



**Liverpool
Public Health
Observatory**

Liverpool Public Health Observatory

Top Tips for healthier providers of health-care in Merseyside and Cheshire

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Liverpool Public Health Observatory (LPHO) is commissioned by the Merseyside Directors of Public Health, through the Cheshire and Merseyside Public Health Intelligence Network, to provide public health research and intelligence for the local authorities of Halton, Knowsley, Liverpool, St. Helens, Sefton and Wirral.

LPHO is situated within the University of Liverpool's Division of Public Health and Policy.

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1. Executive Summary

Introduction

Liverpool Public Health Observatory (LPHO) was commissioned by Merseyside and Cheshire Directors of Public Health to produce this report in order to support providers of health-care in focusing on the actions they can take to improve health. This report is relevant to secondary and specialist care, as well as community health, including mental health and learning disability service providers. The report builds on previous reports that were carried out by LPHO in 2006, which focussed on hospitals. The report is a review of secondary data, alongside examples of local delivery from Merseyside and Cheshire.

Aims

- To provide a rationale and a guide for health-care providers to become effective health promoting organisations - for their patients, their staff, and the communities they serve.

Objectives

- Provide a focus on which key health promotion areas that providers can make a positive contribution towards, relating to specific public health challenges in Cheshire & Merseyside.
- Provide a strong argument for executive and senior management support of acute, specialist and community health organisations becoming health promoting organisations.
- Demonstrate the potential impact that health promoting hospital providers could have across the regional and local footprint.
- Provide a summary of evidence based interventions and best practice that health promoting providers can benchmark or implement.

Key findings

- There is a strong business case for becoming a health-promoting provider of health-care. It is in the interests of all hospitals and healthcare providers to play a role in preventing poor health, in order to provide quality of care to patients and their families as well as to reduce unnecessary hospital admissions. For example, patients who smoke and drink less are less likely to be admitted to hospital. There are also many benefits of implementing health-promoting interventions for staff: national studies have shown associations between lifestyle and sickness absence – staff who undertook physical activity outside work had a lower incidence of absence and mental health problems, for example. Studies have also demonstrated an association between workforce well-being and key measures such as patient satisfaction and Trust performance.
- The key elements in successfully becoming a health-promoting provider of health-care are senior level buy-in, having appropriate resources to implement changes, having an action plan, and ensure that adequate evaluation and monitoring takes place.
- A range of support is available for organisations to become health promoting organisations. This includes using the World Health Organization's Health Promoting Hospital standards and framework, signing up to the Workplace Wellbeing Charter or making a pledge as part of the Department of Health's Public Health Responsibility Deal.
- Health-promoting providers need to consider how interventions will be monitored and evaluated, including how value for money will be measured, prior to their implementation.

Conclusion

In conclusion, there is a strong evidence base for organisations to become health-promoting providers. There are challenges in doing this, but a wide range of support, such as that from the World Health Organization, to become a health promoting hospital, as well as local networks, Public Health England, and the Department of Health¹ is available. In addition, at a time of increased financial constraints it will improve patient care and deliver financial savings for health-care providers.

¹ <https://responsibilitydeal.dh.gov.uk/health-at-work-pledges/>

1. Full report

2.1 Introduction

Liverpool Public Health Observatory (LPHO) was commissioned by Merseyside and Cheshire Directors of Public Health to produce this report in order to support providers of health-care in focusing on the actions they can take to improve health. This review includes top tips for patients, families, staff, and communities. It includes secondary and specialist provision, community health, mental health and learning disability. In compiling this guide, we have chosen specific settings (e.g. hospitals) as an example of what can be achieved, although the information may apply to a range of other settings, including social care, or GP care, for example. The report includes a review of relevant literature, as well as examples of local delivery from Merseyside and Cheshire. Literature from 2000 onwards was reviewed.

2.2 Aims and objectives

Aim

- To provide a rationale and a guide for organisations to become effective health promoting organisations: for their patients, their staff, their families, and the communities they serve.

Objectives

- Provide a focus on which key health promotion areas that providers can make a positive contribution towards, relating to specific public health challenges in Cheshire & Merseyside.
- Provide a strong argument for executive and senior management support of acute, specialist and community health organisations becoming health promoting organisations.
- Demonstrate the potential impact that health promoting providers could have across the regional and local footprint.
- Provide a summary of evidence based interventions and best practice that health promoting providers can benchmark or implement.

3. Background

3.1 Public health challenges for Cheshire and Merseyside

This section briefly outlines health challenges in Cheshire and Merseyside.

3.1.1 Population of Cheshire and Merseyside

Cheshire and Merseyside as a whole has a population of 2,409,463, according to Office for National Statistics (ONS) figures from 2011². Table 1 below shows that the percentage of under 16s in Cheshire and Merseyside (17.9%) was slightly less than the population of England as a whole (18.9%). Cheshire and Merseyside had a slightly higher percentage of 65-84 year olds (15.4%) than England as a whole (14.2%).

Table 1: Population by age group, 2011

Ages	Cheshire and Merseyside		England	
	Number	%	Number	%
Under 16	432,368	17.9	10,030,130	18.9
16-24	287,891	11.9	6,276,693	11.8
25-64	1,265,123	52.5	28,070,679	52.9
65-84	370,599	15.4	7,536,349	14.2
85 and over	53,482	2.2	1,193,318	2.2
Total	2,409,463	100	53,107,169	100

Source: ONS: www.localhealth.org.uk. Information from the Cheshire and Merseyside Public Health England Centre³.

3.1.2 Deprivation

According to the Index of Deprivation⁴, there was a higher proportion of households where people received means tested benefits in Cheshire and Merseyside (17.7%) than in England as a whole (14.7%). There were a higher proportion of children living in income deprived households in Cheshire and Merseyside (23.5%) than in England as a whole (21.8%). The proportion of people aged over 60 who were living in deprivation, as measured by the number of households who were receiving pension credit, in Cheshire and Merseyside (21.8%) was higher than in England as a whole (18.1%).

3.1.3 Ethnicity

The proportion of residents from Black and Minority Ethnic (BME) population in Cheshire and Merseyside (4.5%) is much smaller than in England as a whole (14.6%). The proportion of people who cannot speak English well or at all was less in Cheshire and Merseyside (0.6%) than in the population as a whole (1.7%).

3.1.4 Health

The proportion of people whose health was bad or very bad, in Cheshire and Merseyside, as measured by ONS Census figures for 2011, was higher (7.1%) than the England average (5.5%). The percentage of people who had a limiting long term illness or disability (20.9) in Cheshire and Merseyside was also higher than the national average (17.6%). The number of people providing unpaid care, in Cheshire and Merseyside, in 2011, for one hour per week (11.6%), or 50 or more hours per week (3%), was also higher than the England average (10.2% and 2.4% respectively.)

Cancer incidence figures show that lung cancer, in particular, in Cheshire and Merseyside, is significantly worse than the England average. The Standardised Registration Ratio (SRR)⁵ for all cancers (106.2) in Cheshire and Merseyside, based on 2005-9 figures, was higher than for England

² www.localhealth.org.uk

³ file:///C:/Users/clewis/AppData/Local/Microsoft/Windows/Temporary%20Internet%20Files/Content.Outlook/EXFWON40/Cheshire%20%20Merseyside%20PHE%20Centre.pdf

⁴ CLG: www.localhealth.org.uk: see

file:///C:/Users/clewis/AppData/Local/Microsoft/Windows/Temporary%20Internet%20Files/Content.Outlook/EXFWON40/Cheshire%20%20Merseyside%20PHE%20Centre.pdf

⁵ Source –UK Association of Cancer Registries (now part of Public Health England, National Cancer Data Repository).

file:///C:/Users/clewis/AppData/Local/Microsoft/Windows/Temporary%20Internet%20Files/Content.Outlook/EXFWON40/Cheshire%20%20Merseyside%20PHE%20Centre.pdf

as a whole (100). Lung cancer, in particular, was worse than the England average, with a SRR of 126.1, amounting to 10,023 people with lung cancer.

Premature mortality was significantly worse in Cheshire and Merseyside than in England as a whole. The Standardised Mortality Ratio (SRR) for premature deaths in people aged under 65, for all causes, for 2006-10 was 115.4. Premature deaths in people aged under 75 was 115.9⁶. 8 out of 9 local authorities within Cheshire and Merseyside healthy life expectancy at birth (2010-12) for both males and females is similar or worse than the England average.

In terms of healthcare and premature mortality, for excess under 75 mortality rates in adults with serious mental illness (2011-12), all local authorities perform similar or worse than the England average. Suicide rate (2010-12) for all local authorities is similar to the England average. All local authorities within Cheshire and Merseyside perform similar or better than the England average for all preventable sight loss indicators (2012-13).

The percentage of obese children in reception year⁷, 2009/10-2010/11, in Cheshire and Merseyside, 10%, amounting to 7,436 children, was significantly higher than the England average of 9.6%. In the same year, the percentage of obese children in Year 6, in Cheshire and Merseyside, 20.2%, amounting to 14,035, was significantly higher than the England average of 19%. However, the percentage of obese adults in Cheshire and Merseyside, 23.3%, 2006-8, was lower than the England average of 24.1%. The percentage of binge drinking adults, 2006-8, was significantly worse in Cheshire and Merseyside (21.9%) in Cheshire and Merseyside than in England as a whole (20%), amounting to 418,569 adults in Cheshire and Merseyside. In addition, the percentage of healthy eating adults in Cheshire and Merseyside, 2006-8, 26.2%, was significantly lower than the percentage for England overall (28.7%).

3.1.5 Use of health-care in Cheshire and Merseyside

These challenges have an impact on use of health-care in Cheshire and Merseyside. Emergency hospital admissions for all causes are higher in Cheshire and Merseyside than the England average⁸. The Standardised Admission Ratios (SARs) for 2006/7 to 2010/11, for all causes, for Cheshire and Merseyside was 132.4, significantly worse than the England average (100). The figure for emergency admissions for COPD was 143.5, amounting to 36,607 admissions. For coronary heart disease, this figure was 120.4, amounting to 42,167 admissions. Hospital stays for self-harm were significantly higher in Cheshire and Merseyside (SAR 133.8) than for England as a whole, as were stays for alcohol related harm (132).

3.1.6 Wider measures of health

The proportion of young people achieving at least 5 GCSEs grade A-C in Cheshire and Merseyside in 2010/11 (59%) was similar to England as a whole (58.2%)⁹. The proportion of 5 year olds who had a good level of development (58.3%) was similar to the national average (58.8%). The proportion claiming out of work benefit (4.5%) in Cheshire and Merseyside in 2010/11 was higher than the national average (3.6%). Long term unemployment rate per 1,000 population was also higher in Cheshire and Merseyside (7.9%) than in England as a whole (7.9%).

In terms of wider determinants of health, 8 out of the 9 local authorities within Cheshire and Merseyside percentage of pupil absence (2012/13) is similar or worse than the England average. Overall, Cheshire and Merseyside perform worse than the England average. The majority of local authorities first time entrants to the youth justice system (2013) is similar or better than the England average. Overall, Cheshire and Merseyside perform better than the England average. 5 of the 9 local authorities perform similar or better than the England average for 16-18 year olds not in education,

⁶ file:///C:/Users/clewis/AppData/Local/Microsoft/Windows/Temporary%20Internet%20Files/Content.Outlook/EXFWON40/Cheshire%20%20Merseyside%20PHE%20Centre.pdf

⁷ file:///C:/Users/clewis/AppData/Local/Microsoft/Windows/Temporary%20Internet%20Files/Content.Outlook/EXFWON40/Cheshire%20%20Merseyside%20PHE%20Centre.pdf

⁸ file:///C:/Users/clewis/AppData/Local/Microsoft/Windows/Temporary%20Internet%20Files/Content.Outlook/EXFWON40/Cheshire%20%20Merseyside%20PHE%20Centre.pdf

⁹ PHOs (now part of Public Health England), ONS, NOMIS, DfE:

file:///C:/Users/clewis/AppData/Local/Microsoft/Windows/Temporary%20Internet%20Files/Content.Outlook/EXFWON40/Cheshire%20%20Merseyside%20PHE%20Centre.pdf

employment or training (2013). The majority of local authorities (6 of the 9) perform similar or better than the England average for percentage of households that experience fuel poverty (2012)..

3.1.7 Differences and similarities between the health of people in Cheshire and Merseyside

Although this report considers both Cheshire and Merseyside, there are significant differences between the two counties. There are also wide variations within districts – the large-scale Warrington Health and Wellbeing Survey 2013, for example, found that smoking rates in the district were 26% in the most deprived quintile, compared to 7% in the least deprived¹⁰. It is also important to note that, despite public health challenges, there have been some improvements in public health in Cheshire and Merseyside in recent years – the Warrington Health and Wellbeing Survey 2013 also found that 57% of people were eating 5 portions of fruit or vegetables per day, which represented an improvement since 2006. In addition, smoking rates had decreased from 20.4% in 2006 to 13% in 2013.

3.2 National public health priorities

In addition, as stated in the NHS 2014 report ‘Five Year Forward View’¹¹, there have also been changes in patients’ personal preferences - many people wish to be more informed and involved with their own care, for example, challenging the traditional divide between patients and professionals. Technology is also transforming patient care, and different ways of organising care are developing, breaking down boundaries between hospitals and primary care, for example. In addition, in the wake of the global recession, NHS spending growth is unlikely to return to the 6%-7% real annual increases of the last decade. There have also been policy changes affecting the topics covered in this document since the previous ‘Top Tips’ report was produced in 2006, such as the ban on smoking indoors in public places under the Health Act 2006¹².

Public Health England (PHE)¹³ is the expert national public health agency which fulfils the Secretary of State for Health’s statutory duty to protect health and address inequalities, and executes his power to promote the health and wellbeing of the nation. Public Health England’s report ‘Our priorities for 2013/14’¹⁴ lists ‘helping people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, and alcohol’ as its first priority. Therefore, these are the key issues that are examined as part of this document. In a Chapter on ‘Improving health in the workplace’, Public Health England states that it aims to;

“Support employers large and small...to establish the business case for supporting a healthy workforce, securing adoption of practical evidence-based interventions and to build support for the Responsibility Deal¹⁵ among employers. The Public Health Responsibility Deal embodies the Government’s ambition for a more collaborative approach to tackling the challenges caused by our lifestyle choices. It aims to tap into the potential for businesses and other influential organisations to make a significant contribution to improving public health. Organisations signing up to the Responsibility Deal commit to taking action voluntarily to improve public health through their responsibilities as employers, as well as through their commercial actions and their community activities”. To become a national Responsibility Deal partner, an organisation must sign up to all of the core commitments and supporting pledges, at least one collective pledge and register with the Department of Health. The Public Health at Work Responsibility Deal includes a number of collective pledges on health at work issues¹⁶ - these are discussed in more detail in Chapters 4-8. Organisations are encouraged to lead where they expect others to follow by developing the employment practices of PHE to become a key exemplar of the aspirations embodied in the Responsibility Deal to support a healthy and productive PHE workforce. Organisations are also encouraged, where relevant, to pledge to encourage subcontractors and supply chains to endorse

¹⁰ http://www.warrington.gov.uk/info/200952/joint_strategic_needs_assessment/1622/jsna_data/2

¹¹ <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

¹² http://www.legislation.gov.uk/ukpga/2006/28/pdfs/ukpga_20060028_en.pdf

¹³ <https://www.gov.uk/government/organisations/public-health-england>

¹⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192676/Our_priorities_final.pdf

¹⁵ <https://responsibilitydeal.dh.gov.uk/about/>

¹⁶ <https://responsibilitydeal.dh.gov.uk/health-at-work-pledges/>

actions to implement good health and wellbeing activities. One of the benefits of this 'Top Tips' document will be to help ensure that these aims are met in Cheshire and Merseyside.

The Public Health Outcomes Framework Healthy Lives, Healthy people: Improving Outcomes and supporting transparency¹⁷ sets out a vision for public health, focussing on not only on how long people live, but on how well they live at all stages of life

3.3 The role of the NHS in tackling public health challenges

The NHS has an important role to play in promoting the health of its patients, staff and communities and to reduce health inequalities. It provides a setting through which a range of health promoting activities can take place¹⁸. In addition, although England is moving towards a pensionable age of 68, projections show that three-quarters of the population do not have disability-free life expectancy until the age of 68. If society, and the health sector, wish to have a healthy population, working until 68, action must be taken to both raise the general level of health and flatten the social gradient.

The NHS is the biggest employer in the country. It can create the conditions for a healthy workforce, and can influence the social determinants of health, as reported in the recent 'Due North report'¹⁹. In February 2014, PHE commissioned an inquiry to examine Health Inequalities affecting the North of England as part of 'Health Equity North', a programme of research, debate and collaboration, set up by PHE to explore and address health inequalities. The inquiry panel concluded that the health sector can influence health inequalities through 3 main areas of activity. Firstly by providing equitable high quality health care, secondly by directly influencing the social determinants of health through procurement and as an employer, and thirdly as a champion and facilitator that influences other sectors to take action to reduce inequalities in health. Providers of health-care can also influence inequalities through decisions on procurement, use of the Public Services (Social Value) Act 2012, which requires 'public authorities to have regard to economic, social and environmental well-being in connection with public services contracts; and for connected purposes'²⁰, and work in partnerships with local communities, as recommended in the Due North report²¹.

Three major reviews in recent years – Carol Black's review of the health of Britain's working age population, Working for a Healthier Tomorrow²², the Boorman Review of NHS Health & Well-being²³ and the Marmot Review: Fair Society, Healthy Lives, in 2010²⁴ have advocated a new approach to well-being through health strategies at work. The Marmot Review Team was commissioned by Barts and The London NHS Trust (BLT) to draw up a strategy for actions to improve the health and well-being of their workforce. The NHS is the largest employer in the country, so it is crucial that each Trust acts as a model employer and takes the lead in health promotion. This will only happen by first engaging staff and then engaging with the wider community. BLT is taking forward and leading the agenda as one of the first NHS Trusts to set out to implement the recent reviews' recommendations.

According to a report from the NHS Future Forum²⁵, when faced with conflicting messages from, some may need support from professionals to help them take the best care of themselves. People trust the NHS and expect it to help them stay well, as well as treating them when they ill. The NHS

¹⁷ <https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency>

¹⁸ <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report>

¹⁹ <http://www.cles.org.uk/wp-content/uploads/2014/09/Due-North-Report-of-the-Inquiry-on-Health-Equity-in-the-North-final1.pdf>

²⁰ <http://www.legislation.gov.uk/ukpga/2012/3/enacted>

²¹ <http://www.cles.org.uk/wp-content/uploads/2014/09/Due-North-Report-of-the-Inquiry-on-Health-Equity-in-the-North-final1.pdf>

²² Black C. (2008) Workingfor a healthier tomorrow. TSO:

London. <http://www.workingforhealth.gov.uk/documents/working-for-ahealthier-tomorrowtagged.pdf>

²³ Boorman S. (2009) NHSHealth and Well-being Report. [http://www.nhshealthandwellbeing.org/pdfs/NHS Staff H&WB Review Final Report VFinal20-11-09.pdf](http://www.nhshealthandwellbeing.org/pdfs/NHS%20Staff%20H&WB%20Review%20Final%20Report%20VFinal20-11-09.pdf)

²⁴ The Marmot Review (2010)

Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post- 2010. The Marmot Review:London <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

²⁵ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216423/dh_132114.pdf

has a responsibility to support individuals, their carers and family to think and act more healthily wherever possible, and guide them to any further help they might need – especially those who can find it difficult to access NHS services. According to this report, millions of people talk to NHS staff every day, spanning a diverse range of professions. Each day, GPs and practice nurses see over 800,000 people and dentists see over 250,000 NHS patients. There are 31,000 NHS sight tests, while approximately 1.6 million people visit a pharmacy. We can also encounter healthcare professionals in schools, at home and in practices, surgeries and hospitals. Therefore there are many opportunities every day for the NHS to help to improve people's health and wellbeing and reduce health inequalities. A visit from a midwife or health visitor, for example, is an opportunity to talk about a new parent's anxieties and consider options for accessing mental health support. A check-up prior to surgery is an opportunity to talk about concerns about smoking, diet and physical activity, for example.

In addition, Dame Carol Black's and David Frost's 2011 report 'Health at work – an independent review of sickness absence'²⁶ highlighted the role that employers can play in reducing sickness absence. Recommendations included a health and work assessment and advisory service²⁷, as well as improving sickness and absence management. Recommendations were also made about the future direction for the health and work agenda, which included addressing the needs of people who have mental health problems. In 2013, the Government published Fitness for Work: the Government response to 'Health at Work – an independent review of sickness and absence'²⁸, supporting the recommendations in Black and Frost's report, and outlining initiatives and interventions that would help to create a healthier and more productive workforce. The Government has continued the investment in the health and work programme which followed the 2008 Black Review.

