

# **Health Inequalities National Support Team**

**How to Develop a Health Gain Programme (HGP)  
for Frontline Staff to Address Lifestyle Issues**

**DH INFORMATION READER BOX**

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HR / Workforce	Commissioning
Management	IM & T
<b>Planning /</b>	Finance
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<b>Circulation List</b>	
<b>Description</b>	This Health Gain Programme 'How to guide' was developed by the Health Inequalities National Support Teams (HINST) with 70 local authorities covering populations in England. Local areas could use this approach when analysing whether a population level improvements could be achieved from a set of best-practice and established interventions. This is offered as useful resource for commissioners and providers: use is NOT mandatory.
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<b>Contact Details</b>	Health Inequalities National Support Team 3rd Floor, Wellington House, 133 - 155 Waterloo Road London SE1 8UG  <a href="http://www.dh.gov.uk/HINST">www.dh.gov.uk/HINST</a>
<b>For Recipient's Use</b>	

# Health Gain Programme

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### Foreword

National Support Teams (NSTs) were established by the Department of Health from 2006 to support local areas – including Local Authorities, Primary Care Trusts (PCTs) and their partners – to tackle complex public health issues more effectively, using the best available evidence. By undertaking intensive, ‘diagnostic’ visits to local areas, spending time with key leaders (commissioners and providers) including clinicians and front-line staff, the ten NSTs provided intelligence, support and challenge to local areas to assist in their achieving better public health outcomes. The programme finished in March 2011.

The ten subject specific teams (Sexual Health, Tobacco Control, Health Inequalities, Teenage Pregnancy, Childhood Obesity, Alcohol Harm Reduction, Infant Mortality, Response to Sexual Violence, Vaccination and Immunisation and Children and Young People’s Emotional Wellbeing and Mental Health) were commissioned and established with a focus on improving health and reducing health inequalities.

The ten teams undertook more than 450 visits to local partnerships during the course of the programme and their findings and successes have been documented in Knowledge Management and Evaluation reports. Each team also produced reports setting out and consolidating the learning from their work. A further report that captures best practice identified by each team is planned to enable local areas to continue using the expertise and lessons learnt from the NST model.

The NST process involved a desk review of key documentation and data-based intelligence, and interviews with key informants, often in combination with a series of workshops or focus groups. Collation and analysis of findings was immediate, and the findings, including strengths and recommendations, were fed back straight away and on site to the key local players and leadership. Recommendations were accompanied by offers of support, either at the time of reporting, or as part of follow-up activity.

The Department is publishing a number of reports which distil the learning from the programme, and exemplify the methodology employed.

## Executive Summary

This guide is one of a series developed by the Health Inequalities National Support Team (HINST), in its work with the 70 local authorities covering populations in England with the highest levels of deprivation and poorest health. It is a summary of local views on good practice. The suggested approaches are not mandatory, and reflect learnings from a snapshot in time. Where there is clear established evidence to support interventions, this has been signposted in the footnote. This is offered as useful resource for commissioners and providers: use is NOT mandatory.

The topic of this 'how to guide' - How to Develop a Health Gain Programme (HGP) for Frontline Staff to Address Lifestyle Issues - was selected for its potential impact on health and wellbeing, and on mortality and life expectancy in the short, medium or long term. It provides advice on achieving best outcomes at **population level**, and for identifying and recommending changes that could be introduced locally.

This guide is designed as a short checklist for commissioners and providers based on the team's experience of work conducted by local areas and published literature. It will be particularly useful for; the Health and Wellbeing Boards in developing their strategy across all local organisations; for those involved in the new commissioning arrangements; and for individual organisations in their service and workforce planning. The work requires a balance between challenge to providers and a population focus. The following 7 core steps are included and described:

1. *Making the case:*
  - Locally relevant intelligence on impact of health risk taking behaviours and intervention effectiveness and cost benefit modelling
  - Staff health: supporting staff to improve their own health and therefore become more effective advocates
2. *Getting started:* Leadership and co-ordination using change management approaches across all levels of the partnerships (commissioning, management, frontline and specialist provider)
3. *Workforce development:* embedding behaviour change function into workforce planning, including a clearly defined behaviour change function.
4. *Tools for systematically implementing the health gain programme:* Appropriate behaviour change competence and confidence for staff to empower individuals to partake in health-seeking behaviours
5. *Service responsiveness:* Referral pathways, balanced service portfolio, adequate service volumes, supported self-management
6. *Audit, monitoring and feedback:* Improving local service effectiveness, appropriate monitoring and governance and referral feedback loops
7. *Capturing and negotiating this work into contracts or separate health gain schedules:* developing and maintaining the agreement.

## How to Develop a Health Gain Programme (HGP) for Frontline Staff to Address Lifestyle Issues

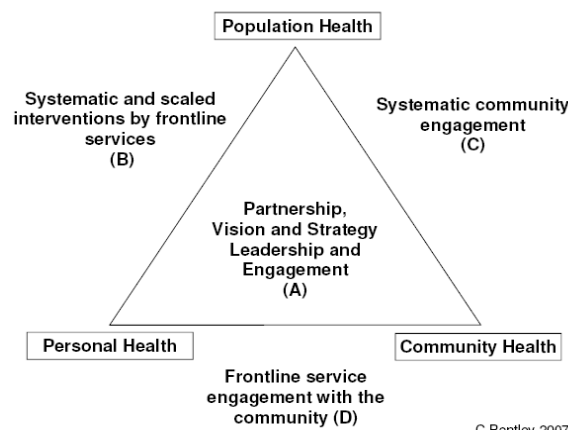
**This guide is designed to make every contact with a health and social care professional a health promoting contact with clear advice, support and sign-posting to appropriate service to prevent illness or recurrence of illness”**

### Introduction

HINST has chosen to prioritise this topic as one of its ‘How to guides’ for the following reasons:

- The development of one-to-one interventions by frontline services that is supported by local leaders, links to engagement with local communities and maximises the impact of local partnerships, provides a systematic and scaled approach to the NICE public health guidance 6<sup>1</sup> recommendation, ‘making every contact count’. This fulfils the ‘personal health’ level interventions of the Health Inequalities National Support Team (HINST) Framework (figure 1). Personal health interventions need to be developed alongside community health intervention to achieve optimal population health gain.

Figure 1: Producing change at population level



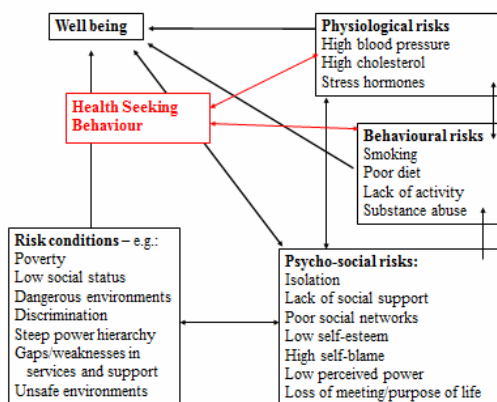
- NHS and health and social care providers are not systematically offering lifestyle support to all those who could benefit from it, and as a result the potential population health benefits are not being achieved. Only with system, scale and sustainable approaches will such activity contribute to measurable change and reduced mortality at population level.
- The potential for change is significant. The acute sector, for example, sees patients and relatives who are suffering the effects of ill health, which provides an excellent opportunity for seeking health information and advice to support their relatives while in a heightened state of health awareness. This puts the

<sup>1</sup> NICE Public Health Guidance 6. Behaviour Change at Population, Community and Individual Levels (October 2007)

majority of these patients at their most receptive to health messages, and support for lifestyle change. Community health and social care services work with people in communities who have the poorest health and are some of the most vulnerable people in our society.

- Action in this area of work will support existing frontline workforce to help contribute to the Quality and Productivity Challenge (QIPP) by: transforming pathways, supporting commissioning for equality and efficiency, and improving provider efficiency and innovation (especially through secondary prevention and, over the longer term, through primary prevention).
- Engaging the population employed by the public sector in health gain will have a positive impact on population health. This will be achieved by not only raising awareness and positively influencing health behaviours of staff and their families but also by the provision of consistent frontline advice delivered by competent and confident staff to support health-seeking behaviour. This will only be achieved through empowerment of staff and implementation of change management approaches to workforce and organisational development.
- Addressing health gain with system and scale responds to the direction set out in the NHS White Paper, *Equity and Excellence: Liberating the NHS*<sup>2</sup>. This outlines the importance of shared decision-making - 'no decision about me without me' - the partnership approach required between the public and the NHS. The Government's objectives highlight reducing morbidity and mortality and improving outcomes for all. Health-seeking behaviour has an undisputed impact on health outcomes. This relationship between health-seeking behaviour, wellbeing and physiological risk is illustrated in figure 2.

Figure 2: Relationship between health-seeking behaviour, wellbeing and physiological risk



- This guide will be particularly useful for the Health and Wellbeing Boards to consider when developing their Health and Wellbeing Strategy to support them in having a whole system response to their local lifestyle issues. It will

also be useful for the new GP Commissioning Consortia, other local commissioning as well as for local organisations in their work programme and workforce planning.

**Context**

**What is the purpose of this ‘how to guide’?**

The purpose of this guide is to support local areas to develop and systematically harness the work of frontline staff across health and community services, including hospitals and community health services, to improve staff, patient/client and visitor health (with a particular focus on smoking, obesity, alcohol and falls). Doing this will make health improvement everyone’s business. This guide may also be used by some local authority and voluntary sector services.

The HINST have identified two critical elements to implementation:

- Scaled behaviour change competence
- Systematised response to identified need.

The aim of a health gain programme as outlined in this guide is not for all staff to become behaviour specialists but to have consistency in approach to health gain.

The numbers of patients, clients and carers who come into contact with frontline staff are significant. At present the NHS and health and social care providers are not systematically offering lifestyle support to all those who could benefit from it, and as such the potential population health benefits are not being achieved.

