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We trust you will find this commissioning guidance for the Prevention-at-scale agenda in Thames Valley and Milton Keynes for 2016/17 useful.

This year there are two main differences in our approach:

- We heard from you that it was a valuable resource which would be made more valuable by bringing together the advice from our partners as well. This now includes support and guidance from PHE, the Oxford AHSN and HEE.
- This year as well as bringing you this guidance as a web portal which aims to be intuitive, convenient and more detailed - we are able to provide pdf copies of the guidance which should aid accessibility and provide an opportunity to print and share should you so wish.

While the Guidance is segmented by the clinical areas covered by the SCN, we would like to stress some underlying principles:

- Prevention is a key priority for all and is everyone’s responsibility. We are pleased to partner with PHE and bring their message to you with ideas for what needs to be addressed, examples of how it can be done and the potential gain from the initiatives.
- The integration of mental and physical health is key to providing holistic patient-centred care. This is gaining traction in clinical areas such as perinatal mental health, cardiovascular disease and serious mental illness, the entire long term condition agenda and end of life care.
- With the significant proportion of health care burden on patients and the system related to long term conditions, the importance of the TV LTC transformational programme cannot be overemphasised. The traction that programme has gained in primary care now needs to be firmly embedded and systematised.
- The current push for system working gives us all the opportunity to contribute in different ways and at varying levels towards the same aim. We hope this guidance will provide an opportunity to connect widely and pose questions, share good practice and offer practical solutions. Your SCN leads contact details can be found at the end of this guidance (alongside your other clinical network leads)
Blueprint for the "radical upgrade" in Prevention

Targeted advice tackling unhealthy behaviours is provided at the point of care

- Alcohol consumption is reduced and related hospital admissions are lowered by 2020/21
- Smoking prevalence is reduced (in line with the national ambition to reduce prevalence to 13%) and attributable hospital admissions in people aged 35+ lowered by 10% by 2020/21
- Very Brief Advice & Onward Referrals

A healthier environment is created by health and care providers and local employers

- Prevalence of obesity is significantly lower due to improved approach to food and catering
- Employment of people with long-term conditions (LTCs) is improved, so the gap between the overall employment rate and the rate for people with LTCs is reduced
- The health and wellbeing of staff employed by health and care providers is improved

Improved patient pathway, from early action to better management

- More patients with diabetes, hypertension, atrial fibrillation and hypercholesterolaemia have their condition diagnosed and optimally managed
- Number of injuries due to falls in people aged 65+ are lowered, with admissions due to falls decreasing by 10% by 2020/21, through improved and better coordinated preventative services.
Our Lives in Thames Valley

Prevention in Thames Valley
Figure 1: Upper tier local authorities in Thames Valley

Upper Tier Local Authorities in the Thames Valley

Lower Tier Local Authorities in the Thames Valley
Burden of Disease in Thames Valley

GBD: The South East by Cause

Global burden of disease
Thames Valley has an ageing population with population growth in the 65+ years age groups where more people can be expected to be living with long term conditions and multiple morbidities, making it important to understand the causes of disability in the population. The global burden of disease looks at disability adjusted life years (DALY), an indicator that measures the years of life lost prematurely and those lived in less than full health.

15 Health inequalities in West Berkshire

Figure 18: The top causes of morbidity in the South East – Global Burden of Disease
Lifestyle & Behaviours

Alcohol

Evidence:

- In England, 25% of the population (33% of men and 16% of women) consume alcohol at levels that increase their risk of alcohol-related ill health \( \text{(analysis of health survey for England 2013)} \).
- The annual cost of alcohol-related harm to the NHS in England is £3.5 billion, a third of which is due to alcohol-related hospital admissions.
- Alcohol misuse contributes significantly to 48 health conditions, wholly or partially, due either to acute alcohol intoxication or to the toxic effect of alcohol misuse over time. Conditions include cardiovascular conditions, cancers, depression, and accidental injuries. Risk of ill health increases exponentially as regular consumption levels increase. Most of these harms are preventable.

Root causes

- Limited awareness of health risks from alcohol consumption; addictive nature of alcohol; failure of health professionals to address alcohol as a causal factor in patients’ ill health; socio-economic deprivation; lack of local system join-up.

Public health ambitions

- Reduce excessive alcohol consumption and associated burden on NHS and Local Authorities (LAs) and wider society to:
  1. Reduce alcohol-related hospital admissions, re-admissions, length of stay and ambulance call-outs by 2020/21
  2. Reduce the burden on NHS, police and social care services from high volume service users
  3. Reduce the impact of parental alcohol misuse on children
Establish alcohol care teams in acute hospitals

Aim to reduce the harm to individuals, including to those whose alcohol use impacts most heavily on services. Seek to achieve this by improving staff awareness of alcohol-related ill health in hospitals and providing specialist care to alcohol misusing patients, through:
1) case identification and brief advice
2) comprehensive alcohol use assessments
3) care planning
4) delivering medically assisted alcohol withdrawal management and psychotherapeutic interventions and
5) plan safe, accelerated discharge and continued alcohol treatment in community services.

Note: Alcohol Assertive Outreach Teams should be considered as a complementary intervention

A review of evaluations indicates that successful Alcohol Care Teams (ACTs), regardless of team composition, geographic location or size of hospital, combine:
• clearly defined alcohol pathways with referrals to and from the community
• a 7-day service with particular focus on Friday, Saturday and Sunday and
• involvement of a larger group of healthcare staff, including ward nursing and specialist medical staff.

Evidence
Effectiveness: a consultant-led, multi-disciplinary ACT in Bolton saved 2,000 alcohol-related bed days and reduced readmissions by 3%. An external evaluation showed a 43% reduction (3,814 – 2,155) in alcohol-related A&E attendances alone, in the year following the introduction of a small alcohol care team in the Alexandra Hospital, Worcestershire.

Costs: a team of 4 alcohol specialist nurses providing 7-day ACT service costs c£165,000 p.a. (based on Royal Bolton case study).

Net savings: the case study demonstrates net savings of £471,000 p.a. from a 7-day alcohol care team, a return of investment (ROI) of £3.85 for every £1 invested, a year from implementation.
Lifestyle & Behaviours - Selected intervention (continued)

Evidence

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Currently 73% of hospitals have an ACT. A 100% national roll-out of ACTs could result in net savings to the NHS of £38m p.a. after implementation.

– Can be commissioned by CCGs, with an opportunity for co-commissioning with Local Authorities (LAs)
– Can be delivered by acute hospitals

Progress indicators:

- **Alcohol-related hospital admission (narrow measure): number of admissions** (by CCG and LA)
- **Emergency alcohol-specific readmission to any hospital within 30 days of discharge following an alcohol-specific admission** (by CCG)

Ambulance call-out data (locally held data by ambulance service)

References and further information:

- **Alcohol Care in England’s hospitals: (PHE) 2014**
- **QIPP Alcohol care teams: case study**
- **Newcastle Alcohol Care and Treatment Service**
- **Passetti et al., 2008, Pilot study of assertive community treatment methods to engage alcohol-dependent Individuals**
- **Hughes et al., 2013 “Salford alcohol assertive outreach team: a new model for reducing alcohol-related admissions”**
- **PHE Good practice prompts for planning comprehensive interventions 2016-17**
- **Alcohol Concern’s Blue Light project manual**
Provide Alcohol Identification and Brief Advice in primary and secondary care settings
Aims to reduce the risk of harm to individuals from their alcohol consumption, by encouraging lower consumption which can result in fewer alcohol-related conditions and hospital admissions.

Seeks to achieve this by tackling the poor understanding of alcohol-related health risks amongst patients and professionals through:
1) training of healthcare staff in e.g. General Practice or hospital wards;
2) increasing screening of patients (using Audit-C scratch cards)
3) providing simple brief advice on alcohol consumption to cover potential harm and strategies to reduce alcohol intake; and where relevant
4) referral for specialist treatment.

Screening and Intervention Programme for Sensible Drinking (SIPS) Trials: 3,562 patients routinely presenting to 34 primary care practices and 3,737 patients presenting to 9 A&E in England were screened for hazardous alcohol use and those who were positive were offered brief advice. Results confirmed international evidence that simple brief advice was clinically effective and cost effective in reducing consumption and alcohol problems.

Evidence
Effectiveness: Identification and Brief Advice (IBA) can reduce weekly drinking by between 13% and 34%, resulting in 2.9 – 8.7 fewer drinks per week. This will reduce relative risk of alcohol-related conditions by c14%, and absolute risk of lifetime alcohol-related death by c20%.

Costs: PHE estimates that the cost per screening and IBA intervention would be on average £4.5 per person (one-off). The component costs are £3.4 (screening) and £7 (screening and brief advice), when delivered in primary care; with only c30% of those screened above the threshold and receive brief advice.
Net savings: PHE estimates that the net saving to the NHS per person receiving brief advice could be on average £24 p.a.(or equivalently a saving of £120 over 5 years). If everybody attending their next GP appointment was screened, IBA could result in up to £200m net savings in year 5.

