prevention Work Stream Update
and
Prevention within the NHS Long Term Plan

SOUTH YORKSHIRE AND BASSETLAW
INTEGRATED CARE SYSTEM COLLABORATIVE PARTNERSHIP BOARD

10 MAY 2019

1. Purpose

A. To provide an update on progress of the three agreed priority areas within the ICS Prevention Work Stream:

- **Embedding the treatment of tobacco dependence in secondary care – the QUIT programme**
- To **increase access for a wider range of residents of SY&B to social prescribing** as a gate way to accessing non-medical forms of support and to empower clients to enhance their own well being
- **Systematic quality improvement in the identification and management of clinical risk factors for cardiovascular disease (AF, hypertension and cholesterol)**

B. To highlight the possibility of some funding to support QUIT funding from Yorkshire Cancer Research – as long as we can demonstrate in the business case a commitment from all partners to also contribute to the costs.

C. To summarise the key prevention priorities within the NHS Long Term Plan

D. Notes the key risks associated with the prevention programme

1. Key issues

A. Update on existing SYB Prevention Priorities

1. Embedding the treatment of tobacco dependence in secondary care – the QUIT programme

Background

It is estimated that 25% of people admitted to hospital are active smokers. Smoking is the single largest cause of ill health in SY&B; current adult smoking prevalence in SY&B is significantly worse than the England average.

The QUIT Programme was endorsed for implementation in hospitals in SY&B a year ago.

QUIT is a comprehensive secondary care treatment programme, where active smokers will be systematically identified on admission to hospital, provided with nicotine replacement therapy, advised to stop smoking and referred for stop smoking support. The approach recognises that **smoking is an addiction; reframing the way we treat smoking to medicalise it rather than considering it to be a lifestyle choice**.

The Aims of the SY&B QUIT Programme are:

- Every health care professional is aware of the smoking status of every patient they care for
- Every health care professional has the competence and confidence to offer help to stop smoking through direct action and referral
- Every patient has access to the best available treatments and expert support to treat this disease
- There is recognition that tobacco addiction is a chronic and relapsing disease, not a lifestyle choice
- Staff policies support all hospital staff to quit or remain tobacco-free during working hours, including the offer of smoking cessation support and appropriate short term medication
- All the hospitals in SY&B become institutions of health promotion and truly smokefree zones

The programme is based on 4 steps:

Q – Question - all hospital patients should be asked if they are a current smoker and, ideally asked to exhale into a CO monitor and results noted in their patient record

U- Understand - smoking is an addiction, CO monitoring provides a strong indication of the level of addiction, noting the result in patient records provides evidence that the conversation has taken place and can contributes to patient motivation to quit

I – Inform - patients should be informed that the hospital is smoke free and patients and visitors are unable to smoke anywhere on site but they can access NRT support for the duration of their stay

T – Treatment - NRT/ Varenicline and other options should be available as soon as possible on arrival on the ward; patients should be given brief advice and referred to stop smoking support.

The key benefits and outcomes seen in similar programmes (London[1],Ottawa [2]) include reduced admission rates at 30 days and 1 year, reduced deaths and an increase in successful quitters.

For example, the **evidence from the Ottawa model for smoking cessation** (OMSC) showed:

- An **11.1% increase** (from 18.3% to 29.4%) in **long-term quit rates** among general patient population.[3]
- **35%** of the patients who received the OMSC were **smoke-free at 6-months**, compared to only 20% of the usual care participants.[4]
- Patients who received the OMSC were **50% less likely to be re-admitted** to the hospital for any cause, and **30% less likely to visit an emergency department** within 30 days;
- Smokers who received the OMSC were **21% less likely to be re-hospitalized** and **9% less likely to visit an emergency department over 2 years;**
- Most importantly, smokers who received the OMSC had a **40% reduction in risk of death over 2 years.**

Progress to date

- The QUIT Programme was endorsed for implementation by the Acute Federation Chief Executives and the CCG Accountable Officers a year ago.

[1] London Clinical Senate Helping smokers quit http://www.londonsenate.nhs.uk/helping-smokers-quit/

[2] Ottawa Smoking Cessation Model https://ottawamodel.ottawaheart.ca/

[3] Reid RD, Mullen KA, Slovinec D'Angelo ME, Aitken DA, Papadakis S, Haley PM, et al. Smoking cessation for hospitalized smokers: an evaluation of the "Ottawa Model". Nicotine Tob Res. 2010;12(1):11-8.