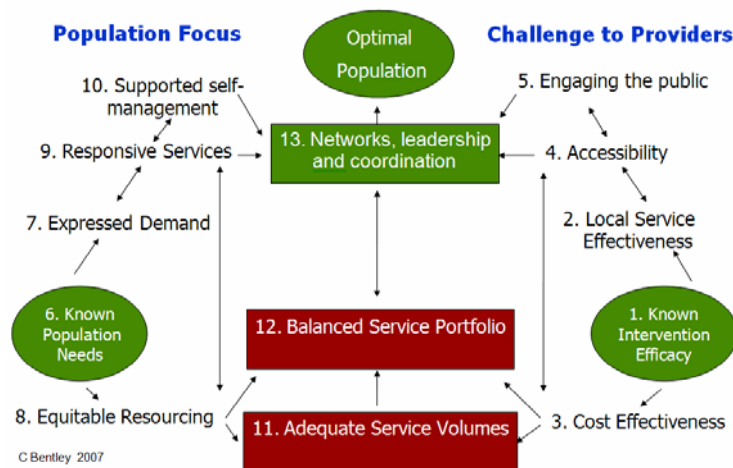


Figure 3 Commissioning for Best Population Level Outcomes.

The HINST has recommended that, in order to make such activity systematic, so as to potentially make a significant improvement at population level all elements of the Commissioning for Best Population Level Outcomes (see figure 3 below), need to be considered.



This guide seeks to build on and develop this approach.

### **When should the guide be used?**

- *By Commissioning Partners:* The guide is best used when formulating commissioning plans to meet population health needs. It aims to support the establishment of health gain as part of the main contracts with providers and by embedding principles into all workforce and organisational planning.
- *By Providers:* The guide may be particularly useful when planning the response or 'offer' to NHS, GP consortia and local authority partners' contracts, workforce planning and organisational development plans.

### **What should be included in local health gain work?**

This guide considers the following five behaviours:

- smoking
- harmful alcohol use
- physical activity
- healthy eating
- falls prevention in older people

These behaviours have potential impact on mortality in the short term and influence on population level health outcomes.

The first four risk behaviours are common to cardiovascular disease, respiratory diseases and diseases of the endocrine system; they contribute significantly to excess and premature deaths, increased hospital episodes and length of hospital stay. Evidence of the impact of these behavioural/lifestyle issues on ill health, mortality and the NHS is outlined in Appendix 1. This information could be copied into Board proposals to support local intelligence.

As the programme of health gain develops, local areas may consider adding further public health issues, based on local priorities and service capacity. The following topics, were suggested by local areas in contact with the HINST:

- housing and debt
- employment
- flu/pneumococcal vaccination paediatric opportunistic vaccine uptake
- mental health
- substance misuse
- cancer screening uptake
- tuberculosis
- sexual health

These could be tailored to specific patient groups as part of a comprehensive programme of work within that clinical area. Providing frontline staff with core competencies in relation to behaviour change means they can apply the approach to a range of behaviours and issues.

### **Who benefits from the Health Gain Programme?**

Both patients and staff will benefit from the implementation of a systematic approach to health gain. This guide is designed to support a partnership approach to making

health gain everyone's business and can be expanded to include a variety of approaches. There are also cost savings to be achieved in improving health outcomes of patients, the public and staff, and improving the efficiency of service.

Development of this approach to address lifestyle behaviours will raise awareness in staff, the majority of whom are likely to live in the local community; this alone can have a significant influence on addressing these lifestyle issues in the population. Patient and staff health is inextricably linked with evidence showing that organisations that promote health and well-being of their staff have better clinical outcomes, higher patient and staff satisfaction and lower sickness rates<sup>3</sup>.

The acute sector in England has over 139,000,000 patient contacts per year<sup>4</sup> providing a critical opportunity for introducing health gain measures. Traditionally the acute sector has focused on the medical diagnosis and cure approach, but recently some trusts have begun to see the benefits of a more holistic health care approach. This could be further supported by the vertical integration of acute and community services.

A disproportionate number of patients (and therefore relatives/visitors) in acute hospitals are from the most deprived sections and areas of the community. In addition, mental health trusts and learning disability trusts have some of the most vulnerable people in the population going through their care system. These patients have a significantly greater risk of poor physical health, often with less opportunity to be screened in order to pick up early signs of disease and to provide support to make lifestyle changes.

### **Who should be involved?**

This guide is for both commissioners and providers (NHS and local government). This approach may also be broadened to be adopted by other local government, private and voluntary sector services. Where possible and appropriate the guide makes a distinction between action needed by commissioners and providers. For all providers this work needs to include support for the workforce to improve their own health so that staff can become better advocates, and the large numbers in the workforce with improved health will contribute to a shift in population health.

In addition, and of great importance in terms of scaling up this effort to achieve whole population change, there is a section on how this work can be captured in the commissioning process and supported through workforce planning.

### **Undertaking the work**

This guide is designed as a short checklist for commissioners and providers. These steps are based on need identified from qualitative work conducted by localities and published literature and require a balance between challenge to providers and a population focus. The following 7 core steps are included and described:

#### *1. Making the case:*

- Locally relevant intelligence on impact of health risk taking behaviours and

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<sup>3</sup> NHS Health and Well-being. Final Report (2009) - Boorman Review

<sup>4</sup> Hospital Episode Statistics

- intervention effectiveness and cost benefit modelling
  - Staff health: supporting staff to improve their own health and therefore become more effective advocates
2. *Getting started*: Leadership and co-ordination using change management approaches across all levels of the partnerships (commissioning, management, frontline and specialist provider)
  3. *Workforce development*: embedding behaviour change function into workforce planning. Clear defined behaviour change function. Appropriate behaviour change competence and confidence for staff to empower individuals to partake in health-seeking behaviours
  4. *Tools for systematically implementing the health gain programme*: Appropriate behaviour change competence and confidence for staff to empower individuals to partake in health-seeking behaviours
  5. *Service responsiveness*: Referral pathways, balanced service portfolio, adequate service volumes, supported self-management
  6. *Audit, monitoring and feedback*: improving local service effectiveness, appropriate monitoring and governance and referral feedback loops
  7. *Capturing and negotiating this work into contract or workplace health strategy*: developing and maintaining the agreement.

At the end of each section there is a list of resources to support further reading.

## Step 1: Making the case

*Policy and locally relevant intelligence on impact of health risk taking behaviours and intervention effectiveness and cost benefit modelling*

### 1. Policy levers, tools and initiatives

It will be essential to connect this work to central and local policy levers, tools and initiatives in making the case for commissioning a health gain programme. The following are key examples of these:

- National Institute for Health and Clinical Excellence (NICE) Guidance (2007)<sup>5</sup>: *Behaviour Change at Population, Community and Individual Levels*  
The guidance highlights the multiple benefits of individual level interventions as the following extract reveals:

There is overwhelming evidence that changing people's health-related behaviour can have a major impact on some of the largest causes of mortality and morbidity. The Wanless report (Wanless 2004) outlined a position in the future in which levels of public engagement with health are high, and the use of preventive and primary care services are optimised, helping people to stay healthy... At present, there is no strategic approach to behaviour change across government, the NHS or other sectors, and many different models, methods and theories are being used in an uncoordinated way.

Identifying effective approaches and strategies that benefit the population as a whole will enable public health practitioners, volunteers and researchers to operate more effectively, and achieve more health benefits with the available resources.

- *The Department of Health is setting up national workstreams* aimed at making changes to the national policy framework to transform pathways, help commissioners to commission for quality and efficiency, improve provider efficiency, and innovation (especially widespread adoption of best practice) and prevention (in the medium term, especially through secondary prevention and, over the longer term, through primary prevention). These will be key enablers for achieving making every contact count.
- *Analysis of All Age All Cause Mortality (AAACM)* across England and Wales demonstrates ischemic heart disease as the leading cause of mortality in males (22% AAACM) and females (16% AAACM), followed by cerebrovascular disease (stroke) 8.7% for males and 12.6% for females, followed by lung cancer and respiratory disease respectively for males and females<sup>6</sup>. These lifestyle factors are estimated to cost the NHS £10bn annually, society £37bn and cause 140,000 preventable deaths each year. Together smoking and alcohol cause 25% of the Disability Adjusted Life Years (a measure combining the years of life lost and years lived with disability) lost in the UK.

<sup>5</sup> p6

<sup>6</sup> ONS 2005

- *QIPP (Quality, Innovation, Productivity and Prevention)*: The health system is responding to the challenge for the NHS to make around £20bn of efficiency savings by 2014-15, with the focus firmly on improving quality and efficiency simultaneously. It will be useful to present the costs and benefits of addressing prevention at a local level, to understand what contribution it can make to this challenge. Text Box 1 presents a resource pack to support local analysis of cost effectiveness of interventions for lifestyle issues.

**Text box 1: Cost effectiveness of prevention intervention for lifestyle behaviours – Yorkshire and Humber Public Health Observatory**

Yorkshire and Humber Public Health Observatory have in partnership developed the [NHS Yorkshire and the Humber QIPP resource pack: May 2010 \(STAYING HEALTHY\)](#)<sup>7</sup>. The pack presents step-by-step analysis of lifestyle behaviours, cost implications and potential cost savings following intervention. The resource pack considers prevalence of lifestyle behaviours, cost to the NHS, attributable admissions, attributable deaths and evidence and cost of interventions.

Further modelling work has been conducted and trailed in a number of localities. The model was developed by Professor Malcolm Whitfield, Director of the Centre for Health and Social Care Research at Sheffield Hallam University and addresses on a locality basis the key questions:

- How much would we have to change the risk factors to reduce the burden of disease?
- What order of savings could we achieve on healthcare costs in the first five years?
- How much could we realistically invest in getting lifestyle change?