– Can be commissioned by CCGs and/or LAs, with an opportunity for co-commissioning
– Can be delivered by GPs and nurses in primary care; and doctors, nurses and/or health care assistants in hospitals

Progress indicators

Alcohol-related hospital admission (narrow measure): number of admissions
Alcohol-related hospital admission (broad measure): number of admissions
Hospital admissions for alcohol-related conditions
Alcohol-related mortality

References and further information

Health Innovation Network, “IBA commissioning toolkit”
NICE Public Health Guidance 24 “Alcohol-use disorders: prevention”
PHE alcohol learning resources – IBA resources and training
SIPS Trial: Findings
SIPS Trial: Emergency Departments
Establish Alcohol Assertive Outreach Teams (AAOT) to reduce repeat users of hospital and other services such as police and social services.

CCGs and LAs work together to commission outreach teams in hospitals or the community that complement alcohol care teams by identifying and proactively engaging patients with repeated admissions. AAOT will also work face-to-face with patients to implement tailored care plans that address their alcohol dependence, mental/physical health and welfare needs.

Ensure sustained engagement with high-impact users.

Local Authorities work with CCGs to establish pathways and commission specialist services that engage high-impact users as a priority.

Ensure alcohol treatment systems provide prompt access for parents who are identified as harmful/dependent drinkers with agreed pathways between services to maximise support and reduce risks to children and families.

Local Authorities establish clear pathways to alcohol treatment and commission interventions for families where parental alcohol misuse may pose a risk.
**Tobacco**

Evidence
Smoking is the single largest cause of health inequalities and premature death, responsible for 17% of all deaths in people aged 35+. Nearly 1 in 5 adults smoke and there are around 90,000 regular smokers aged between 11 and 15. Smoking is the primary reason for the gap in life expectancy between those in the most deprived quintile and those in least deprived quintile.

The annual cost of smoking to the public is estimated to be £13.8bn in England. Of that, direct costs to the NHS are estimated to be £2bn and costs to social care £1.1bn. Smoking causes cancers, circulatory disease, respiratory disease as well as impotence and infertility. Smokers that manage to quit reduce their lifetime cost to the NHS and social care providers by 48%.

The biggest short-term savings opportunity lies in helping smokers who are in contact with the NHS; the greatest long-term savings would come from preventing people from ever smoking altogether.

Root causes
Around two-thirds of smokers started before the age of 18 for a variety of reasons including smoking role models, availability of tobacco and peer pressure. Once a smoker, they are more likely to be sick, more often. When in touch with secondary care services, the screening and referral rates to evidence based smoking cessation support services are low.

Public health ambitions
Reduce national smoking rates across the population to 13% and associated burden on NHS, LAs and wider society to:
1. Reduce the number of smoking attributable admissions by 2020/21
2. Increase delivery of very brief advice on smoking cessation in health care settings (acute and mental health)
3. Decrease rates of smoking during pregnancy
Tobacco - Selected interventions

1. Provide screening, advice and referral in secondary care settings – CCGs work with LAs to commission secondary care providers to provide screening, advice and referral in acute and mental health trusts, and ensure that the care plan at discharge of patients who smoke addresses their tobacco dependence.

Aims to accelerate the savings to the NHS by treating tobacco dependence as an essential part of care plans for patients.

Seeks to achieve this through a comprehensive approach as per NICE PH48 by:

1) assess (using CO monitoring) and recording smoking status during every patient episode;
2) providing very brief advice (VBA) about the smoking cessation offer and immediate access to nicotine replacement therapies (NRT) and/or pharmacotherapies;
3) offering smokers access to specialist in-situ quitting support;
4) automatic e-referral for intensive behavioural support and other specialist treatment;
5) making secondary care settings smoke-free; and where relevant,
6) training of healthcare staff to deliver interventions.

Success will also require continuing care after discharge. Patients who smoke should leave hospital with a clear treatment plan to address their tobacco dependence. Portsmouth Hospital provided support to staff to deliver VBA and introduced electronic referral of patients to stop smoking services. This led to an increase in numbers of staff trained by 415%, which led to an increase in referrals by 602%.

Evidence

Effectiveness: the quit rates amongst patients who want to quit and take up a referral are between 15% and 20% compared to 3% to 4% amongst those without a referral. A Cochrane Review highlighted the appropriateness of offering VBA to all hospitalised smokers, regardless of admitting diagnosis.
Tobacco - Selected interventions (continued)

**Costs:** PHE estimates total costs of the intervention to be c£620 per successful quitter. Of these, the NHS could incur a one-off c£130 per successful long-term quitter from NRT delivery and follow-up, and could face a potential one-off investment from setting up an Electronic Referral System (ERS) of c£11k and annual ERS maintenance costs of c£3.5k. LAs could incur £490 of costs per successful quitter, through commissioning Local Stop Smoking Services (LSSS).

**Net savings:** cumulative c£340 per quitter over the first 5 years to NHS (i.e. average savings of £68 p.a.), assuming it is phased and excl. the ERS investment. The intervention can become net saving in year 4 after implementation.

- Can be commissioned by CCGs (assess/VBA) and LAs (LSSS), with options for joint commissioning arrangements
- Can be delivered by NHS trusts; LSSS providers in community settings; free online training resources from the National Centre for Smoking Cessation and Training

**Progress indicators**
- Prevalence of smoking among persons aged 18 years and over
- Smoking cessation advice for smokers with selected conditions
- Directly standardised rate of Smoking Attributable Admissions in people aged 35 and over
- Successful quitters at 4 weeks per 100,000 smokers

**References and further information**
- NICE Public Health guidance 48 ‘Smoking cessation: acute, maternity and mental health services’
- NICE Public Health guidance 45 ‘Smoking: Harm Reduction’
- London Clinical Senate programme: Helping Smokers Quit: Adding value to every clinical contact by treating tobacco dependence
- National Centre for Smoking Cessation and Training; including the clinical case for proving stop smoking support to hospitalised patients
Tobacco

**Trusts to implement** NICE guidance PH45 “Smoking: Harm reduction” – CCGs commission trusts to provide support for temporary abstinence for smokers unready to stop smoking completely or permanently, which may include cutting down to quit and long-term nicotine use to prevent relapse to smoking.

Aims to reduce harm from smoking by implementing NICE guidance PH45. The best thing a smoker can do is to stop. Where an individual is unable or unwilling to stop smoking, a programme of harm reduction can enable temporary abstinence or smoking reduction, such as during a hospital stay or a ‘stop before the op’ initiative. Supporting people to abstain in this way improves medical outcomes and reduces complications.

Seeks to achieve this by
1) providing appropriate information on harm reduction to healthcare staff;
2) enabling them to support patients who have independently used a harm reduction approach to make the next step towards quitting; and
3) support the use of or prescription of nicotine containing products long term.

Case Study: a briefing on the short-term benefits of preoperative smoking cessation in London modelled up to 5,300 fewer post op complications; resulting in up to 4,000 bed days saved, £1.1m savings to commissioners and up to £2.8m savings to hospital trusts.

Evidence
NICE assessed scenarios which sought to help someone quit or reduce their consumption, and of these, 3 were cost saving and 12 were highly cost effective.

Costs per QALY were as low £437. Of the scenarios based around temporary abstinence 5 were highly cost effective. They ranged from an estimated £765 per QALY to £8,464 per QALY.
Tobacco

NICE found that the benefits outweigh the costs; except in scenarios where NRT was prescribed for more than 5 years and quit rates were modelled at less than 4%.

- Can be commissioned by CCGs and LAs, with options for joint commissioning arrangements
- Can be delivered by NHS trusts; LSSS providers in community settings; free online training resources from the National Centre for Smoking Cessation and Training

Progress indicators

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Smoking cessation advice for smokers with selected conditions
Directly standardised rate of Smoking Attributable Admissions in people aged 35 and over
Successful quitters at 4 weeks per 100,000 smokers

References and further information

Framework for local conversations on implementing a harm reduction approach; following NICE PH45
NICE Public Health Guidance 45: Smoking: harm reduction
Temporary abstinence from smoking prior to surgery reduces harm to smokers
Joint Briefing: Smoking and Surgery
Stop before the op: a briefing on the short term benefits of preoperative smoking cessation in London

Assess all pregnant women for carbon monoxide to identify potential smoking and refer for specialist support – Healthcare professionals screen all pregnant women at ante-natal appointments and refer women with elevated levels to specialist services.

All mental health trusts to have smoke free buildings and grounds with staff trained to facilitate smoke cessation – CCGs require acute trusts to implement smoke free policies on estate grounds and support staff to encourage compliance with the policy.
Diet and Obesity

Evidence
The annual costs associated with obesity to the wider economy, NHS and social care systems are estimated to be £27 billion, £6.1 billion a year and £352 million respectively.