In addition, the Health, Work and Wellbeing initiative²⁹ was launched. This is a cross-government initiative that aims to improve the general health and wellbeing of the working-age population, as well as supporting more people with health conditions to stay in work or enter employment. The initiative involves working with employers, trades unions and healthcare professionals to create healthier workplaces and improve occupational health services and rehabilitation support, by educating individuals and raising awareness, improving the range and capacity of occupational health services, and providing practical and effective support for employers, and, of particular relevance for the NHS and other health-promoting organisations³⁰, encouraging public sector organisations to lead by example on health at work. The NHS 'Five Year Forward View'³¹, which was published in October 2014, also states that the future health of millions of children, along with the sustainability of the NHS now depend on a radical upgrade in prevention and public health. It points out that, Derek Wanless³² 2002 health review, which warned that, unless the country took prevention seriously, we would be faced with a sharply rising burden of avoidable illness, has not been acted upon- the NHS is now dealing with the consequences of this. The 'Five Year Forward View' states that the NHS will therefore now back hard-hitting national action on obesity, smoking, alcohol and other major health risks. This will include developing and supporting new workplace incentives to promote employee health.

3.4 The business case for becoming a health promoting hospital

In addition to helping organisations to meet national standards, there is a strong business case for becoming a health-promoting provider.

²⁶ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216423/dh_132114.pdfhttps://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181060/health-at-work.pdf

²⁷ Occupational health is a specialist branch of medicine focusing on the health of staff in the workplace

²⁸ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181072/health-at-work-gov-response.pdf

²⁹ <https://www.gov.uk/government/policies/helping-people-to-find-and-stay-in-work/supporting-pages/co-ordinating-the-health-work-and-wellbeing-initiative>

³⁰ <http://www.nhshealthatwork.co.uk/health-work-wellbeing.asp>

³¹ <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

³² http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009293

3.4.1 The business case for investing in health promotion activities with patients and their families

Increasingly, there is a desire for people to be treated in community settings, and to only be admitted to hospital when absolutely necessary. In order to achieve this, all NHS organisations must play their part in preventing poor health. This will contribute to fewer unnecessary hospital admissions. As discussed in more detail in sections 4-8, improving the health of patients, staff, and the wider community, in terms of smoking cessation, healthy eating, physical activity, sensible alcohol consumption, and, mental health, can have a large impact on hospital admissions. For example, Recent Standardised Admission Ratios for Cheshire and Merseyside for emergency admissions for chronic obstructive pulmonary disease (COPD), was 143.5, amounting to 36,607 admissions, which was significantly worse than the England average (100): the main cause of COPD is tobacco smoke, including second-hand or 'passive' smoking³³. For coronary heart disease, where again smoking is a major risk factor this³⁴ figure was 120.4, amounting to 42,167 admissions. Hospital stays for alcohol-related harm were significantly higher in Cheshire and Merseyside (SAR 132) than for England as a whole.

Hospitals and other healthcare settings should work in partnership with organisation such as local councils, housing providers, and Citizens Advice Bureaus³⁵ to create one stop shops for patients where, in addition to meeting their physical needs, their social needs can also be met. 'One stop' shops could provide signposting to organisations who can assist with housing, for example. This will contribute to a reduction in inequalities, which will also have an impact on population health and wellbeing. Several public health teams across Merseyside have developed, or are planning, Integrated Wellness Services (IWS)³⁶, which usually involve patients being holistically assessed and triaged at a single point of access 'hub', and referred to other services as appropriate. IWS services support community development and build upon community assets – also see section 8.2.3.

3.4.2 The business case for staff

According to Dame Carol Black's report 'Working for a healthier tomorrow'³⁸, many common diseases are directly linked to lifestyle factors, but these are generally not the conditions that keep people out of work. Instead, common mental health problems and musculoskeletal disorders are the major causes of sickness absence and worklessness due to ill-health. This is compounded by a lack of appropriate and timely diagnosis and intervention. As the largest employer in the country, large cost savings could be made by preventing sickness absence. In addition, improving the wellbeing of staff of health-promoting providers can lead to an improvement in quality of care.

The Boorman³⁷ review into health and well-being in the NHS also found that there are associations between lifestyle and sickness absence: staff who smoke six or more cigarettes a day have higher incidence of absence and longer absences. Staff with poor general physical health reported more absence and for longer periods of time than those in good health, while staff who undertook physical activity outside work had a lower incidence of absence and mental health problems than those who did not. Boorman's review showed clear links between workforce well-being and key measures such as patient satisfaction and Trust performance³⁸. The NHS loses over 10 million working days each year due to sickness absence alone. According to a Department of Health report, 14 evaluation studies in the USA found that health promotion measures led to a 12–36 per cent reduction in sickness absence and a 34 per cent saving in absenteeism costs³⁹. There are financial costs associated with the focus on maintaining a functioning workforce, as well as social costs and risks associated with presenteeism. Presenteeism is high in the NHS: many NHS workers are working when they feel unwell. This poses a risk to health and safety both of staff and patients as well as financial costs: presenteeism costs £605 per employee per year, compared with absenteeism which

³³ <http://www.who.int/respiratory/copd/causes/en/>

³⁴ <http://www.world-heart-federation.org/cardiovascular-health/cardiovascular-disease-risk-factors/>

³⁵ <http://www.adviceguide.org.uk/england.htm>

³⁶ <http://www.kingsfund.org.uk/sites/files/kf/chris-mcbrien-elspeth-anwar-knowsley-poster-mar13.pdf>

³⁷ Boorman S. (2009) NHS Health and Well-being Report. [http://www.nhshealthandwellbeing.org/pdfs/NHS Staff H&WB Review Final Report VFinal 20-11-09.pdf](http://www.nhshealthandwellbeing.org/pdfs/NHS%20Staff%20H&WB%20Review%20Final%20Report%20VFinal%2020-11-09.pdf)

³⁸ Boorman S. (2009) NHS Health and Well-being Report. [http://www.nhshealthandwellbeing.org/pdfs/NHS Staff H&WB Review Final Report VFinal 20-11-09.pdf](http://www.nhshealthandwellbeing.org/pdfs/NHS%20Staff%20H&WB%20Review%20Final%20Report%20VFinal%2020-11-09.pdf)

³⁹ Boorman S. (2009) NHS Health and Well-being Report. [http://www.nhshealthandwellbeing.org/pdfs/NHS Staff H&WB Review Final Report VFinal 20-11-09.pdf](http://www.nhshealthandwellbeing.org/pdfs/NHS%20Staff%20H&WB%20Review%20Final%20Report%20VFinal%2020-11-09.pdf)

costs £335 per employee per year⁴⁰. A focus on improving people's general health will lead directly to reduced presenteeism and absenteeism and therefore improved performance – as also stated in the Government's 2013 report 'Fitness for work: the Government response to 'Health at work – an independent review of sickness absence'⁴¹.

3.4.3 The business case for the wider community

Health providers have a role in developing health literacy of patients, staff, and the wider community. The World Health Organization⁴² defines health literacy as the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health Literacy means more than being able to read pamphlets and successfully make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment. Defined this way, Health Literacy goes beyond a narrow concept of health education and individual behaviour-oriented communication, and addresses the environmental, political and social factors that determine health. Health education, in this more comprehensive understanding, aims to influence not only individual lifestyle decisions, but also raises awareness of the determinants of health, and encourages individual and collective actions which may lead to a modification of these determinants. Such health education leads to health literacy, leading to personal and social benefit, such as by enabling effective community action, and by contributing to the development of social capital.

The health sector has an important role to play in tackling health inequalities, as outlined in the Marmot Review⁴³ and in the 'Due North' report⁴⁴. In February 2014, Public Health England (PHE) commissioned an inquiry to examine Health Inequalities affecting the North of England. This inquiry was led by an independent Review Panel of leading academics, policy makers and practitioners from the North of England. This is part of 'Health Equity North' - a programme of research, debate and collaboration, set up by PHE, to explore and address health inequalities. The inquiry panel concluded that the health sector can influence health inequalities. In addition to providing equitable high quality health care, the NHS, as the largest employer in the UK, with the highest purchasing power, can directly influence the social determinants of health through procurement and as an employer. It can use the Public Services (Social Value) Act 2012⁴⁵, an Act which requires public authorities 'to have regard to economic, social and environmental well-being in connection with public services contracts; and for connected purposes', as mentioned above, in order to do this. This might be achieved by employing local people, or procuring local materials, for example, or by working in partnership with other organisations, and supporting local voluntary organisations. Finally, hospitals and health providers can influence other sectors to take action to reduce inequalities in health.

3.5 Why has this guide been produced?

The report builds on previous reports that were carried out by Liverpool Public Health Observatory in 2006, which focussed on healthy hospitals. Given the changing landscape following significant NHS reform, with new public health challenges and evidence, the top tips document needs to be refreshed. The scope of this review is broader than that of the original review, and includes hospital community trusts, and other health care providers, as well as hospitals. New evidence has also emerged since 2006, with other relevant research having been published. Three major reviews in recent years – Carol Black's review of the health of Britain's working age population, Working for a Healthier Tomorrow⁴⁶, the Boorman Review of NHS Health & Well-being⁴⁷ and the Marmot Review: Fair

⁴⁰ The Sainsbury Centre for Mental Health (2007) Policy Paper 8 – Mental Health atWork: Developing the business case. http://www.scmh.org.uk/pdfs/mental_health_at_work.pdf

⁴¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181072/health-at-work-gov-response.pdf

⁴² <http://www.who.int/healthpromotion/conferences/7gchp/track2/en/>

⁴³ <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report>

⁴⁴ <http://www.cles.org.uk/wp-content/uploads/2014/09/Due-North-Report-of-the-Inquiry-on-Health-Equity-in-the-North-final1.pdf>

⁴⁵ <http://www.legislation.gov.uk/ukpga/2012/3/enacted>

⁴⁶ Black C. (2008) Working for a healthier tomorrow. TSO:

London. <http://www.workingforhealth.gov.uk/documents/working-for-ahealthier-tomorrowtagged.pdf>

⁴⁷ Boorman S. (2009) NHS Health and Well-being Report. [http://www.nhshealthandwellbeing.org/pdfs/NHS Staff H&WB Review Final Report VFinal20-11-09.pdf](http://www.nhshealthandwellbeing.org/pdfs/NHS_Staff_H&WB_Review_Final_Report_VFinal20-11-09.pdf)

Society, Healthy Lives, in 2010⁴⁸ have advocated a new approach to well-being through health strategies at work. As discussed in the previous section, Public Health England's report 'Our priorities for 2013/14'⁴⁹ lists 'helping people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, and alcohol' as its first priority. Therefore, these are the key issues that are examined as part of this document. The landscape of public health has also changed considerably since 2006, following the Health and Social Care Act 2012⁵⁰, which has seen public health teams move from being based within the NHS to within local authorities, for example.

The Cheshire and Merseyside Healthy Providers Network⁵¹ network has been in place since the summer of 2012. The purpose of the network has been to provide a collaborative forum for acute trusts and provider trusts to work together on a common theme of improving health and reducing health inequalities. Until recently, the Network has been hosted by Liverpool Community Health NHS Trust, and currently has 19 member organisations. The future of the network is now uncertain due to funding constraints. Nevertheless, this guide will support network members and other organisations by providing the relevant evidence base and examples of practice for members and others.

⁴⁸ The Marmot Review (2010)

Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post- 2010. The Marmot Review:London
<http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

⁴⁹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192676/Our_priorities_final.pdf

⁵⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138257/A1.-Factsheet-Overview-240412.pdf

⁵¹ <http://www.alderhey.nhs.uk/wp-content/uploads/Newsletter-issue-1.pdf>

4. Provide smoking cessation services and a smoke-free environment

Smoking – key facts

Smoking prevalence in Cheshire and Merseyside

- 5 of the 9 local authorities within Cheshire and Merseyside have adult smoking prevalence rates that are above the England average, therefore tackling smoking is an important issue in this region. In Merseyside, only prevalence rates on the Wirral (18.4%) were lower than the England average.

Cost of smoking to the NHS

- Recent Standardised Admission Ratios for Cheshire and Merseyside for emergency admissions for COPD was 143.5, amounting to 36,607 admissions, which was significantly worse than the England average (100). For coronary heart disease, this figure was 120.4, amounting to 42,167 admissions

Smoking related deaths

- Deaths from coronary heart disease, stroke, cancer and respiratory diseases, all of which have been shown to have a link to smoking, are all significantly higher in Cheshire and Merseyside than in England as a whole.

4.1 What is the issue?

Table 1 below shows that, according to 2014 Health Profiles compiled by the Association of Public Health Observatories⁵², 6 of the 9 local authorities within Cheshire and Merseyside have smoking prevalence rates that are above the England average of 19.5%, using latest rates available from 2012. Therefore, tackling smoking is an important issue in this region. However, it is important to note that smoking rates have declined over time. Table 2 below shows that rates have declined in all local authority areas in Cheshire and Merseyside apart from St. Helens since 2009-10. Nationally, smoking rates had declined from 21.2% in 2009/10, to 19.5% in 2012.

Table 2: Smoking prevalence rates in Cheshire and Merseyside

District	Smoking rates (%) 2012	Smoking rates (%) 2009-10
Liverpool	24.5	26.5
Knowsley	23.6	28.2
St. Helens	23.1	21.6
Halton	22.6	24.0
Sefton	19.7	19.3
Wirral	18.4	21.5
Warrington	17.8	22.5
Cheshire East	16.3	19.0
Cheshire West and Chester	15.0	20.5
England	19.5	21.2

Source: Association of Public Health Observatories Health Profiles <http://www.apho.org.uk/default.aspx?RID=49802>

According to Public Health England⁵³, the Standardised Admission Ratios (SARs) for 2006/7 to 2010/11, for Cheshire and Merseyside for emergency admissions for chronic obstructive pulmonary disease (COPD) was 143.5, amounting to 36,607 admissions, which was significantly worse than the England average of 100. For coronary heart disease, this figure was 120.4, amounting to 42,167 admissions. As smoking is a risk factor for both these conditions⁵⁴, it is important that smoking is tackled in Cheshire and Merseyside. Providers of health-care are in an excellent position to do this⁵⁵.

In addition, Standardised Registration Ratios (SRRs) for lung cancer, four out of five cases of which are caused by smoking⁵⁶ in 2005-9, were higher in Cheshire and Merseyside (SRR 126.1) than the England average (100). Nationally, according to the General Household Survey⁵⁷, it is estimated that around a quarter (25%) of all admissions with a primary diagnosis of respiratory diseases, 15% of admissions with primary diagnosis of circulatory diseases, 11% with a primary diagnosis of cancer and 1% with a primary diagnosis of diseases of the digestive system, are attributable to smoking. According to Public Health England⁵⁸, Standardised Mortality Ratios (SMRs) for deaths from coronary heart disease (113.2), stroke (108.4), cancer (112.2), and respiratory diseases (119.9), all of which have been shown to have a link to smoking, are significantly higher in Cheshire and Merseyside as a whole than the England average.

The World Health Organization (WHO) estimates that in 2005 5.4 million people died due to tobacco use. Tobacco-related deaths are projected to increase to 8.3 million deaths per year by 2030⁵⁹.

⁵² <http://www.apho.org.uk/resource/view.aspx?RID=50215®ION=50151&SPEAR=>. Association of Public Health Observatories are now part of Public Health England.

⁵³ file:///C:/Users/clewis/AppData/Local/Microsoft/Windows/Temporary%20Internet%20Files/Content.Outlook/EXFWON40/Cheshire%20%20Merseyside%20PHE%20Centre.pdf

⁵⁴ <http://www.world-heart-federation.org/cardiovascular-health/cardiovascular-disease-risk-factors/>

⁵⁵ Boorman S. (2009) NHS Health and Well-being Report. [http://www.nhshealthandwellbeing.org/pdfs/NHS Staff H&WB Review Final Report VFinal 20-11-09.pdf](http://www.nhshealthandwellbeing.org/pdfs/NHS_Staff_H&WB_Review_Final_Report_VFinal_20-11-09.pdf)

⁵⁶ <http://www.cancerresearchuk.org/cancer-info/healthyliving/smoking-and-cancer/smoking-and-cancer>

⁵⁷ 2010 data on hospital admissions, in England in 2011/12, among adults aged 35 and over from the General Household Survey http://data.gov.uk/dataset/general_household_survey

⁵⁸ file:///C:/Users/clewis/AppData/Local/Microsoft/Windows/Temporary%20Internet%20Files/Content.Outlook/EXFWON40/Cheshire%20%20Merseyside%20PHE%20Centre.pdf

⁵⁹ <http://www.who.int/respiratory/copd/causes/en/>

The Department of Health's Public Health Responsibility Pledge encourages organisations, including the NHS, to sign up to the pledge to;

"We will encourage staff to stop smoking, by facilitating onsite stop smoking support services or by encouraging them to attend local stop smoking services during working time without loss of pay. We will also take action to reduce other risks to respiratory health arising in the workplace".

NICE have also produced useful guidance on workplace interventions to promote smoking cessation, which can be accessed at <http://www.nice.org.uk/guidance/PH5>

E-cigarettes or electronic nicotine delivery systems (ENDS) are another issue that need to be considered by health-care providers, and included in smoking policies. ENDS are devices whose function is to vaporize and deliver to the lungs of the user a chemical mixture typically composed of nicotine, propylene glycol and other chemicals. Most ENDS are shaped to look like their tobacco counterparts, but they are also sometimes made to look like everyday items such as USB memory sticks. They are not currently available on the NHS. ENDS are commonly believed by consumers to be safer than smoking tobacco, but their safety has not been demonstrated. Plans have been announced to regulate electronic cigarettes from 2016, but until this happens, they are only covered by general product safety legislation⁶⁰.

⁶⁰ [http://www.nhs.uk/Conditions/Smoking-\(quitting\)/Pages/Treatment.aspx](http://www.nhs.uk/Conditions/Smoking-(quitting)/Pages/Treatment.aspx)

4.2 What can NHS providers do?

4.2.1 Patient based interventions

4.2.1.1 Community interventions

NICE (National Institute for Health and Care Excellence) quality standards describe high-priority areas for quality improvement in a defined care or service area. The Smoking Cessation: supporting people to stop smoking quality standard covers smoking cessation, which includes support for people to stop smoking and for people accessing smoking cessation services⁶¹. There is evidence that people who smoke are receptive to smoking cessation advice in all healthcare settings. It is therefore important that healthcare practitioners proactively ask people if they smoke, and offer advice on how to stop. Healthcare practitioners include, but are not limited to, doctors, nurses, midwives, pharmacists, dentists, opticians and allied health professionals.

Smoking cessation services provide the most effective route to stopping smoking, but many people who smoke do not use these services when they try to stop. It is therefore important that practitioners are aware of and make use of the opportunities to refer people who smoke to an evidence-based smoking cessation service.

It is important that NHS providers ensure that;

- Patients are asked if they smoke, and those who smoke are offered advice on how to stop.
- Patients who smoke are offered a referral to an evidence-based local stop smoking service.

4.2.1.2 Secondary care interventions

NICE has published guidance that states that all NHS secondary care settings should become completely smoke-free to help all patients who smoke, including those receiving mental health treatment, to stop smoking whilst they receive care, and preferably help them to stop for good.⁶² The guidance also seeks to promote stop smoking among staff or to abstain from smoking while at work. Stopping smoking at any time has considerable health benefits for people who smoke, and for those around them. For people using secondary care services, there are additional advantages, including shorter hospital stays, lower drug doses, fewer complications, higher survival rates, better wound healing, decreased infections, and fewer re-admissions after surgery. Secondary care providers have a duty of care to protect the health of, and promote healthy behaviour among, people who use or work in their services. This duty of care includes providing them with effective support to stop smoking or to abstain from smoking while using or working in secondary care services. This guidance aims to support smoking cessation, temporary abstinence from smoking and smokefree policies in all secondary care settings. It recommends;

- Strong leadership and management to ensure premises remain smokefree
- All hospitals have an on-site stop smoking service
- Identifying people who smoke, offering advice and support to stop
- Providing intensive behavioural support and pharmacotherapy as an integral component of secondary care
- Integrating stop smoking support in secondary care with support provided by community-based services
- Ensuring staff are trained to support people to stop smoking while using secondary care services
- Supporting staff to stop smoking or to abstain while at work.
- Ensuring there are no designated smoking areas or staff-facilitated smoking breaks for anyone using secondary care services.

⁶¹ <http://www.nice.org.uk/guidance/qs43>

⁶² <http://www.nice.org.uk/guidance/ph48>

4.2.2 Staff based interventions

Since the implementation of the smokefree provisions of the Health Act in 2007⁶³, smoking in all enclosed public places and workplaces is prohibited across the UK. This has resulted in virtually all enclosed work and public places being smoke-free. People today are most likely to be exposed to the harmful effects of secondhand smoke in the home. This affects the health of smokers, their family and friends and visitors including health and social care staff.

Employers have a duty to provide a working environment for employees that is safe and without risks to health. However, there is no law to protect anyone working in a client's home in relation to secondhand smoke. Employers and employees rely on the understanding and goodwill of the client to refrain from smoking.

In response to this, The Health Equalities Group⁶⁴ has developed the 'Breathing Space – Your Home - Our Workplace' award for organisations in Cheshire and Merseyside. The main purpose of Breathing Space is to protect staff in the community from exposure to secondhand smoke in the home environment. The initiative also aims to protect clients and their family and friends from secondhand smoke and to promote local stop smoking services. Breathing Space is awarded to organisations that demonstrate their commitment to best practice standards to minimise the effect of secondhand smoke for their community staff and the clients they serve. Guidance is provided to managers about the steps that need to be taken to acquire and maintain the Breathing Space award and to staff who have face-to-face contact with clients in their own homes. The Breathing Space award replaces the Mersey and Cheshire Charters, which were launched in 2009. Over 200 organisations across the region were awarded the original Charter.