The decipher tool is available on the following website: <http://www.sportseng.org/sheftool/>

## 2. Data and evidence

- *For Commissioners*
  - Relate local population profiles (found in the JSNA, annual reports by the Director of Public Health and other local resources) and the understanding of local health inequalities life expectancy and AAACM numbers to the patient flows/staff health and skills profile across the providers in your area.
  - Consider data for smoking, harmful alcohol use, physical activity, healthy eating, falls prevention in the elderly and any other topic selected for this work.
  - Use the above information to develop local commissioning arrangements and contracts.
  - This should include information collected from providers as outlined below (see 'for providers' in this section).
  - Where possible, these known health needs should be modelled with population characteristics to identify unmet need, ensuring that services are commissioned to respond to demand.
  - Consider the numbers needed to treat to adjust appropriate volumes of service to respond to need (see text box 2)

<sup>7</sup> <http://www.yhpho.org.uk/resource/item.aspx?RID=79123>

**Text box 2: Numbers required to treat for behaviour change interventions**

The numbers of people needed to treat with behaviour change interventions will have to be considerable if they are to result in a successful change in population outcomes.

The following diagram illustrates that the quality and effectiveness of services delivering the support interventions will continue to be an important issue. In addition, there will be a number of other components which will also contribute to the patchiness of successful outcomes.



It is not within the scope of this paper to explore this issue in detail. However, some important factors will include:

- Reducing variability in engagement and empowerment of patients
  - Supported self management
  - Segmentation and 'insight' – one size doesn't fit all
  - Menu of options for access and support
- Attention to supportive environments will include systematic engagement of communities to support individuals:
  - Carers and families
  - Communities (e.g. neighbourhoods, cultural groups, schools and workplaces)
  - Institutions (e.g. care homes, prisons)

- *For Providers:* Intelligence regarding the local population needs is available by using:
  - Local catchment population data (available from the local public health team or Public Health Observatory (PHO)). Health profiles can be used to assess population health needs, current public health priorities and future health demands.
  - Hospital Episode Statistics (HES): data on the health of local patients
  - Staff survey and or audit
    - data on staff health
    - data on staff skill level and volume (brief advice/brief intervention/specialist advice)
    - data on current lifestyle support being given in organisation.

**Example – data collection**

- *Hampstead, London:* The Royal Free Hampstead NHS Trust undertook a health needs assessment of their patient population. The aim of this work was to help target health improvement services more effectively, plan their response to future population needs, identify priority areas and assess some of their services in relation to health inequalities.

They looked at over half a million patient episodes across a year to 'plot' where the majority of their patients came from to help them define their catchment population in more detail. They then used national data sources and health profiles to look at the health needs of this group. They also analysed these data by emergency and elective admissions, which showed higher number of patients from the more deprived local wards presenting as emergency admissions. The largest single group admitted non-electively were aged 66 and over, in social housing with high care needs.

The hospital profile is now used in the hospital's business planning process and to help them better understand patients and the future health needs of the local population. Looking at health needs from a hospital perspective has helped make the data more relevant to their hospital staff and has taken into account the catchment area as opposed to just the borough where the hospital is based.

**Contact:** Angela Bartley, Public Health Lead: [Angela.bartley@nhs.net](mailto:Angela.bartley@nhs.net)

### **1. Staff health: supporting staff to improve their own health and therefore become more effective advocates**

There is a strong evidence base for investment in improving health and well-being of staff, including far-reaching benefits in terms of hospital performance and quality. In the majority of areas, providers will be the largest employer of local people; therefore investment in staff health will benefit the local population.

The Boorman *Health and Well-being Review*<sup>8</sup> recommends that all NHS organisations provide staff health and wellbeing services that are:

- centred on prevention (of both work-related and lifestyle-influenced ill-health)
- fully aligned with wider public health policies and initiatives
- seen as a real tangible benefit to working for the NHS

There is a clearly evidenced link between staff health and wellbeing and patient experience, safety and effectiveness of care. Developing agreement for health gain across all frontline staff will raise awareness and knowledge of making positive changes to health-related behaviours for staff.

All NHS and local government organisations should have a comprehensive programme of staff health in place, which covers mental, physical and social aspects of health. This could include national initiatives such as 'Bike to Work' tax free scheme as well as schemes aimed at combating stress and musculoskeletal problems – two of the largest contributors to staff absenteeism.

- *For Commissioners*
  - It is important for Commissioners to ask Providers to demonstrate within evidence of staff wellbeing within the programme (see below).
- *For Providers*
  - In line with NICE guidance, providers should implement staff health and wellbeing programmes that aim to create a health-promoting environment for staff as well as individual support for staff
  - NHS annual staff survey gives an opportunity to ask a small number of local questions. This could be used to ask staff their views on the level of support for health promotion activities in the organisation and ideas for other programmes of work.

Monitoring of health promotion initiatives will be important to ensure lower paid staff are engaging with these initiatives and that they comply with the principles of the Equality Act 2000.

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<sup>8</sup> Department of Health (2009) *NHS Health and Well-being*. Boorman Report



**Example: staff health**

- *West Midlands*: NHS West Midlands are working on a scheme that builds on existing work to devise a set of approaches integrating top down leadership and bottom up participation by health and social care staff in initiatives to improve their health and wellbeing. The scheme will evaluate how this integrated approach will help deliver:
  - more effective management of sickness absence
  - cost, productivity and efficiency savings, thus contributing to the NHS West Midlands QIPP Workforce programme
  - self perceived changes in staff performance
  - staff becoming more effective in enabling lifestyle behaviour change in patients/clients/service users.

The seven elements to improve staff health by NHS West Midlands are of illustrated diagrammatically below.



**Contact:** Sally James – Public Health Workforce Specialist NHS West Midlands: [sally.james@westmidlands.nhs.uk](mailto:sally.james@westmidlands.nhs.uk)

**2. Resources**

Further information on the QIPP programme

[http://www.institute.nhs.uk/cost\\_and\\_quality/qipp/cost\\_and\\_quality\\_homepage.html](http://www.institute.nhs.uk/cost_and_quality/qipp/cost_and_quality_homepage.html)

- Health Investment Network: Collates available costing tools to support commissioners.  
<http://www.networks.nhs.uk/nhs-networks/health-investment-network>
- Department of Health (2010) *Equality and Excellence: Liberating the NHS*  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_117353](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353)
- NICE (2007) *Behaviour Change at Population, Community and Individual Levels*.  
<http://www.nice.org.uk>
- NICE (2008) *Workplace Health Promotion: how to encourage employees to become more active*



## Step 2: Getting started

### *Leadership and coordination of the agenda using change management approaches*

The context within which a health gain programme is developed will be important, as it will determine the receptiveness of staff, organisational leadership and partner organisations to engage with the programme. It will therefore be important to understand the local context, and to use that understanding to determine the necessary approaches. This will make sure there is high level of stakeholder buy-in needed for systematic and industrially-scaled delivery of health gain. An important part of getting started will be to develop and establish robust leadership and governance, with important elements included in early negotiation.

### 1. Engaging partners

- *For Commissioners in NHS and local authorities:* It is helpful to engage with all main partners on this agenda for increased impact and understanding of the landscape. This should include:
  - Increasing large statutory organisations' understanding about what the NHS is trying to achieve. Also supporting and/or encouraging action by the local authority within their provision of services commissioned by health and ultimately to consider their own commissioning of other non-health related services. As the examples below show, local authorities have sometimes taken a key role in raising the profile of health improvement work across sectors.
  - The voluntary sector, who will often be providers of services to which referrals can be made and will need to be aware of any expected increase in the volume of referrals. Other parts of the voluntary sector may also consider themselves in a good position to have their frontline staff trained to undertake brief advice and referrals to appropriate services.
  - Existing commissioned specialist services and cross-boundary commissioners /providers.
  - Public health analytical capacity to support providers with relevant data collection and analysis to support providers commencing this work
- *For Providers:* Depending on how well the local partnerships are engaged with this agenda in the local area it would be an advantage to have contact with main partners on this agenda, particularly other service providers (especially any awareness-raising work by other sectors) and to have a close working relationship with the PCT and GP Consortia in terms of:
  - data collection and analysis
  - engagement events for staff
  - the contract between these organisations
  - commissioning and links to appropriate specialist services for referrals.

**Note for all sectors:** It is important that high-level and scaled-up awareness-raising work on this agenda is matched with sufficient and effective training of frontline staff to deliver appropriate advice and direction to patients/clients (see Step 3, Tools for implementing a health gain programme, and Step 4, Workforce development).

### Examples – Engaging partners

- *Greenwich*: Greenwich Council has run a ‘Health: Everyone’s Business’ training course to provide participants with the knowledge, skills and language to promote health within key Council roles, and to develop a core group of public health champions working in key decision-making roles across Council functions. Four courses have been run to date with a fifth one planned for 2011. Each course consists of 1 day training per month for 6 months with a project element relating to the participants’ areas of work.

**Contact:** Tracy Carpenter, Healthier Communities Team:

[Tracy.carpenter@greenwich.gov.uk](mailto:Tracy.carpenter@greenwich.gov.uk)

- *Haringey*: Haringey Council has undertaken some successful work with their Overview and Scrutiny Committee, open to all elected members, in raising their knowledge and interest in health inequalities through a training and education event in October 2008. A further event was held in 2010, open to all elected members as well as statutory and voluntary sector partners focusing on health inequalities in relation to mental health, physical activity and tobacco control. They are planning to build on and extend this work in 2011.

### Contacts

Melanie Ponomarenko, Overview and Scrutiny Services:

[Melanie.ponomarenko@haringey.gov.uk](mailto:Melanie.ponomarenko@haringey.gov.uk)

Jodie Szwedzinski, Adult Services: [Jodie.Szwedzinski@haringey.gov.uk](mailto:Jodie.Szwedzinski@haringey.gov.uk)

- *Nottingham*: Nottingham City Council and NHS Nottingham City jointly deliver ‘Making Reducing Health Inequalities Everyone’s Business’. The programme has evolved over the past four years, based on feedback and evaluation, and consists of two separate training sessions:
  - One is for managers or team leaders who can influence the planning, commissioning and delivery of services
  - Another is delivered in a specific geographical area within the City and involves local workers, community groups and residents.

More than 600 cross-sector staff, volunteers, councillors and residents have participated: resulting in an increased awareness of Nottingham’s health inequalities, a greater understanding of how individual roles and services contribute to the agenda, and enhanced partnership approaches to tackling health inequalities.