Over one fifth of 4-5 year old children, more than a third of 10-11 year olds, and two thirds of English adults, are obese or overweight. Being obese can increase the risk of developing a range of serious diseases, including hypertension, type 2 diabetes, cardiovascular diseases, some cancers, obstructive sleep apnoea, and musculoskeletal problems.

Root causes
Poor diet and physical inactivity are causal factors of obesity. Excess weight gain is a result of an imbalance between energy consumed and energy expended. Environments in England tend to encourage over consumption of food and physical inactivity. Obesity disproportionately affects the most deprived communities.

Public health ambitions
Reduce the proportion of children leaving primary school overweight or obese and tackle excess weight in the adult population to:

• Reduce the risk of a wide range of chronic diseases, principally type 2 diabetes, hypertension and cardiovascular disease including stroke, as well as cancer
• Reduce the financial burden on the NHS and social care services and the costs to the wider economy
• Reduce the longer term impact on children and young people including consequences for the physical and mental health in both the short and the longer term
Diet and Obesity - Selected interventions

1. CCGs and LAs ensure there are evidence based weight management services accessible to their local population –through co-commissioning across the obesity pathway and that these are robustly evaluated.

Aims to ensure children, families and adults (identified through the National Child Measurement Programme and NHS Health Checks) achieve a healthier weight.

This can be achieved by ensuring there are evidence based weight management services accessible to their local population. This should include provision of tier 2 and tier 3 weight management services; tier 4 services and post-surgery services to support overweight and obese individuals in achieving a healthier weight. Services should be co-commissioned across the obesity pathway, based on the most effective interventions and incorporate a robust evaluation.

In 2013, approximately 69,000 adults in England were referred to Weight Watchers and Slimming World under the NHS referral schemes.

Evidence*

*Data based on a theoretical example using the weight management economic tool that will be published by PHE in summer. It is assumed a tier 2 intervention funded by LAs that recruits 100 men and 200 women with an average age of 46 years, a mean starting BMI of 30 kg/m2, and a 30% drop out rate.

Effectiveness: participants completing a 12 week intervention could lose an average of 2 kg/m2, maintain this for c6 months followed by gradual weight regain.
Costs: estimated at a total upfront cost of £60 per person enrolled.

Net savings: over a 5-year period, average annual health and care savings are c£20 p.a. per person enrolled (i.e. cumulative saving of c£100 per person over 5 years). Weight management interventions aim to have lifelong impact and are unlikely to manifest as high cost savings in the short-term. This intervention could be cost saving to the health and care system by year 4.

- Can be commissioned by CCGs and LAs
- Can be delivered by weight management providers, health care professionals and public health professionals

Progress indicators

Excess weight in 4-5 and 10-11 year olds
Excess weight in adults

References and further information

- NICE Public Health guidance 53 ‘Weight management: lifestyle services for overweight or obese adults’
- NICE Public Health guidance 47 ‘Weight management: lifestyle services for overweight or obese children and young people’
- NICE Public Health guidance 53 Economic Modelling Report (Tier 2 adults)
- PHE: Mapping of Weight Management Services: provision of tier 2 and tier 3 services
- PHE: Standard Evaluation Framework for weight management services
- PHE: How to make weight-loss services work for men
- BOMSS: Tier 3 commissioning guide
Implement Government Buying Standards for food and catering services (GBSF) across a range of public settings and facilitate the uptake of nutrition policy tools – CCGs and LAs to require providers to do this and promote consistency across hospital and health settings and local businesses.

Aims to increase the procurement of healthier food and drink options within public settings which fully reflect current government dietary recommendations and wider standards for food and drink.

This can be achieved through: increasing the uptake of Government Buying Standards for Food and Catering Services (GBSF) and going beyond these standards to adopt PHE's healthier catering guidance and supporting tools.

Hull and East Yorkshire Hospitals NHS Trust in 2014 made healthier, more sustainable eating easier by ensuring full compliance with GBSF in patient, staff, and visitor catering. Retail outlets now sell smaller portion sizes of confectionery, savoury snacks and sugary drinks. While higher catering standards cost more in some areas, the Hull and East Yorkshire Hospital NHS Trust achieved savings of £60k per annum by producing some meals in-house, which have been reinvested in wider catering improvements.

Evidence
In 2011, food and drink sales in public sector organisations accounted for 6.5% of total sales in the food service sector. At £2.1bn, this provides a large-scale opportunity with significant purchasing power to influence the diets of those who use these services.

In 2008 meeting catering guidance in a care home setting reduced total fat consumption by 12g, saturated fat by 13g and salt by 0.1g while micronutrients such as iron, potassium and folate increased by 50% to 75%; all meeting government recommendations.

Buying healthier food following the implementation of GBSF in two canteens in 2013 resulted in an increase in annual sales of 9% and 17% respectively when compared to 2012, in part due to the perception of food being more appetising when made on site.

- Can be commissioned by all public and private sector organisations
- Can be delivered by all settings with food outlets, including schools and hospitals. Caterers with public sector contracts
Diet and Obesity – Progress Indicators

Compliance with GBSF (at present self-reporting through reporting via Greening Government Commitments Annual Report)
Patient led-assessment of the care environment (PLACE).

References and further information

PHE Healthier and more sustainable catering guidance
Defra: A plan for public procurement: food and catering: the balanced scorecard
DH: Healthy Lives, Healthy People
PHE: Sugar reduction: the evidence for action
Patient-led assessments of the care environment (PLACE)
Global Burden of Disease

Integrate weight management and mental health services – CCGs and LAs work together with providers to enable access into appropriate community and clinical obesity services for individuals suffering with mental health illness and/or with learning disabilities.

Tackle the obesogenic environment – CCGs and LAs work together to support healthier food and drink choices, increase physical activity opportunities and reduce sedentary behaviour and access to energy dense food and drinks.

Make every contact count – health and care professionals empower healthier lifestyle choices and improve access to relevant and appropriate obesity services supported by All Our Health.
Physical Activity

Evidence
It is estimated that physical inactivity costs the NHS £0.9 billion, and additional £6.5 billion each year to wider society. The UK Chief Medical Officers recommend adults undertake at least 150 minutes per week of moderate physical activity, muscle strengthening activities on two days per week and minimise extended periods of sitting.

Current evidence shows that 20% of men and 25% of women are doing less than 30 minutes activity per week, and 62.5% of those with chronic and long term health conditions are inactive.

An inactive person has 38% higher hospital bed days, 5.5% higher GP visits and 13% higher use of specialist services. Physical activity can reduce the risk and help the management of over 20 chronic conditions.

Root causes
Health care professionals lack training in delivering effective behaviour change advice to patients
The built environment, workplaces and education settings do not routinely support active lifestyles and active travel

Public health ambitions
Prevent premature deaths and long term conditions by:
• Reducing the number of physically inactive people and increasing the number of people achieving the level of activity in the CMO guidelines
• Ensuring health care professionals have the skills to deliver brief advice on physical activity to patients to Make Every Contact Count
• Selected interventions

1. Health care professionals to deliver effective brief advice on the benefits of physical activity – invest in raising skills and knowledge of health care professionals such as the PHE clinical champions Programme.
• Aims to increase the proportion of people achieving more than 30 min of moderate activity each week and the proportion undertaking at least 150 mins per week through brief advice from healthcare professionals.
• Seeks to achieve this by training healthcare professionals, via GP clinical champions, to provide physical activity brief advice. GP clinical champions provide peer-to-peer cascade teaching the healthcare professionals (GPs, nurses, allied health professionals). They train health professionals to integrate physical activity brief advice into routine health advice to Make Every Contact Count.
• There are six PHE pilot areas. The evaluation estimates that each year of training by a champion will move over 180,000 adults out of inactivity and at least 27,000 to achieving the CMO guidelines. On a larger scale, PHE estimates that 400 professionals providing brief advice over a year could prevent 26 cases of type 2 diabetes, 18 cases of CVD, 37 cases of IHD, 6 cases of depression (and result in 1 additional serious road traffic accident would result from increase in active travel.)
Evidence

Effectiveness: PHE estimates that each clinical champion can train 150 qualified healthcare professionals (HCP) and 200 healthcare professionals in training (trainees) per year. HCP are expected to have c10,000 patient contacts, and trainees, c5,000 contacts per year. PHE estimate that 40% of those trained will retain the information and act on it and that in 64% of consultations the patient is eligible for the intervention and will receive advice. Finally PHE expect that 30% of targeted patients will respond to a very brief intervention and 15% of those patients taking action achieve 150 minutes per week of physical activity.

Costs: PHE estimates the intervention costs c£111 per professional trained by a clinical champion. These costs would accrue to PHE. The costs of providing very brief advice are not included.