The Workplace Wellbeing Charter also provides advice for employers on tackling smoking⁶⁵. The Charter recommends that a working smoke-free policy is in place, and staff are aware of it – the policy should extend to all smoking habits, including electronic cigarettes. For a rating of 'excellent', all open outdoor areas should be clearly signposted as smoke-free, and steps taken to prevent smoking in these areas. Employers should actively promote stop smoking services, and allow staff time to attend.

⁶³ http://www.google.co.uk/url?url=http://www.parliament.uk/briefing-papers/sn04414.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=kNlpVPcsguhqrPaB-Ag&ved=0CCYQFjAD&sig2=eaUXEnYKjnU3bD1CDTuHug&usg=AFQjCNHCpygyoXvmGgBGiN4AwnV_WHgeBQ

⁶⁴ <http://www.hegroup.org.uk/>

⁶⁵ http://wellbeingcharter.org.uk/media/PDF/WWC_Self_Assessment_Standards_A4_Booklet_Liverpool_2_WEB.PDF

4.3 Examples of local delivery

4.3.1 Alder Hey Children's NHS Foundation Trust

What was the issue?

Alder Hey is uniquely placed to play a critical role in improving the health and wellbeing of children, young people and their families. The hospital sees and treats over 250,000 children a year, approximately 500,000 parents/carers and a significant number of other family and friends. As England's first Paediatric Health Promoting Hospital accredited by the World Health Organization, staff at Alder Hey want to ensure that the entire site is Smoke Free. Smoking is not allowed in any area within the Trust premises including grounds and car parks. This includes the use of Electronic Cigarettes.

The dangers of second hand smoke can be serious, and the hospital aims to protect the air that children, families and staff breathe whilst at the hospital. As a paediatric hospital, parents may wish to smoke due to the stressful situations they are in. The hospital has employed concierge staff to provide support with tackling this role, and, with the help of volunteers, regularly challenge families who smoke on site.

What was the intervention (including any timescales)?

Since 2008, the hospital has been using innovative campaigns to deliver smoke free messages to our patients, parents, families and staff. Some examples are as follows:

- Colouring books designed by illustrations from our patients on the dangers of smoking
- Money boxes designed by patients to give to adults to "stop and save"
- Big Cig, where a life sized cigarette walked around the Trust talking to parents smoking onsite
- 'Alder Hey say No Way' campaign, which involved promotional material produced around parent smoking on site. This included banners, posters, leaflets, and business cards for staff to give to parents if they were seen smoking.
- Poster competitions from patients on the dangers of smoking, which were then displayed around the Trust
- Design a stamp competition: patients designed a postage stamp which was fixed to all letters that were sent from the Trust during a week in March, to coincide with No Smoking Day
- Smoke free policy has been updated to reflect changes in practice due to the increase of electronic cigarettes.
- There have been ongoing challenges to ensure this programme is maintained. Regular staff walkabouts are carried out, and an escalation process is in place for families who continue to smoke on site.

What have been the benefits to patients/staff/the wider community?

The benefits to patients, families and staff have been enormous as they are being treated in a smoke free environment. There are also added benefits to the environment as the walkways are clear from smoke and cigarette ends.

Is there any cost/benefit analysis or information available?

There have been minimal costs for promotional materials and resources.

Contact details

Liz Grady, Health Promotion Practitioner, Alder Hey Children's NHS Foundation Trust.

Email: Elizabeth.grady@alderhey.nhs.uk. Telephone: 0151 252 5024.

4.3.2 Cheshire and Wirral Partnership NHS Foundation Trust (CWP)

What was the issue?

Social and health inequalities for people with mental health conditions linked to smoking. Cheshire and Wirral Partnership NHS Foundation Trust (CWP) recognised our responsibility to support people who use our services and staff to avoid harm from smoking. The trust are approaching smoking as a clinical and stigma issue rather than a social choice.

What was the intervention (including any timescales)?

In February 2014 CWP introduced a Nicotine Management Policy across all CWP Services and premises. The approach to the Policy was prepared, discussed and agreed over approximately 18 months prior to introduction. During this period a Trustwide Steering Group was set up to lead policy decisions and produce Trustwide and Local Action Plans to enable successful implementation of the Policy. Areas covered within the Action Plans included:-

- Training
- Communication of the Policy changes
- Guidance for Inpatient and Community staff
- Production of Frequently Asked Questions and Answers
- Revised Nicotine Replacement Therapy Guidelines.

The Trust also ran a series of Trustwide and Local Conferences for staff to cover promotion of the new Policy and to allow debate of the new Policy and give staff an opportunity to raise any questions or concerns regarding implementation.

Trust Board commitment to the Policy was established from an early stage via a Board Paper and presentations of the proposals and ongoing Board support has been key in implementation and monitoring of the Policy.

What have been the benefits to patients/staff/the wider community?

The new Policy has provided clarity and guidance to allow the introduction of a smoke free environment within CWP Services. People who access our services and staff have access to support to stop smoking and inpatients have speedy access to NRT products and advice. We have pledged that inpatients will be able to see someone who can assess their nicotine dependency and prescribe NRT within 2 minutes of arriving on any of our wards.

Contact details

Avril Devaney, Director of Nursing, Therapies and Patient Partnership.

Email: avril.delaney@cwps.nhs.uk

Bill Woods, Clinical Service Manager –Ageing Well.

Email: bill.woods@cwps.nhs.uk

4.4 Other useful resources

<http://publications.nice.org.uk/workplace-interventions-to-promote-smoking-cessation-ph5>

<http://www.hscic.gov.uk/catalogue/PUB11454/smok-eng-2013-rep.pdf>

<http://www.nice.org.uk/Guidance/PH45> Tobacco: harm-reduction approaches to smoking –PH45, June 2013.

NICE guidance: Smoking cessation in secondary care: acute, maternity and mental health services, Nov 2013. (<http://beta.nice.org.uk/guidance/PH48>)

Summary of NICE guidance on smoking cessation in secondary care settings:

<http://www.nice.org.uk/nicemedia/live/11375/31866/31866.pdf>

5. Provide opportunities for healthy eating

Obesity – key facts

Prevalence of obesity

- The percentage of obese children in reception year¹, 2009/10-2010/11, in Cheshire and Merseyside, 10%, amounting to 7,436 children, was higher than the England average of 9.6%. In the same year, the percentage of obese children in Year 6, in Cheshire and Merseyside, 20.2%, amounting to 14,035, was higher than the England average of 19%. However, the percentage of obese adults in Cheshire and Merseyside, 23.3%, 2006-8, was lower than the England average of 24.1%.

Obesity and the NHS

- Malnourished patients in hospital stay longer and are more likely to develop complications or infections. They also visit their GPs more often.
- Obesity can cause a range of serious health conditions, including type 2 diabetes, coronary heart disease, some types of cancer, including breast and bowel cancer, and stroke
- Health problems associated with being overweight or obese cost the NHS more than £5 billion every year.
- Obesity and overweight also affect NHS staff. Over half of all the food provided in NHS hospitals is served to staff and visitors. Hospitals also have a role in supporting staff to make healthier choices.
- A Department of Health audit estimated in 2009 that of the 1.2 million staff in the NHS, approximately 300,000 would be classified as obese and a further 400,000 as overweight.

5.1 What is the issue?

According to 'NHS choices', obesity is a term to describe someone who is very overweight, with a lot of body fat⁶⁶, and it affects 1 in 4 adults, and 1 in 5 children aged 10-11 in the UK. Body Mass Index (BMI) is the most commonly used method of measuring if someone is overweight for their height. For most adults, a BMI of 25 to 29.9 is considered overweight, a BMI of 30 to 39.9 means you are considered obese, and a BMI of 40 or above is considered severely obese⁶⁷.

Obesity can cause a range of serious health conditions, including type 2 diabetes, coronary heart disease, some types of cancer, including breast and bowel cancer, and stroke⁶⁸. It is estimated to cause about 31% of coronary heart disease and 11% of stroke worldwide, according to the British Heart Federation⁶⁹. National Health statistics estimate the cost of obesity related conditions to the NHS as £4.2 billion per year⁷⁰. It is estimated that if the current trend continues, by 2050 this will translate to an additional £45.5 billion per year in NHS costs⁷¹.

The food that is served in hospitals and other health-care environments can have a huge impact on patient health, as well as staff and visitors: over half of all the food provided in NHS hospitals is served to staff and visitors. Hospitals also have a role in supporting staff to make healthier choices. Hospitals also have a wider social responsibility: as major purchasers and providers of food and catering services, they have the opportunity to put sustainability at the heart of their work. This might include reducing waste, embedding high standards of farm and food production, reducing their carbon footprint and making their catering contracts accessible to small businesses⁷².

The UK's National Institute for Health and Care Excellence⁷³ (NICE) has put part of the blame for obesity on "obesogenic environments". In simple terms, environments that encourage people to eat unhealthily and not do enough exercise. Providers of health-care can ensure that the health-care environment is conducive to healthy eating.

According to a report that Liverpool Public Health Observatory produced in 2012⁷⁴, poor diet could be costing the NHS on Merseyside £116.9m to £175.4m each year. A breakdown of estimated costs within Merseyside is shown in Table 3 below:

Table 3: Estimated annual cost to the NHS of poor diet across Liverpool City Region

Estimated annual cost to the NHS of poor diet across Liverpool City Region					
Halton	Knowsley	Liverpool	St Helens	Sefton	Wirral
£9.2m to £13.8m	£11.6m to £17.4m	£35.8m to £53.7m	£21.9m to £32.9m	£14.0m to £21.1m	£24.3m to £36.5m

NICE guidelines published 28th May 2014⁷⁵ - Managing overweight and obesity in adults – lifestyle weight management services.

In addition, tackling this issue can lead to a reduction in health inequalities. Inequalities in childhood obesity are widening⁷⁶. As stated in the 'key facts' section above, although obesity in adults in lower in Cheshire and Merseyside than in England as a whole, obesity in children in reception year and in Year 6 is higher than in England as a whole.

⁶⁶ <http://www.nhs.uk/conditions/Obesity/Pages/Introduction.aspx>

⁶⁷ <http://www.nhs.uk/conditions/Obesity/Pages/Introduction.aspx>

⁶⁸ <http://www.nhs.uk/conditions/Obesity/Pages/Introduction.aspx>

⁶⁹ <http://www.world-heart-federation.org/cardiovascular-health/cardiovascular-disease-risk-factors/>

⁷⁰ Government Office for Science (2007) *Tackling Obesity: Future Choices*, Foresight Report.

⁷¹ http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/PublicHealth/Healthimprovement/Obesity/DH_079713

⁷² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/348617/Hosp_food_panel_report.pdf?utm_medium=email&utm_source=The+King%27s+Fund+newsletters&utm_campaign=4577543_HMP+2014-08-29&dm_i=21A8_2Q41Z_FLWSFM_A0Q9K.1: The Hospital Food Standards Panel's report on standards for food and drink in NHS hospitals. Department of Health, August 2014

⁷³ <http://www.bbc.co.uk/news/blogs-magazine-monitor-27601593>

⁷⁴ http://www.liv.ac.uk/media/livacuk/instituteofpsychology/publichealthobservatory/89_diet_prev_prog_FINAL.pdf

⁷⁵ <http://publications.nice.org.uk/managing-overweight-and-obesity-in-adults-lifestyle-weight-management-services-ph53>

⁷⁶ https://www.noo.org.uk/uploads/doc/vid_18988_PHEconf_Poster_NCMPinequalities_v2.pdf

National statistics on childhood obesity also show that tackling obesity is of increasing importance. Across the six years of the National Child Measurement Programme⁷⁷ (NCMP) there has been a decrease of around 0.13% per year in the prevalence of obesity among boys in reception year, although girls in reception do not show a significant trend. However, obesity prevalence for children in Year 6 shows a statistically significant increase for both boys and girls. In terms of ethnicity, the only population group to show a decrease in obesity prevalence since 2007/08 was white boys in Reception. Child obesity is also closely correlated with deprivation - there is evidence that socioeconomic inequalities in obesity prevalence are increasing. In reception, obesity prevalence is decreasing by around 0.1% to 0.3% per year in the least deprived areas, but remaining constant in the most deprived areas. In Year 6, obesity prevalence is increasing at a rate of around 0.5% per year in the most deprived areas, whilst remaining relatively stable in the least deprived areas. Therefore, tackling obesity is paramount in areas of greater deprivation.

In terms of workplace health, only 15% of NHS trusts have a policy or plan to help tackle staff obesity, according to a report by the Royal College of Physicians and the Faculty of Occupational Medicine⁷⁸. The findings come from the first national audit⁷⁹ within the NHS of NICE public health guidance for the workplace, which involved almost 900,000 employees from 282 trusts across England. The Department of Health estimated in 2009 that of the 1.2 million staff in the NHS, approximately 300,000 would be classified as obese and a further 400,000 as overweight. But despite this, the audit found that little is being done to encourage staff to adopt a healthier lifestyle. Less than one in three trusts offered evidence-based weight management programmes for their staff, and just 31 per cent promote healthy options for staff in their shops. Out of the 42 trusts that did have a plan or policy for tackling staff obesity, only 13 measured uptake of any programmes by different staff groups such as by grade, gender or ethnicity.

⁷⁷ <http://www.hscic.gov.uk/ncmp>

⁷⁸ <http://www.nice.org.uk/newsroom/news/NHSTrustsFailingToTackleStaffObesity.jsp>

⁷⁹ <http://www.rcplondon.ac.uk/resources/nice-public-health-guidance-workplace-organisational-audit>

5.2 What can NHS providers do?

5.2.1 Patient based interventions

The Hospital Food Standards Panel (HFSP)⁸⁰ report recommends that providers should develop a food and drink strategy that includes the nutrition and hydration needs of patients, as well as a strategy for sustainable procurement of food and catering services.

- The Nutrition Alliance⁸¹ recommend that;
 - Patients to be screened on admission to hospital, and re-screened weekly, to identify those who are malnourished, or at risk of becoming malnourished.
 - Nutritional status should be documented in care plans.
 - Hospitals to include specific guidance about nutritional services in Clinical Governance arrangements.
 - Patients to be involved in planning and monitoring of food services
 - Implement protected mealtimes
 - Hospitals to aim to deliver an excellent experience of food service and nutritional care 24 hours a day
 - Hospitals to support a multi-disciplinary approach to nutritional care
- Nutrition and Hydration Digest (The British Dietetic Association)⁸² recommends
 - There should be a dedicated liaison dietician in every hospital department to lead development and training
 - Only registered nutritionists, and appropriately trained dieticians, should undertake nutritional analysis
 - Hospitals should consider the differences in nutritional needs between 2 groups of patients – the nutritionally well, and the nutritionally vulnerable. Malnutrition Universal Screening Tool (MUST)⁸³ (British Association of Parenteral and Enteral Nutrition) or equivalent validated nutrition screening tool. ‘MUST’ is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese

Other resources that health-care providers can draw on include the Department of Health’s Public Health Responsibility Deal. To become a Responsibility Deal partner, organisations must sign up to pledges, some of which are around healthy eating in the workplace, for example;

- Ensuring the availability of healthier foods and beverages in all available channels to employees
- Working with caterers to reformulate recipes to provide meals which are lower in fat, salt, and energy, and do not contain artificial trans fats
- Provision of responsibly sized portions of foods
- Provision and promotion of the consumption of fruit and vegetables through availability and price promotion

⁸⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365960/20141013_Hospital_Food_Panel_Report_Complete_final_amended_for_website_oct_14_with_links.pdf

⁸¹ http://www.bapen.org.uk/pdfs/coe_leaflet.pdf

⁸² <https://www.bda.uk.com/publications/professional/NutritionHydrationDigest.pdf>

⁸³ http://www.bapen.org.uk/pdfs/must/must_full.pdf

5.2.2 Staff based interventions

- The Hospital Food Standards Panel⁸⁴ report recommends that providers should develop a food and drink strategy that covers the whole hospital community, including staff, as well as a sustainable procurement of food and catering services
- Public Health England (PHE)'s guidance⁸¹ includes important nutrition principles that can be applied to staff and visitor catering
- The Nutrition Alliance⁸⁵ recommend that staff receive regular training on nutritional care and management
- Employers can also sign up for the Workplace Wellbeing Charter⁸⁶, which was originally developed by Liverpool Primary Care Trust, and is an opportunity for organisations of all sizes to demonstrate their commitment to the health and well-being of their workforce. The recommendations include;
 - Provide staff with appropriate and accessible information on healthy eating
 - Wherever possible, provide eating facilities that are clean and user friendly, away from work areas
 - Actively promote healthier options in any on-site catering facilities
 - To receive an 'excellence' rating, offer a rolling schedule of events to promote the importance of healthy eating, alongside internal or external support for those who want to lose weight. Source food locally, using local providers. Pricing strategy to promote healthy options.

5.2.3 Community based interventions

- Develop a strategy for sustainable procurement of food and catering services
- Use of hospital grounds for community growing schemes

⁸⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365960/20141013_Hospital_Food_Panel_Report_Complete_final_amended_for_website_oct_14_with_links.pdf

⁸⁵ http://www.bapen.org.uk/pdfs/coe_leaflet.pdf

⁸⁶ http://wellbeingcharter.org.uk/media/PDF/WWC_Self_Assessment_Standards_A4_Booklet_Liverpool_2_WEB.PDF

5.3 Examples of local delivery

5.3.1 The Healthy Lifestyles Project, Ashworth Hospital, Mersey Care NHS Trust.

Ashworth Hospital is a 228 bedded NHS hospital within the Secure Division of Mersey Care NHS Trust. It provides specialist inpatient care to those who require treatment under conditions of special security on account of their “dangerous, violent or criminal propensities” , according to the National Health Service Act, 1977: Section 4, 2008.⁸⁷

What was the issue?

The evidence relating to the poor physical health and reduced life expectancy of patients with Serious Mental Illness (SMI) has been acknowledged in policy for at least 14 years⁸⁸. It has been reported that, in the past decade, the physical morbidity and mortality of people with serious Mental Illness has increased⁸⁹, with Lambert and colleagues⁹⁰ identifying that people with Serious Mental Illness die 15 – 30 years earlier than the general population.

Within Ashworth Hospital, a large number of patients are either overweight or obese (88% in August 2013⁹¹), have diabetes (20% in March 2014⁹²), hypertension (21% under hypertension monitoring August 2013⁹³) and other long term conditions. Such conditions are arguably exacerbated via the secure environment, with limited opportunities for exercise on wards, access to food on request (in particular, an historical culture of second helpings at meal times) and many patients take prescribed medication which have side-effects of weight gain and lethargy. Calorific, high fat, high salt snacks are also available for patients to buy.

What was the intervention (including any timescales)?

The Healthy Lifestyles project was introduced as part of the Commissioning for Quality and Innovation (CQUIN) targets for Ashworth Hospital, and was piloted on two wards within the hospital, with the primary focus on preventing an increase in the BMI of patients that are overweight or obese. Following extensive staff and patient consultation, patients were provided with freshly prepared individual packaged meals, providing a calorific appropriate meal to each patient. Dietary advice was offered to staff and patients, using 1:1 education, group discussions, and pictorial guides. Staff training was provided by the Health Promotion Coordinator and Dietician. Exercise equipment was also introduced to the wards, providing further opportunities to exercise

What have been the benefits to patients/staff/the wider community?

One year from the start of the project, significant weight loss was observed, with the intervention wards losing a combined total of 93 Kilos, whilst those on the control wards had gained 109 Kilos. The many successes of the project, including weight loss, have contributed to the roll out of the Healthy Lifestyles programme to other wards. The challenge now is to ensure that the motivation of patients and staff members continues in this difficult area of lifestyle change.

Contact details

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Email: Paula.Carroll@merseycare.nhs.uk

⁸⁷ National Health Service Act, 1977: Section 4, 2008

⁸⁸ National Service Framework for Mental Health (1999)

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/browsable/DH_4096400

⁸⁹ Park, T., Usher, K., & Foster, K. (2011) Description of a Healthy Lifestyle Intervention for People with Serious Mental Illness Taking Second Generation Antipsychotics. *International Journal of Mental Health Nursing*. 20, 428 - 437

⁹⁰ Lambert, T. J. R., & Newcomer, J. W. (2009) Are the Cardiometabolic complications of schizophrenia still neglected? Barriers to care. *Medical Journal of Australia*, 190, 4, S39 – S42

⁹¹ Snapshot from August 2013 from routine data collection

⁹² Snapshot from March 2014 from routine data collection

⁹³ Snapshot from August 2013 from routine data collection

5.3.2 Wirral University Teaching Hospital NHS Trust

What was the issue?