[4] Mullen KA, Manuel DG, Hawken SJ, et al. Tob Control Published Online First: 2016. doi:10.1136/tobaccocontrol-2015-052728

- A SY&B Steering Group meets every other month. Membership consists of Local Authority Public Health, Public Health England and Hospital Representatives. CCG representatives are copied into invitations and notes from meetings; they have opted not attend meetings routinely although might do on an ad hoc basis.
- A launch event was held on 7th November, which was very well attended and lead to an increase in commitment and momentum in Trusts.
- A further SYB event is planned for the 22 May, which focuses on sharing the learning from Greater Manchester, who have implemented an Ottawa model in Wythenshaw hospital and are now planning to roll it out in an additional 6 hospitals in Greater Manchester.
- Hospitals have identified an Executive Sponsor and all acute hospitals now have a local QUIT steering group.
- Places are progressing at varying rates. Due to lack of resources hospitals have predominantly been focusing on what can be done to support a smoke free site (eg change in signage), awareness raising, identifying clinical champions and ensuring pharmacy stocks a range of NRT products.
- No Trusts are yet delivering the QUIT intervention to patients at scale.

NHS England Service Specification and Long Term Plan Funding

The QUIT programme is in line with commitments given in the **NHS Long Term Plan** that:

- By 2023/24, all people admitted to hospital who smoke will be offered Ottawa style NHS-funded tobacco treatment services (ie the QUIT programme), with modified programme for expectant mothers, and their partners.
- There will be a new universal smoking cessation offer as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services. On the advice of PHE, this will include the option to switch to e-cigarettes while in inpatient settings

We understand from the national NHS England team that:

- a **national service specification** for an Ottawa like model is currently being drafted and will be shared shortly.
- there will be **dedicated NHSE funding** for Ottawa style NHS-funded tobacco treatment services, but this will not commence until 2021/22, other than possibility of a small number of early adopter sites next year.

Risks

While we have **good commitment from the Trusts, implementation is being hindered by lack of resources**.

There is a danger that the **current momentum will be lost** if resource is not quickly identified or that the models implemented are so ‘diluted’ that we will not achieve the desired outcomes.

There is **limited programme management capacity** at both SYB system and Trust level.

At a system level the QUIT Programme lead is currently trying to juggle her NHS England post and her alignment 2 days a week to the ICS (plus a third day funded by the ICS). This is:

- proving very difficult to sustain
- is insufficient capacity to drive the programme forward and support development of shared resources across SYB.

Trust QUIT leads, have mainly had this extra responsibility added into their already stretched job plans.

Local ownership and planning is essential, as is building on existing services and expertise. However, the result of lack of funding and programme management support means that implementation is currently **progressing patchily with limited co-design or coordination across places**, running the **risk of:**

- Duplication of effort
- Inconsistent messages, training programmes, clinical pathways and clinical guidelines
- Leading to possibility of:
  - Dilution of possible impacts
  - Staff confusion/frustration if working across Trusts and needing to work to different protocols
  - Patients falling through the net if they receive hospital care in a different Place to their local community stop smoking service if there is not consistency as to at what stage in the pathway patients move between hospital smoking services and community smoking services
  - Inequities in provision across SYB

There is also a need to ensure that QUIT implementation occurs across Mental Health Trusts as well as acute Trusts.

Potential External Funding to Support QUIT Implementation

Yorkshire Cancer Research have expressed an interest in **funding the specialist stop smoking advisors** needed **within acute trusts** to implement the QUIT **programme for 18 months.**

Before taking a paper to their Board, the ICS needs to demonstrate that the ICS, Trusts, CCGs and Local Authorities will make an interim investment until the NHS England funding is available:

- to **cover the costs of other elements needed to implement QUIT** (eg coordination and management of the programme and specialist stop smoking advisors, staff training, pharmacotherapy, specialist stop smoking support post discharge)
- to **cover costs of the specialist advisors after 18 months** if there is a delay to, or a shortfall in, the national NHSE funding that is due in 2021/22.

If Yorkshire Cancer Research do agree to support the programme:

- they **would become a partner** in the programme and be **acknowledged in all publicity and materials** relating to the QUIT programme.
- We would need to agree some milestones and KPIs with them.