Net savings: PHE estimates that net savings of £8 p.a. could be saved to NHS per professional trained (avg over the first 5 years of the intervention).
  – Can be commissioned by: CCG and/or LAs in partnership with PHE
  – Can be delivered by GP clinical champions or other healthcare clinical champions, and healthcare professionals

Progress indicators

Percentage of adults classified as ‘inactive’
Percentage of physically active adults

References and further information

NICE PH44 Physical Activity: brief advice for adults in primary care
NICE physical activity return on investment tool
Making Every Contact Count resources (PHE)
Physical activity & health CPN e-learning modules
Motivational interviewing CPD e-learning module
Making Every Contact Count e-learning
Evaluation of medicine undergraduate teaching materials
Physical Activity continued

2. Increase active travel for staff, patients and local population – develop travel plans with supporting local activation to get staff, patients and the local population to walk and cycle.

Aims to increase the proportion of people achieving more than 30min of moderate exercise each week and the proportion undertaking at least 150 mins per week through everyday walking and / or cycling.
Seeks to achieve this active travel plans with supporting local activation activities like walking groups, cycling classes and workplace reinforcement through the Workplace Wellbeing Charter.
These can be combined with evidence-backed, population-based interventions, such as ‘Beat the Street’. Commissioners and providers within footprints are encouraged to set stretching active travel targets and monitor the impact of their interventions through annual surveys. Travel plans can reduce the proportion of people arriving by car by 18%.

Evidence
A North West Reading CCG commissioned population-based ‘beat the street’ intervention engaged 11% of the population (>23,000 people). Over 1,200 adults who had moved into activity were still achieving 150 minutes per week 12 months after intervention.

Department for Transport estimates a 35:1 cost-benefit ratio of for interventions that increase cycling and walking. Evidence suggests active travel plans are more effective with supporting activation activities like cycling classes or group walking interventions.

The Kings Fund calculated that getting one more person to walk to school pays back £768; and to cycle to work rather than by car between £539 and £641 in terms of NHS savings, productivity improvements and reductions in air pollution and congestion.

- Can be commissioned by CCGs and LAs
- Can be delivered by LAs and NHS within primary, secondary, and social care settings.
Physical Activity continued

Progress indicators
- Percentage of adults classified as ‘inactive’
- Percentage of physically active adults
- Percentage of journeys to GP, Hospitals, Schools by walking/cycling

References and further information
- Start active, stay active
- NICE PH41: walking and cycling
- NICE PH8: Physical activity and the env.
- PHE active travel briefing for local government
- LGA and PHE: Obesity and the environment
- NHS SDU briefing on active travel planning
- WHO health economic assessment tool for walking and cycling
- DfT's Claiming the Health Dividend
- National Cycling Network

CCGs and LAs to invest in evidence-based exercise programmes for patients – for example, providing exercise referral schemes where patients receive supervised support by trained professionals.

Adopt and promote PHE’s campaigns – local government, NHS providers and CCGs to draw on Start4Life, Change4Life and One You campaigns.

Employers to adopt the Workplace Wellbeing Charter – this can help employers to target physical activity programmes at their staff most effectively – see health and work slides.
Sexual Health

Evidence
There are approximately 6,000 new HIV diagnoses each year. Of these, 42% are late diagnoses, which have higher levels of morbidity and mortality compared to those diagnosed promptly and a ten-fold increased risk of death in the year following diagnosis.

Treating HIV is estimated to cost the NHS £770 million per year (2014). Around 85,000 people accessed HIV services in 2014 and the annual per person cost of providing HIV care was estimated to be around £9,000. Preventing one UK-acquired HIV infection would save c£0.36m in undiscounted lifetime treatment and clinical care costs.

It is also estimated that just over half of all pregnancies in England are planned. The Department of Health estimates that the annual direct costs to the NHS of unplanned pregnancy are around £240m, with an estimated unit cost of around £1,600 which includes costs from abortions, maternity care, miscarriage and mental health problems. Not all unplanned pregnancies can be prevented but more effective contraceptive methods can reduce prevalence.

Root causes
Inequalities and lack of information on contraceptive choices and their relative effectiveness; stigma and lack of information about sexual health and sexually transmitted infections; lack of access to HIV testing and contraceptive choices.

Public health ambitions – reduce prevalence of sexually transmitted infections, late diagnosis and unplanned pregnancies by:
• Improved access to high quality, actionable information about sexually transmitted diseases, sex and contraceptive choices and effectiveness
• Improved access to STI testing and full range of effective contraceptive methods, available in most appropriate care setting
Sexual Health (continued)

Selected interventions
1. Increase access to the most effective Long-Acting Reversible Contraceptives (LARCs) in various care settings – GPs to offer LARC as part of their contraception offer and secondary care providers to include LARC as part of a contraception offer within routine maternity and abortion pathways.
   - Aims to increase the effectiveness of female contraception methods by improving access to highly effective long-acting reversible contraceptives (LARC) to reduce the number of unplanned pregnancies.

Seeks to achieve this by improving knowledge about and skills to fit and remove LARC amongst healthcare staff and making LARC more widely available through:
1) making LARC routinely available as part of GP contraceptive offer;
2) include LARC in routine maternity and abortion pathways and where relevant; and
3) deliver training programme to healthcare professionals (GP, practice nurses, midwives) to ensure they are confident to provide advice.

Barriers to wide-spread uptake include lack of integration and join-up due to fragmentation of the commissioning cycle and dispersed funding responsibilities, which can be overcome by taking a more collaborative approach.

Wigan Borough CCG and Wigan Council pooled and aligned budgets to commission sexual health services collaboratively, which led to significant savings to the CCG and improvements in non-attendance rates and uptake of LARC.

Evidence

Effectiveness: LARC are non-user dependent and 99.9% effective in preventing unwanted pregnancy compared to 92% for the contraceptive pill (typical use) or 82% for the male condom (typical use).
Costs: Based on a peer-reviewed paper supporting NICE guidelines, PHE estimated that the provision of LARC for one user over 5 years costs £514 i.e. ~£100 per user p.a.; the oral contraceptive pill costs £456 over the same time horizon; there may also be one-off training costs for GPs and other professionals to learn how to fit and remove LARCs, which could be ~£1m in year 1 nationwide.

Net savings: PHE estimates that if 1,000 women switch from oral contraceptive to LARCs, 291 unplanned pregnancies could be avoided over 5 years. This leads to average net savings to the NHS of £65 p.a. per switcher (total net savings of £327 over 5 years). If LARCs are available nationwide as outlined above, annual net saving to the NHS in year 1 would be £5m rising to £23m in year 5.

– Can be commissioned by CCGs (abortion and maternity services); NHS England and LAs fund contraceptives supplied in community sex health services and in GPs
– Can be delivered in General Practice and hospitals and other secondary care providers who provide maternity and abortion services

Progress indicators
Totally prescribed LARC excluding injections
GP prescribed LARC excluding injections
Sexual and Reproductive Health Services prescribed LARC excluding injections

References and further information
PHE 2014, Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV – including further case studies
NICE 2013, Long-acting reversible contraception the effective and appropriate use of long-acting reversible contraception
Department of Health, 2013 Commissioning Sexual Health services and interventions – Best practice guidance for local authorities
PHE 2015, Commissioning regional and local HIV sexual and reproductive health services
Sexual Health (continued)

2. Expand access to HIV testing in high-prevalence areas – GPs and hospitals to offer testing at all general hospital admissions and at newly registered patients in GP clinics.
   - Aims to expand HIV testing to offer testing at all general hospital admissions and at newly registered patients in GP clinics in the 66 LAs with the highest diagnosed HIV to reduce late diagnosis and onward transmission rates.
   - Seeks to achieve this by expanding HIV testing in general medical services in areas of high diagnosed HIV prevalence through:
     1) offering HIV tests routinely at GP registration or hospital admission
     2) for GPs: testing through additional blood test or point-of-care tests (POCTs)
     3) for hospitals to add HIV test to routine blood tests upon hospital general medical admission.

Current barriers include lack of awareness and training which can be addressed by clinical training, awareness raising and improved protocols.

**Brighton LA** implemented successfully routine HIV testing in primary care and community venues. This decreased the rate of late diagnosis from 51% to 33%, and an increased diagnosis of HIV in GP and community settings (27% in 2000 to 59% in 2012).

Evidence

A diagnosis of HIV can reduce onward transmission through treatment and changes in behaviour. Individuals diagnosed with HIV infection demonstrated a reduction in risk behaviour which has been shown to contribute to a reduced rate of onward transmission.

Costs will accrue to the NHS from administering HIV tests (registrar time and material costs) in acute medical admission units (estimated at £12 per person per test) or tests done in GP settings (estimated at £20 per person per test).

Savings accrue due to prevented onward HIV transmission and reduced, expensive late diagnosis (care costs for late stage diagnosis have been estimated at £12,800; care costs for early diagnosis £10,500 (both 2008 prices)). Over a 10-year period, increasing HIV screening as outlined above has the potential to save £278 million.