To introduce healthier eating for staff, patients and visitors in Wirral University Teaching Hospitals. The NHS is the largest public procurer of food, spending £500 million on food per year and serving 800,000 meals a day in hospitals. Consequently, the NHS is in a good position to help change people's eating habits by promoting a balanced diet. Serving and making available nutritious and value-for-money food can improve patient recovery times, staff morale and staff health. The choice of retail outlets or vending machines in NHS buildings sends strong messages that can reinforce or undermine the principles of healthy eating. Wirral University Teaching Hospital NHS trust catering department supplies up to 20,000 patient meals and 20,000 transactions in the sales and provision of food to staff and visitors per week.

What was the intervention (including any timescales)?

The aim of the Merseyside hospital project was to pilot and evaluate interventions to increase the amount of local and healthy food provision in Merseyside hospitals. It was to achieve this through a number of key strands:

- Pilot and evaluate healthy eating intervention (options): price subsidies/alterations of healthy options; menu changes in kitchen (using different ingredients); home made fresh soup
- Increase locally procured food: identify contracts coming up for renewal within project duration and invite/support suitable local producers to tender
- Awareness raising of project and its goals/ethos among hospital staff e.g. awareness days, communication linked with payslips, surveys, opportunities for staff involvement
- Evaluation of project to support the identification of good practice for wider dissemination and expansion of the project

The initial main project launch at Wirral in September 2008.

- Applications were received from a number of hospitals across Greater Merseyside to participate in the project.
- Heart of Mersey and Groundwork arranged meetings with the hospitals, to provide feedback and identify the most suitable way forward on the food agenda
- The first step of the project was to carry out a baseline audit which would help the development of the project within the hospital setting. This was presented to the Trusts at the introductory meetings.
- A Mersey-wide steering group was set up to oversee and guide the delivery of the project – this will meet approximately once a quarter and comprise of representatives from the hospitals, PCTs, Groundwork, Heart of Mersey and other relevant stakeholders. The first meeting took place in September 2007.
- The results of the base line audit was finalised in January 2008, with an agreed action plan for improvement.
- The adoption of the Nourish brand
- The Trust, WUTH catering Department put together an action plan of improvements to work through during 2008/9 and onwards.
- The final evaluation of the project was completed in September 2009 . This included the completion of an online questionnaire. The evaluation report was collated by an external market research company and presented to the Trust.

What have been the benefits to patients/staff/the wider community?

- Reducing salt, added sugar, total and saturated fat in all menus and increasing fruit and vegetables and fibre in processed and convenience food, and catered meals;
- Introducing 100% fresh vegetable soups for in bed patients;
- Increase access to fruit, vegetables and higher fibre foods;
- Promoting healthier portion sizes;
- Improving the availability of affordable healthy foods;
- Patient/customer access to nutritional information via direct and indirect marketing.

Since the initial campaign and recognition from the North West Healthy eating award W.U.T.H has seen sales of food and in particular fruit and salad items increase significantly year on year.

The increase and demand for these items was proving so popular that a request to increase the size of the main counters in both hospital restaurants by a full refurbishment was agreed. The refurbishment was completed in 2011 /12 which consisted of a number of large salad, vegetables and fruit self serve counters. The initial investment cost was soon recovered due to demand popularity and continues to increase each year.

Contact details

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5.4 Other useful resources

Many of the recommendations in the previous section were taken from the 'The Hospital Food Standards Panel's (HFSPs) report on standards for food and drink in NHS hospitals'⁹⁴, which was launched in August 2014 by the Department of Health. The Hospital Food Standards Panel's (HFSPs) report The HFSP is an independent group established by the Department of Health and led by Dianne Jeffrey, chairman of Age UK. The report made a number of recommendations for promoting healthy eating in hospitals.

New NICE weight loss guidelines for the NHS in England will advise people to "lose a little and keep it off" for life. The National Institute for Health and Care Excellence (NICE) wants overweight people sent to slimming classes with the aim of a 3% weight loss.⁹⁵

NICE have provided guidance 'Obesity: working with local communities'⁹⁶.

⁹⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/348617/Hosp_food_panel_report.pdf?utm_medium=email&utm_source=The+King%27s+Fund+newsletters&utm_campaign=4577543_HMP+2014-08-29&dm_i=21A8,2Q41Z,FLWSFM,A0Q9K

⁹⁵ <http://www.bbc.co.uk/news/health-27586149>

⁹⁶ <http://publications.nice.org.uk/obesity-working-with-local-communities-ph42>

6. Provide opportunities for physical activity

Physical activity – key facts

- Around one in two women and a third of men in England are damaging their health through a lack of physical activity, according to the 2012 Health Survey for England, costing the UK around £7.4bn a year
- Regular physical activity can reduce the risk of heart disease, stroke, having a second heart attack in people who have already had one, developing high blood pressure, and developing type 2 diabetes.
- Physical inactivity is the fourth largest cause of disease and disability in the UK. It is responsible for 1 in 6 (17%) of deaths in the UK, making it as dangerous as smoking
- The percentage of obese children in reception year¹, 2009/10-2010/11, in Cheshire and Merseyside, 10%, amounting to 7,436 children, was significantly higher than the England average of 9.6%. In the same year, the percentage of obese children in Year 6, in Cheshire and Merseyside, 20.2%, amounting to 14,035, was significantly higher than the England average of 19%. However, the percentage of obese adults in Cheshire and Merseyside, 23.3%, 2006-8, was lower than the England average of 24.1%.

6.1 What is the issue?

Around one in two women and a third of men in England are damaging their health through a lack of physical activity, according to the 2012 Health Survey for England⁹⁷, costing the UK around £7.4bn a year⁹⁸. If current trends continue, the increasing costs of health and social care will destabilise public services and take a toll on quality of life for individuals and communities, according to Public Health England⁹⁹.

According to NICE, the definition of physical activity is “Any force exerted by skeletal muscle that results in energy expenditure above resting level”¹⁰⁰. It can encompass everything from competitive sport to walking, cycling and the general activities involved in daily living. The amount of physical activity that is needed to keep someone healthy varies according to age,^{101 102}

- Babies: Babies should be encouraged to be active from birth. Before babies begin to crawl, encourage them to be physically active by reaching and grasping, pulling and pushing, moving their head, body and limbs during daily routines. Once babies can move around, encourage them to be as active as possible in a safe and supervised play environment
- Toddlers: Children who can walk on their own should be physically active every day for at least 3 hours. This should be spread throughout the day, indoors or outside
- Children under 5 should not be inactive for long periods, except when they're asleep. Watching TV, travelling by car, bus or train or being strapped into a buggy for long periods are not good for a child's health and development
- Young people aged 5-18 need to do at least 60 minutes of physical activity every day, which should range between moderate-intensity activity, such as cycling and playground activities and vigorous-intensity activity, such as fast running and tennis. On three days a week, these activities should involve muscle-strengthening activities, such as push-ups, and bone-strengthening activities, such as running
- Healthy adults: Adults aged 19-64 need to do at least 150 minutes of moderate-intensity aerobic activity, such as cycling or brisk walking, per week, as well as muscle strengthening activities, involving all major muscle groups at least 2 days per week
- Adults aged over 65, who are generally fit and have no health conditions that limit the amount of activity that they can do, should do at least 150 minutes of moderate-intensity aerobic activity such as cycling or fast walking every week, and muscle-strengthening activities on 2 or more days a week that work all major muscle groups.

However, the Health Survey for England 2012¹⁰³ found that over one in four women and one in five men do less than 30 minutes of physical activity a week, so are classified as 'inactive'. In some ethnic minority communities, this falls to less than 1 in 10. A similar problem exists in children, with just over half of boys and a third of girls aged 2 to 10 years old achieving the recommended levels for this age group¹⁰⁴. Lack of physical activity is a risk factor for a range of serious health conditions: physical inactivity increases the risk of heart disease and stroke by 50%, according to the World Heart Federation¹⁰⁵. Obesity is a major risk for cardiovascular disease and predisposes you to diabetes. Diabetes is a risk factor for cardiovascular disease. According to a global study¹⁰⁶, physical inactivity is

⁹⁷ <http://www.hscic.gov.uk/catalogue/PUB13218>

⁹⁸ Scarborough P, Bhatnagar P, Wickramasinghe KK, Allender S, Foster C, Rayner M (2011) The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs. *Journal of Public Health* 33 (4): 527-535.

⁹⁹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/353384/Everybody_Active__Every_Day_evidence_based_approach_CONSULTATION_VERSION.pdf

¹⁰⁰ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1424733/>

¹⁰¹ DH (2011) *Start Active, Stay Active: A report on physical activity from the four home countries' Chief Medical Officer.*

¹⁰² <http://www.nhs.uk/Livewell/fitness/Pages/physical-activity-guidelines-for-adults.aspx>

¹⁰³ <http://www.hscic.gov.uk/catalogue/PUB13218>

¹⁰⁴ <http://www.nhs.uk/news/2012/11/november/pages/nice-nanny-state-parking-cost-claims-are-untrue.aspx>

¹⁰⁵ <http://www.world-heart-federation.org/cardiovascular-health/cardiovascular-disease-risk-factors/>

¹⁰⁶ Murray et al. (2013) UK health performance: findings of the Global Burden of Disease Study 2010. *The Lancet* 381: 997-1020.

the fourth largest cause of disease and disability in the UK. Physical inactivity is responsible for 1 in 6 (17%) of deaths in the UK¹⁰⁷, making it as dangerous as smoking¹⁰⁸.

The percentage of obese children in reception year¹, 2009/10-2010/11, in Cheshire and Merseyside, 10%, amounting to 7,436 children, was significantly higher than the England average of 9.6%. In the same year, the percentage of obese children in Year 6, in Cheshire and Merseyside, 20.2%, amounting to 14,035, was significantly higher than the England average of 19%. However, the percentage of obese adults in Cheshire and Merseyside, 23.3%, 2006-8, was lower than the England average of 24.1%.

Promoting physical activity is important, as regular physical activity has a range of benefits. It can help achieve and maintain a healthy weight, lower both total blood cholesterol and triglycerides, increase 'good' cholesterol, reduce blood pressure, reduce the risk of developing colon cancer and possibly other cancers, reduce feelings of stress, anxiety and depression, build and maintain healthy bones, muscles, and joints, and keep older adults physically strong and better able to move about without falling or becoming too tired. In addition, being active is also good for children's educational attainment, it can boost workplace productivity and reduce sickness absence and it can even reduce crime and anti-social behaviour¹⁰⁹.

In addition, as there are differences in physical activity levels between groups, according to Public Health England¹¹⁰, leading to ill health, then tackling physical activity helps tackle health inequalities. South East England, for example, has the highest proportion of both men and women meeting recommended levels of physical activity, while North West England has the lowest, according to the 102 Health Survey for England. Men are more active than women in almost every age group, with 6 in 10 women not participating in sport or physical activity¹¹¹. Physical activity declines with age – by the age of 75, only 1 in 10 men and 1 in 20 women are sufficiently active for good health¹¹². Only 1 in 4 people with learning difficulties take part in physical activity each month, compared to over half of people without a disability¹¹³. There are differences in physical activity levels according to race - only 11% / 26% of Bangladeshi women and men are sufficiently active for good health, compared with 25% / 37% of the general population¹¹⁴.

However, more needs to be done to tackle this issue. According to a large-scale survey by the Royal College of Physicians and the Faculty of Occupational Medicine¹¹⁵, only 32% of organisations who participated in the survey said that they have a plan or policy in place to encourage and support staff to be more physically active.

¹⁰⁷ Lee I-M, *et al.* (2012) Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. *The Lancet* 380: 219–29

¹⁰⁸ Wen CP, Wu X (2012) Stressing harms of physical inactivity to promote exercise. *The Lancet Online* S0140-6736 (12) 60954-4

¹⁰⁹ Laureus Sport for Good Foundation. Teenage Kicks: the value of sport in youth crime. 2011

¹¹⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/353384/Everybody_Active__Every_Day_evidence_based_approach_CONSULTATION_VERSION.pdf

¹¹¹ Active People Survey 2007; cited in Public Health England's 'Everybody Active, Every Day': https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/353384/Everybody_Active__Every_Day_evidence_based_approach_CONSULTATION_VERSION.pdf

¹¹² Health Survey for England - 2009 Trend tables. (2010) The Health and Social Care Information Centre; available at www.ic.nhs.uk/pubs/hse09trends Accessed 20th April 2014

¹¹³ Sport England Active People Survey December 2013 (sport once a month, any sport, any duration)

¹¹⁴ Joint Health Surveys Unit (2006). Health Survey for England 2004: Health of Ethnic Minorities. The Information Centre: Leeds.

¹¹⁵ <http://www.nice.org.uk/newsroom/news/NHSTrustsFailingToTackleStaffObesity.jsp>

6.2 What should NHS providers do?

6.2.1 Physical activity for patients

- Encourage patients to be active¹¹⁶

- According to NICE (2013)¹¹⁷ guidelines;
 - Do not rely on visual clues to determine physical activity levels – use validated tools such as GPPAQ¹¹⁸ to assess physical activity levels
 - Advise adults who have been assessed as being inactive to do more physical activity, with the aim of achieving the UK physical activity guidelines
 - When delivering brief advice, tailor it to the person's goals, current level of activity and ability, circumstances, preferences, and health status
 - Record the outcomes of the discussion, and give patients a written outline of the advice and goals that have been discussed.
 - Ensure that the impact of interventions is evaluated¹¹⁹.

- In their 2009 report 'promoting physical activity for children and young people'¹²⁰, NICE recommend that Chairs of children's trusts and Directors of children's services, amongst others, should;
 - Ensure there is a coordinated local strategy to increase physical activity among children and young people, their families and carers. The strategy should ensure that there are local indoor and outdoor opportunities for physical activity where children and young people feel safe. Ensure that initiatives are well-publicised
 - Ensure physical activity initiatives aimed at children and young people are regularly evaluated. Evaluations should measure uptake among different groups
 - Remove locally identified barriers to participation, such as lack of privacy in changing facilities, restrictive dress policies, inadequate lighting, poorly maintained facilities and lack of access for children and young people with a disability.
 - Ensure physical activity programmes are run by people with the relevant training or experience. Establish continuing professional development programmes for people involved in organising and running formal and informal physical activities.

- According to a NICE 2014 report¹²¹ policy makers and commissioners should not fund exercise referral schemes for people who are sedentary or inactive but otherwise apparently healthy. Exercise referral schemes should only be for people who are sedentary or inactive and have existing health conditions or other factors that put them at increased risk of ill health.

¹¹⁶ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/353384/Everybody_Active__Every_Day_evidence_based_approach_CONSULTATION_VERSION.pdf

¹¹⁷ <http://www.nice.org.uk/guidance/ph44/chapter/1-recommendations>

¹¹⁸ The general practice physical activity questionnaire (GPPAQ) is an example of a validated questionnaire for assessing someone's (aged 16–74) current level of physical activity. The index can be cross-referred to Read Codes and can be used to determine whether brief advice might be appropriate

¹¹⁹ National Obesity Observatory (2012) Standard Evaluation Framework for physical activity interventions.

¹²⁰ <http://www.nice.org.uk/guidance/ph17/chapter/1-recommendations#the-recommendations>

¹²¹ <http://www.nice.org.uk/guidance/ph54/chapter/1-recommendations>

6.2.2 Physical activity for staff

According to NICE, employers can promote physical activity in the workplace by¹²²;

- Introduce and monitor an organisation-wide, multi-component programme to encourage and support employees to be more physically active
- Help employees to be physically active during the working day, for example, by encouraging them to take the stairs or walk to external meetings. Those involved with campus sites should ensure that different parts of the site are linked by appropriate walking and cycling routes¹²³.
- Encourage employees to walk, cycle or use another mode of transport involving physical activity to travel part or all of the way to and from work (for example, by developing a travel plan).

Employers can also sign up for the Workplace Wellbeing Charter¹²⁴. Charter recommendations include;

- Encourage staff to take regular breaks
- Promote physical activity opportunities in the local area

6.2.3 Physical activity for the wider community

- Pedestrian and cycle access to hospitals and other health-promoting environments to be ensured
- Use of stairs to be encouraged, e.g. by improving lighting/decor on stairwells and signposted clearly
- WHO (2005) suggests making hospital facilities available to the wider community.

¹²² <http://www.nice.org.uk/guidance/PH13>

¹²³ <http://pathways.nice.org.uk/pathways/physical-activity#content=view-index&path=view%3A/pathways/physical-activity/making-changes-in-other-areas-to-encourage-physical-activity.xml>

¹²⁴ http://wellbeingcharter.org.uk/media/PDF/WWC_Self_Assessment_Standards_A4_Booklet_Liverpool_2_WEB.PDF

6.3 Examples of local delivery

6.3.1 The Walton Centre¹²⁵

What was the issue?

Staff Sickness in January 2010 was over 7%¹²⁶. There was a strong reliance on bank, agency, and locum staff. There were no opportunities for staff to undertake activity classes on site.

What was the intervention (including any timescales)?

The Walton Centre has been implementing a Health and Wellbeing (H&WB) strategy called “Work Well: The Walton Way” since March 2011. This supports a number of strategic objectives including; reducing sickness absence, improving the patient experience, supporting staff in improving their own health and well-being and achieving Investors in People Health and Well-Being award. In terms of physical activity, the Trust now has a well-established weekly timetable of events including a running club, zumba classes, pilates and circuit training. The running club is free for staff, whilst the exercise classes are subsidised by the trust.

What have been the benefits to patients/staff/the wider community?

This H&WB strategy and action plan has proved very successful due to the involvement of staff and unions in its development and implementation and has led to significant cost savings due to a reduction in sickness absence and agency spend.

Is there any cost/benefit analysis or information available?

- Staff sickness has reduced from over 7% in January 2010 to a monthly average of around 4%
- The use of bank, agency and locum staff has decreased.
- Staff Survey¹²⁷ results show that staff have a more positive attitude towards health and wellbeing, communication, job satisfaction and many other key areas.
- Work pressure felt by staff was lower than when compared to other specialist trusts
- The Walton Centre was the first Trust in the north of England to achieve the IIP Health and Wellbeing award and achieved IIP Gold in May 2014

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¹²⁵ The Walton Centre, the only specialist neurosciences trust in the UK, based in Liverpool¹²⁵, agreed to develop a health and wellbeing strategy to review current activities, and set out what was needed to meet national and local drivers. This led to the development of “Work Well the Walton Way” and a supporting comprehensive action plan to address: obesity, physical exercise, health promotion and advice, drug and alcohol misuse, smoking cessation, training and leadership, and staff engagement.

The NHS Staff Survey¹²⁵ is recognised as an important way of ensuring that the views of staff working in the NHS inform local improvements and input in to local and national assessments of quality, safety, and delivery of the NHS Constitution.

¹²⁶ Sickness absence is monitored monthly through the national Electronic Staff Record (ESR) system

¹²⁷ The staff survey is a yearly survey that all NHS Organisations undertake.

6.3.2 NHS North West Games

What was the issue?

The NHS North West Games was inspired by the build-up to the 2012 Olympic Games. During that year there was increasing excitement at the prospect of the UK hosting the Olympics and trust leaders were keen to harness this excitement to encourage staff to enjoy physical activity. The overall aim of the project was to increase staff physical activity, promote healthy living and by doing so impact not just the lives of staff but also that of their families, as knowledgeable and professional role models and also as NHS service users themselves.

The initial event was based on evidence from the national, regional and local health data. At the heart of this initiative was the need to create something that would continue to motivate and inspire staff to engage in physical activity beyond the day of the event. The NHS North West Games is now in its 4th year; this year's events have taken place and have been evaluated and we are now starting to plan for the games in 2015.

What was the intervention (including any timescales)?

The project design involved an annual competitive games day. Activities include football, netball, badminton, rounders, table tennis, golf and 5K runs, as well as dance and Zumba and numerous health promotion stands targeting both participants and spectators. Over the past four years the event has evolved, and other activities have been included, such as 5K runs and a golf day.

The event has been instrumental in driving health and wellbeing plans in all the participating trusts and has become one of the central points of those trusts' health and wellbeing strategies. The NHS Games is seen as both a driver and enabler for the delivery of individual trusts' health and wellbeing strategy and action plans to deliver improved trust performance.

There has been visible leadership with some Board members participating in the Games and some healthy trust competition with previous winners eager to improve, to defend their title or challenge previous winners. The 'fair play winners' award also encouraged staff and teams who demonstrated team spirit and the values of the NHS constitution. This was very important to the project team as we wanted to encourage participation and involvement from the less active, to encourage those who did not regularly exercise.

What have been the benefits to patients/staff/the wider community?

In 2014 some 14 Trusts participated in the events which took place over 3 weekends - around 1000 members of NHS staff were involved in physical activity. The notable outcomes were a reduction in sickness absence, reduction in agency spend, year on year improvement in work pressure felt by staff as measured by staff survey, improved morale in workplace and improved team working, and improved patient survey scores.

There have also been increases in physical activities in the longer term; participants have gone on to join regular sports clubs who train and meet weekly. Trusts now have teams who train and play regularly in readiness for the following years events. Entrants to the 5K runs now regularly enter local running events together as a group. Other benefits were Health and Wellbeing IIP Award and Charter Accreditation, and participants have greater knowledge of public health initiatives.