Further discussion is needed with Yorkshire Cancer Research around whether they would also like to sponsor the mental health specialist advisors.

A **business case** is currently under development. Box two, outlines suggested contributions from the different partners.

Box two Extract from QUIT Business case with suggested contributions from the different partners

Cancer Alliance pays for:

- Part of the system level programme management
- A SYB clinical lead
- Development of on line training resources and material.

ICS Transformation Funding covers the cost of:

- Healthy Hospital Programme Manager for each Acute and Mental HealthTrust
- Hospital based Stop Smoking Manager for each Trust
- Admin support for the Healthy Hospital Programme Manager and Hospital Stop Smoking
- And provides contribution in kind for Communications and Engagement

Yorkshire Cancer Research fund:

- Hospital based specialist stop smoking advisors in Acute Trusts (including Sheffield Children Hospital)
- ? Hospital based specialist stop smoking advisors in Mental Health Trusts

Acute and Mental Health Trusts cover the costs of:

- Pharmacotherapy while the patient is an inpatient and for inpatient and outpatient TTAs
- Direct costs – eg printing of leaflets, CO monitors, signage
- Contributes in kind areas such as:
  - Clinical and managerial leadership, Comms and engagement expertise
  - Staff training, Pharmacy staff time
  - IT support
  - Staff asking smoking status, recording CO levels, provision of very brief advice, offering and providing NRT, referral and liaison with specialist stop smoking advisors

The costs to NHS Trusts will be partly covered by the NHS England tobacco and alcohol CQUIN indicator for Trusts in 2019/20. This covers non-specialist advice - the asking of smoking status and provision of brief advice and offer of NRT.

Local Authorities:

- Community based stop smoking advisors

CCGs:

- Contribution to Pharmacotherapy post discharge

Next steps

- Completion of business case and discussion with all SYB partners and Yorkshire Cancer Research
- Continued engagement with SY&B Hospitals, LA Public Health Specialist Stop Smoking Commissioners, CCG's, Cancer Alliance and other stakeholders to achieve implementation of the SY&B ICS QUIT Programme. This includes **collaborative development** of the following to ensure a consistent programme across the ICS with local ownership:
  - Clinical pathway including Pharmacotherapy Options

- QUIT Comms (with local branding)
- QUIT Training ('e' learning)
- Evaluation Metrics
- SY&B Vaping/ E-Cigs Position Statement

- Support each Hospital through active involvement at local Trust QUIT Steering Groups, facilitate shared learning through a SY&B ICS Steering Group, facilitate task and finish groups to develop specific aspects of the programme ('do it once') and hold SY&B ICS Learning Events
- Identify funding for and appoint a QUIT Clinical Lead (0.2 wte)

2. To increase access for a wider range of residents of SY&B to social prescribing as a gate way to accessing non-medical forms of support and to empower clients to enhance their own well being

Progress:

Since October 2018 the SYB Social Prescribing Steering Group's engagement has identified a number of themes (box three)

Box Three Themes from SYB Social Prescribing Engagement

Success of current social prescribing service

1. **Current social prescribing services** in SY&B are:
   - **Well regarded by professionals and clients**
   - **Performing well** against their current service specifications and KPIs
   - **Considered by NHSE to be some of the best in England**.
   - Supporting and acknowledging the **value and diversity of the voluntary sector** to enable a client centred approach focussing on 'what matters to me'.
2. There is a widespread view that social prescribing is working well in SYB because it is a **non-medical model that is localised, delivered by the voluntary sector and based within communities.**
3. **High impact patient outcomes are being achieved** and are being captured in case histories and in changes in clients' wellbeing scores.

There is currently unmet need and great potential for future expansion of social prescribing

- Potential to decrease inequities in referral rates from general practice
- A **much wider cohort of people could benefit from social prescribing than current referral criteria allow.** Stakeholders noted the benefit of having a **two pronged approach** of both:
  - **Wide referral criteria** so that many people can be referred into the service
  - A **targeted approach of integrating social prescribing into the pathways for people with specific needs that may benefit greatly from social prescribing** eg chronic pain, frequent attenders to A&E
- There is **strong support for the diversification of who can refer in to the social prescribing scheme**
- However, if referral routes are to be increased then:
  - The **increase in referral routes needs to be phased in line with an increase in capacity** and funding
  - Link workers and social prescribing managers need to have sufficient **time to provide education / support to new referrers on who would benefit from social prescribing and what it can offer**, so that referrals are made appropriately.
- One of the success factors of the current social prescribing schemes has been the **close relationships developed between the link workers and the primary care referrers.** A **high level of visibility**, particularly initially, is needed to encourage referrals and to provide feedback on the outcomes for the people referred.