- Can be commissioned by LAs and CCGs with options for joint commissioning arrangements, and adoption of an integrated approach across all pathways.
- Can be delivered in all primary care (GPs) and secondary care (general medicines hospital admissions) providers.
Sexual Health (continued)

Progress indicators

Coverage of HIV testing measured in GUM
% of adults (aged 15 or above) newly diagnosed with HIV at a late stage of infection
Rate of new HIV diagnosis per 100,000 population among people aged 15 or above
Prevalence of diagnosed HIV infection per 1,000 among persons aged 15 to 59 years

References and further information

PHE 2014, Addressing Late HIV Diagnosis through Screening and Testing
NICE PHG91 (forthcoming)

3. Reduce increasing rates of STIs and improve detection of STIs – GP to ensure that good prescribing practice and national guidance on the management of STIs in primary care is followed, and to refer diagnosed with STIs to specialist services including for partner notification.
Evidence
Drug use and dependency can significantly affect people, their families, friends and the wider community. It commonly co-exists with a wide range of physical and mental health problems. UK drug misuse costs society £10.7bn a year (2010/11), with a conservative estimate of £80m pa in NHS costs alone.

An estimated 300,000 people in England are dependent on heroin and/or crack, but use is not evenly spread and tends to cluster in areas of high deprivation. Past or present injecting drug use is associated with Hepatitis C and other blood borne viruses, general poor health and a high risk of overdose. Nearly one in nine deaths registered among people in their 20s and 30s in England and Wales in 2014 were related to drug misuse.

There is increasing use and problems associated with other drugs, including new psychoactive substances, image and performance-enhancing drugs, and growing concern about dependence on prescribed and over-the-counter medicines.

Root causes
Socioeconomic deprivation; the addictive nature of drugs being used; experience of abuse/trauma; stigma/complexity as a barrier to accessing protective services; health and social care professionals finding it difficult to identify problem use early and appropriately intervene.

Public health ambitions
- Prevent dependence forming, or prevent it becoming entrenched
- Reduce the preventable death and health harm caused by drug misuse
- Reduce the impact of parental drug misuse on children
Selected interventions
1: Regular review of patients prescribed medicines liable to dependence.
   – Aims to reduce addictions to medicines (ATM) among GP patients.

Seeks to achieve this by:
1) GPs identify patients with repeat prescription for medicines liable to dependence (either as part of ongoing clinical practice or through one-off systematic audit of GP patient register).
2) GPs request identified patients to attend an appointment to review prescription.
3) GPs review effectiveness and patient need for prescription and decide to either continue prescription; change prescription; or end prescription.

PHE is working with a pilot site in Doncaster with 10 GP practices. Each practice nominated an ATM Champion who received relevant training and carried out additional patient appointments where necessary. The reviews focussed on Pregabalin use in the GP practices and conducted audits of use in April and September 2015 and compared outcomes pre- and post-intervention.
Collectively, the GP surgeries reduced prescribing of Pregabalin by 29% (ranging from: – 88% to +5%). This represents an annualised gross saving from reduced prescribing costs of £120,000 compared to an investment of £10,000.

Evidence
Effectiveness: Based on the Doncaster pilot, the programme reduced prescriptions of the pain killer Pregabalin between April and September 2015 by 29%.

Costs: Evidence from the Doncaster pilot site suggests that the intervention costs £19.5 per patient seen (i.e. everyone with a repeat prescription for Pregabalin is audited, but only a proportion are seen by a GP). These costs accrue to the NHS from additional GP appointments (Doncaster saw 462 additional 15min GP appointment at £19.50 per appointment) and training of GPs (one-off total costs of £1,000 for 60 GPs).
Drugs (continued)

Net savings: Evidence from the Doncaster pilot site shows net savings of £182 p.a. per patient. These savings accrued to the NHS from a lower number of prescriptions of Pregabalin or less expensive prescriptions.

- Can be commissioned by CCGs, with an opportunity for joint-commissioning with Las.
- Can be delivered by CCGs. Local drug treatment providers can provide training GPs on ATM, including signposting to appropriate local services.

Progress indicators

Local prescriptions data is available via the NHS Prescription Services prescribing toolkit. National Drug Treatment Monitoring System (NDTMS) quarterly reports can be used to track changes in the profile of medicines causing problems locally.

References and further information

RCGP Substance Misuse and Associated Health, (n.d.) Prescription and over-the-counter medicines misuse and dependence.
Drugs (continued)

2: Naloxone provision targeted at high-risk groups to prevent fatal overdoses – health professionals to provide targeted support to overdose survivors, by e.g. raising awareness of heightened future fatal OD risk, providing naloxone to frequent ambulance and A&E users, and referring to specialist treatment

3: Screen, identify and treat Hepatitis C in the community – LAs to commission drug treatment services, needle and syringe programmes, and outreach services such as ‘Find and Treat’. The new Hepatitis C treatments are provided via the 22 NHS England operational delivery networks.

4: Co-commission care for co-existing substance misuse and mental health issues – CCG and LAs commission a targeted intervention focused on delivery of crisis response/ongoing care to this complex needs group by addressing exclusion.

5: Implement comprehensive drug treatment systems that provide prompt access for parents who are identified as using drugs with agreed pathways between services to maximise support and reduce risks to children and families – LAs establish clear pathways to drug treatment and commission interventions for families where parental drug misuse may pose a risk.
Clinical Pathways

AF, hypertension, hypercholesterolemia

Evidence
Diseases caused by high blood pressure are estimated to cost the NHS over £2 billion every year. Over 5 million people are unaware they have high blood pressure, yet it affects more than 1 in 4 adults and is one of the biggest risk factors for premature death and disability in England.

High blood pressure accounts for 12% of all visits to GPs in England. People from the most deprived areas are 30% more likely to have high blood pressure. Atrial fibrillation (AF) related illnesses cost the NHS over £2.2bn pa. The risk of suffering a stroke is increased by nearly 500% for AF patients. AF affects nearly 2% of the population.

As many as 60% of adults in England have raised cholesterol, a key risk factor for cardiovascular disease (CVD) which in total costs £19bn to the UK economy each year. It is estimated that 1 in 500 people have Familial Hypercholesterolemia.

Root causes
Poor diet, being overweight, smoking, excess alcohol consumption and physical inactivity are leading risk factors for developing high blood pressure and high cholesterol. Some people will have genetic disorders such as Familial Hypercholesterolemia. Upon developing a condition, many individuals are undiagnosed. Once diagnosed, many conditions are managed ineffectively, increasing the probability of developing further complications.

Public health ambition
– Higher proportion of patients with hypertension, atrial fibrillation and familial hypercholesterolemia are diagnosed and optimally managed, through an enhanced use of NHS Health Checks, pharmacies and community settings
Clinical Pathways (continued)

Selected interventions

• LAs commission [NHS Health Checks](#) and CCGs support providers to increase offer of Health Checks, testing and risk assessment (being more proactive with deprived groups), particularly via GPs and outreach testing e.g. pharmacy.

• CCGs support primary care to ensure patients receive optimal care and drug treatment where relevant; extend the role of pharmacists in clinical management; and support patient activation and self-care.

These steps can be taken to improve management of the following conditions:

• Atrial Fibrillation.
• Hypertension (high blood pressure).
• Familial hypercholesterolemia (high cholesterol).
• Diabetes.

1: Reduce the incidence of avoidable AF-related strokes

Aims to reduce the incidence of avoidable AF-related strokes by 5000 nationally over the next 5 years. Seeks to achieve this by

a) increasing the proportion of known AF patients who are offered and started on appropriate treatment from 74% to 89% over the next 5 years;

b) introducing regular systematic audit in all practices (using tool such as [GRASP-AF](#)) to identify people at risk who are not anticoagulated or who are sub-optimally anticoagulated;

c) increasing opportunistic detection rates in line with expected prevalence through NHS Health Checks and other mechanisms; and d) strengthening and upskilling clinical leadership on AF.

In Leicester City CCG during April – June 2014, 23% of patients admitted to hospital with a stroke had known AF, of these only 38% were on anticoagulation. By 2015, prescription of anticoagulation for known AF patients rose to 82.6%; opportunistic screening identified 138 AF patients; 37 strokes prevented; and estimated prevention savings of £499K.
Clinical Pathways (continued)

Evidence
Effectiveness: 1 stroke will be prevented for every 25 patients treated with anticoagulation, whereas 1 stroke can be prevented for every 67 patients treated with aspirin.

Costs: PHE estimates the cost per intervention, when prescribing anticoagulation, is £648 per patient p.a. in year 1, increasing to £1k by year 5. Cost of the anticoagulation per person p.a. ranges from £283 to £800.