The programme’s success is based on:

- Training residents alongside those delivering frontline services – building a rich, deeper understanding of complex local issues and together, working out what is needed to tackle them
- Local leaders and senior management supporting the programme – they are a key part of the delivery team.

The programme stands alone but delegates are encouraged to further their knowledge of public health issues and many have since participated in the ‘Get Healthy Nottingham’ training which leads to the Royal Society of Public Health’s ‘Health Awareness’ and ‘Understanding Health Improvement’ qualifications.

**Contacts:**

Sharan Jones, Health and Wellbeing Manager:

[sharan.jones@nottinghamcity.gov.uk](mailto:sharan.jones@nottinghamcity.gov.uk)

Yesmean Khalil, Head of Health Promotion Commissioning:

[yesmean.khalil@nottinghamcity.nhs.uk](mailto:yesmean.khalil@nottinghamcity.nhs.uk)

**2. Leadership and governance of the health gain programme**

Commissioning for lifestyle interventions lies with local government and the NHS. Accountability will be through the Health and Wellbeing Boards. Consideration will need to be given to local context and to specialist services and existing delivery plans. The health gain programme may be stand-alone or an element of a wider public health programme (e.g. Health Promoting Hospitals). There also needs to be consideration of the lead organisation where there are acute commissioning units in operation.

In order for this work to be successful, it will be important that there is senior leadership within the partnership arrangements for these commissioning plans and within each organisation where this work is being taken forward.

**3. Negotiation**

In consultation with partners and for each organisation, it will be important to negotiate the following:

- *Aims and objectives:* The aims and objectives of the programme need to be defined and include:
  - *Context:* defining the specific geographical areas / wards and services to be included and whether opportunistic advice and /or condition management
  - *Target population(s):* considering differences in patient pathways (i.e. Map of Medicine)
  - *Intervention:* it will be essential to define the intervention for each context and to make the distinction between brief advice: opportunistic advice at the request of the individual; brief intervention: and structured advice that includes assisting the individual to consider and change their attitudes and beliefs including the provision of more formal intervention
  - *Delivery plan:* Optimise staff/patient/carer/family contacts across all of the priority areas at the time of contact rather than patient/carer/family being referred to attend multiple services.
- *Resourcing*
  - Consideration will need to be given to delivery, and opportunity cost of systematic health gain activity, within existing tariffs and block contracts.
  - Negotiation will need to take into consideration workforce resourcing in terms of new ways of working and education and training requirements, as well as new information support. Workforce plans and financial support plans should reflect this.
  - Modelling will be advisable to ensure specialist services (e.g. smoking cessation support and weight management), are developed to be able to manage increased volume and referral rates from frontline services.

### 4. Resources

- Map of Medicine. Available at <http://healthguides.mapofmedicine.com/choices/map/index.html>

### Step 3: Workforce development

#### *Embedding behaviour change function into workforce planning*

A systematic approach to service and workforce planning will be required. Is there sufficient assurance that appropriate planning and workforce development are in place?

To deliver a health gain programme, the capacity and capability to provide brief advice and interventions covering the chosen health behaviours will need to be developed across all included services. Trust management will need to address staffing issues to ensure that capacity exists to screen all patients in all appropriate clinical areas. The aim might be that every appropriate contact is a health-improving one.

#### 1. Core elements

- *Systematic workforce planning and development:* A systematic workforce planning and development process (including education and training plans) to harness frontline staff capability to be able to identify risk to individuals, undertake brief interventions and support maintenance. This should be supported by a change management approach.

Commissioners and providers could negotiate for these components to be defined within plans for example:

- acute trusts and along main patient pathways
  - community health services
  - mental health services
  - Local authority commissioned health and social care services
  - Health and social care services commissioned from the voluntary and community sector.
- *Human resource and workforce strategies:* Human resource and workforce strategies and regional workforce plans would include a strategic commitment to deliver on health inequalities.
    - Dedicated or identified financial resources to deliver the changes in ways of working/roles, and the way they are monitored.
    - Workforce activity and new ways of working: service providers should be able to demonstrate to the Board and commissioners the following:
      - understanding of the local population need
      - engagement with staff
      - mapping of current skills and assessment of gaps
      - demonstration of workforce activity to deliver the health gain programme
      - demonstration of how the transferable skills for behaviour change across all the priority areas are being acquired and maintained
  - *Organisational development plans - PCTs and Service Providers:* Organisational development and related plans should reflect:
    - the culture change needed to make health gain everyone's business and

- embed the principles of ‘good business’<sup>9</sup>
  - the evidence base for health gain.
- *Leadership strategies:* These should clearly describe how this workforce development will contribute to the health and wellbeing of local populations.
- *Staff appraisals:* All relevant frontline staff should have a personal development measure that is related to delivering brief advice and interventions. Providers will need to be able to provide evidence to commissioners of the competence of staff to deliver brief advice and interventions in the different service areas.
- *Programmes of education and training:* To support new ways of working so that the right person with the right skills is in the right place at an appropriate time to deliver health improvement interventions, there will need to be new education provision and continuous professional development requirements.

Commissioners and service providers could benefit from working with education providers (higher education or further education institutions) to:

- identify training needs
  - engage staff, explore and address barriers and facilitators to adopting the approach
  - check that training is fit for purpose to meet these needs. It will probably not be necessary to build new bespoke programmes as there are many courses already available. It would be beneficial, and prepare for future flexibility, if initial training could be generic, brief intervention training. This could then be supported by specialist information on each health area (e.g. smoking, alcohol etc)
- *Communications and knowledge management:* Up to date, evidence-based information will be essential so that workforces are providing quality advice. The programme will require effective knowledge management processes to ensure timely regular updates across all priority areas.

## 2. Examples

- *Yorkshire and Humber:* Yorkshire and Humber have recently produced *Prevention and Lifestyle Behaviour Change: a Competence Framework*. This is essentially a commissioning-level framework for workforce transformation, to embed competencies to enable every contact across health and social care to promote health and wellbeing. It aims to ensure that every appropriate intervention is competent. The framework provides four levels of practice ranging from signposting ideas at level 1 to specialist / advance approach at level 4 (not all staff will be able to deliver at each level). Work is underway to extend the framework to social care. The principles need to be incorporated into undergraduate and postgraduate education and continuous professional development.

**Contacts:** Karen Payne, Public Health Workforce Lead, NHS Yorkshire and the Humber: [Karen.Payne@yorksandhumber.nhs.uk](mailto:Karen.Payne@yorksandhumber.nhs.uk)

<sup>9</sup> Department of Health (2009) *NHS Health and Well-being*. Boorman Report

There a number of case studies in Yorkshire and Humber progressing this agenda:

- *Leeds*: Accredited behaviour change course was developed in partnership between Yorkshire and the Humber NHS and Leeds Metropolitan University for frontline health and social care staff: The framework is being used in Leeds to help design a one day, clinical skills module on 'Generic Skills, Health Behaviour Change Training'. It has also been used to develop a 1½ hr training for staff in Leeds teaching Hospital Trust, commencing with cardiology staff.  
**Contacts**: Candia Allen and Ann Sunderland: [candia.allen@nhsleeds.nhs.uk](mailto:candia.allen@nhsleeds.nhs.uk)
- *Sheffield*: Organisational Development Strategy: Using the framework to embed behaviour change in OD strategy.  
**Contacts**: Chris Nield and Christine Joy, NHS Sheffield  
[chris.nield@sheffieldpct.nhs.uk](mailto:chris.nield@sheffieldpct.nhs.uk) or [christine.joy@sheffieldpct.nhs.uk](mailto:christine.joy@sheffieldpct.nhs.uk)
- *Hull*: Use of Prevention and Lifestyle Behaviour Change: This approach enables frontline health staff working in a hospital setting with the knowledge and skills to enable them to support in-patients with making healthier lifestyle choices.  
**Contact**: Kate Birkenhead NHS Hull [kate.birkenhead@hullpct.nhs.uk](mailto:kate.birkenhead@hullpct.nhs.uk)
- *Sheffield*: Small Changes: a weight management service for adults using the framework to assure service provision.  
**Contact**: Trevor Simper, [t.simper@shu.ac.uk](mailto:t.simper@shu.ac.uk)
- *Wirral*: Wirral PCT has developed systematic training of frontline staff for brief interventions with the aim of enabling staff to make every contact a health promoting opportunity. Issues highlighted by the training included the need to affect policies and procedures, difficulties of freeing staff to attend; ensuring staff understand the relevance of the training to their role and evaluating the success of training such a large group. Training in the Wirral has been provided by external organisation, but will revert to in-house provision in April 2011.  
**Contacts**  
Philip Baines, Health Promotion Strategy Manager: [Philip.baines@wirral.nhs.uk](mailto:Philip.baines@wirral.nhs.uk)  
Julie Graham, Senior Health Improvement advisor: [Julie.graham@wirral.nhs.uk](mailto:Julie.graham@wirral.nhs.uk)
- *Derbyshire*: The Health Gain Programme in Derbyshire is supported by a partnership working and whole systems change management approach to engagement and training of staff. The approach is designed to changing hearts and minds, understanding hurdles and barriers and is embedded considering user views and evaluation.

The content takes participants through a journey that addresses: The meaning of health and wellbeing to individuals; Employee health & wellbeing; Definitions of health & wellbeing; Determinants of health; Health inequalities; Health promotion and promoting health & wellbeing; Barriers to promoting health & wellbeing;



Understanding behaviour change; Core communication skills; Where to access information; Referrals to health promotion specialists. This includes a three hour long session with PowerPoint presentation, group exercises, discussion and individual reflection. Staff are encouraged to undertake steps 1-3 of the NHS Derbyshire e-learning: Level 2 Award in Understanding Health Improvement accredited by the Royal Society for Public Health. The resources is available at: [www.uhi-online.co.uk](http://www.uhi-online.co.uk)

**Contact:** Linda Saxe, Programme Manager, NHS Derbyshire County:  
[Linda.saxe@derbyshirecountypct.nhs.uk](mailto:Linda.saxe@derbyshirecountypct.nhs.uk)

### 3. Resources

- Powell, K, Thurston, M (2009) *Commission training for behaviour changes interventions: evidence and best practice in delivery*. Good practice guide undertaken by NHS North West Public Health Teaching Network

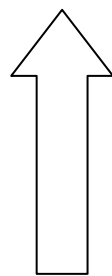


## Step 4. Tools for systematically implementing the health gain programme

To deliver an equitable health gain programme and achieve significant health outcomes at a population level, the programme will need to be applied systematically across specific providers and within patient pathways. It will therefore be important to develop a standardised approach. This is essential for both services that are responsive to individual need and to maintain delivery of the approach by frontline staff. This was highlighted in the insight work commissioned by NHS North West into the barriers and enablers for frontline delivery. The following tools will help develop strategy and policy to achieve this systematic and standardised approach.