- Therefore, **embedding link workers within other key referring agencies / pathways** maybe the **most effective way of giving access to social prescribing to these clients** and prevent inappropriate referrals or these patients hitting primary care and having to be onwardly referred by primary care practitioners.

Key patient cohort and referral pathways to develop

Stakeholders have highlighted the particular potential of social prescribing to:

- Support people with **mental health conditions**, and to help **prevent the need for secondary care mental health services** and to support the earlier discharge from secondary care mental health services (See appendix six for more details).
- Work within **acute secondary care settings** - Barnsley, Bassetlaw and Sheffield are all currently piloting secondary care models.
- Work with **ambulance and 111 services**
- Offer an alternative to, or to complement, **social care**, preventing people escalating within social care settings.

Children and young people

- SY&B services are currently for people over the age of 18 but the Universal Personalised Care Model, which includes social prescribing, is for all ages.
- The Long Term Plan gives a commitment to offer social prescribing for young carers.
- Each Place is likely to already have a range of services for young people that takes a social prescribing like approach (eg some CAMHS, family centres in Barnsley, some educational services). Given the variation in services at Place, a localised approach will be needed in each Place to explore the role of social prescribing for children and young people.

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Social prescribing has two key elements:

- The link worker connector scheme
- All the services that clients then access – many of which are community assets or support from the voluntary sector.

The engagement highlighted that **social prescribing link worker activity cannot keep increasing without concurrent investment in the services that they refer people on to, in particular the Voluntary sector.**

If these services do not have sufficient capacity there will be limited impact on outcomes from increasing link worker numbers and referrals.

Stakeholders were clear that the **voluntary sector must be supported and resourced to receive existing and future referrals.**

While there was much support from stakeholders, for the models in some SY&B Places of **funding following social prescribing referrals**, it was noted that **unless there is also wider funding for the VCS sector**, this could lead to **social prescribing becoming the gate keeper rather than gateway to VCS services.**

In line with the recognition in the NHS Long Term Plan, stakeholders have noted the value that voluntary sector partners can offer to many vulnerable client groups and their role in **helping to decrease health inequalities.**

There was a call for the NHS to consider how it can work with local authorities and voluntary sector infrastructure support organisations, to fund and support a vibrant community and voluntary sector.

One suggestion was for **consideration to be given as to how the voluntary sector can support people when developing all relevant care pathways.** If their **potential offers are built in to care pathways** then we will be able to help to prevent some of the problems that later result in people needing social prescribing and more intensive support. For example, many areas commission services Family Support Services from the Stroke Association to support people who have had a stroke and their carers, helping them get back to active life and employment.

Social prescribing and the Long Term Plan and Primary Care Network DES

A **number of NHSE documents** have been published since January 2019 that taken together **set out a new NHSE vision for social prescribing across England:**

- The NHS Long Term Plan
- Universal Personalised Care: Implementing the Comprehensive Model
- Social prescribing and community based support: summary guide
- Investment and evolution: A five year framework for GP contract reform to implement the NHS Long Term Plan
- Network Contract Directed Enhanced Service: Contract Specification 2019/20
- Network Contract DES Guidance for 2019/20 in England
- The BMA Primary Care Network Handbook

The NHS Long Term Plan sets out ambitious targets for the expansion of social prescribing, which were further developed in the **Universal Personalised Care Model.**

Social prescribing is one of the **six evidence-based and inter-linked components of the Universal Personalised Care model**, each of which is defined by a **standard, replicable delivery model**.

The Universal Personalised Care Model sets out the **level of ambition** for the **scale of social prescribing across England:**

- **Fund the recruitment and training of over 1,000 social prescribing link workers to be in place by the end of 2020/21**, rising further so that **by 2023/24 all staff within GP practices have access to a link worker** as part of a nationwide infrastructure of primary care networks, enabling social prescribing and community-based support to benefit up to an estimated 900,000 people.
- Up to five link workers per primary care network of 50,000, **supporting up to 3% of the local population per year,** or around **one full-time equivalent link worker per 10,000 local population**.
- It also suggests a **maximum potential scale of around 5% of the population**, or around 3 million people, **benefiting from social prescribing per year** as part of the **'universal' tier of the comprehensive model**.