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6.4 Other useful resources

- Public Health England's 2014 report 'Everybody Active, Every Day'
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/353384/Everybody_Active_Every_Day_evidence_based_approach_CONSULTATION_VERSION.pdf
- Physical activity and health in Europe: evidence for action. Nick Cavill, Sonja Kahlmeier and Francesca Racioppi: http://www.euro.who.int/_data/assets/pdf_file/0011/87545/E89490.pdf
- Making changes in other areas to encourage physical activity: NHS environment:
<http://pathways.nice.org.uk/pathways/physical-activity#content=view-node%3Anodes-nhs-environment&path=view%3A/pathways/physical-activity/making-changes-in-other-areas-to-encourage-physical-activity.xml>
- NICE guidance. Relevant guidance includes;
 - PH2, 2006. 'Four commonly used methods to increase physical activity'.
<http://www.nice.org.uk/guidance/ph2>
 - PH8, 2008. 'Physical activity and the environment'.
<http://www.nice.org.uk/guidance/PH8>
 - PH13, 2008. 'Promoting physical activity in the Workplace'.
<http://www.nice.org.uk/guidance/PH13>
 - PH17, 2009. 'Promoting physical activity for children and young people'
<http://www.nice.org.uk/guidance/PH17>
 - PH41, 2012. 'Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation'
<http://www.nice.org.uk/Guidance/PH41>
 - PH44, 2013. Physical activity: Brief advice for adults in primary care
<http://www.nice.org.uk/guidance/PH44>
 - PH54, 2014. Exercise referral schemes to promote physical activity
<http://www.nice.org.uk/guidance/ph54>

7. Encourage sensible drinking of alcohol

Alcohol – key facts

- Hospital stays for alcohol-related harm were significantly higher in Cheshire and Merseyside (SAR 132) than for England as a whole.
- The 2014 Health Profiles for England showed that proportions of under 18s admitted to hospital for alcohol-specific conditions was higher in all 9 Cheshire and Merseyside local authority areas than England as a whole. Among adults, hospital stays for alcohol-related harm were proportionally higher in all the Merseyside local authority areas, and in Warrington, than in England as a whole.
- The Government Alcohol Strategy claims alcohol-related harm is now estimated to cost society (England) £21 billion annually
- Alcohol use can impact on a range of health conditions, including psychological problems such as depression, and alcohol-related accidents or physical illness such as acute pancreatitis. In the longer term, harmful drinkers may go on to develop high blood pressure, cirrhosis, heart disease and some types of cancer, such as mouth, liver, bowel or breast cancer.

7.1 What is the issue?

According to NICE guidance¹²⁸, harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol. The Change for life¹²⁹ 'lower risk daily guidelines' state that women should have no more than 2-3 units of alcohol per day, the equivalent of a standard glass of wine, whilst men should have no more than 3-4 units per day –only slightly more than a pint of strong lager or beer.

Harmful drinking could include psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis. In the longer term, harmful drinkers may go on to develop high blood pressure, cirrhosis, heart disease and some types of cancer, such as mouth, liver, bowel or breast cancer.

Alcohol dependence affects 4% of people aged between 16 and 65 in England (6% of men and 2% of women), and over 24% of the English population (33% of men and 16% of women) consume alcohol in a way that is potentially or actually harmful to their health or well-being. Alcohol dependence is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example, liver disease or depression caused by drinking). Dependence can be divided into categories of mild, moderate and severe. People with mild dependence (those scoring 15 or less on the Severity of Alcohol Dependence Questionnaire (SADQ))¹³⁰ do not usually need assisted alcohol withdrawal. People with moderate dependence usually need assisted alcohol withdrawal, which can typically be managed in a community setting, whilst people who are severely alcohol dependent will need assisted alcohol withdrawal, typically in an inpatient or residential setting.

Of the 1 million people aged between 16 and 65 who are alcohol dependent in England, only about 6% per year receive treatment. Reasons for this include the often long period between developing alcohol dependence and seeking help, and the limited availability of specialist alcohol treatment services in some parts of England. Additionally, alcohol misuse is under-identified by health and social care professionals, leading to missed opportunities to provide effective interventions.

Alcohol misuse is also an increasing problem in children and young people, with over 24,000 treated in the NHS for alcohol-related problems in 2008 and 2009. Comorbid mental health disorders commonly include depression, anxiety disorders and drug misuse, some of which may remit with abstinence from alcohol but others may persist and need specific treatment. Physical comorbidities are common, including gastrointestinal disorders, and neurological and cardiovascular disease. In some people these comorbidities may remit on stopping or reducing alcohol consumption, although many experience long-term consequences of alcohol misuse that may significantly shorten their life.

The 2014 Health Profiles for England show¹³¹ that under 18s admitted to hospital due to alcohol-specific conditions was proportionally higher in all 9 local authority areas in Cheshire and Merseyside than in England as a whole. The England rate per 100,000 population for 2010/11 to 2012/13 (pooled) was 44.9. Among adults, the number of hospital admissions involving an alcohol-related primary diagnosis or an alcohol related external cause, per 100,000 population, was higher in 7 of the 9 Cheshire and Merseyside local authority areas, including all the Merseyside areas, than in England as a whole. The England rate was 637 per 100,000 population, directly age standardised rate per 100,000 population, 2012/13. Table 4 below shows that the only two local authority areas in Cheshire and Merseyside that had rates per 100,000 that were less than the England average were Cheshire East and Cheshire West and Chester. Therefore, tackling alcohol use in Cheshire and Merseyside is an important issue. The Government Alcohol Strategy claims alcohol-related harm is now estimated to cost society (England) £21 billion annually.^u, including NHS costs, at about £3.5 billion per year (at

¹²⁸ <http://www.nice.org.uk/guidance/cg115/chapter/introduction>

¹²⁹ <http://www.nhs.uk/Change4Life/Pages/alcohol-lower-risk-guidelines-units.aspx>

¹³⁰ http://www.alcohollearningcentre.org.uk/_library/Resources/ALC/severity_of_alcohol_dependence_questionnaire.pdf

¹³¹ <http://www.apho.org.uk/resource/view.aspx?RID=50215®ION=50151&SPEAR=>

2009–10 costs), and alcohol-related crime, at £11 billion per year (at 2010–11 costs), and lost productivity due to alcohol, at about £7.3 billion per year (at 2009–10 costs, UK estimate)¹³².

Table 4: Hospital related admissions in Cheshire and Merseyside

District	Rate of under 18s admitted to hospital due to alcohol-specific conditions, per 100,000 population	Rates of adults admitted to hospital involving an alcohol-related primary diagnosis or an alcohol related external cause, per 100,000 population
St. Helens	99.5	855
Liverpool	86.4	810
Wirral	80.2	856
Sefton	78.1	731
Halton	73.5	814
Cheshire East	64.8	540
Knowsley	61.1	859
Cheshire West and Chester	54.4	552
Warrington	52.3	859
England	44.9	637

Source: 2014 Health Profiles for England. Rate per 100,000 population for 2010/11 to 2012/13 (pooled)

Regularly drinking above the lower risk guidelines increases the possibility of suffering more serious health problems, including cancer of the throat, oesophagus or larynx. Regularly drinking two large glasses of wine (ABV 13%) or two pints of strong lager (ABV 5.2%) a day could make you three times as likely to get mouth cancer, breast cancer in women (regularly drinking just above the guidelines increases the risk of getting breast cancer by around 20%), liver disease such as cirrhosis and liver cancer - if you regularly drink just above the lower-risk guidelines, the risk of liver cirrhosis increases by 1.7 times, stroke, heart disease, heart attack, pancreatitis, and reduced fertility. Alcohol consumption can also exacerbate a range of other issues – intimate partner violence, for example, which is described by the World Health Organization¹³³ as ‘any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in that relationship’. Alcohol consumption, especially at harmful or hazardous levels¹³⁴, is a major contributor to the occurrence of intimate partner violence.

¹³² <http://www.ias.org.uk/Alcohol-knowledge-centre/Economic-impacts/Factsheets/Economic-costs.aspx>

¹³³ http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/ft_intimate.pdf

¹³⁴ http://www.who.int/substance_abuse/terminology/who_lexicon/en/

7.2 What can health-care providers do?

Patient based interventions

A 2009 Department of Health publication¹³⁵ recommended;

- Appointment of Alcohol Health Workers or Alcohol Liaison Nurses
- Commission local social marketing activity which build on the evidence provided by the national social marketing programme
- Where appropriate, screening in Accident and Emergency about drinking patterns, in order to inform care planning, may be effective, such as reception staff asking patients to complete questionnaires before the patient is seen by a doctor¹³⁶. If someone attending is intoxicated, then opportunistic interventions are unlikely to be effective, although they might be successful on a subsequent attendance for suture removal, for example.

NICE recommends that^{137,138},

- Chief executives of NHS and local authorities should prioritise alcohol-use disorder prevention as an 'invest to save' measure
- NHS professionals should routinely carry out alcohol screening as an integral part of practice - discussions could take place during new patient registrations, when screening for other conditions, managing chronic disease, seeing someone for an antenatal appointment or treating minor injuries. Where screening everyone is not feasible or practicable, NHS professionals should focus on groups that may be at an increased risk of harm from alcohol, including people with relevant physical conditions such as hypertension and gastrointestinal or liver disorders, relevant mental health problems such as anxiety or depression, those who have been assaulted, or are at risk of self-harm
- If there is local demand, staff should also be trained to deliver extended brief interventions
- For children aged 10-15 years, follow the guidelines in the Department of Health's 'Seeking consent: working with children'¹³⁹. Parents or guardians should be involved in decisions about treatment and care. Obtain a detailed history children's alcohol use, including background factors such as family issues. Consider referral to child and adolescent mental health services, social care or to young people's alcohol services for treatment, as appropriate. Ensure discussions are sensitive to the child or young person's age and their ability to understand, health and social needs, culture, faith and beliefs, and the setting.
- All staff in contact with parents who misuse alcohol and who have care of or regular contact with their children, should take account of the impact of the parent's drinking on the child, and be aware of and comply with the requirements of the Children Act (2004).
- For young people aged 16-17, complete a validated alcohol screening questionnaire. In most cases, AUDIT¹⁴⁰ (alcohol use disorders identification test) should be used. Screening tools should be appropriate to the setting. Focus on key groups that may be at an increased risk of alcohol-related harm, e.g. those who have had an accident or a minor injury, who are at risk of self-harm, or who are looked after or involved with child safeguarding agencies. Again, assess the young person's ability to consent to alcohol-related interventions and treatment.
- Care of young people in transition between paediatric and adult services should be planned and managed according to the best practice guidance described in 'Transition: getting it right for young people'¹⁴¹

¹³⁵ Department of Health 2009b. Signs for improvement – commissioning interventions to reduce alcohol-related harm

¹³⁶ Patton R, Shute J, Hinchley G, Ranzetta L (2009). Efficacy of alcohol screening in the accident and emergency department managed by reception staff: a pilot study. *Emergency Medical Journal*, 2009; 26; 424-425.

¹³⁷ <https://www.nice.org.uk/guidance/ph24>

¹³⁸ <http://www.nice.org.uk/guidance/cg115/chapter/person-centred-care>

¹³⁹ http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007005

¹⁴⁰ Babor TF, Higgins-Biddle JC, Saunders JB (2001) The alcohol use disorders identification test – guidelines for use in primary care. Geneva: World Health Organization. In 2013, a revised Alcohol Use Disorders Identification Test Consumption, AUDIT C, was launched: <http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&child=4898>

¹⁴¹ <https://www.gov.uk/government/organisations/department-of-health>

- Do not offer simple brief advice to anyone who may be dependent on alcohol. Instead, refer them for specialist treatment. Work on the basis that offering an intervention is less likely to cause harm than failing to act where there are concerns
- If the service user agrees, families and carers should have the opportunity to be involved in decisions about treatment and care. Families and carers should also be given the information and support they need in their own right
- When working with people who misuse alcohol, build a trusting relationship and work in a supportive, empathic and non-judgemental manner, taking into account that stigma and discrimination are often associated with alcohol misuse. Ensure discussions take place in settings in which confidentiality, privacy and dignity are respected, and provide information appropriate to a person's level of understanding. Avoid clinical language without explanation
- Make sure that comprehensive written information is available in an appropriate language or, other accessible format. Provide independent interpreters (someone who is not known to the service user) if needed
- For people who misuse alcohol and have comorbid depression or anxiety disorders, treat the alcohol misuse first as this may lead to significant improvement in the depression and anxiety.

7.2.2 Staff based interventions

- Employers can also sign up for the Workplace Wellbeing Charter¹⁴². Charter recommendations include;
 - Ensure that a Working Alcohol and Substance Misuse policy is in place. Make new employees aware of relevant policies, information and support services at induction
 - Provide employees with information about the effects of alcohol and substance misuse that is appropriate, acceptable and accessible
 - For a rating of 'excellent', managers to have access to information on how to identify the signs of alcohol/substance misuse and be aware of where to signpost employees who have a problem
- Make the full range of interventions available to patients available to staff¹⁴³

7.2.3 Community interventions

Display leaflets and posters in waiting areas giving contact details for local alcohol services.

¹⁴² http://wellbeingcharter.org.uk/media/PDF/WWC_Self_Assessment_Standards_A4_Booklet_Liverpool_2_WEB.PDF

¹⁴³ http://www.liv.ac.uk/media/livacuk/instituteofpsychology/publichealthobservatory/77_LATEST_DRAFT_-_Alcohol_and_demand_management_Oct_09.pdf

7.3 Examples of local delivery

7.3.1 Salford

Brief description of intervention, including any timescales

Caseload of top 30 patients (based on coding), managed via profiling and intensive case management. The team work with these patients for at least 6 months, and then discharge the patient into the care of either the community alcohol or mental health teams.

Rolling caseload of approximately 302 ARA (alcohol related admissions) patients, generated from a monthly report of approximately 10 patients. This group of patients are often time consuming, but mostly liaison work. The team work with these patients for an average of 3 months.

CQUIN (2013/14) – The Support Time and Recovery workers (STaR) contact all patients scoring 1 AAF (Alcohol Attributable Fraction) post discharge and offer support/signposting - excluding patients already known or open to services. This is to ensure that patients who may not have been screened on admission, who do not have support in place, are picked up post discharge, and don't 'slip through the net'.

Details of benefits, including any cost savings

Savings are based on the caseload of 105 patients (average of 26 new patients each cohort). Savings are calculated based on cohort's activity in the 6 months before the intervention, and compared with the intervention period and activity for the 12 months post discharge from the team. The activity/cost is calculated for each individual cohort and tracked over time. Tariff savings are calculated using data provided by the CCG, based on NHS numbers.

FYE 2011-12	A&E	Admissions
Cohort 1	240	101
Cohort 2	47	36
Total	287	137
Tariff cost	£15,128	£175,716

FYE 2012-13	A&E	Admissions
Cohort 1	186	79
Cohort 2	198	115
Cohort 3	200	159
Cohort 4	124	74
Total	708	427
Tariff cost	£66,020	£490,561

Total Savings

	PYE	FYE	
	2011/12	2012/13	TOTAL
A&E attendances	287	708	995
Admissions	137	427	564
Tariff	£190,844	£556,581	£747,425
Bed Days	48	617	665

Savings for commissioners

	PYE	FYE	
	Year 1	Year 2	TOTAL
A&E attendances	287	708	995
Admissions	137	427	564
Bed Days	48	617	665
Tariff Savings	£190,844	£556,581	£747,425
Cost	£300,000	£300,000	£600,000
Savings per year	-£109,156	£256,581	147,425

Savings from 2ARA caseload were not calculated as proactively preventing escalation of activity – however savings potentially much more than this. Savings in the wider system are difficult to quantify at this stage – however the implementation of the STAR tool will give a more holistic assessment of the patient journey, and track levels of engagement with services. There was no real change in zero length of stay.

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8. Promote mental health and well-being across the life course

Mental health and well-being- key facts

- Mental health problems are very common. According to a national, gross-government, 2011 strategy, 'No health without mental health', at least 1 in 4 people will experience a mental health problem at some point in their life
- According to the 2014 Health Profiles for England, 6 of the 9 local authority areas in Cheshire and Merseyside had a higher than average proportion of hospital stays for self-harm.
- Merseyside local authorities scored lower than the England average in 2012-13 for self-reported well-being : <http://fingertips.phe.org.uk>
- The 'fingertips' data also showed that mental health admissions for children aged 0-17, in 2012-3, were higher in Cheshire and Merseyside (106.1 per 100,000) than for England as a whole (87.6)
- People with one long-term condition are two to three times more likely to develop depression than the rest of the population. People with three or more conditions are seven times more likely to have depression.
- Severe loneliness (feeling lonely all or most of the time) occurs in around 6% of the general population. Levels are highest amongst those aged under 25 (9%) and over 55 (9%).
- Evidence that clearly shows that a workforce in good health is also beneficial to employers has developed in recent years: The NHS loses over 10 million working days each year due to sickness absence alone. A large scale review (Boorman) showed clear links between workforce well-being and key measures such as patient satisfaction and Trust performance.

8.1 What is the issue?

The World Health Organization defines mental health as 'a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'¹⁴⁴. The positive dimension of mental health is stressed in WHO's definition of health¹⁴⁵ as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Mental health, emotional wellbeing and resilience concerns the way we feel about ourselves, conduct relationships, handle stress or deal with loss. Good mental health and resilience are fundamental to good physical health, relationships, education and work, as well as being key to achieving our potential. Common mental health problems such as anxiety, depression, panic disorders, phobias and obsessive compulsive disorder can cause great emotional distress, and can affect how we cope with day-to-day life and ability to work¹⁴⁶. Wellbeing can be defined as ...'the dynamic process that gives people a sense of how their lives are going, through the interaction between their circumstances, activities and psychological resources or 'mental capital'. Mental wellbeing is central to making behaviour changes. Mental wellbeing is about having a sense of coherence about the behaviour and its affects, feeling motivated to make any changes, having confidence in our ability to make the change and control to sustain it and feeling optimistic that the change is worthwhile for our future. The science of 'subjective well-being' suggests that as well as experiencing good feelings, people need

- a sense of individual vitality
- to undertake activities which are meaningful, engaging, and which make them feel competent and autonomous
- a stock of inner resources to help them cope when things go wrong and be resilient to changes beyond their immediate control¹⁴⁷.

Mental health problems are very common. According to a national, cross-government, 2011 strategy, 'No health without mental health'¹⁴⁸, at least 1 in 4 people will experience a mental health problem at some point in their life, and 1 in 6 adults has a mental health problem at any one time. 1 in 10 children aged between 5 and 16 years has a mental health problem, and around 10 and 13% of 15-16 year olds have self-harmed.

Table 5 below shows that, according to the 2014 Health Profiles for England¹⁴⁹, 6 of the 9 local authority areas in Cheshire and Merseyside had a higher than average proportion of hospital stays for self-harm, meaning that this is an important issue to address, particularly in these local authority areas. Suicide rates were higher in 4 of the 9 Cheshire and Merseyside local authority areas than the England average, and lower in 5, meaning that this is a important issue for providers of health-care to address, particularly in these areas where rates were higher than the England average.

Public Health England 'fingertips' data showed that 5 of the 6 Merseyside local authorities scored lower than the England average for self-reported well-being¹⁵⁰. This data was not available for Cheshire local authorities.

Severe loneliness (feeling lonely all or most of the time) occurs in around 6% of the general population. Levels are highest amongst those aged under 25 (9%) and over 55 (9%). Amongst older people, those especially at risk include ethnic minority elders (24%-50%), those who are visually or hearing impaired, and those aged 80 plus. Others found to be at risk include those who are single, widowed, divorced or separated, economically inactive, living in rented accommodation or in debt and children with special needs¹⁵¹. Public Health England data¹⁵² showed that the percentage of social

¹⁴⁴ http://www.who.int/features/factfiles/mental_health/en/

¹⁴⁵ <http://www.who.int/about/definition/en/print.html>

¹⁴⁶ <http://www.nhs.uk/NHSEngland/AboutNHSservices/mental-health-services-explained/Pages/accessing%20services.aspx>

¹⁴⁷ <http://www.nationalaccountsofwellbeing.org/learn/what-is-well-being.html>

¹⁴⁸ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

¹⁴⁹ <http://www.apho.org.uk/resource/view.aspx?RID=50215®ION=50151&SPEAR=>

¹⁵⁰ <http://fingertips.phe.org.uk/search/mental%20health#gid/1/pat/43/ati/102/page/0/par/X25003AA/are/E06000049>

¹⁵¹ <http://www.liv.ac.uk/media/livacuk/instituteofpsychology/publichealthobservatory/LPHO,loneliness,final.pdf>

care users who had as much social contact as they would like was similar or higher than the England average in all Cheshire and Merseyside local authorities. The percentage of adult carers who had as much social contact as they would like was similar or higher than the England average in 8 of the 9 Cheshire and Merseyside areas, but was much lower in Liverpool (27.4%) than the England average (41.3%).