Net savings: PHE estimates that the intervention would result in net saving to the system of c£1,453 per person p.a. by year 5. These can be broken down into c£1,815 p.a. per person savings to the social care system and a cost to the NHS of £362 per person p.a. This cost would contribute towards improved care and quality, and patient safety.

• Can be commissioned by CCGs supported by Academic Health Science Networks
• Can be delivered by a range of health care professionals (detection) and GPs, specialist nurses and haematologists (treatment and management)

Progress indicators
Number of AF related strokes (SSNAP)
Proportion of patients with a CHA2DS2VASc score ≥ 2 on anticoagulation treatment without exception reporting (QOF)
The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification (QOF)

References and further information
NICE guideline CG180 Atrial fibrillation: management
AF: how can we do better? CCG profiles
Atrial fibrillation prevalence estimates
CVD Prevention opportunities
CVD: Primary Care Intelligence Packs
Innovation exchange
Sentinel Stroke National Audit Programme
NHS RightCare commissioning for value and atlas of variation
2: Improve management for patients with high blood pressure
Aims to increase the proportion of people with a hypertension diagnosis whose blood pressure is optimally managed to less than 140/90mmHg.
Seeks to achieve this by implementing innovative approaches to managing hypertension consisting of
a) regular systematic audits of practice registers (using practice audit tools such as EMIS or GRASP-BP) to identify diagnosed hypertensives with suboptimal BP control
b) developing the role of community and general practice based pharmacists to monitor and control blood pressure (BP) of sub-optimally managed hypertensives, support adherence to drug regime and advise on lifestyle change; and
c) wider use of self-monitoring by patients to help eliminate false-readings and provide a clearer picture of the BP over time;

In Dudley, practice-based pharmacists (PBP) worked with GP practices to identify patients with undiagnosed or sub-optimally managed hypertension. Using the EMIS search and report system, PBPs identified 11,000 hypertensives who were not treated to target and diagnosed 27,800 new hypertensives. This is projected to lead to cost savings of c£13m from avoided hospital admissions over 5 years.

Evidence
Effectiveness: based on the Dudley pilot, 90% of GP practices achieved optimal treatment targets of 140/90mmHg for their hypertensive population (the standard is 50%, and inter-practice variation 6-99%).

Costs: PHE estimates costs of c£28 to per new controlled person in year 1 (average cost of one 10 minute and three 5 minute consultations with a pharmacist at £64 hourly unit cost), based on the assumption that achieving a BP treatment to target for one patient will require 4 consultations with a PBP.

Net savings: PHE estimates that system net savings would be c£14 p.a. per controlled patient over a 5 year horizon. Of these, c£5.75 would accrue to the NHS and c£7.91 would accrue to Local Authorities.

- Can be commissioned by CCGs or, if part of the NHS Health Checks, by LAs
- Can be delivered by GPs and / or pharmacists in primary in General Practice or community pharmacies
Diabetes

Evidence
Diabetes treatment currently costs the NHS £9.8 billion a year, which represents around 10% of the annual NHS budget. Indirect societal and productivity costs raise this figure to nearly £23.7 billion.

It is estimated that in 2015 there were 5 million people aged 16 years and over with non-diabetic hyperglycaemia.
There is a direct association between obesity and type 2 diabetes – those who are overweight or obese are at higher risk of developing the condition and 90% of people with type 2 diabetes are overweight or obese.

Two thirds of English adults and one third of 11-15 year olds are currently overweight or obese. Projections show that 70% of people will be overweight or obese by 2034 and one in ten will develop Type 2 diabetes. People with diabetes are at risk of a range of health complications including CVD, blindness, amputation, kidney disease and depression.

Root causes
Rise in prevalence of obesity; ignorance of unhealthy levels of sugar consumption; socio-economic deprivation (type 2 diabetes is 40% more common among people in the most deprived quintile compared with those in least deprived quintile).

Public health ambitions
Reduce the projected growth in incidence of diabetes
Improve support for self-care in people with a diagnosis of diabetes
Improve the treatment and care of people with diabetes
Diabetes (continued)

Selected interventions
1: NHS Diabetes Prevention Programme – in particular, CCGs and LAs support NHS Health Checks, primary care and NHS Diabetes Prevention Programme providers (where in place) to jointly implement effective referral pathways.
   – Aims to prevent cases of Type 2 diabetes.

Seeks to achieve this by:
   a) identifying those at high risk of developing Type 2 diabetes,
   b) confirming non-diabetic hyperglycaemia and
   c) referring them to a behavioural intervention programme.

The National Diabetes Prevention Programme (NDPP) is designed to tackle current variation in the provision and underpinning evidence of local diabetes prevention programmes, and will be available nationally by 2020.

The STP process offers an opportunity to support the implementation of the NDPP. LAs and CCGs should work with regional teams to undertake an assessment of readiness to join the programme. LAs and CCGs will work together to identify the at risk population and jointly implement effective referral pathways with primary care, NHS Health Checks and NDPP providers.

Evidence
Effectiveness: the PHE evidence review found that diabetes prevention programmes can reduce progression to Type 2 diabetes compared to usual care by 26%.
Costs: the intervention is nationally commissioned. The costs to local stakeholders are to be confirmed and will vary according to the chosen referral pathway.

Net savings: Based on the NDPP running for 5 years, NHS England estimates suggest an average cumulative net saving to the NHS of £31m within 15 years* (excluding local expenditure), with additional savings to the social care system of £4m. This will vary depending on final costs agreed with providers and programme attendance rates.

*Please note that new modelling is expected to become available shortly and estimates are likely to change as a result.

– Intervention commissioned by NHS England and supported by LAs and CCGs in case finding and implementation of referral pathways.
– Intervention delivered by NDPP providers on a national framework, called off locally through mini-competitions

Progress indicators
Uptake of the NHS DPP (to be published – tbc)
Retention to the NHS DPP (to be published – tbc)
Incidence of diabetes among Service Users (CCG IAF)

References and further information
PHE evidence review – Diabetes Prevention Programmes
NCVIN prevalence estimates (2015)
NHS DPP website
NICE PH38 Type 2 diabetes: prevention in people at high risk
Diabetes

2: Increase the proportion of newly diagnosed diabetes patients attending a structured education course.

- Aims to improve patient outcomes and reduce complications associated with diabetes.

Seeks to achieve this by increasing the proportion of newly diagnosed type 1 and type 2 diabetes patients attending structured education by 10% per year. This will be measured by the National Diabetes Audit (NDA) and reviewed annually. Only 5.7% of newly diagnosed diabetes patients attended a course in 2014/15. A lack of robust data collection on provision and uptake, services which are insufficiently holistic for patients’ needs and referrals of insufficient quality are some of the principal barriers to achieving good uptake. CCGs will seek to address these by reviewing performance of local practices, ensuring that local processes are in place to track attendances and audit outcomes, developing referral strategies, and encouraging practices to sign-post patients to supportive digital resources.

Evidence

Effectiveness: structured education can support patients to stabilise blood glucose levels, reducing the risk of complications and improving quality of life, thus reducing the financial burden on the NHS and wider social care system.

Costs: NHS England estimates that the cost of X-PERT (type 2 diabetes focused) per person attending is between £55-£65 (based on delivery to c3,500 patients by four educators).

A diabetic service can set up a DAFNE project (type 1 diabetes focused) with a cost of c£8,000 in year 1 and c£3,700 in years 2 and 3 respectively.

Net savings: NHS England estimates that X-PERT could save between £66-£76 per person p.a. One organisation delivering the programme to c3,500 patients could save c£260k per year.

Delivery of DAFNE could deliver savings of an estimated c£93,000 per 100,000 population.

- Can be commissioned by CCGs
- Can be delivered by Foundation Trusts, social enterprises, charities or private sector organisations that meet NHS standards and costs
Diabetes (continued)

Progress indicators
Number of patients attending a structured education course within a year of diagnosis (CCG IAF – as measured by the NDA)
Practice-level performance on offers and take up – as measured by the NDA
Patient attendance and outcomes – as measured by locally implemented systems

References and further information
APPG report on structured education (March 2015)
NICE NG28 Type 2 diabetes in adults: management
Evaluation of X-PERT
QIPP evaluation of DAFNE

3: Reduce variation in treatment target achievement through all GP practices meeting the 2014/15 median level, to be reviewed annually. CCGs support local GPs to perform at the level of the median, in relation to the 3 NICE-recommended diabetes treatment targets (HbA1c <=58mmol/mol (7.5%); cholesterol <5mmol/L; blood pressure <=140/80 mmHg).

4: Establish multi-disciplinary diabetic foot teams – CCGs support the provision of multi-disciplinary diabetic foot teams for people with diabetic foot disease, and access to specialist diabetes teams for inpatients with diabetes

5: Provide specialist support – CCGs ensure all secondary care providers have inpatient specialist teams, and consider introducing provision for specialists to provide support and advice to GPs.
Mental Health

Evidence
Mental health problems cost the NHS £14bn p.a; and wider societal costs are estimated at £100bn. Of these, perinatal mental health costs the NHS £1.2bn, and wider social costs of £8.1bn for each annual birth cohort.