### 1. The Nuffield Bioethics Intervention Ladder

The intervention ladder is a useful way of thinking about the different ways that interventions can affect people's choices. The higher up the ladder, the more intrusive the intervention and the stronger justification required.



- » Eliminate choice
- » Restrict choice
- » Guide choice by disincentives
- » Guide choice by incentives
- » Guide choice by changing the default policy
- » **Enable choice**
- » **Provide information**
- » Do nothing

Consideration should be given to whether screening questions and or prompts to raise the issue at the first appropriate time can be included in standard admission and registration procedures, administered by current clinical teams within their current workload, or would require additional staff to be employed with a specific health gain remit. In addition, consideration should be given to the behaviour change function required of the frontline staff. This does not mean that all frontline staff should be trained as behaviour change specialists. Competence frameworks such as the one written by Yorkshire and Humber, which considers Lifestyle and Prevention Behaviour Change<sup>10</sup> may be considered to address this.

The Nuffield intervention ladder can also be applied to ensure that commissioning for health gain provides choice and information to the public to support decision making. This will include working in partnership with people who have less confidence to change their behaviour. It is expected that processes would be adopted to monitor and evaluate the effectiveness of different delivery models.

By ensuring that every contact with the public sector is a health promoting contact, patients and the public are provided with information and where appropriate enabled to make choice through empowerment and responsive service; either self-management or referral to specialist service.

<sup>10</sup> See step 3, examples.

## 2. Healthy Foundations: Health Motivation Segmentation

To support the frontline, providers and commissioners to understand the variance in intensity of intervention required the Department of Health's; Healthy Foundations, health motivation segmentation (illustrated in figure 3) can be used to enhance understanding of difference in interventions required.

The segmentation indicates the level of intensity of intervention required by each group and therefore should support staff to refer to appropriate intensity and complexity of intervention (e.g. supported self management, specialist service referral) dependent on the different characteristics of the population (with percentages of the size of those segments in relation to the whole population).

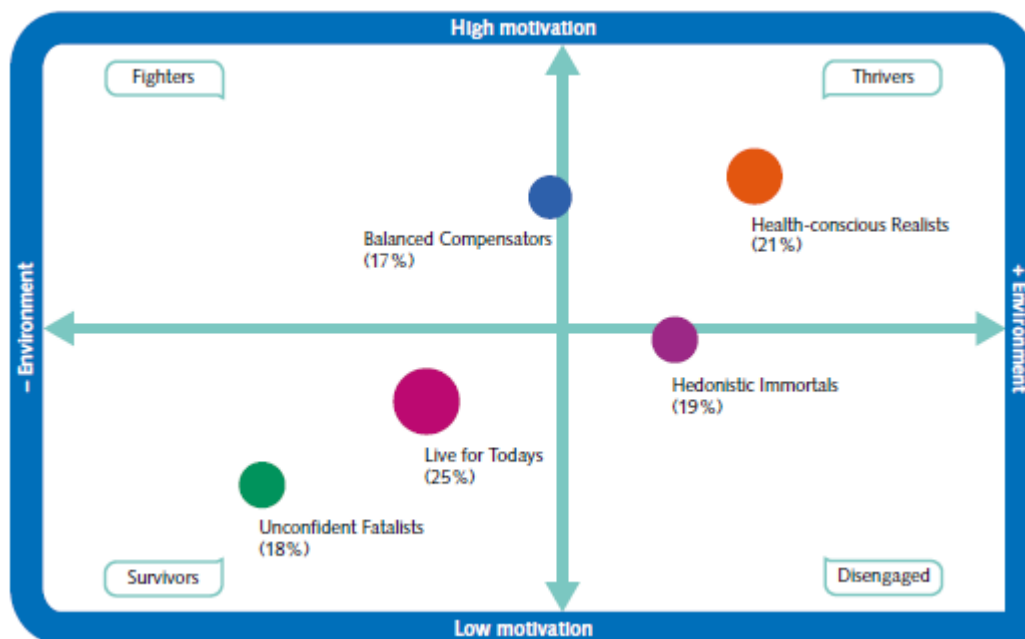


Figure 3: Healthy Foundations, health motivation segmentation

## 3. Action Control Self-Regulation Theory

A review of taxonomy of behaviour change interventions for low income groups highlights the importance of two core components: individual-led goal setting, supported by information and monitoring. The Action Control Self-Regulation Theory (Kanner 1970) (Figure 4) illustrates these basic principles for achieving behaviour change.



This framework - shown in Figure 5 - is supported by a practice handbook and nationally recognised qualifications.

## Behaviour Change Handbook

- Evidence reviewed and current 2010
- Handbook acts as ‘toolkit’ for practice
- E.Learning..... [www.healthtrainerhandbook.com](http://www.healthtrainerhandbook.com)



Figure 5: Improving health: changing behaviour - NHS health trainer handbook. E-Learning Tool

## 5. Systematising approaches

To achieve optimal outcomes, systematising the approach is beneficial. This should support::

- Identification of appropriate type and intensity of intervention for individuals (with regard to each lifestyle behaviour). (see Appendix 2 for guidance)
- Availability of self-management materials where required
- Provision of advice/brief behaviour change interventions for each of the health topics options (e.g. alcohol, falls etc.). (see Appendix 2 for guidance)
- Direct referral into an appropriate care pathway of specialist service and feedback on referral outcomes (Screening should only be conducted where there are clear explicit referral pathways into treatment services.)

## 6. Example of another Tool

- *E-learning tool for delivering Brief Opportunistic Advice (BOA) & Making Every Contact Count:* The purpose of the tool is for making staff more *aware* of opportunities to promote change in their day-to-day work, give them the *basic* skills to introduce lifestyle behaviour change into the conversation and the *knowledge* to signpost support services in the right way. It includes training in the core health messages (across five public health areas), gives staff an understanding of why delivery of BOA is an important part of their role, and trains them in how and where to signpost into lifestyle services effectively.

[www.nhslocal.nhs.uk](http://www.nhslocal.nhs.uk)

**Contact:** Sally James, Public Health Workforce Lead. NHS West Midlands  
[sally.james@westmidlands.nhs.uk](mailto:sally.james@westmidlands.nhs.uk)

## Step 5: Service responsiveness

### 5. Referral pathways

Pathways for health gain should be of the same standard as clinical referral pathways. These should consider the patient journey and optimise the staff contacts across all of the priority areas at any one time in the following ways;

- *Review of existing treatment pathways:*
  - *Capacity:* interventions must be available with sufficient capacity so that the demands of a large-scale health gain programme can be met. This will be established following your review of your population needs.
  - *Capability:* reviews should consider the availability of interventions. It is important to note that this may differ across commissioner boundaries, and this should be considered in commissioning plans. (see step 1)
- *Intervention as part of disease pathway:* (see Map of Medicine see page 20 for reference)
- *Intervention for opportunistic contact:* such as family visiting/outpatient appointments

### 6. Examples

- *Stockport:* Stockport NHS Foundation trust (SFT) has developed a comprehensive programme of work within their hospital that includes a Lifestyle Service which involves training and motivating frontline SFT staff to assess patients for risk factors, implement very brief interventions and refer to key workers. It includes a lifestyles coordinator and key workers for alcohol, smoking and weight management. Evaluation of the service includes monitoring of the completion of health promotion assessments, monitoring referral rates and patient satisfaction information regarding assessment and referral practices. The service has developed Integrated Care Pathways for health promotion and an electronic referral system.

#### Contacts

Gary Cook, Consultant Epidemiologist: [Gary.cook@stockport.nhs.uk](mailto:Gary.cook@stockport.nhs.uk)

Charlotte Haynes, Research & Projects Lead: [charlotte.haynes@stockport.nhs.uk](mailto:charlotte.haynes@stockport.nhs.uk)

Jan Sinclair, Lifestyles Services Co-ordinator: [Jan.sinclair@stockport.nhs.uk](mailto:Jan.sinclair@stockport.nhs.uk)

Judith Morris, Director of Nursing & Midwifery: [Judith.morris@stockport.nhs.uk](mailto:Judith.morris@stockport.nhs.uk)

- *Hampstead, London:* The A&E reception team at the Royal Free Hampstead NHS Trust collect data from all patients presenting with violent assault injuries (many of which are alcohol related). This includes details of the assault (e.g. location and use of alcohol). The data are anonymised and then shared with Camden Safety Partnership, in order to target local crime problem hotspots. This work has been shown to be effective in reducing crime and overtime A&E admissions for assaults.

Another example from the Trust was a pilot looking at the effectiveness of offering opportunistic vaccinations as part of a child's outpatient attendance. Staff asked patients whether they had been immunised. If they had not been, staff gave

advice on the benefits of immunisation and offered to do the vaccination in the clinic if any patients were behind in their immunisation schedule. Although numbers to date are small, there was a 47% uptake within a population who previously refused to have their children vaccinated in the community, demonstrating the acceptability of this service. The programme has now been commissioned and they are planning to extend this to inpatient paediatric wards and the A&E paediatric department.