This will require a **several fold increase in social prescribing activity in SYB** and an increase in the **number of link workers to 1 per 10,000 population**.

Primary Care Networks are **key to NHSE's vision for social prescribing.** Box four summarmises key elements of the Primary Care Network DES in relation to social prescribing.

The SYB Social Prescribing Steering Group has produced a **support pack for Primary Care Networks,** to help them navigate all of the documents that have been produced.

Box Four Social Prescribing and the Primary Care Network DES

- The NHSE **Primary Care Network DES service specification for personalised care** will expect PCNs to **deliver a national model for social prescribing from 20/21**, **supporting 3 – 5% of the population per year.**
- **Activity level** expectations within the PCN specification will **increase over three years.** The Social Prescribing Steering Group **predicts** this is likely to be from **1 % population supported by social prescribing in 20/21 to 3% by 22/23**.
- PCN's performance will be monitored by NHSE via a **national dashboard**
- **All practices** need to be able to refer to social prescribing link workers and link workers **must accept referrals from a wide range of agencies**. In **19/20** link workers will accept **referrals from member practices**, **expanding from 20/21 to take referrals from a wide range of agencies** (including but not limited to pharmacists, hospitals, AHPs, fire service, police, job centres, social care services, housing associations, VCS). PCNs who already have access to social prescribing services may take referrals from other agencies prior to 20/21.
- **Funding for *new* link workers** is available through the **PCN DES Additional Role Reimbursement Scheme – with 100% of salary and on costs** up to Agenda for Change band 5 being reimbursable. Funding is available **from July 2019.**
- **Existing social prescribing services must continue** to be commissioned. **CCGs must continue funding for link workers identified in the NHSE baseline survey.**
- **The GP Contract Framework** suggests that **networks may choose to fund local voluntary sector organisations to employ the link workers and run the service on their behalf.**
- Link workers need to have **accredited training.**
- **The Network Contract DES enables PCNs to sub contract the provision of services.**
- PCNs have to collaborate with local partners to develop a **shared local social prescribing plan.**

Risks

While NHSE's wish to expand social prescribing is welcome and in line with our existing ICS priority, the level of the national ambition is very high and the delivery model through Primary Care Networks poses some risks:

- As existing social prescribing schemes must continue, there is a danger of multiple services within one place, if PCNs choose to deliver the link worker activity in house or via a different provider to the current social prescribing connector schemes.
- The NHSE Summary Guide to Social Prescribing notes that social prescribing works best when all local partners work together to build on existing assets and services. It recommends that successful schemes generally have collaborative commissioning arrangements and recognise that local relationships matter and that strong community networks are built on trust and take time to develop. It will be essential that PCNs work together with CCGs, LAs, VCS infrastructure organisations and neighbouring PCNs to develop a local plan for social prescribing.
- The funding available through the Network DES only covers the salary and on costs of link workers, it does not cover all of the other costs that go along side employing link workers eg management, training, supervision, IT, travel
- Link workers need suitable support, regular supervision and training. They also need an in-depth understanding of and relationship with the local VCS. It will be challenging for PCNs

to have the necessary expertise and local networks in order to adequately train, supervise and manage link workers. The SYB ICS support pack therefore recommends that PCNs consider sub-contracting the additional link worker activity to existing local social prescribing services.

- Potential danger that the successful non-medical model of social prescribing in SYB becomes over professionalised and 'medicalised'

The local VCS is fragile and will be unable to cope with the level of national ambition for social prescribing without financial and development support.