Table 5: Hospital stays for self-harm, and suicide rates, Cheshire and Merseyside

District	Hospital stays for self-harm per 100,000 population	Suicide rates per 100,000 population
St. Helens	348.9	9.9
Halton	325.9	7.8
Wirral	310.2	7.2
Warrington	309.1	6.8
Knowsley	267.3	10.4
Sefton	194.4	9.4
Cheshire East	170.8	7.3
Cheshire West and Chester	170.0	8.6
Liverpool	153.3	7.9
England	188	8.5

Source: 2014 Health Profiles for England. Directly age standardised rates per 100,000 population, 2012/3. Suicide rates refer to directly age standardised mortality rates from suicide and injury of undetermined intent

Mental health problems are common at every stage across the life course. According to NHS Choices, nearly 850,000 children and young people aged five to 16 years have a mental health problem – about 10% of the population. Fewer than one in 10 accesses treatment. At least one in four people experiences a diagnosable mental health problem in any one year. There are very strong links between mental and physical health – poor physical health can cause poor mental health, and vice versa¹⁵³. According to the Royal College of Psychiatrists¹⁵⁴, even a cold is likely to make us miserable, so it is not surprising that more serious physical illnesses can have an adverse affect on our mental health. Any illness that affects our ability to function normally can reduce our wellbeing and lead onto mental illness. In addition, depressive illnesses may make physical illnesses worse and make it harder to recover from them.

CHAMPS Public Health Network has produced a briefing on measuring mental well-being, and is encouraging people to use the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) to measure the impact of interventions¹⁵⁵

Continuing to look at mental health across the life course, it is important to be aware of mental health issues around pregnancy and childbirth. A brief period of feeling emotional and tearful, known as the 'baby blues'¹⁵⁶ usually around 3-10 days after giving birth, is very common, affecting around 85% of new mothers, as well as some new fathers. However, around 10-15% of new mothers develop a much deeper depression known as post-natal depression, which can range from being mild to very severe, and it is important that relevant health professionals are able to identify the symptoms, and refer parents to relevant help where necessary.

Work also has a strong impact on mental health. Good employment is good for mental and physical health, although poor quality work does not have the same beneficial effect¹⁵⁷. Good work is characterised by a living wage, having control over work, in-work development, flexibility, protection

¹⁵² <http://fingertips.phe.org.uk/search/loneliness#gid/1/pat/43/ati/102/page/0/par/X25003AA/are/E06000049>

¹⁵³ <http://www.rcpsych.ac.uk/healthadvice/viewpoint/mentalphysicalhealth.aspx>

¹⁵⁴ <http://www.rcpsych.ac.uk/healthadvice/viewpoint/mentalphysicalhealth.aspx>

¹⁵⁵ <http://www.champspublichealth.com/writedir/f67eMeasuring%20mental%20wellbeing%20using%20WEMWBS-FINAL.pdf>

¹⁵⁶ <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/feeling-depressed-after-birth.aspx>

¹⁵⁷ The Marmot Review (2010) Fair Society, Healthy Lives Strategic Review of Health Inequalities in England post-2010. The Marmot Review: London

from adverse working conditions, ill health prevention and stress management strategies, and support for sick and disabled people that facilitates a return to work¹⁵⁸.

There is a strong business case for ensuring good mental health in the workplace. The large-scale Boorman review showed clear links between workforce well-being and key measures such as patient satisfaction and Trust performance¹⁵⁹. The NHS loses over 10 million working days each year due to sickness absence alone. NHS employees have high levels of sickness absence (10.7 days per staff member) in comparison with both the average for the public sector (9.7 days) and the private sector (6.4)¹⁶⁰. The Government's 2013 'Fitness for work: the Government response to 'Health at work – an independent review of sickness absence'¹⁶¹ reported a large-scale survey¹⁶² that showed a quarter of all employers reported that sickness absence was a barrier to productivity in their organisation. According to a Department of Health report, 14 evaluation studies in the USA found that health promotion measures led to a 12–36 % reduction in sickness absence and a 34 per cent saving in absenteeism costs¹⁶³.

Presenteeism¹⁶⁴, or attending work whilst unwell, is also high in the NHS. It poses a risk to health and safety both of staff and patients as well as financial costs. Presenteeism costs £605 per employee per year, compared with absenteeism which costs £335 per employee per year¹⁶⁵. Around 43% of NHS staff felt some form of pressure to return to work when ill, whilst 10% reported that work had a negative impact on their health and well-being¹⁶⁶. A focus on improving people's general health will lead directly to reduced presenteeism and absenteeism and therefore improved performance.

Many health-care workers may also work shifts. Evidence studies suggest that the risk of cardiovascular disease in shift workers is increased by about 40%¹⁶⁷. Night shift workers are at increased risk of work accidents, as well as cardiovascular and gastro-intestinal problems¹⁶⁸. People who work more than eight hours per day for any number of days in a month have much higher absence rates than those who never do so: long working hour cultures in organisations also have an impact on attendance rates¹⁶⁹. Working more than 11 hours a day is associated

¹⁵⁸ The Marmot Review (2010) Fair Society, Healthy Lives: Strategic Review of Health. Inequalities in England post- 2010. The Marmot Review: London

¹⁵⁹ Boorman S. (2009) NHS Health and Well-being Report. [http://www.nhshealthandwellbeing.org/pdfs/NHS Staff H&WB Review Final Report VFinal 20-11-09.pdf](http://www.nhshealthandwellbeing.org/pdfs/NHS%20Staff%20H&WB%20Review%20Final%20Report%20-%2011-09.pdf)

¹⁶⁰ Boorman S. (2009) NHS Health and Well-being Report. [http://www.nhshealthandwellbeing.org/pdfs/NHS Staff H&WB Review Final Report VFinal20-11-09.pdf](http://www.nhshealthandwellbeing.org/pdfs/NHS%20Staff%20H&WB%20Review%20Final%20Report%20-%2011-09.pdf)

¹⁶¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181072/health-at-work-gov-response.pdf

¹⁶² Young, V. and Bhaumik, C. (2011) *Health and wellbeing at work: a survey of employers*. DWP Research Report No 750. Available at: <http://research.dwp.gov.uk/asd/asd5/rports2011-2012/rrep750.pdf>

¹⁶³ Boorman S. (2009) NHS Health and Well-being Report. [http://www.nhshealthandwellbeing.org/pdfs/NHS Staff H&WB Review Final Report VFinal 20-11-09.pdf](http://www.nhshealthandwellbeing.org/pdfs/NHS%20Staff%20H&WB%20Review%20Final%20Report%20-%2011-09.pdf)

¹⁶⁴ <http://www.acas.org.uk/index.aspx?articleid=3582>

¹⁶⁵ The Sainsbury Centre for Mental Health (2007) Policy Paper 8 – Mental Health atWork: Developing the business case. http://www.scmh.org.uk/pdfs/mental_health_at_work.pdf

¹⁶⁶ Van Stolk C, Starkey T, Shehabi A and Hassan E (2009) NHS Workforce Health and Wellbeing Review: Staff Perception Research. http://www.nhshealthandwellbeing.org/pdfs/NHS_HWB_Survey_Report_Final.pdf; Boorman S. (2009) NHS Health and Well-being Report. [http://www.nhshealthandwellbeing.org/pdfs/NHS Staff H&WB Review Final Report VFinal 20-11-09.pdf](http://www.nhshealthandwellbeing.org/pdfs/NHS%20Staff%20H&WB%20Review%20Final%20Report%20-%2011-09.pdf)

¹⁶⁷ Härmä M. (2006) Workhours in relation to work stress, recovery and health. *Scandinavian Journal of Work, Environment & Health* 32(6): 502–514

¹⁶⁸ Swerdlow A. (2003) *Shift Work and Breast Cancer: A Critical Review of the Epidemiological Evidence* (Research Report 132), Sudbury, UK, HSE Books, Available [November 2004] at <http://www.hse.gov.uk/research/rrpdf/rr132.pdf>

¹⁶⁹ Boorman S. (2009) NHS Health and Well-being Report. [http://www.nhshealthandwellbeing.org/pdfs/NHS Staff H&WB Review Final Report VFinal 20-11-09.pdf](http://www.nhshealthandwellbeing.org/pdfs/NHS%20Staff%20H&WB%20Review%20Final%20Report%20-%2011-09.pdf)

with a threefold risk of myocardial infarction¹⁷⁰ and a fourfold risk of type two diabetes¹⁷¹. Long working hour cultures in organisations also have an impact on attendance rates¹⁷².

The main causes of sickness and ill-health retirement among NHS workers are similar to other employment sectors. The most were musculoskeletal disorders, alongside stress, depression and anxiety, which can be tackled by health and wellbeing strategies, which can be effectively treated and rates reduced if they are tackled at an early stage¹⁷³. It has also been shown that effective leadership improves sickness and absence rates¹⁷⁴.

There are associations between lifestyle and sickness absence. Staff who smoke six or more cigarettes a day, firstly, have higher incidence of absence and longer absences – a survey found that 20% of NHS staff smoke, slightly lower than the proportion in the general population, but higher than might be expected given the higher proportion of higher grade staff than in the general population¹⁷⁵. Staff who undertook physical activity outside work had a lower incidence of absence and mental health problems than those who did not. Just as poor working conditions are socially graded, there is a social class gradient in behaviours that negatively affect health, such as drinking and smoking. Therefore, effective preventive interventions will have to address health inequalities and be aimed at relevant staff groups. In addition, the lowest grade workers suffer most and have higher rates of absence, specifically those in 'precarious jobs', where exposure to multiple stressors (from low wages to job instability to lack of control over strenuous tasks) results in unhealthy work¹⁷⁶. A range of research relates issues such as job security¹⁷⁷, job satisfaction¹⁷⁸ and support networks¹⁷⁹, to various psychological and physical health impacts, such as depression, cardiovascular and coronary heart disease and musculoskeletal disorders. To address this, employers will gain the most benefits by focussing attention and effort increasingly down the social scale.

In 2013, the Department for Work and Pensions commissioned an independent review¹⁸⁰ on mental health problems, and their impact on people's ability to work, to supplement the Department for Work and Pensions report 'Working for a healthier tomorrow'¹⁸¹. In response to this review the Secretary of State for Health is committed to continuing to support the health and wellbeing of NHS staff and the further reduction of sickness absence levels. The NHS Constitution¹⁸² also commits 'to provide support and opportunities for staff to maintain their 'health and well-being and safety'.

¹⁷⁰ Sokeyima S, Kagamimori S. (1998) Working hours as a risk factor for acute myocardial infarction in Japan: case-control study. *British Medical Journal* 317: 775–780; Van der Hulst M. (2003) Long work hours and health. *Scandinavian Journal of Work Environment and Health* 29(3):171–88

¹⁷¹ Kawakami N, Araki S, Takatsuka N, Shimizu H, Ishibashi H. (1999) Overtime, psychosocial working conditions, and occurrence of non-insulin dependent diabetes mellitus in Japanese men. *Journal of Epidemiology and Community Health* 53: 359–63

¹⁷² Boorman S. (2009) NHS Health and Well-being Report. http://www.nhshealthandwellbeing.org/pdfs/NHS_Staff_H&WB_Review_Final_Report_VFinal_20-11-09.pdf

¹⁷³ Boorman S. (2009) NHS Health and Well-being Report. http://www.nhshealthandwellbeing.org/pdfs/NHS_Staff_H&WB_Review_Final_Report_VFinal_20-11-09.pdf

¹⁷⁴ Griffeth RW, Hom PW, Gaertner, S. (2000) A Meta-Analysis of Antecedents and Correlates of Employee Turnover: Update, Moderator Tests, and Research Implications for the Next Millennium. *Journal of Management* 26(3): 463–488

¹⁷⁵ Office for National Statistics (2009) Smoking Habits in Great Britain. <http://www.statistics.gov.uk/cci/nugget.asp?id=313>

¹⁷⁶ Benavides FG, Benach J, Diez-Roux AV and Roman C (2000) How do types of employment relate to health indicators? Findings from the Second European Survey on Working Conditions. *Journal of Epidemiology and Community Health* 54: 494–501; Benach J and Muntaner C (2007) Precarious employment and health: Developing a research agenda. *Journal of Epidemiology and Community Health* 61: 276–277

¹⁷⁷ Ferrie JE (2001) Is job insecurity harmful to health? *Journal of the Royal Society of Medicine* 94: 71–76;

¹⁷⁸ Creed P A, Muller J and Machin M A (2001) The role of satisfaction with occupational status, neuroticism, financial strain and categories of experience in predicting mental health in the unemployed. *Personality and Individual Differences*: 30 (3): 435–447;

¹⁷⁹ Pentti J and Theorell T (2000) The effect of change in the psychosocial work environment on sickness absence: A seven year follow up of initially healthy employees. *Journal of Epidemiology and Community Health* 54: 484–493.

¹⁸⁰ <https://www.gov.uk/government/publications/mental-health-and-work>

¹⁸¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209782/hwwb-working-for-a-healthier-tomorrow.pdf

¹⁸² <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/handbook-to-the-nhs-constitution.pdf>

Another issue that can affect people across the life course is domestic abuse. In order to compliment existing initiatives, Merseyside and Cheshire Directors of Public Health have agreed that domestic abuse should be the focus of a 2014/15 campaign, due to be launched late January 2015, as it is a significant public health issue, having a major impact upon those directly affected and their families, according to a recent briefing¹⁸³. Domestic abuse affects one in three women and one in five men¹⁸⁴. In 2012/13, 4,537 incidents of domestic violence were reported to the police in Cheshire, and 33,261 on Merseyside¹⁸⁵. Exacerbating factors such as alcohol use are of key concern and the campaign will highlight the scale and impact as well as engaging the public to make domestic abuse less of a hidden issue in communities. There will be opportunities for healthcare settings to be involved with the campaign and Champs will be holding a Masterclass jointly with NICE in February 2015. For further information, or to get involved, please email Pippa Sargent (pippasargent@wirral.gov.uk), Suzanne McGuckin (suzannemcguckin@wirral.gov.uk), or call 0151 666 5123.

In addition, as well as employers, and NHS staff, taking action on alcohol and substance misuse¹⁸⁶, it is important that they are also aware of other addictions such as gambling. According to a 2013 report from the National Centre for Social Research¹⁸⁷, using data collected from two large-scale surveys, problem gambling, described as 'gambling to a degree that compromises, disrupts or damages family, personal or recreational pursuits',¹⁸⁸ found the prevalence of problem gambling to be 0.4% or 0.5%, depending on which measure of problem gambling was used. In addition we know that a further 1% of adults (about half a million) were categorised as 'moderate-risk' gamblers. This means that in total around 700,000 adults in England and Scotland are either moderate risk or problem gamblers¹⁸⁹, meaning that it is important for health-care providers to be aware of this issue, and be aware of organisations such as GamCare¹⁹⁰ who can provide support.

Maintaining good mental health continues to be important throughout the life course. Mental health of older adults is also paramount. There are approximately 570,000 people with dementia in England, a figure that could double in the next 30 years¹⁹¹. At the end of the life course, end of life care is also an important issue¹⁹². NICE have issued a number of guidelines on managing end of life care¹⁹³, including the importance of assessing a patient's emotional state at key times during the course of a physical illness.

In addition, there is a strong case, taking wellbeing in its broadest sense, for hospitals to have a positive impact on wider determinants of health for patients and staff – for example, working with partners such as the council, housing providers, citizens advice etc to create one stop shops for patients where it isn't just their physical needs that are resolved, but potentially their social needs as well. Every interaction occurring in the hospital setting should have the potential to have a positive impact on peoples' lives., as recommended in the NHS Future Forum's recommendation¹⁹⁴ to 'Make Every Contact Count'¹⁹⁵: every healthcare professional should use every contact with an individual to maintain or improve their mental and physical health and wellbeing where possible, whatever their specialty or the purpose of the contact.

¹⁸³ CHAMPS Public Health Collaborative Service ,Domestic Abuse Campaign Briefing , November 2014

¹⁸⁴ Flatley, J. (2013) Focus on: Violent Crime and Sexual Offences, 2011/12. Office for National Statistics and Home Office Joint Statistical Bulletin, Office for National Statistics, London.

¹⁸⁵ <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-328149>

¹⁸⁶ <http://wellbeingcharter.org.uk/index.php>.

¹⁸⁷ <http://www.gamblingcommission.gov.uk/PDF/Gambling%20behaviour%20in%20England%20Scotland%2010072014.pdf>

¹⁸⁸ Lesieur HR, Rosenthal MD. Pathological gambling: a review of the literature (prepared for the American Psychiatric Association Task Force on DSM-IV Committee on disorders of impulse control not elsewhere classified) J Gambling Stud. 1991;7:5–40.

¹⁸⁹ http://www.gamblingcommission.gov.uk/gh-press/2014/health_survey_analysis.aspx

¹⁹⁰ <http://www.gamcare.org.uk/>

¹⁹¹ <http://www.nhs.uk/NHSEngland/AboutNHSservices/mental-health-services-explained/Pages/accessing%20services.aspx>

¹⁹² <http://www.nhs.uk/Planners/end-of-life-care/Pages/what-is-end-of-life-care.aspx>

¹⁹³ <http://cks.nice.org.uk/palliative-cancer-care-general-issues#!scenario>

¹⁹⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216423/dh_132114.pdf

¹⁹⁵ <http://www.makeeverycontactcount.co.uk/>

In addition, the New Economics Foundation's (NEF) 5 ways to wellbeing¹⁹⁶ provide simple actions that individuals can adopt in their everyday lives in order to promote people's wellbeing. The Five Ways to Wellbeing were developed by NEF from evidence gathered in the UK government's Foresight Project on Mental Capital and Wellbeing. The evidenced based actions are;

- Connect: with the people around you. With family, friends, colleagues and neighbours.
- Be Active: Go for a walk or a run. Step outside. Cycle. Discover a physical activity that you enjoy that suits your level of fitness.
- Take Notice: Be curious. Savour the moment. Be aware of the world around you and what you are feeling.
- Keep Learning : Try something new. Take on a different responsibility at work.
- Give: Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time.

8.2 What can health-care providers do?

8.2.1 Interventions for patients

Give patients clear information on their condition, and how they can manage it themselves¹⁹⁷

Communication with family and friends is important when someone is in hospital. Allow mobile phone use, where their use does not affect the safety of patients or other people, patients' privacy and dignity, or the operation of medical equipment¹⁹⁸

NHS trusts should have written policies covering the use of mobile phones, including those with built-in cameras, as well as policies covering other cameras, and video recording equipment¹⁹⁹

Raise awareness (for example by posters or postcards) of the New Economics Foundation's (NEF) '5 ways to well-being'²⁰⁰, as described in section 8.4

Be aware that those who have been diagnosed with physical health conditions, such as cancer, may also experience problems with their mental health, such as depression. Treatment for physical symptoms may also have a positive impact on physical health²⁰¹

Provide support for patients who have alcohol, substance use²⁰² or other addictions such as gambling

Staff may initially find it daunting to raise issues connected with mental wellbeing due to fears of starting up a long conversation, or not having the specialist knowledge to deal with what's raised, according to CHAMPS²⁰³. CHAMPS suggest that this can be overcome by using positive tools that focus on solutions rather than problems, such as the NEF 5 ways to wellbeing, or through social prescribing or signposting. Mental wellbeing is hugely affected by social factors including debt, unemployment, housing, relationships and isolation. There are lots of agencies that can provide support and many localities have a directory of these. Health agencies may also run a social prescribing scheme/ community referral to sources of support in the community such as arts, exercise, learning, books or debt advice. Being aware of the social conditions affecting someone's ability to make healthy choices is crucial. Signposting information can easily be given during brief interventions²⁰⁴.

Suicide Awareness training - 30 minute sessions designed around the time-limitations of clinical staff- is being implemented in a number of areas in Cheshire and Merseyside. For more information, please contact the suicide lead within your local public health team. In addition, the Cheshire Merseyside Suicide Prevention Network²⁰⁵ was formed in 2008 to seek greater co-ordination of responses to and understanding of patterns of suicide. Please see CHAMPS website for more information:

<http://www.champspublichealth.com/cheshire-and-merseyside-suicide-reduction-network-cmsrn>.