**Contact:** Angela Bartley, Public Health Lead: [Angela.bartley@nhs.net](mailto:Angela.bartley@nhs.net)

- *Lancashire:* Lancashire Teaching Hospitals NHS Foundation Trust are part of the North West's 'Advancing Quality' initiative. Part of their public health work includes utilising their electronic patient record system to monitor the smoking status of inpatients, deliver support while in hospital and, where appropriate, initiate immediate electronic referral to the local Stop Smoking services. This scheme is an example of a bundle of interventions for everyone with a particular condition 'coming through the door'.

General background on the Advancing Quality initiative and FAQs is available electronically.

### **Contacts**

Christine Simpson, Advancing Quality Project Manager:

[Christine.simpson@lthtr.nhs.uk](mailto:Christine.simpson@lthtr.nhs.uk)

Denise Morris, Public Health Co-ordinator, Royal Preston Hospital:

[Denise.morris@lthtr.nhs.uk](mailto:Denise.morris@lthtr.nhs.uk)

## **7. Resources**

- Healthy Foundations Segmentation reports and toolkits available by contacting: [social.marketing@dh.gsi.gov.uk](mailto:social.marketing@dh.gsi.gov.uk)

## Step 6: Audit, monitoring and feedback

All health improvement and health promotion work / programmes need to incorporate a process of auditing and monitoring to check that progress is being made and to make adjustments as necessary to improve outcomes. This can take the form of audit and / or survey of staff and patients or clients and / or qualitative research methodologies. This information should be shared with both frontline healthcare staff as well as commissioners and should be reflected as a requirement within contracts. This provides the opportunity to revisit the steps outlined in the above governance arrangements section.

### 1. Stages

- *Aims and objectives:* Aims and objectives of the programme should be defined and include:
  - context
  - target population(s)
  - outcome measures (behaviours(s), social factors, onward referrals (e.g. to Stop Smoking or Weight Management programmes))
- *Determining scale:* This work needs to be of sufficient scale in selected trust/ organisation (mental health / acute / community health/ local authority) to optimise the impact.

PCTs / GP Consortia could support providers to carry out Health Equity Audits on patient notes, for example, to ensure that coverage is equitable across all staff. Also feedback should be captured from the supporting lifestyle services to ensure appropriate pre-referral advice is offered and referrals are made, and that frontline health care staff are adequately kept up-to-date with the results of their efforts in contributing to these services.

- *Communications:* It is important that well-articulated criteria and operational guidance of process and outcomes related to the respective care pathways are available for all staff.
- *Collection and data assure data:* A minimum data set needs to be identified to routinely capture (where possible) data items recording patient involvement, measure adherence to the operational guidance and monitor referral numbers to specialist support services. Electronic capture may not be feasible for all patient data, but every effort should be made to develop and use systems to encourage relevant data capture. Access to electronic data and use of analytical tools such as excel or other statistical packages could enable routine monitoring. Where possible data should be recorded on all the protected equality characteristics.<sup>12</sup>

<sup>12</sup> "The Equality Act 2010 sets out 9 protected characteristics. These are Age, Disability, Gender Reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion and belief, Sex and Sexual orientation. See the Equality and Human Rights Commission website for further information on the protected characteristics <http://www.equalityhumanrights.com/advice-and-guidance/new-equality-act-guidance/protected-characteristics-definitions/> and on the purpose of equality information [http://www.equalityhumanrights.com/uploaded\\_files/EqualityAct/PSED/information\\_guidance.pdf](http://www.equalityhumanrights.com/uploaded_files/EqualityAct/PSED/information_guidance.pdf).

- *Feedback:* The outputs from such data analysis should be fed back to local frontline staff, managers and commissioners, and where appropriate, to patient advisory groups.

### 2. Example

- *Stockport:* Stockport NHS Foundation Trust developed their 'Health Promotion in Hospitals Project' (HPH) through health promotion audit, staff and patient interviews and surveys. A HPH brochure states that "[Public health] needs to be implemented not only in the framework of limited projects but as a comprehensive overall approach integrated within hospital/health service (quality) management systems".

In addition to the lifestyle service mentioned in Step 5, the project developed audit as part of their regular assessment process, health promotion leaflet distributions, health promotion notice boards on all wards and patient areas and availability of scales. Following on from the project, the National Health Promotion in Hospitals Audit (NHPHA) was also established ([www.nhphaudit.org](http://www.nhphaudit.org)).

**Contact:** Charlotte Haynes, NHPHA Lead: [charlotte.haynes@nhphaudit.org](mailto:charlotte.haynes@nhphaudit.org)

### 3. Resources

- NICE Guidance (2007) *Behaviour Change at Population, Community and Individual Levels* Available at [www.nice.org.uk](http://www.nice.org.uk)
- Healthcare Quality Improvement Partnership provides tools and guidance on audit methodology : [www.hqip.org.uk](http://www.hqip.org.uk)
- A specific national web-based audit tool has been designed to assist acute and mental health trusts audit their health promotion practice to patient: [www.nhphaudit.org](http://www.nhphaudit.org)
- To support evaluation, the Medical Research Councils guidance *Developing and evaluating complex interventions* is a useful resource and can be found at [www.mrc.ac.uk/Utilities/Documentrecord/index.htm?d=MRCOO4871](http://www.mrc.ac.uk/Utilities/Documentrecord/index.htm?d=MRCOO4871)
- Support for involving patients in research and surveys can be found at INVOLVE: [www.invo.org.uk](http://www.invo.org.uk) This is a national advisory group whose role is to support and promote active public involvement in NHS, public health and social care research.
- In addition, the Pickers Institute's patient feedback toolkit may be of help: [www.pickereurope.org/usingpatientfeedback](http://www.pickereurope.org/usingpatientfeedback)



## Step 7: Capturing and negotiating this work into a contract or separate Health Gain Schedule

*Protects, stabilises and enhances this work for both commissioners and providers*

- *For Commissioners:* The HINST have seen examples where this work has been well developed as part of the commissioning process in a variety of health and social care providers often led by public health commissioners. It will be a local judgement as to whether this will be best negotiated as part of the contract with providers (which may carry more weight with providers who are already aware of inclusion of health gain), or developed as separate document, which allows for greater expansion of the health gain programme, as seen, for example, in North Tyneside's Health Gain Schedule (an example below)

To ensure sustainability of health gain, contractual agreements should be within a strategic approach to support embedding health gain into workforce planning for the longer term. In addition, contractual agreements should support change management programmes rather than be stand-alone, considering the importance of engagement and leadership of the agenda.

- *For Providers:* The HINST have encountered provider trusts that have developed this health gain work with no encouragement from commissioners. In fact, one of those large acute trusts has worked hard to get it included in their contract with their PCT. This guide may help to negotiate this. It will be important to include all the relevant sections that have been covered above in this document within the Health Gain Schedule (HGS) (including a requirement for audit, monitoring, and feedback) and then adapted to the particular service or organisation.

### National lever: Commissioning for Quality and Innovation (CQUIN)

CQUIN<sup>13</sup> allows NHS coordinating commissioners and providers to negotiate contractual arrangements to link payment of providers to locally determined and stretching goals, linking payment to quality. These goals may be used for benchmarking quality against similar providers.

The development of a HGS fits within the guiding principles of CQUIN. Development of the schedule will require commissioners and providers to work in partnership to develop a programme for quality and innovation. The HGS will enable contractual agreements to implement initiatives to address NHS Operating Plan priorities informed by local population needs. It will facilitate holistic review of patient pathways for wellbeing and rigor in monitoring initiatives for addressing wellbeing.

The development of the HGS and the influence on health inequalities can also be considered using the CQUIN framework for impact assessment.

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<sup>13</sup> Department of Health (2008) *Using the Commissioning for Quality and Innovation (CQUIN) Payment Framework. For the NHS in England 2009/10*. Available at [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_091443](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443) and [http://www.institute.nhs.uk/world\\_class\\_commissioning/pct\\_portal/cquin.html](http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html)

### National regulation

- *Care Quality Commissions Core (CQC):* The Care Quality Commission (CQC) is the regulator of health and adult social care in England. It is required by the Health and Social Care Act 2008 to “protect and promote the health, safety and welfare of people who use health and social care services”.

*Liberating the NHS* (2010) highlights how the role of the CQC will be strengthened.

Legislation requires that providers of health and adult social care are required to be registered with CQC and to meet and continue to be compliant with registration requirements set out in [CQC's Guidance](#). This guidance sets some expectations in relation to, for example, advice given by staff to individuals about lifestyle change. The relevant references are as follows:

#### *Prevention and health improvement*

- Outcome 1: 1e covers provision of information about lifestyle change
- Outcome 4:
  - 4A covers individual needs assessment and prevention as an issue relationship between a provider and an individual
  - 4O covers provision of harm reduction advice
- Outcome 5:
  - 5E covers access to facilities for breastfeeding

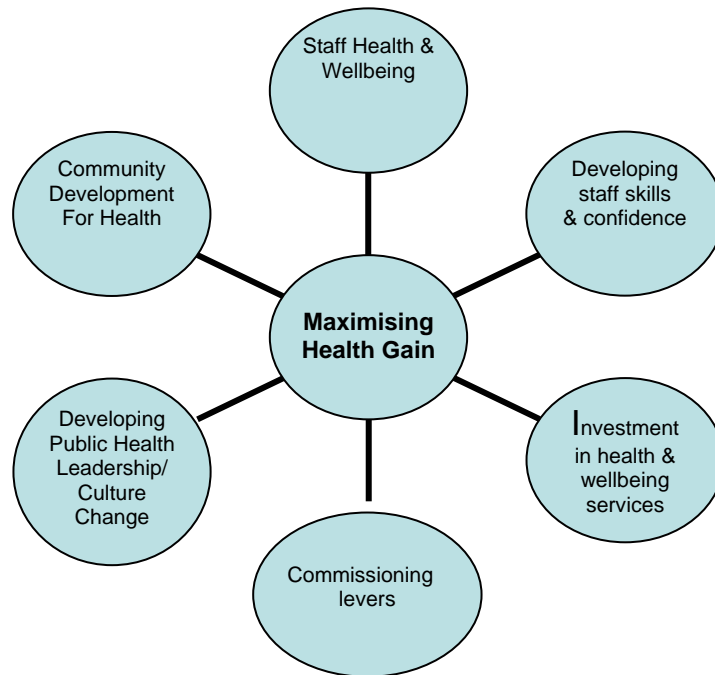
### 4. Examples

- *Newcastle and North Tyneside:* The Directors of Public Health in Newcastle and North Tyneside have developed a ‘Health Gain Schedule’ as part of the Newcastle and North Tyneside Community Health Contract to specify the contribution of the provider to public health delivery ([www.northtynesidepct.nhs.uk/publications](http://www.northtynesidepct.nhs.uk/publications))

The schedule goes into much greater delivery detail than is possible within the Community Contract service specifications. In particular, the Health Gain Schedule clarifies the contribution of each service area to performance in public health. It also aims to set each service in a local and national context for health improvement.