Next Steps

1. **Support the PCNs to implement the new NHSE social prescribing model**, including:
    - Dissemination of a social prescribing support pack for PCNs
    - Offer support to PCNs/Places to develop their collaborative 5 year place social prescribing plans
    - To support the expansion of referral routes into social prescribing, co-design with relevant agencies framework pathways and guidance in relation to social prescribing and:
        - Mental health services
        - Secondary care
        - YAS/111/police/fire service
        - learning disability and autism services
        - children and young people
2. Aggregate the five place based plans to form a **5 year SY&B system plan for social prescribing**
3. **Increase the ICS focus on working with and enabling a thriving voluntary sector** that delivers social prescribing and wider ICS programme, linking with the planned partnership working between the LA and ICS on connectedness
4. **Encourage Place based representatives on the Social Prescribing Steering Group to stimulate local discussion around how the services clients are referred on to will be supported to expand.**

3. Systematic quality improvement in the identification and management of clinical risk factors for cardiovascular disease (AF, hypertension and cholesterol)

Progress

- An SYB CVD Prevention **Task Group** has been established, chaired by Greg Fell
- Interviews for a **CVD Prevention Clinical Lead** post will take place in May.
- **Priority areas for collaborative action** have been agreed (box five).

- The **Academic Health Science Network** has undertaken an innovation review and are planning to ask a small number of practices to co-design an improved self-management pathway for people with CVD clinical risk factors.
- British Heart Foundation have been **mapping cardiac rehab services** across Y&H
- AHSN are supporting a small number of practices to adopt a **QI approach to improving identification and management of AF.**

Box Five SYB CVD Prevention Task Group – Key areas for collaborative action

1. **Governance & Leadership,** including agreeing level of ambition
2. Establish baselines and additional **data needed to support a PHM approach**
3. Work with NHS **RightCare** to deliver the Cardiovascular National Priority Initiative in SYB
4. **Coordinate & improve professional, patient & public communications**

   Develop a SYB CVD prevention communications plan that includes approach for

   a) Professionals
   b) Public
   c) Patients and carers
5. Share **clinical guidelines** and update in line with new NICE guidance
6. In association with the **Academic Health Science Network**, undertake an innovation review and pilot an innovation in a number of practices
7. Explore the role the **wider primary care workforce** (in particular clinical & community pharmacists and Physician Associates) could play in the prevention pathway & in reducing GP/practice nurse workload
8. **Support the PCNs to maximise CVD prevention** and to prepare for the implementation of the national CVD prevention and diagnosis service specification.
9. Improve **cardiac rehabilitation** services & uptake

CVE Prevention, the Long Term Plan and Primary Care Network DES

The Long Term Plan notes that cardiovascular disease is the single biggest area where the NHS can save lives over the next 10 years. It gives a commitment to **improve the early identification** of the clinical risk factors for CVD and to ensure that they are **treated quickly and effectively**.

This will include better detection of familial hypercholesterolemia through the NHS genomic programme. There is also going to be a new national CVD audit for primary care.

The Primary Care Network DES will include a **national service specification for CVD prevention** and diagnosis, that will commence in 2021/22. Few details are currently available but it is likely to include case finding and management of AF, hypertension and dyslipidaemia.

Several of the additional roles that can be funded through the reimbursement scheme (eg Clinical Pharmacists and Physician Associates) will provide additional capacity to support CVD management.

The **2019/20 NHS Planning Guidance** requires CCGs to work with **NHS RightCare to improve the management of hypertension and AF.**

Risks

Lack of SYB level programme management support - - The Public Health Speciality Registrar who has been supporting this work moved placements last week. This leaves just 1 day a week of support from PHE to support the SYB level working and this will finish in September.

Unwarranted variations between practices - QOF data still shows marked variations between practices in the proportion of their predicted prevalence that have been identified and how well managed patients are. **QI approaches** can support practices that have the most opportunity to improve to change practice but many CCGs are **lacking in appropriate capacity/skill sets to provide or coordinate this support.**

While the SYB level work can contribute to the action plans that CCGs need to develop with RightCare, they are focusing on areas that will make an impact in the medium term and will not have immediate impacts. CCGs will therefore also need to consider what actions they can take at a local level to support practices to improve care this year.