¹⁹⁶ <http://www.neweconomics.org/projects/entry/five-ways-to-well-being>

¹⁹⁷ <http://www.health.org.uk/public/cms/75/76/313/2434/Helping%20people%20help%20themselves%20publication.pdf?realName=03JXkw.pdf>

¹⁹⁸ <http://www.nhs.uk/chq/pages/2146.aspx?CategoryID=68&SubCategoryID=162>

¹⁹⁹ <http://www.nhs.uk/chq/pages/2146.aspx?CategoryID=68&SubCategoryID=162>

²⁰⁰ <http://www.neweconomics.org/projects/entry/five-ways-to-well-being>

²⁰¹ <http://www.nhs.uk/news/2014/08August/Pages/Depression-therapy-aids-other-cancer-symptoms.aspx>

²⁰² <http://wellbeingcharter.org.uk/index.php>

²⁰³ <http://www.champspublichealth.com/page.aspx?pageid=989&ParentID=0>

²⁰⁴ <http://www.champspublichealth.com/page.aspx?pageid=989&ParentID=0>

²⁰⁵ <http://www.champspublichealth.com/cheshire-and-merseyside-suicide-reduction-network-cmsrn>

8.2.2 Interventions for staff

Access the NHS employers website²⁰⁶ for support on implementing NICE guidance

Link into the NHS Employers health and wellbeing network²⁰⁷

Raise awareness (for example by posters or postcards) of the New Economics Foundation's '5 ways to well-being'²⁰⁸, as described in section 8.4

Sign up for the Workplace Wellbeing Charter²⁰⁹. Employers who sign up for the Charter can access help and support available through a website: <http://wellbeingcharter.org.uk/index.php>. The recommendations include;

- Organisations should be aware of their responsibilities under the Equality Act 2010, along with other equality legislation
- Reasonable adjustments are available to employees in line with recommendations made in a Statement of Fitness for Work²¹⁰
- Effective policies and procedures on bullying and harassment, on whistle blowing, and to manage disciplinary and grievance procedures, are in place, alongside flexible working policies and family friendly policies, and relevant health and safety policies
- Ensure a system that recognises and rewards hard work is in place. Ensure that education and development opportunities are routinely available to management and staff
- Line managers should have relevant leadership and management training
- Organisations should have a health, work and well-being strategy in place, as well as a mental wellbeing policy that follows the principles of the Health and Safety Executives Management Standards for Stress²¹¹. Provide a confidential support service for staff who come forward with problems. Actively encourage social support groups and volunteering
- Absence rates should be collected and monitored, and a clear attendance management policy should be in place, alongside documented return to work procedures, and policies to support staff who on long term sick leave
- Ensure that the workplace in conducive to health and employee welfare is addressed – provide drinking water, washing facilities, clean water etc.
- Connect 5 Training Programme is a training programme for workers or volunteers who want to help clients and service users to improve their mental health and wellbeing. Participants progress through stages, dependent on how much of their role involves working with people experiencing poor mental health and wellbeing. For more information, please contact Nikki Jones, Public Health Manager at Wigan Council, by email: nicolajones3@wirral.gov.uk.
- Use the Mental Wellbeing Assessment Tool (MWAT)²¹², which provides a structured, evidence based approach to assessing and improving the effectiveness of policies, proposals, programmes and projects
- The Mental Wellbeing Checklist is a useful, simple way of referring to the evidence based protective factors for mental wellbeing, the wider determinants of mental wellbeing and the groups most vulnerable to poor mental wellbeing²¹³
- Time to Change is a national campaign to tackle stigma around mental health, and a wealth of information and support is available on the Time to Change website: <http://www.time-to-change.org.uk/about>

8.2.3 Interventions for community

It is likely that the higher incidence of absence for female staff is influenced by caring responsibilities rather than sickness. Individual work-time control such as flexitime or time banking was shown to reduce absence, specifically among employed women (Ala-Mursla et al, 2005).

²⁰⁶ <http://www.nhsemployers.org/>

²⁰⁷ <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing/copy-of-leading-the-way/health-and-wellbeing-leads-network>

²⁰⁸ <http://www.neweconomics.org/projects/entry/five-ways-to-well-being>

²⁰⁹ http://wellbeingcharter.org.uk/media/PDF/WWC_Self_Assessment_Standards_A4_Booklet_Liverpool_2_WEB.PDF

²¹⁰ <http://www.acas.org.uk/index.aspx?articleid=2832>

²¹¹ <http://www.hse.gov.uk/stress/standards/>

²¹² <http://www.champspublichealth.com/writedir/80dfMental%20Well-being%20Impact%20Assessment%20Tool.pdf>

²¹³ <http://www.champspublichealth.com/writedir/de18mental-wellbeing-checklist-a4.pdf>

Raise awareness (for example by posters or postcards) of the New Economics Foundation's '5 ways to well-being'²¹⁴, as described in section 8.4.

An Integrated Wellness Service (IWS) has been developed in Knowsley²¹⁵, and a number of public health teams within Cheshire and Merseyside are looking at developing (IWS) in 2015. An Integrated Wellness Service is defined as providing support to people to live well, by addressing the factors that influence their health and wellbeing and building their capability to be independent, resilient and maintain good wellbeing for themselves and those around them²¹⁶. Key principles of an IWS also include²¹⁷;

- Single point of access 'hub'
- Holistic assessment of individuals
- Hub triages clients based upon need and provides on-going support.
- Service supports community development and builds upon community assets.

²¹⁴ <http://www.neweconomics.org/projects/entry/five-ways-to-well-being>

²¹⁵ <http://www.kingsfund.org.uk/sites/files/kf/chris-mcbrien-elspeth-anwar-knowsley-poster-mar13.pdf>

²¹⁶ http://www.liv.ac.uk/media/livacuk/instituteofpsychology/publichealthobservatory/Wellness_Services_cost-effectiveness_review_Final_Report.pdf

²¹⁷ <http://www.kingsfund.org.uk/sites/files/kf/chris-mcbrien-elspeth-anwar-knowsley-poster-mar13.pdf>

8.3 Examples of local delivery

8.3.1 The use of a liaison psychiatric nurse to promote good health, treatment and prevention of mental ill health in a general hospital setting in North West England²¹⁸

What was the issue?

Patients can develop mental health problems during major changes in physical health, which may escalate without intervention. Preventative measures and health education can reduce demand on services and improve quality of life for patients. The hospital identified that, prior to the intervention, patients had limited access to services to address this.

What was the intervention?

The aim was to improve health outcomes for adults who have a physical illness which impacts on their mental and psychological well being. The objectives were to provide a clinic for patients who have chronic physical ill health, and mental health problems associated with this. The service will be informed by NICE guidelines. Care given will use recent research and education to address the stigma attached to mental illness. The success of the service will be measured by reducing re-admission rates to acute wards.

The liaison nurse targeted personal development and, in particular, post grad qualifications, towards providing the type of liaison psychiatry service which isn't just involved in the A&E department but provides ongoing, holistic care for a much wider set of needs related to mental health. This includes a teaching qualification which was essential to raise the profile of mental health needs and address negative attitudes and beliefs about mental illness currently held amongst some healthcare workers.

The liaison psychiatry team now offers a wide range of mental health and psychological interventions for patients through the use of out-patient nurse led clinics. The clinics focus on adjustment issues which often incorporate anxiety and depression. The general physicians refer direct to the service. This is accepted if appropriate, if not, the team offers the most appropriate route of action by signposting or advice on management. The patient is then assessed in the out patient nurse led clinic and offered follow up sessions. The team uses health promotion and up to date research to explain and explore mental health issues to patients, carers and all health care professionals to develop a more positive view of mental health generally. The team have been instrumental in changing attitudes and beliefs about working with individuals with mental health issues.

What were the benefits?

The team incorporate all NICE guidelines relating to mental illness. They also use the care programme approach, utilising care planning and reviews to regularly monitor individual progress. Patients, carers and referrers provide regular feedback on the service and care provided, which is used to shape further interventions. There is excellent attendance at clinics. Educational audits are completed regularly to highlight best practice. Regular meetings with multidisciplinary colleagues in the hospital are held. A psychiatric liaison service conference has been held this year with a range of speakers from mental health and physicians highlighting joint working addressing physical and mental health care needs.

Health care professionals should be aware of the need to be preventative and informative. They need to know how to identify an area of mental health, follow up, referral and where to seek advice.

Contact Details

Name: Wendy Harlow
Organisation: Sussex Partnership NHS Foundation Trust
Email: wendy.harlow@sussexpartnership.nhs.uk

²¹⁸ <http://www.nice.org.uk/usingguidance/sharedlearningimplementingniceguidance/examplesofimplementation/eximpresults.jsp?o=185>

8.3.2 Liverpool Community Health - Wellbeing Wheel

What was the issue?

.Liverpool Community Health (LCH) staff work across 100 different locations within the Merseyside area – LCH's 3000 staff are based within a variety of different environments. This can make it difficult for staff to know about and access the range of support on offer.

What was the intervention (including any timescales)?

To support the wellbeing agenda, LCH offers staff a range of interventions and initiatives. As well as occupational health services, the trust offers fast track stop smoking services, alcohol support services, weight management groups and food and nutritional information, travel scheme benefits, childcare benefits, training to support managers to support their staff, lifestyle support initiatives, and gym membership.

Through consultation with staff, the trust recognised that staff and managers found it hard to navigate their way around the LCH intranet, which created a barrier to accessing the relevant support. In March 2014, the LCH Wellbeing Wheel was launched. This is an internet based, staff facing 'one stop shop' that incorporates all the different initiatives that are available to LCH staff. The wheel itself is an eye catching visual. Under the wheel, staff are offered a menu of services which group all the interventions available under relevant headings. The Wellbeing Wheel contains each of the 'five ways to wellbeing' so clearly demonstrates what is offered under each of the '5 ways'. It is also being used to form staff health and wellbeing branding – it has a recognisable logo that will promote visual identification and will illustrate dedication of LCH to the health and wellbeing of its staff.

What have been the benefits to patients/staff/the wider community?

Liverpool Community Health (LCH) recognises that employees' health and wellbeing can have a direct effect on the quality of care that is delivered to patients. A healthier workforce is better for patient experience, patient safety and clinical outcomes. The trust recognises that an engaged workforce is more likely to be a productive one, and that health and wellbeing is a vital part of engagement

Contact details

Ben Towell, Liverpool Community Health NHS Trust
Email: ben.towell@liverpoolch.nhs.uk

8.4 Other useful resources

One of the pledges on the Department of Health's Public Health Responsibility Deal²¹⁹, which organizations are encouraged by the Department of Health to sign up to, is;

'We will include a section on the health and wellbeing of employees within annual reports and/or on our website. We will record our sickness absence rate and actively manage this as an organisation'.

Other pledges that an organisation can make include;

"We will create an environment where anyone with past or present experience of mental health issues is valued, respected and able to flourish. This will involve providing all staff with the environment, knowledge and tools to develop and maintain emotional resilience and mental wellbeing, while raising awareness of, and providing support for, mental health in the workplace. This will include at least one of the following:

- Encouraging all members of staff to consider the impact of their behaviours and decisions on the wellbeing of themselves and those they work with, manage and have a duty of care for. This will include creating and sustaining an organisational culture where the risks from work-related stress are being effectively managed and controlled.
- Provide specific training for line managers to promote mental wellbeing and resilience. Identify early opportunities to support staff with mental health needs. This will include raising awareness amongst staff, e.g. materials promoting self-awareness, guidance on disclosure of mental ill health, how to identify early signs and symptoms and practical issues such as positive recruitment practices and managing disclosure.
- Providing opportunities for employees to support and develop their overall wellbeing by taking a holistic approach to a healthier life, covering nutritional awareness, physical activity and social engagement.
- Taking a demonstrable and positive stand against mental health stigma and discrimination in the workplace, for example by supporting the 'Time to Change' movement.
- Embedding the principles of the Mental Health Workplace Adjustments Guide (developed through the Responsibility Deal's health at work network) within HR procedures to ensure that people experiencing mental ill health are managed at work in the best way possible with reasonable flexibilities and workplace adjustments
- We will treat people within our organisation with respect and dignity. We will do everything we can to prevent stalking, violence or abuse either in the workplace or that which has an effect on people in the workplace, whether from a colleague, family member or anyone else. This will include having guidance in place which is suitable to the size of our organisation. The guidance will ensure that an appropriate, safe and sensitive response can be implemented and our employees supported when they raise such an issue".²²⁰

In order to support the Government's response to the Francis report, NHS Employers²²¹ is developing materials to help with discussions about emotional wellbeing – these will be launched in November 2014. In addition, NHS employers are developing training for managers in managing mental health in the workplace. The role of a manager is key to the development of mental wellbeing of staff. This can be a difficult role and some managers do not feel that they have the competence and/or confidence to enable them to fulfil this role. Training will include how to manage staff with mental health problems in the workforce, and for managers, how to manage a mentally healthy workplace, and how to manage their own mental health. If you are interested in finding out more about this project please email louise.murray@nhsemployers.org. NHS Employers also produced a briefing paper, 'leading the NHS workforce through to recovery'²²², which offers employers guidance on how to manage at a time of increasing financial pressures through careful workforce planning and doing more with less.

NHS Employers also has a health and wellbeing network, which host regular events on this issue – please see <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing/copy-of-leading-the-way/health-and-wellbeing-leads-network>. The network is also developing toolkits based on the NICE workplace health guidance, these are due for publication late

²¹⁹ <https://responsibilitydeal.dh.gov.uk/health-at-work-pledges/>

²²⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181072/health-at-work-gov-response.pdf

²²¹ <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing/copy-of-leading-the-way/improving-emotional-wellbeing-in-the-nhs>

²²² http://www.nhsemployers.org/~media/Employers/Publications/Leading_the_NHS_workforce_through-Briefing_66.PDF

2014²²³. Following a workplace organisational audit carried out by Health and Work Development Unit at the Royal College of Physicians in 2013, NHS Employers also created a number of web pages to provide support in implementing the guidelines set out by NICE²²⁴. Full guidance is available on the NICE website²²⁵. The 6 sets of guidance covered are;

- Management of long-term sickness and incapacity for work (PH19)
 - Promoting physical activity in the workplace (PH13)
 - Promoting mental wellbeing at work (PH22)
 - Workplace interventions to promote smoking cessation (PH5)
 - Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children (CG43)
 - Physical activity and the environment (PH8)
- Useful resources in Cheshire and Merseyside;
- The NW Introduction to behaviour change e-learning course includes a section on mental health and wellbeing <http://walkgroveonline.com/healthchats/home.php>
 - Western Cheshire Making Every Contact Count training materials include a Mental health and wellbeing training guide, course programme, case studies, and powerpoint handout <http://www.wcheshirepct.nhs.uk/default.asp?page=MECC/MECC.asp>
 - Healthy Sefton Positive Mental Wellbeing http://www.healthysefton.nhs.uk/Positive_Mental_Wellbeing.htm
 - Liverpool Making Every Contact Count guide includes mental wellbeing as the first topic for discussion: <http://www.champspublichealth.com/writedir/a58fLCH%20booklet.pdf>
 - Wirral use the Five Ways to Wellbeing as a framework for mental wellbeing: <http://www.champspublichealth.com/writedir/314bWirral%205%20ways%20Bookmarks.pdf>
 - A scoping study into wellbeing brief intervention undertaken by ChaMPs: <http://www.champspublichealth.com/page.aspx?pageid=989&ParentID=0>
Further information on wellbeing brief intervention can be found on the CHAMPS website.

²²³ <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing/copy-of-leading-the-way/health-and-wellbeing-leads-network>

²²⁴ <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing/keeping-staff-well/nice-guidance-on-supporting-staff-returning-to-work>

²²⁵ <http://www.nice.org.uk/>

9. Summary of recommendations

The Workplace Wellbeing Charter²²⁶ provides guidance on all the issues below. For all the topics, it is important that the impact of initiatives is monitored and evaluated. This section provides a brief summary of recommendations - for a full list of actions for health-providers, please see Chapters 4-8.

9.1 Provide smoking cessation services and a smoke-free environment

For patients

- Healthcare professionals should proactively ask patients if they smoke, and offer advice on how to stop. Offer referral to an evidence-based local stop smoking service.
- A working smoke-free policy is in place, and staff are aware of it – the policy should extend to all smoking habits, including electronic cigarettes.

For staff/ wider community

- Employers should actively promote stop smoking services, and allow staff time to attend
- All open outdoor areas should be clearly signposted as smoke-free, and steps taken to prevent smoking in these areas.

9.2 Provide opportunities for healthy eating

For patients

- Access the Hospital Food Standards Panel²²⁷ report for detailed recommendations on healthy eating for patients and staff
- Screen patients on admission, and re-screened weekly, to identify those who are malnourished
- Implement protected mealtimes
- There should be a dedicated liaison dietician in each hospital department
- Source food locally, using local providers.

For staff/wider community

- Ensure a healthy eating statement is in place, and staff are aware of it. Provide eating facilities that are clean and user friendly, away from work areas.
- All on-site catering facilities to provide healthy options that are actively promoted. Implement a pricing policy that promotes healthy options where possible.

9.3 Provide opportunities for physical activity

For patients

- Encourage patients to be active, in line with guidelines on recommended physical activity levels recommended by the Chief Medical Officer²²⁸. Tailor advice given to patients' goals, circumstances and health status, and provide patients with a written outline of advice given.
- Chairs of Children's Trusts and Chief Executives of Primary Care Trusts, amongst others, should ensure that there is a coordinated local strategy to increase physical activity among children and young people, their families and carers. The strategy should ensure that there are local indoor and outdoor opportunities for physical activity where children feel safe.

For staff/wider community

- For staff, develop and monitor an organisation-wide plan, multi-component programme to support employees to be physically active. Develop a travel plan
- Encourage staff to take regular breaks
- Encourage patients and employees to take the stairs rather than the lift
- Pedestrian and cycle access to health-promoting environments to be ensured.

²²⁶ http://wellbeingcharter.org.uk/media/PDF/WWC_Self_Assessment_Standards_A4_Booklet_Liverpool_2_WEB.PDF

²²⁷ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365960/20141013_Hospital_Food_Panel_Report_Complete_final_amended_for_website_oct_14_with_links.pdf

²²⁸ ²²⁸ DH (2011) *Start Active, Stay Active: A report on physical activity from the four home countries' Chief Medical Officer.*

9.4 Encourage sensible drinking of alcohol

For patients

- Chief Executives of NHS and local authorities should prioritise alcohol-use disorder prevention as an ‘invest to save’ measure’, as recommended by NICE²²⁹
- NHS professionals should routinely carry out alcohol screening as an integral part of practice. Managers of NHS-commissioned services must ensure staff are trained to provide screening and brief advice, as well as brief interventions, where there is local demand. An appropriately trained professional must also be available to provide supervision to these staff
- Where service users agree, involve families and carers in decisions about treatment and care. Provide families and carers with the information and support that they need.

For staff/wider community

- Make the full range of interventions available to patients available to staff
- Display leaflets and posters in waiting areas, giving contact details for local alcohol services.

9.5 Improve mental health and well-being

For patients

- Be aware that a patient’s diagnosis with physical health conditions may also have an impact on their mental health. Addressing mental health issues can also have a positive impact on physical symptoms
- Empower patients by providing them with written information on any health conditions, and how they can manage it themselves
- Communication with friends and family is important when someone is in hospital. Allow mobile phones use, where their use does not compromise the safety or privacy of patients or others, or the use of medical equipment
- Provide support for patients and staff who have problems with alcohol or substance misuse, or other addiction such as gambling addictions

For staff/wider community

- For staff, organisations should have a health, work and wellbeing strategy in place. Provide a confidential support services for staff who come forward with problems. Record and monitor absence rates.
- Ensure that the workplace is conducive to health and employee welfare –for example, through providing drinking water, washing facilities, places to eat lunch away from work stations.
- Raise awareness (for example by using posters or postcards) of the New Economics Foundation’s ‘5 ways to wellbeing’²³⁰

²²⁹ <https://www.nice.org.uk/guidance/ph24>

²³⁰ <http://www.neweconomics.org/projects/entry/five-ways-to-well-being>

10. Implementation

In this chapter, we explore what an organisation needs to have in place to become a health promoting provider and what tools and frameworks exist to support this. This chapter is based on the experiences of the Cheshire and Merseyside Health Promoting Providers Network, but further information can be sought from the websites provided at the end of the chapter.

10.1 Becoming a health promoting provider

Enablers

Primarily, becoming a health promoting provider requires organisational commitment, drive and resource. The following elements are considered enablers in supporting implementation

Executive level support

This is essential if the organisation is truly committed to embedding prevention approaches in to their core business. The role of this executive level champion is to ensure that the commitment to health promotion is integrated in to other organisational strategies as well as to ensure the organisation is properly resourcing and promoting health promotion initiatives and approaches is important. The executive sponsor should also chair the steering group (see below).

A clear strategy and action plan

These need to be developed for each organisation. Frameworks already exist that can be utilised (see below). However, it is important that the strategy is developed in line with local needs and has buy-in both from staff and patients locally. For example, a health promotion strategy for a children's hospital will have different priorities than an all-male mental health secure unit. Linking in with the local public health teams in local authorities and using the Joint Strategic Needs Assessment will also help to identify priorities for your local area.

Director of Public Health support

Engaging with the local public health team is important in order to understand their priorities and to use their expertise and resources. Developing projects in partnership with the local public health teams can also contribute to outcomes outlined in the Public Health Outcomes Framework.

A steering group

The role of the steering group is to monitor progress against the actions and steer future development. The organisation needs to ensure that the steering group fits within its governance structures so that its work is reported at Board level. The steering groups should have representatives from different departments within the organisation and include clinical and non-clinical staff, Human Resources and management staff. Membership of the steering group should be at a level of seniority that can unblock barriers to implementation and influence success.

Workforce resource

The level of staff resource required will vary depending on the size of the organisation and what you want to achieve. Investing in strategic leadership in public health will help to ensure prevention is embedded across the organisation. Organisations with a dedicated health promotion practitioner will be able to oversee the implementation of appropriate, specific interventions. Each of the organisations that have received accreditation (see below) have had dedicated staff resource, such as a health promotion practitioner. Other NHS organisations have employed a Consultant in Public Health, who can provide strategic leadership within the organisation, as well as provide a range of public health skills and advice to the organisation on health care quality, health protection and health improvement.

Broader workforce engagement

Engaging the workforce in a health promoting agenda is also important and there are many ways in which this can be done. Examples include developing public health champions within teams,

encouraging take-up of training, such as the every contact counts training, for all staff and engaging the workforce in activities to improve health and wellbeing. Foundation Trusts have extended this to their membership and there are examples of health and wellbeing events being held for members.