**Contact:** Ian Atkinson, Public Health Business Manager, NHS North of Tyne  
[ian.atkinson@northoftyne.nhs.uk](mailto:ian.atkinson@northoftyne.nhs.uk)

- *Ashton, Leigh and Wigan:* NHS Ashton, Leigh and Wigan has developed a programmed approach to making health gain everyone’s business. This approach is illustrated below, and is clearly structured to incorporate engagement across the partnership.



**Contact:** Claire Roberts, Public Health Development Manager. NHS Ashton, Leigh and Wigan  
[claire.roberts@alwpct.nhs.uk](mailto:claire.roberts@alwpct.nhs.uk)

- *East Midlands:* East Midlands Health Gain Programme for Making Every Contact Count. The programme includes: Potential use of NHS Sustainability Model covering process, **staff** and organisation; Tailored to making every contact count & ensuring relevance to non-NHS Setting; Incorporate examples and resources, Exploring embedding behaviour change within clinical pathways; Testing out the framework and evaluation.

**Contact:** Maureen Murfin, Workforce Development, NHS Debyshire  
[Maureen.Murfin@ntlworld.com](mailto:Maureen.Murfin@ntlworld.com)

- *Solihull NHS Care Trust:* There are several examples of successful smoking CQUIN's in the West Midlands. Typically, CQUIN's require an agreement between the coordinating commissioner and provider that requires evidence - based, relevant and robust quality indicators. These schemes work best when aligned with wider work on improving quality and increasing innovation. Achieving this requirement enables the provider organisation to receive payment. In Solihull, CQUIN has been successfully implemented during 2010/11 for training 20% of Community Services staff in the provision of Brief Interventions for Healthy Lifestyles. This initiative is likely to be expanded to include 100% of Community Service staff trained in brief advice by the end of 2012 with a requirement to refer an identified percentage of clients into Lifestyle Services.
- *Birmingham and Solihull Cluster - QIPP Workstream:* This workstream has prioritised Alcohol and Smoking as areas for intervention and recognised the opportunities for joint contracting. The development of a joint CQUIN for alcohol

and smoking covering both the training and routine delivery of Brief Advice has been developed for 2011/12. This CQUIN is aimed to cover eight specialty areas where smoking and alcohol cause or exacerbate the resultant health conditions. Negotiations for implementation of this CQUIN are currently being agreed between Commissioning PCT s and the acute provider (Heart of England Foundation Trust).

**Contacts:**

Alison Trout, Head of Healthy Lifestyles, Solihull NHS Care Trust.

Alison.Trout@solihull-ct.nhs.uk

Deryn Bishop, Lead for Alcohol and the lead for content on Every Contact Counts Brief Advice and Brief Interventions Training Programme, West Midlands Strategic Health Authority, deryn.bishop@nmhdu.org.uk

- *South Staffordshire Primary Care Trust*. Two CQUIN's are in place with Queens Hospital Burton and the Mental Health Foundation Trust in South Staffordshire to deliver brief intervention advice. This was based on the regional CQUIN offered to all trusts that was highly recommended. Both CQUIN's have been in place since April 2010, for Queens Hospital CQUIN the outpatient clinics selected are Maternity and Cardiology. Payment is made on the achievement of the percentage of smokers/tobacco users receiving a brief intervention to reduce tobacco use including being given written advice as per NICE guidance. This includes simple advice to stop using tobacco; an assessment of the patient's commitment to quit; offer of pharmacotherapy and/or behavioural support; provision of self-help material and referral to more intensive support such as the NHS Stop Smoking Services.

Both CQUINs have performed well and the indicators met. It is important that BIA training is embedded from the start of the CQUIN being implemented.

**Contact:** Kate Sutcliffe, Public Health Development Officer, South Staffordshire Primary Care Trust

Kate.Sutcliffe@southstaffspct.nhs.uk

## Authors and Acknowledgements

Written by:

**Jude Williams. Deputy Head of the Health Inequalities National Support Team**

**Lucy Gate. Associate Delivery Manager for the Health Inequalities National Support Team**

- Acknowledgements

Ben Anderson, Honorary Lecturer/SpT in Public Health, NHS Sheffield/SchARR, University of Sheffield.

In order of appearance in the document

Angela Bartley, Public Health Lead: Royal Free Hampstead NHS Trust

Sally James – Public Health Workforce Specialist NHS West

Tracy Carpenter, Healthier Communities Team: Greenwich Council

Melanie Ponomarenko, Overview and Scrutiny Services: Haringey Council

Jodie Szwedzinski, Adult Services: Haringey Council

Sharan Jones, Health and Wellbeing Manager: Nottingham City Council

Yesmean Khalil, Head of Health Promotion Commissioning: NHS Nottingham City

Karen Payne, Public Health Workforce Lead, NHS Yorkshire and the Humber:

Candia Allen, Public Health Facilitator NHS Leeds

Ann Sunderland, Senior Lecturer/ Course Leader, Faculty of Health and Social Sciences, Leeds Metropolitan

Chris Nield, Public Health Consultant, NHS Sheffield

Christine Joy, Principal HR Manager NHS Sheffield

Kate Birkenhead, Health Improvement Manager NHS Hull

Trevor Simper, Senior Lecturer, Sheffield Hallam University

Philip Baines, Health Promotion Strategy Manager: NHS Wirral

Julie Graham, Senior Health Improvement Advisor: NHS Wirral

Linda Saxe, Programme Manager, NHS Derbyshire County

Gary Cook, Consultant Epidemiologist: NHS Stockport

Charlotte Haynes, Research & Projects Lead and National Health Promotion in Hospital Audit Lead: NHS Stockport

Jan Sinclair, Lifestyles Services Co-ordinator: NHS Stockport

Judith Morris, Director of Nursing & Midwifery: NHS Stockport

Christine Simpson, Advancing Quality Project Manager: Lancashire Teaching Hospitals NHS Foundation Trust

Denise Morris, Public Health Co-ordinator, Royal Preston Hospital:

Ian Atkinson, Public Health Business Manager, NHS North of Tyne

Claire Roberts, Public Health Development Manager. NHS Ashton, Leigh and Wigan

Maureen Murfin, Workforce Development, NHS Derbyshire

Alison Trout,, Head of Healthy Lifestyles, Solihull NHS Care Trust

Deryn Bishop, Lead for Alcohol and the Brief Advice and Brief Interventions Training Programme, West Midlands Strategic Health Authority

Kate Sutcliffe, Public Health Development Officer, South Staffordshire PCT

## Appendix 1: Rationale: Summary of National Policy for the Five Selected Behaviours

### Smoking

Around 8.5 million people in England smoke and half of are likely to die prematurely because of their habit. Smoking remains the single biggest cause of preventable death in the UK, killing over 80,000 people per in England alone<sup>14</sup>. In addition, there are many hundreds of thousands of avoidable hospital admissions each year, costing the NHS billions of pounds. Smoking also significantly contribute to health inequalities between different socioeconomic and ethnic groups, and many more than any other identifiable factor, smoking contributes to the gap in healthy life expectancy between those most in need and those most advantaged.

Many health problems are linked directly to smoking, including cancers, cardiovascular disease and lung diseases, the exacerbation of which often results in hospitalisation. Furthermore, smoking increases the risk of postoperative complications and increased recovery time. Some benefits of the hospital inpatient quitting include:

- decreasing risk post surgical cardiac and respiratory complications
- less likely to need to be admitted to intensive care
- quick wound / fracture healing.
- quicker recovery and shorter period of time in hospital<sup>15</sup>

The NICE guide recommends that all smokers should be advised to quit (unless there are exceptional circumstances), and that hospital clinicians should refer people who smoke to intensive support services such as NHS Stop Smoking Services.

### Falls

Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK<sup>16</sup> and as such, the identification of those older people at high risk of falling and the provision of appropriate preventative services can have a significant population level impact on quality of life in the over 75 age group. Falls not only cause significant morbidity and mortality in this age group, but also result in a significant number of avoidable hospital admissions, and in many cases significant continuing care needs

The NICE guide for the assessment and prevention of falls in older people recommends:

Older people in contact with health care professional should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s.<sup>17</sup>

### Alcohol misuse

Around 10 million adults in England drink in excess of the Government's

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<sup>14</sup> Information Centre (2008)

<sup>15</sup> Based on Department of Health guidance (2009) *Stop Smoking Interventions in Secondary Care*

<sup>16</sup> Department of Health (2001) *National Service Framework for Older People*

<sup>17</sup> NICE (2004): <http://www.nice.org.uk/CG21>



recommended low risk guidance. This misuse is related to 48 medical conditions, including, for example, haemorrhage, stroke, diabetes, and hypertensive diseases<sup>18</sup>. Table 1 within the NWPFO guide illustrates the increased risk to ill health. This increased risk has clear implications for premature mortality.

The estimated cost of alcohol misuse on the NHS, primary and secondary and emergency departments is currently around £2.7 billion a year<sup>19</sup>, currently responsible for around 6% of all hospital admissions per year and increasing. For every £1 spent on intervention, £5 is saved by public sector<sup>20</sup>. The most deprived people have four to fifteen times greater alcohol-specific mortality and up to ten times great alcohol-specific admissions to hospital<sup>21</sup>.