Next Steps

1. Appoint a SYB **CVD Prevention Clinical Lead and identify adequate resources to support the SYB CVD prevention work**
2. Collaboratively develop a SYB ICS **CVD Prevention communications plan** for the public, patients and professionals
3. **Support PCNs to prepare for the PCN DES service specification for CVD.**
    a. In conjunction with AHSN **co-design and pilot** with a number of primary care practices an innovation to support improvements in the self-management of CVD clinical risk factors
    b. Develop a **support pack for PCNs** that includes:
        - Suggestions on which elements within the CVD prevention pathways could in future be undertaken by the **new PCN additional roles** (eg clinical pharmacists, physician associates, link workers)
        - Sharing of local CVD prevention **clinical guidelines** and resources
        - **Examples of innovations** found in the AHSN review
        - Links with the **communications** plan above
4. Understand our baseline **cardiac rehabilitation** position and review evidence of good practice

B. Prevention and the Long Term Plan

The Long Term Plan commits to **improve the upstream prevention of avoidable illness** and to move from **reactive care to active population health management.**

Going a step further than the Five Year Forward View, the Long Term Plan commits to the delivery of a **new NHS prevention programme** with **funded actions** that the **NHS will take (table one).**

It also commits that the **NHS will make action to drive down health inequalities central to everything we do.**

It notes that a more concerted and systematic approach to **reducing health inequalities** and **addressing unwarranted variation in care is needed** - For reasons of fairness, overall outcomes improvement & moderation of demand for NHS and other essential public services.

ICSs will be expected to **set out in 2019 how they will reduce health inequalities** by **2023/24** and **2028/29**.

The Long Term Plan recognises that **good health is about more than healthcare alone**, and expects that **ICSs** will provide **stronger foundations for working with local government and voluntary sector partners** on the broader agenda of **prevention and health inequalities.**

It suggests that ICSs should partner with and **commission local voluntary sector** service provision and **support to vulnerable and at-risk groups -** encouraging and supporting innovation.

Table one NHS Long Term Plan Prevention Priorities (Government targets given in italics) – the Must Dos funded by the NHS	
Smoking: *Smoke free society*	• By **2023/24**, **all people admitted to hospital** who smoke will be offered Ottawa style **NHS-funded tobacco treatment services** (ie the QUIT programme), with modified programme for e**xpectant mothers, and their partners.** • **New universal smoking cessation offer** as part of **specialist mental health services** for long-term users of specialist mental health, and in **learning disability services**
Obesity: *Halve childhood obesity & significantly ↓ gap in obesity between children from the most and least deprived areas by 2030.*	**NHS will provide**: • Access to **weight management services in primary care** for people with a diagnosis **of type 2 diabetes** or **hypertension with a BMI of 30+** • By 2022/23, **treat a further 1,000 children a year for severe complications related to their obesity**, such as diabetes, cardiovascular conditions, sleep apnoea and poor mental health • Fund a **doubling** of the **NHS Diabetes Prevention Programme** over the next five years, including a new digital option • **All trusts** deliver the **next version of hospital food standards**, including substantial restrictions on high fat, salt and sugar food.
Alcohol	• Hospitals with the highest rate of alcohol dependence-related admissions will have **Alcohol Care Teams** funded by **CCGs health inequalities funding** supplement
Air pollution	• NHS will work to **reduce air pollution from all sources** - Specifically cut NHS business mileages and fleet air pollutant emissions by 20% by 2023/24; 90% of the NHS fleet will use low emissions engines by 2028, and heating from coal and oil fuel sources in NHS buildings will be fully phased out.
Antimicrobal resistance	• Implementation of the new **five-year action plan on Antimicrobial Resistance**

A number of the **LPT prevention 'must dos' are Trust focused**. It is therefore suggested that these are grouped together as a **Healthy Hospital Programme** and include:

- QUIT
- Alcohol care teams
- Food standards
- Active transport
- Staff H&WB
- Social Prescribing in the acute setting

The **QUIT business case** includes a **Healthy Hospital Programme Manager** for each Trust, who will provide leadership and programme management support initially for the QUIT programme and then extend out to the other areas above.

As well as the commitments in the prevention chapter and some **specific commitments for health inequalities,** the Long Term Plan has **prevention related commitments throughout the other chapters.** These are summarised in table two.

One of the five financial tests within the LTP, is that the:

Test 3: The NHS will reduce the growth in demand for care through better integration and prevention

Risks:

Although the original STP plan had '**Prevention at the heart of everything we do'** as a strap line, we have yet to achieve a 'radical upgrade' in prevention in SYB. Marked inequalities in health continue across SYB and many people continue to die prematurely from preventable disease.

Our communities and health and care organisations cannot afford for us to collectively miss this opportunities within the LTP to increase our focus, and achievements, on preventing ill health and reducing inequalities.