In any given year in England, nearly 1 adult in 4 experiences at least one mental health problem. Diagnosable mental health problems are experienced by 23% of adults and 10% of children (aged 5-16). 25% of women experience a mental health problem during pregnancy or the first year after childbirth. This is equivalent to 11m adults in England (2013), of whom 8m have a common mental health problem.

Physical and mental health are closely linked. People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England; and of these deaths, 2/3 are due to avoidable physical illness.
Although 3 out of 4 people with physical illness receive treatment, only 1 in 4 people with mental health problems do.

Root causes
The impact of parental mental health; low income; employment and housing status; discrimination; isolation and marginalisation.

Public health ambitions – to reduce prevalence of mental health and mental health related emergency admissions by:
• Improving earlier and wider access to mental health services including for children and new mothers
• Improving the physical health of those with mental health problems
• Reducing the disability employment gap (see health and work slides)
Mental Health (continued)

Selected interventions
1: Maternity staff to offer mental health support to women in pregnancy and after childbirth – CCGs commission maternity pathways that embed perinatal mental health support in line with NICE guidelines.
Aims for every women to be able to access evidence-based specialist mental health advice, support and treatment during the perinatal period

Seeks to ensure that every footprint establishes a comprehensive perinatal pathway with 4 key components;
a) access to mental health advice and support embedded within universal maternity, health visiting and GP services;
b) routinely asking about mental health in all consultations with pregnant women and to one year after childbirth;
c) rapid access to psychological therapies for all women who will benefit;
d) clear pathways including support during and after childbirth, specialist perinatal community teams, parent-infant services, and appropriate access to mother and baby units.

Homerton Hospital (London) train all of their practitioners to ensure pregnant women are offered access to the perinatal mental health care pathway(component a) in a timely fashion. When booking their appointments women are routinely asked about their mental health. This has reduced the number of late diagnoses of mental health problems which has increased rates of full recovery.

Evidence
In Hampshire Trust the intervention increased the number of pregnant women being referred into the mental health pathway. In 2012/13 c690 of the c5,700 women giving birth at Hampshire Trust were referred into the pathway, compared to 425 in 2011/12. This resulted in a reduction in occupied bed days across the Trust from 98/1000 births in 2011/12, to 75/1000 in 2012/13.

London School of Economics estimates the total costs of the intervention (components a-d) to the NHS are £407 per birth. Per birth costs for each component being:
(a) £205 for training and specialist supervision;
(b) £18 mental health assessments
(c and; d) £184 specialist psychological and clinical support and networks.
London School of Economics estimates that the provision of perinatal mental health services are cost saving to the NHS. Early intervention in psychosis has been shown to save £3.98 for every £1 spent over a 2-5 year (component c).

- Can be commissioned by CCGs.
- Can be delivered by maternity services, communities, specialist community or inpatient services

Progress indicators

Perinatal mental health: Estimated number of women requiring support during pregnancy or postnatal period

Percentage of women who were asked the recommended questions for prediction and detection of mental health issues

Maternal deaths from psychiatric causes (suicide or substance misuse) related to a pregnancy

References and further information

Mental health taskforce

NICE CG192 Antenatal and postnatal mental health

Mental health promotion and prevention: the economic case (LSE)

Maternal depression: implications for systems serving mother and child

The cost of perinatal mental health problems — LSE

Maternal depression: implications for systems serving mother and child

2: Support smokers within the mental health trusts to quit – trusts deliver care in entirely smoke free buildings and grounds with appropriate support.

Aims to reduce smoking related ill-health for patients of mental health trusts and their staff.

Seeks to achieve this by

a) enforcing smoke free buildings and ground;

b) providing a mix of very brief advice and intensive interventions training to all staff;

c) consistently recording smoking status;

d) offering stop smoking support to all people who smoke.
Mental Health (continued)

16 out of 59 MH Trusts are currently smoke free in buildings and grounds. Current smoking rates for those receiving inpatient treatment of less than 12 weeks is 34%, for longer stays the rate is 70%.

South London and Maudsley NHS Foundation Trust achieved a reduction in medication costs by implementing smoke free policies. It also saved 4 hours a day of staff time previously used to facilitate smoking escorting, and reinvested savings in therapeutic activities.

Evidence

Effectiveness: PHE estimates 95% of patients could be screened and that 95% of those who are smokers could be given appropriate help to quit. It is estimated the long term quit rate for long term patients is 40%, and 25% for short term patients.

Costs: PHE estimates the intervention could cost £1,430 p.a. to the health and care system, on average over 10 years. The average cost per person to the NHS is £790 p.a. over 10 years, and £640 to LAs. This includes nicotine replacement therapy, one off set up cost, training and estate costs e.g. activities to replace smoking.

Net savings: PHE estimates net savings of £1,460 p.a. per person to the health and care system, on average over 10 years. The average net saving per person to the NHS is £1,890 p.a. over 10 years, although this comes at a net cost to LAs of £430.

– Can be commissioned by CCGs and Las
– Can be delivered by staff in mental health trusts and local stop smoking services
Mental Health (continued)

Progress indicators
Local tobacco control profiles
Smoke free status of mental health trusts

References and further information
NICE PH48 Smoking: acute, maternity and mental health services guidelines
A range of tools and guidance for providers, and commissioners of mental health services (PHE)
Mental health promotion and prevention: the economic case (LSE)
Statistics on smoking in England 2015 (HSCIC)
The stolen years MH smoking and action report (ASH)

3: Take action to become a suicide safer area – CCGs take active role in developing multi-agency suicide prevention plans, including primary care action, alcohol misuse and support to high risk groups.

4: Provide early intervention in psychosis services – CCG encourage and trusts ensure people experiencing a first episode of psychosis have access to a NICE approved intervention within 2 weeks of referral.

5: Train accident and emergency and other frontline staff in Mental Health First Aid – CCGs commission training for accident and emergency staff, school nurses, maternity, health visitors GPs and walk in Centre.
Healthy Ageing, Dementia and Frailty

Evidence
The number of people over 85 in the UK is predicted to more than double in the next 22 years, from 1.5m to 3.4m. Older people are significant users of hospital beds, with <40s using <1m beds p.a. whilst >85s use >7m (NHS England data, 2015). Promoting active and healthy ageing is essential to compress morbidity as much as possible.

There are 850,000 people living with dementia in the UK, costing on average £5,300 to healthcare and £12,500 in social care costs p.a. It is estimated that the annual cost of dementia to society in the UK is £26.3 billion.

The overall prevalence of frailty detected in hospital has been rising in England; 150K frailty spells identified in January 2013 vs. 65K in 2005.

Root causes

NICE (NG16 guidance) highlights the need to address the following in midlife to reduce the risk of dementia, frailty and disability: give up smoking; be more active; reduce alcohol consumption; eat a healthy diet; and maintain a healthy weight. Across the entire life course, educational attainment and social connectedness are protective factors. The above also impact on healthy aging.

Frailty is caused by the accumulation of health deficits, which accrue with age, and is a predominant risk factor for mobility loss, falls, dependence, institutionalisation and death after exposure to minor illness stressors.

Public health ambitions

• Reduce the risks of dementia, or associated with ageing and frailty to:
• Support people to live longer, healthier lives
• Save the health and social care system money by reducing the prevalence and impact of dementia and co-morbidities across the population
• Reframe ageing positively to promote the prevention of unhealthy ageing
Healthy Ageing, Dementia and Frailty (continued)

Selected interventions
Raise awareness of actions the public can take to reduce their risk of dementia – using midlife healthy lifestyle messages to tackle local dementia risk factor prevalence. Aims to reduce the population risk of dementia.

Seeks to achieve this by:

a) identifying local dementia risk factor profiles via the Dementia Intelligence Network and Dementia Profile, and commissioning appropriately;

b) investing in awareness raising campaigns to target prevalent local risk factors, such as reducing higher blood pressure and promoting smoking cessation in midlife, and promoting physical activity in later life; the simple message “what is good for your heart is good for your head” is valuable and can be supplemented with infographics and resources from Health Matters: midlife approaches to reduce dementia risk; and

c) fully utilising national campaigns and resources such as:

- Support increased uptake of NHS Health Check and the One You Campaign in local areas.
- Ensuring staff undertaking NHS Health Checks undertake the dementia training component, which will be refreshed later this year.
- Ensuring the reducing your risk of dementia booklet is promoted.

Evidence
Evidence suggests that an unhealthy lifestyle can increase the risk of dementia. For example, smoking can double the risk of dementia. Raising awareness of this risk could encourage the implementation of interventions such as smoking cessation interventions and ultimately reduce dementia risk.

Smoking cessation interventions can be 15-20% effective in stopping smoking – see tobacco slides for more detail.