The review of the effectiveness of screening and brief interventions carried out for the forthcoming NICE guidance on 'Alcohol-use Disorders (prevention)' identified evidence for "the positive impact of brief interventions for alcohol misuse on alcohol consumption, mortality, morbidity, alcohol related social consequences, and healthcare resource use"<sup>22</sup>. It highlights that "Brief interventions were shown to be effective in both men and women". Whilst the evidence presented in the effectiveness review was predominantly from primary care, concurring evidence from other healthcare settings was also found, suggesting that similar that similar effectiveness will be seen in acute and mental health trust settings.

### Physical activity

The NICE Public Health Programme Development Group Report '*Modelling to Assess the Effectiveness and Cost-effectiveness of Public Health Related Strategies and Interventions to Reduce Alcohol Attributable Harm in England*' (using the Sheffield Alcohol Policy Model version 2.0<sup>23</sup>), highlights that all of the interventions, including brief interventions, are cost effective. The cost per QALY was between £20 and £440 before healthcare costs avoided are considered. Once these savings are factored into the economic model, 'they result in quality of life participants and net costs savings to the health service: net costs saved per QALY gained vary from and net costs savings to the health service: net costs saved QALY gained from £750 to £3150'.

### Weight management

With almost 2/3 of adults and 1/3 of children in the UK, being overweight or obese, weight management has become a major health priority. The Government's strategy document 'Healthy Weight, Healthy Lives' sets out the ambition to be "the first major nation to reverse the rising tide of obesity and overweight in the population".

<sup>18</sup> NWPFO (2008) *Alcohol Attributable Fractions for England*  
[www.nwpho.net/nwpho/publications/alcoholattributablefractions.pdf](http://www.nwpho.net/nwpho/publications/alcoholattributablefractions.pdf)

<sup>19</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH\\_102813](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_102813)

<sup>20</sup> UKATT Research Team (2005)

<sup>21</sup> Based on DH (2010) *Signs for Improvement – Commission Interventions to Reduce Alcohol – related Harm* [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH\\_102813](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_102813)

<sup>22</sup> " NICE *Final draft of Report 2 Screen and Brief Interventions: Effectiveness Review* p8  
<http://guidance.nice.org.uk/PHG/Wave15/1>

<sup>23</sup> <http://www.nice.org.uk/nicemedia/live/11828/46443/46443.pdf>

## Appendix 2: Summary of National Guidance for Implementation in Relation to the Five Selected Behaviours

### Smoking cessation

The NICE Public Health Intervention Guidance 001 *Brief Interventions and Referral for Smoking Cessation in Primary Care and Other Settings*<sup>24</sup> gives detailed recommendations for smoking related brief interventions.

The NICE guidance recommends that all smokers should be advised to quit (unless there are exceptional circumstances), and that hospital clinicians should refer people who smoke to an intensive support service such as NHS Stop Smoking Services.

Techniques for delivery of 'very brief interventions' are available at [www.nice.org.uk/1001](http://www.nice.org.uk/1001) and [www.smokefree.nhs.uk/resources](http://www.smokefree.nhs.uk/resources)

### Alcohol misuse

The Department of Health / National Treatment Agency for Substance Misuse report *Alcohol Misuse Interventions: Guidance on Developing a Local Programme of Improvement*<sup>25</sup> (2005) identified that

There is considerable potential for growth in the screening, identification and referral of individuals the patterns of hazardous, harmful and dependent use of alcohol in both primary and secondary care (including general hospitals and mental health services (p5)

The overall results including studies in primary care settings show that a majority of these papers "suggest that screening + B1 will result in net cost savings either at the societal level or indeed at the health care payer level" (p59), although the reliability of some of these results is questioned in the review.

The report goes on to point out that even if the use of screening and brief interventions is not cost saving, the analysis shows

that based on UK costs, and estimating per population Quality Adjusted Life Years (QALY) and Disability Adjusted Life Years (DALY) gains and total intervention costs, all the interventions have average cost effectiveness ratios (ACERs) compared to no intervention of lower than £20,000 per additional QALY. This suggests that all these interventions can be classed as cost effective compared to no intervention (p66)

### Alcohol screening tools

Evidence from the Final Draft of *Report 2 Screening and Brief Interventions: Effectiveness Review* to the National Institute for Health & Clinical Excellence indicates that alcohol screening questionnaires are of greater value than laboratory markers or clinical signs in screening for hazardous or harmful alcohol use. The

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<sup>24</sup> <http://www.nice.org.uk/PHI001>

<sup>25</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4123297](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123297)



report looked at evidence for effectiveness relating to a number of screening questionnaires in different settings and with different populations.

For the identification of harmful or hazardous drinking, there are a range of useful AUDIT tools. These and training guidance for 'identification and brief evidence' level 1 alcohol harm reduction can be found at

[www.alcohollearningcentre.org.uk/Topics/Browse/Briefadvice](http://www.alcohollearningcentre.org.uk/Topics/Browse/Briefadvice)

### **Physical activity**

The effectiveness and cost effectiveness of brief interventions in primary care targeted at increasing physical activity have been demonstrated and are documented in the respective NICE reviews<sup>26</sup>. The cost effectiveness report highlights that all of the interventions, including brief interventions, are cost effective, with the cost per QALY being between £20 and £440 before health care costs avoided are considered. Once these savings are factored in to the economic model that "they result in an increase in quality of life for participants and net costs savings to the Health Service: net costs saved per QALY gained varies from £750 to £3150".

Studies of a brief intervention approach in the acute and mental health services have not been carried out, but as with smoking, the models employed in primary care should be adaptable to these settings, and there are no reasons to expect significant changes to the effectiveness or cost effectiveness of the approach.

For primary care, the Department of Health has developed a Physical Activity Care Pathway (PACP), which has been piloted in primary care in a number of areas, and has been evaluated by the British Heart Foundation National Centre for Physical Activity and Health at Loughborough University (yet to be published). The evaluation has shown that the pathway is feasible to deliver and that it gave a useful tool for helping practitioners raise the topic of inactivity and emphasise the importance of activity for health. The pathway was well-supported by practitioners and the use of patient centred motivational interviewing approach was shown to be helpful in increasing the likelihood of patients changing their physical activity behaviour.

The PACP involves four key stages:

- assessment of a patient's activity levels
- brief intervention
- signposting to local physical activity opportunities
- followup consultations

In principle, there is no reason why such an approach cannot be incorporated into a health gain approach in acute and mental health trusts, using the GP Physical Activity Questionnaire (GPPAQ) developed for the PACP as the tool to assess patients and following PACP guidance to determine who should be followed up with a brief intervention and further support.

### **Weight management**

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<sup>26</sup> *Four commonly used methods to increase physical activity; Brief interventions in primary care, exercise referral schemes, pedometers and community based exercise programmes for walking and cycling (2006) and Modelling the cost effectiveness of physical activity interventions (2006)*

The achievement of the ambition of *Healthy Weight, Healthy Lives*<sup>27</sup> will require three foci:

- population level interventions (e.g. through legislation, taxation, national media, etc)
- prevention of obesity through cultural and lifestyle change
- identifying and offering appropriate support to those who are currently overweight or obese.

The inclusion of screening and brief interventions around weight management in the health gain schedule approach offers significant opportunity for progressing the latter focus, and it supported by the NICE guidance on obesity<sup>28</sup>, which states that

the prevention and management of obesity should be a priority for all, because of the considerable health benefits of maintaining a healthy weight and the health risks associated with overweight and obesity.

Both NICE, and the National Obesity Forum advise the use of BMI measures to identify patients in need of advice or referral for further treatment. The National Obesity Forum's 'Obesity Care Pathway' identifies that all patients with a BMI above 25 should be offered 'Health Eating, Physical Activity and Lifestyle Modification Advice', with referral to 'Structured Weight Management and Pharmaco-therapy' being available for those with a BMI of 30 or more (28 or more where co-morbidities exists). The pathway also highlights the need for multi-disciplinary specialist services and surgical interventions to be available to those with high risks.

For the purposes of a health gain schedule the use of BMI may not always be appropriate but the above guidelines should be followed where height and weight data on the patient is available. In addition to the use of BMI measures, clinical/professional judgement and verbal screening question such as 'is your weight an issue that is of concern to you at the moment?' Issues such as eating disorders and body dismorphism may be picked up as well as issues around weight and obesity. Appropriate information, brief intervention support and referral options for those patients should also be available alongside options for those who are overweight and obese.

### Falls

Chapter 6 of the *National Service Framework for Older People* set out the milestones for the development of Integrated Falls Services in all areas by 2005, meaning that all areas should now have appropriate services into which patients identified through the health gain schedule screening as at high risk of falling can be referred. The incorporation of a falls risk assessment into the health gain schedule and the development of appropriate referral pathways into the falls service should not therefore require significant changes to be made.

There are many falls risk assessment tools available, and local falls services should

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<sup>27</sup>[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_114548](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114548)

<sup>28</sup> NICE (2006) *Obesity guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children* Clinical Guidance 43

be consulted to determine their preferred tool, on which the local referral criteria are likely to be based: The *National Service Framework for Older People* identifies the intrinsic risk factors that may indicate a high risk of falling and should therefore feature in a falls risk assessment. These are:

- Balance, gait or mobility problems including those due to degenerative joint disease and motor disorders such as stroke and Parkinson's disease
- Taking four or more medications, in particular centrally sedating or blood pressure lowering medications
- Visual impairment
- Impaired cognition or depression
- Postural hypotension

The FRAT (Falls Risk Assessment Tool) included in the appendix is one of the more widely-used falls risk assessments, and where no local tool already exists would be ideal for use within a health gain schedule programme.

**Appendix 3: Acronyms and abbreviations**

AAACM	All age all cause mortality
BOA	Brief Opportunistic Advice
FRAT	Falls Risk Assessment Tool
GPPAQ	General Practice Physical Activity Questionnaire
HGS	Health Gain Schedule
HINST	Health Inequalities National Support Team
JSNA	Joint Strategic Needs Assessment
NICE	National Institute for Health and Clinical Excellence
PACP	Physical Activity Care Pathway
QIPP	Quality, Innovation, Productivity and Prevention