Existing frameworks

Within Cheshire and Merseyside, a number of organisations have been working towards becoming health promoting providers for a number of years. Some, such as Alder Hey, Ashworth and Liverpool Community Health have already gained World Health Organisation (WHO) ‘Health Promoting Hospital and Healthcare Provider’ accreditation. Others have achieved the Royal Society of Public Health’s (RSPH) award for being a health promoting organisation or partnership. Both of these organisations base their criteria on the Ottawa Charter for Health Promotion and subsequent declarations.

Both the WHO and RSPH provide a framework that organisations can use to self-assess themselves and to develop action plans for becoming health promoting organisations. The table below summarises the standards used by the organisations.

World Health Organisation	Royal Society of Public Health
Management policy	Board level leadership and high level management support
Patient Assessment	Effective strategies, business plans and processes tackling a wide array of health improvement issues and health inequalities
Patient Information and Intervention	Capacity and capability for planning and delivery of health improvement and community wellbeing services
Promoting a healthy workplace	Workplace health improvement for staff
Continuity and cooperation	Engagement with target audiences

The appendix contains a guide that the Cheshire and Merseyside Healthy Providers Network have developed to help organisations achieve WHO status.

Organisations who have received their accreditation believe that it helps to maintain the sustainability of health promotion within the organisation. When accreditation is supported by the Trust Board, it is considered an important achievement which benefits clinical staff and patient outcomes. Similarly, when organisations have experienced difficulties with certain aspects of health promotion, for example maintaining a smoke free site, the Board and staff are able to use the leverage provided by HPH standards to support their actions.

There is a cost to becoming both a WHO HPH and a RSPH accredited organisation. However, those who have achieved this believe that this is small in relation to the gains received.

Becoming part of a network

One way to help an organisation become a health promoting provider is to join a local network, such as the Cheshire and Merseyside Healthy Providers Network. The network is a unique collaboration of healthcare organisations providing a joint approach to improving the health and wellbeing of patients and staff. The purpose of the network is to: coordinate consistent health promotion campaigns; work collectively to identify opportunities for health promoting strategies; support provider organisations to gain Health Promoting Hospital and/or Royal Society of Public Health accreditation; provide a shared repository of best practice (see example of local delivery 10.2).

If WHO accreditation is achieved, organisations then become part of an international network. Annual conferences are held and member organisations can showcase their work to others around the world. The HPH network is also available to support organisations with questions or support on specific

health promotion topics which may be of concern to them. Similarly, going through the process of gaining RSPH accreditation enables organisations to network with others who have similar health promoting aspirations. NHS Employers also operates a health and well-being network for staff with an interest in workforce health and wellbeing. Public Health England has also established a national network which is looking specifically at the role of public health within provider organisations. This network is currently producing a guide outlining the functions of Consultants in Public Health within provider organisations.

Evaluation

It is important to evaluate the impact of health promoting interventions. Ideally an evaluation framework should be developed at the outset so that it is clear what data needs to be collected for any evaluation. Being able to evaluate impact also increases opportunities for the organisation to share good practice with other organisations and at conferences and to secure funding for future initiatives. It also contributes to a developing evidence base of the effectiveness of implementing health promoting initiatives within healthcare settings.

Links

WHO accreditation: <http://www.euro.who.int/en/health-topics/Health-systems/public-health-services/activities/health-promoting-hospitals-network-hph>

RSPH award: www.rsph.org.uk

NHS employers network: healthandwellbeing@nhsemployers.org

Public health in providers: <http://phnetwork.org.uk>

10. 2 Example of local delivery

The Cheshire and Merseyside Healthy Provider Network (CMHPN) was established in July 2012 and is comprised of NHS acute and community health provider organisations from Cheshire and Merseyside. The first meeting was held in June 2012 and terms of reference and membership outlined. The network meets bi-monthly.

The Network Vision:

Cheshire and Merseyside Healthy Providers Network are committed to putting health and wellbeing at the heart of every contact with patients, clients and its own workforce and to promote WHO accreditation for all provider settings in Cheshire and Merseyside.

CMHPN is a unique collaboration of healthcare organisations providing a joint approach to improving health and wellbeing of their patients, clients, and employees. Membership is comprised of staff with senior organisational responsibility and accountability for health improvement initiatives, both at individual and organisational level, typically represented by assistant directors of nursing and health improvement managers. The network has support from the Cheshire and Merseyside Directors of Public Health and Board level support from all participating organisations. 19 Provider organisations participate in the sharing and learning of many health promotion campaign messages including: Dry January, Active April, Sun Safety and Stoptober. The network operates on an informal and voluntary basis with shared responsibility across all member organisations

The network has established a forum for acute and community trusts as well as local authority commissioners to engage with, in order to increase public health activity at an organisational and individual level. This allows a unified approach to be adopted across the region, as social marketing campaigns have a single delivery forum.

To achieve this we have created a framework of public health excellence which individuals and organisations can work towards. All participating organisations are supported to achieve WHO's 'Health promoting hospitals and health services' status. During its first two years, a total of five organisations achieved WHO accreditation. CMHPN has also:

- Developed a strong branding and identity with subsequent annual communication and campaign plans.
- Received funding and support from the Cheshire and Merseyside Directors of Public Health, who have also commissioned the 'Top Tips for Healthy Providers' publication in 2014.
- Produced Network newsletters for cascading consistent health promotion messages and showcasing successes.
- Provided peer support for members in tackling health promotion challenges e.g., WHO/HPH accreditation applications and guiding the development of public health strategies.
- Produced a WHO accreditation step-by-step guide.
- Developed a work plan with stakeholder engagement, objective setting, sharing of ideas, best practice and support for tackling barriers.
- Established a core membership to sustain the network.
- Developed partnerships with Public Health England and CHAMPS collaborative service to deliver coordinated campaigns.
- Aligned a Provider Health Promotion Campaign Calendar – for consistent messaging across all network organisations.
- Presented at the International Conference on Health Promoting Hospitals and Health Services in Barcelona 2014.

If you would like to gain more information or to join the network please contact Julie Curren Public Health Improvement Specialist Support Officer, Liverpool Community Health NHS Trust
julie.curren@liverpoolch.nhs.uk Direct line: 0151 295 3554.

Conclusion

In conclusion, there is a strong evidence base for organisations to become health-promoting providers. There are challenges in doing this, but a wide range of support, such as that from the World Health Organization²³¹, to become a health promoting hospital, as well as Public Health England²³², and the Department of Health²³³, is available.

²³¹ <http://www.who.int/en/>

²³² <https://www.gov.uk/government/organisations/public-health-england>

²³³ <https://responsibilitydeal.dh.gov.uk/health-at-work-pledges/>

11. Appendix – Healthy Providers Network WHO Accreditation guide

Healthy Providers Network

WHO Accreditation Guide

This brief guide has been written to outline the process to become accredited as a WHO Health Promoting Hospital.

The concept of Health Promoting Hospitals is based on the Ottawa Charter (1986). Health Promotion is a core quality issue in hospitals and therefore should be incorporated into the daily work. Health promotion is defined as “the process of enabling people to increase control over, and to improve, their health” (Ottawa Charter for Health Promotion).

Executive Lead

To ensure that the organisation is committed to the HPH (health promoting hospital) constitution it is recommended to have an executive lead who will champion health promotion/public health forward. We would also recommend for them to chair/vice chair the steering group. They will be required to also sign off the WHO letter of intent along with the CEO of the organisation.



who info.pdf

Steering Group

The steering group is a vital part of the HPH process. The steering group will take responsibility for the accreditation of HPH status and ensure that each standard is addressed, they will also develop action plans for areas of concern. Examples of areas they may focus on are as follows:

- ✚ Obesity/Healthy Eating
- ✚ Breastfeeding
- ✚ Smoking
- ✚ Sensible Drinking
- ✚ Dental Health
- ✚ Physical Activity
- ✚ Mental Health
- ✚ Sexual Health
- ✚ Accident Prevention

It is suggested that the following staff should be involved in the group:

- ✚ a senior nurse who may also be responsible for quality /clinical audit
- ✚ a senior and junior doctor
- ✚ a senior manager
- ✚ a human resources/personnel member
- ✚ a member of staff from ancillary professions allied to medicine, general support medical services and a member of staff from general non clinical services.

Staff at all levels in the hospital should be involved in collecting the evidence and supporting a collective response to the compliance of the standard. The steering group will need to meet on a

regular basis to discuss progress with the self-assessment, generate ideas across disciplines and promote greater ownership of the project.

It is also recommended that an open invitation is given across the organisation for interested staff to take part, this could form a sub group and these staff can even be allocated roles or become Health Promotion Champions/advocates to cascade information to colleagues and patients.

Lead for Areas

There are 5 Health Promotion standards in total, it is recommended that a standard lead is appointed for each one. Below are the standards and an example of suggested evidence



WHO Standards and
Evidence BLANK.docx

Standard 1: Management Policy

1.1 The organisation identifies responsibilities for the process of the implementation, evaluation and regular review of the policy

Examples as listed

- Public Health Strategy
- Health Work and Wellbeing strategy
- Strategic priorities for the trust include public health outcomes
- Annual Public Health report.
- Breastfeeding, Smoking and Alcohol policies.
- Health Promotion Campaign calendar of events
- Public Health Brief interventions delivered on admission and discharge by staff.
- Public Health Steering Group Meeting minutes include regular public health updates which reaffirm HPH accreditation.
- The Trust identified personnel and functions for the coordination of HP with dedicated health promotion practitioner or allocated role to someone in the Trust

1.2 The organisation allocates resources to the processes of implementation, evaluation and regular review of the policy.

- Identifiable budget allocated for a year to purchase materials.
- Other sources of funding
- Public Health targets in quality contract.
- Dental Health Good Practice Guide
- Smoking assessment carried out on all admissions.
- Alcohol pathway for AED attendees
- Breastfeeding operational procedures available in all clinical departments.
- Health Promotion information points available in outpatient areas.
- Health Promotion Information point on main corridor for patients to access.
Intranet has dedicated health promotion information pages.

1.3 Staff are aware of the health promotion policy and it is included in induction programmes for new staff.

- Dedicated Health Work and Wellbeing policy in place.
- Staff gym facility on site

- Walk for health lunchtime walks
- Cycle for health, led cycle rides
- Holistic therapist and Chiroprapist for staff
- Dedicated occupational health team
- Staff counselling services
- Yoga classes, circuit training and other physical activity led classes.
- Cycle pods for staff to access if cycling to work
- Various health promotion campaigns focused on improving staff health and wellbeing.
- Flu vaccination campaigns.
- HP staff present during staff induction to inform staff of activities/support available for them.
- Dedicated HWW staff information pages on Intranet site.

1.4 The organisation ensures the availability of procedures for collection and evaluation of data in order to monitor the quality of health promotion activities.

- Data is routinely captured on various HP interventions and is reported to Trust and Public Health Steering Group for discussion. Recent data topics include, Alcohol attendances to AED, percentage of babies breastfed on discharge from neonatal unit, number of children attending the trust with a falls related injury, numbers of children attending with burns from hair straighteners, BMI for children attending endocrine clinic to see if interventions delivered enable a reduction in BMI, referrals to smoking cessation services for staff and families, Dental audit carried out to see if families regularly attended a dentist.
- Evaluation of health promotion activities is carried out for each campaign; this includes interactions with patients and families, referrals made to other services for additional support and opportunity for families to gain further information in the form of leaflets or advice from HP team.

1.5 The organisation ensures that staff have relevant competences to perform health promotion activities and supports the acquisition of further competences as required.

- Health promotion strategy has information for staff on recommendations
- Staff are trained to deliver brief interventions to patients and families on a variety of HP topics.
- Breastfeeding training delivered to staff
- Alcohol brief intervention training delivered to staff

1.6 The organization ensures the availability of the necessary infrastructure, including resources, space, equipment, etc., in order to implement health promotion activities.

- Identifiable budget allocated for a year to purchase materials.
- Dedicated Health Promotion offices.
- Dental equipment obtained with charitable funding
- Breastfeeding training to be delivered with funding from surgical training fund for all neonatal staff
- Campaign space and equipment secured at Alder Road main entrance.

Standard 2: Patient Assessment

2.1 The organization ensures the availability of procedures for all patients to assess their need for health promotion.

- Staff trained to deliver brief interventions to patients and families.
- Smile Clinics carried out weekly by HP team assess their dental health needs.
- Alcohol pathway in place to assess ingestion of alcohol

- Admission information includes health promotion topics and is asked to all patients.

2.2 The organisation ensures procedures to assess specific needs for health promotion for diagnosis related patient groups.

- Change for life materials adapted to incorporate patients with specific needs.
- Health Promotion resources and information provided to patients and families with profound disabilities during physio summer camps.
- Close working relationship with patients in inpatient mental health unit and their families. Supporting them with a variety of issues.
- Dads and Lads, Domestic Violence programme delivered in partnership with colleagues from CAHMS and Everton in the Community.

2.3 The assessment of a patients need for health promotion is done at first contact within the hospital. This is kept under review and adjusted as necessary according to changes in the patient's clinical condition or on request.

- The assessment is documented in the patients nursing assessment during admission.
- Breastfeeding status is asked upon all admissions and transfers to the Trust.
- Midwifery assessment is done on admission for new mums and appointments are made directly with midwife who attends from LWH.
- HP documented in discharge planning.
- Admission information includes health promotion topics and is asked to all patients.

2.4 The patients' needs assessment ensures awareness of and sensitivity to social and cultural background.

- Spiritual care team
- Special diet's
- Religion
- Ethnicity

All the above are captured in the patient's admission details and nursing assessment.

2.5 Information provided by other health service partners is used in the identification of patient needs.

- Referrals from Infant feeding team at LWH
- Midwifery referrals for additional emotional support for new parents
- Smoking cessation referrals
- Safeguarding team referrals

Standard 3: Patient Information and Intervention

3.1 Based on the health promotion needs assessment, the patient is informed of factors impacting on their health and, in partnership with the patient, a plan for relevant activities for health promotion is agreed.

- Health Promotion activities and expected results are recorded in patients records these include smoking information packs and breastfeeding support
- Brush for life dental packs recorded in patient notes.
- Fabio computer programme is used to obtain views on patient satisfaction in relation to information given.
- Questionnaires are given to parents at various campaigns to assess knowledge prior to event and post event to see if improvement.

3.2 Patients are given clear, understandable and appropriate information about their actual condition, treatment, care and factors influencing their health.

- Child friendly information books on specific conditions available
- Welcome to the Trust booklet
- Information available on Trust internet site
- Leaflets and resources are patient focused and age appropriate.
- Fun packs given out to children in clinics and AED which include quizzes, puzzles and colouring covering health promotion topics

3.3 The organisation ensures that health promotion is systematically offered to all patients based on assessed needs.

- Staff trained to deliver brief interventions.
- Admission information includes health promotion topics and is asked to all patients/families.
- Health Promotion Team are contactable by mobile phone for out of hours advice.
- Health Promotion resources and information provided to patients and families with profound disabilities during physio summer camps.
- Close working relationship with patients in inpatient mental health unit and their families. Supporting them with a variety of issues

3.4 The organisation ensures that information given to the patient, and health promoting activities are documented and evaluated, including whether expected and planned results have been achieved.

- Evaluation of health promotion activities is carried out for each campaign and intervention, this includes interactions with families, referrals made to other services for additional support and opportunity for families to gain further information in the form of leaflets or advice from HP team.
- Fabio computer programme is used to obtain views on patient satisfaction in relation to information given
- Questionnaires are given to patients at various campaigns to assess knowledge prior to event and post event to see if improvement
- Public Health Steering Group regularly monitor activities including if anticipated results have been achieved.

3.5 The organisation ensures that all patients, staff and visitors have access to general information on factors influencing their health.

- Information available on intranet for staff to access to give to patients.
- Information also available on external internet page for patients.
- Information uploaded to Trust Facebook/twitter
- Directory of local support services available for patients
- Childrens centres information for children and families to access
- Information for patients to access health promotion services while resident at the hospital.
- Health Promotion information points available in outpatient areas.
- Health Promotion Information point on main corridor for patients and families to access.

Standard 4: Promoting a Healthy Workplace

4.1 The organization ensures the establishment and implementation of a comprehensive Human Resource strategy that includes the development and training of staff in health promotion skills

- Health, Work and wellbeing strategy in place
- Learning and Development Prospectus for staff training, includes training opportunities on HP topics
- Staff handbook for new starters includes information on HP roles within the Trust
- Health, Work and Wellbeing champions across organisation to cascade information and training opportunities to teams.

4.2 The organisation ensures the establishment and implementation of a policy for a healthy and safe workplace providing occupational health for staff

- Health, Work and Wellbeing strategy
- Occupational health service available onsite.
- Staff physiotherapy available
- Staff Counselling services available to all staff
- Flu vaccination campaign for staff
- New staff receive induction that addresses the hospital Health and wellbeing strategy.

4.3 The organisation ensures the involvement of staff in decisions impacting on the staffs working environment.

- Staff side representatives at Health, Work and Wellbeing meetings.
- Lead nurses and HP champions also attend Health Work and Wellbeing meetings.
- Public Health Steering Group has representation from across the trust from staff with interest in HP.
- Breastfeeding Champions lead and develop services within their own areas.

4.4 The organization ensures availability of procedures to develop and maintain staff awareness on health issues.

- Policies for awareness on health issues are available for staff.
- Smoking Policy
- Drugs and alcohol policy
- Stress policy
- Bullying and harassment policy
- Risk management policy
- Smoking Cessation programmes are offered to all staff and information is available on intranet, weekly newsletter and via posters.
- Annual staff surveys focus on a range of topics to assess health and wellbeing of staff.

Standard 5: Continuity and Cooperation

5.1 The organisation ensures that health promotion services are coherent with current provisions and health plans

- HP team have representation at many local, regional and national HP groups and feed information into the Trust.
- Health Improvement meeting which feeds directly into Health and Wellbeing board at LCC
- HP team work in partnership with around 50 partners to deliver HP to patients and families.

5.2 The organisation identifies and cooperates with existing health and social care providers and related organisations and groups in community

- HP team deliver sessions in local children centres and schools across the Merseyside cluster.

- Campaigns delivered in partnership with many health and social care providers in the Trust and also the community.
- Everton in the Community daily workshops delivered in the Trust and also local community, workshops delivered to patients with a range of disabilities.

5.3 The organisation ensures the availability and implementation of activities and procedures after patient discharge during the post-hospitalisation period.

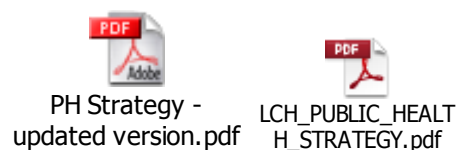
- Patients and families are given HP information during outpatient appointments, these include access to smoking cessation, HP resources, leaflets, colouring packs for children.
- Activity sessions delivered in Endocrine Clinic by HP team which focus on the Change for Life philosophy to encourage families to get active.
- Health Promotion resources and information provided to patients and families with profound disabilities during physio summer camps.
- Close working relationship with patients in inpatient mental health unit and their families. Supporting them with a variety of issues.
- Support available to referral patients/parents upon discharge to local services for continued support.
- Champions in outpatient's clinics trained to deliver brief interventions to patients and parents.
- Dads and Lads, Domestic Violence programme delivered in partnership with colleagues from CAHMS and Everton in the Community.

5.4 The organization ensures that documentation and patient information is communicated to the relevant recipient/follow up partners in patient care and rehabilitation.

- School nurse /health visitor referrals made on discharge for all children.
- GP informed on discharge.
- Referral letters are given on transfer to another hospital

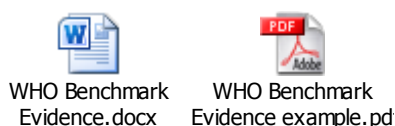
Develop a strategy using Ottawa Charter

The organisation will require a health promotion/public health strategy, examples from Alder Hey Children NHS Foundation Trust and Liverpool Community Health NHS Trust are listed below. The strategy aims and targets will be formed using DOH guidance and also themes of strengths and weaknesses from the five standards. This document does not need to be lengthy but needs to explain the aims and objectives and outcome measures.



Benchmark against standards

Once the standards have been benchmarked a quick guide can be used to traffic light your position, this can be used at the steering group meeting as part of the action planning.



Letter of intent to WHO.

This Letter of Intent, signed by management, is a declaration that the member hospital or health service will abide by the HPH Constitution of the International Network of Health Promoting Hospitals and Health Services (HPH) and implement health promoting activities according to the HPH Constitution and the strategies and policies as defined in the WHO documents. Once this document has been signed and that organisation agrees to adhere to the principles of health promotion it should be sent to WHO in Geneva. It would also be recommended to send hard copies of evidence to them via the post. If approved you will receive a confirmation email and certificate in the post, you will also be required to pay a yearly administration fee of £250.



HPH Letter of Intent
Letter.pdf

Support

If you require any support or guidance then please contact

Liz Grady – Health promotion practitioner

Email: Healthpromotion@alderhey.nhs.uk

Telephone 0151 252 5024