In order to **maximise our opportunities** to make a **real impact** we will need:

- **System commitment** to really make a shift to prevention
- **A slear governance structure** for prevention
- **Senior PH leadership** throughout the system
- **NHS funded PH & Health Improvement capacity & expertise** in the ICS, ACPs, PCNs, Trusts
- **Implementation of the NHSE must dos** and wider PH interventions **at sufficient scale** to have population impact
- **Collaborative working** with communities, LA, voluntary sector and wider partners to support action on the wider determinants of health.

Table two Prevention Priorities in NHS Long Term Plan

Blue = existing SYB prevention priorities; Purple = links with ICS/LA priorities of complex lives, connectedness or physical activity

Green = links with other SYB ICS work streams

NHS Must do NHS Funded Prevention programme priorities	LTP Priorities that link with other current prevention work stream priorities	Other NHS Specific Actions to Reduce Health Inequalities	Prevention related areas in other chapters
QUIT programme + Remit broadened to include a specific focus on smoking in pregnancy, MH & LD services.	**Expansion of social prescribing** (within personalised care) ICSs **to** partner with and **commission local voluntary sector** service provision and **support to vulnerable and at-risk groups** (links to primary care, workforce, MH, Acute)	Continuity of carer model for most vulnerable mothers and babies (maternity ws)	Implementation of Better Births, including infant feeding – (Maternity)
Alcohol care teams in hospitals (Links to MH)		More people **with SMI having physical health check** Do more to ensure that all people **with LD and/or autism** can live happier, healthier, longer lives (mental health)	Perinatal and Childhood Mental Health (Mental health) Adult mental health and suicide prevention (Mental health) Learning disability and autism (Mental health)
Wt management service accessible via primary care (? Going to be extension of NDPP –wait and see) **Hospitals implement healthy premises including new food standards**		**Rough sleepers** have better access to **specialist homelessness NHS mental health support** (mental health)	Cancer Early Diagnosis and Screening (Cancer) MSK - First contact physios – Primary Care (Primary care)
Reduction antimicrobial resistance (Regional PHE group ? any added value of ICS focus)		Specialist clinics for serious gambling problems (mental health)	**Supporting people to age well & Care Homes.** Potential: • Falls prevention • Malnutrition • Oral health • Social isolation - Social prescribing Reablement services (Primary care)
Reduction of air pollution (? ICS Estates work stream)	**CVD clinical risk factor modification (AF, BP, lipids)** (Link with primary care network DES spec)	Support **carers** Mental health and wellbeing of NHS workforce (MH, workforce)	
Suggest grouping together as a **Healthy Hospital Programme:** **(Links ICS Acute Hospital work and workforce)**		All screening and vaccination programmes are designed to support a narrowing of health inequalities (cancer)	**'Shared responsibility for health'** Some elements re LTC may be picked up under the other work streams but no coherent programme on this at ICS level
			Diabetes & stroke 2° prevention

Main Work Stream Links: Primary care, Acute Hospital, Mental health, Maternity, Workforce, Cancer, Comms and Engagement, Digital, PHM

C. Summary and Recommendations

This paper has provided an update on the three existing collaborative prevention priorities, noting progress and risks and also how the priorities fit with the LTP and Primary Care Network DES priorities.

It has also highlighted how the implementation of the QUIT programme is stalling due to lack of resources and that a business case is currently under development that may enable us to secure some external funding to support the programme from Yorkshire Cancer Research.

An overview of the Long Term Plan prevention and health inequalities commitments has been given.

The Board is asked to:

- Note the **progress on the three prevention priorities** and the relationship of these programmes to both the Long Term Plan and Primary Care Networks
- Note the **ongoing development of a QUIT business case** and the possibility of some **funding from Yorkshire Cancer Research**
- Note the **key prevention priorities within the LTP** and that:
    - Several of them relate to Trusts and hence the suggestion of having a **Healthy Hospital Programme**
    - Many other prevention priorities are scattered throughout the LTP and link with **other ICS work streams**
    - **The ICS will have to have a plan as to what it is doing to reduce health inequalities**
- Note and consider the **risks** associated with the current prevention priorities and more broadly with the implementation of the Long Term Plan prevention priorities
- In particular to note the **fragility and limited capacity to support the programme management/ PH input to the SYB collaborative prevention work.**