The annual cost of dementia to society in the UK is estimated to be £26.3bn, a 20% reduction in risk factors per decade could reduce UK prevalence by 16.2% (300,000 cases) by 2050.
This would constitute annual savings to society of £4.26bn vs. current prevalence.

- Can be commissioned by CCGs and LAs based on understanding of population risk and dementia prevalence via the dementia profile
- Can be delivered by providers including primary and secondary care, pharmacies and leisure centres

Progress indicators
Cumulative percentage of the eligible population aged 40-74 offered and received an NHS Health Check
Reduction in smoking prevalence rates
Increase in physical activity levels in local population

References and further information
NICE guidance: Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset
Prime Ministers Challenge on Dementia 2020: Implementation plan
Explore NHS Health Check data
NHS Health Check Programme Introducing the Dementia Component Increasing Awareness & Signposting: E-learning resource
The NHS Health Check in England: an evaluation of the first 4 years

2: CCGs and LAs to invest in evidence driven integrated frailty pathways – the Electronic Frailty Index (eGFI) can identify older people with mild, moderate and severe frailty with robust predictive validity allowing for appropriate intervention to prevent progression, e.g. addressing risk factors for mild frailty. The Healthy Ageing Guide, and the Healthy Caring Guide give further examples of appropriate intervention.

3: CCGs and LAs develop an occupational health response to dementia risk – including working with Alzheimer’s Society to drive uptake of Dementia Friends, the Dementia Friendly Employer’s Toolkit and addressing social isolation.

4: LAs adapt the homes of those experiencing frailty who cannot afford to do so themselves – targeted home adaptation support reduces demand for health and social care by enabling older people to live independently. The Care Act 2014 provides the statutory guidance and the Better Care Fund the framework for local areas to integrate home adaptations into their health and wellbeing commissioning.
Maternity and early years

Evidence
What happens during gestation and in early childhood impacts on **health and wellbeing** and life chances throughout the life course. Babies who have very low weight at birth have a **22 percent** chance of dying within their first year.

The national rate of smoking at time of delivery is 10.6%, but this varies from 2.1% in Westminster to 26.2% in Blackpool. The total annual cost of smoking in pregnancy for infant outcomes is estimated to be **between £12 million – £23.5 million**.

**c26,000** 5-9 year olds were admitted to hospital for the surgical removal of teeth due to tooth decay during 2013-14, costing £15m to the NHS.

Root causes
Low birth weight is caused by exposure to tobacco smoke in the womb; and maternal or fetal stress, infections, and violence toward the pregnant woman. Tooth decay is caused by consumption of sugar in children, and lack of tooth brushing in children.

Public health ambitions
To have healthier babies and increase the proportion of children ready to learn at 2 and ready for school at 5, by:

- Reducing the number of babies with low birth weight at term
- Improving the oral health of children and reduce the oral health gap for disadvantaged children
- Increasing the proportion of parents taking up the offer of early years placement for disadvantaged <2yrs and support for working parents
Selected interventions.

1: Maternity staff to assess all pregnant women for carbon monoxide at antenatal appointment – ensure those with elevated levels are referred for specialist support. Aims to reduce the number of pregnant women who smoke.

- Based on the North East babyClear programme, where 28% of women were smoking at the start of pregnancy, estimates suggest programme would lead to 96 additional quitters per Trust.
- Seeks to achieve this by screening all pregnant women for carbon monoxide (CO) at booking appointment and all other antenatal appointments in maternity services.
- Those having elevated CO levels are referred via an opt-out system to specialist stop smoking support cessation services. Local stop smoking services will require sufficient resourcing to respond to referrals and provide behavioural support and medication.
- The North East has reduced rates of smoking at time of delivery from 21.1% in 2011, to 16.7% in 2015. This has been achieved through partnership working, embedding system-wide implementation of NICE guidance, ensuring CO screening and referral pathways are in place, working closely with both pregnant women and healthcare professionals.

Evidence

Evidence shows that it is possible to double the number of pregnant women who stop smoking during pregnancy once CO screening and an opt-out referral system is put in place.

Based on an unpublished evaluation of the North East babyClear programme (including CO screening, training HCPs, providing materials and stop smoking support), estimates suggest that overall health system cost is c£31 per pregnancy.

The majority of the costs are attributable to the increased referrals to smoking cessation services. This is calculated using an average Trust size of 3,000 deliveries per year.
Maternity and early years continued

Referral rates doubled and birthweight of babies born to mothers who stopped smoking was higher than those who continued.

– Can be commissioned by CCGs, or jointly with Las
– Can be delivered by maternity services within acute trusts

Progress indicators

Smoking status at time of delivery
Low birth weight of term babies
Neonatal mortality and stillbirths

References and further information

Smoking Cessation: a briefing for midwifery staff
Smoking in Pregnancy Challenge Group
NICE PH26 – Smoking: stopping in pregnancy and after childbirth
NICE PH48 Guidance – Smoking: acute, maternity and mental health services
Passive Smoking and Children (RCP)

Implement evidence-based oral health improvement programmes – for example, supervised tooth brushing for children where nursery and/or schools carry out supervised tooth brushing programmes with children. Aims to improve the oral health of children and reduce the oral health gap for disadvantaged children.
Maternity and early years continued

Seeks to achieve this by implementing evidence based programmes that improve the tooth decay outcomes at age 5 years and include:

- targeted supervised tooth brushing in nurseries and schools
- targeted community based fluoride varnish programmes
- targeted provision of toothbrushes and paste
- community water fluoridation schemes

Supervised tooth brushing programmes focus on children in nursery, reception and year 1 classes aged between 3 – 5. Children are closely supervised and educated by staff when brushing their teeth.

Evidence

*PHE is currently developing an ROI tool which will allow local authorities to calculate the costs and savings of the above interventions.

Effectiveness of supervised tooth brushing programmes in nurseries are considered to be effective.

Cost to commissioner per intervention (based on 500 children) is £2-£2.40 p.a. per child. This provides two packs for each child per year containing a brush and toothpaste. Costs for training school staff are estimated to be £15 per delegate for a 3.5hr session.

A Childsmile analysis of a nursery tooth brushing programme in NHS Scotland concluded dental costs of 5 year olds decreased over time.
Maternity and early years continued

The programme cost was £1.7m per year and the estimated annual savings increased from £1.2m in 2003/04 up to £4.7m in 2009/10. N.B. savings from this programme are not directly comparable to England.

– Can be commissioned by LAs and/or NHS England.
– Can be delivered by nurseries, children’s centres, schools (including special schools)

Progress indicators

Tooth decay in children aged 5
Children with one or more decayed, missing or filled teeth
Tooth extractions in secondary care for children under 10 (NHS Outcomes Framework)

References and further information

NICE PH55: Oral health: local authorities and partners
Local authorities improving oral health: commissioning better oral health for children and young people (PHE)
Delivering better oral health: An evidence based toolkit for prevention PHE third edition
Improving oral health: community water fluoridation toolkit (PHE)

3: Sign-post patients to early years services available – healthcare professionals to sign-post and encourage take up of free early years support by eligible, disadvantaged families who are entitled (nursery, education, and/or childcare).

4: Join up of children services – health visitors to ensure all children have access to a universal offer of assessment, early identification and early intervention by working closely with early years practitioners, voluntary organisations, family nurse partnerships, GPs and primary and secondary care providers.

5: Provide perinatal mental health services – CCGs to commission effective specialist community perinatal services for women with severe or complex conditions – see mental health.
Workplace Health

Evidence
The economic cost of working age ill health is £100bn a year to the national economy, with 131m working days lost. Some of this is preventable. Health-related staff absence is higher in the NHS than other sectors, costing £2.4bn a year.

Almost 30% of employees already have a long-term health condition. By 2030, 40% of workers will have at least one long-term condition, increasing the burden on the economy. On average, people with long-term conditions are less likely to be employed. The gap in the employment rate between those with a long-term health condition and the overall employment rate is 8.6% in England.

Employment is a primary determinant of health. Socio-economic factors – of which employment is greatest – are responsible for 50% of an individual’s health status. Unemployment is associated with an increased risk of mortality and morbidity, including cardiovascular disease, poor mental health, suicide and health-damaging behaviours.

Root causes
Inflexible and unsupportive workplaces; over 33% of Employment Support Allowance claimants with a musculoskeletal condition attribute it to work.

Historic disability gap; the employment rate of people with long-term conditions in 2012 was 59.6% and 46.1% among people classified as ‘disabled’, compared to a 73.5% population average.

Public health ambitions
Reduce work-related ill health and health-related work illnesses, and their resulting economic costs by:
1. Creating healthier and more productive workplaces, including a focus on the NHS, LAs and SMEs where there is the greatest potential for improvement
2. Increasing collaboration between the NHS and wider public and employer systems to maximise health and work initiatives
Workplace health (continued)

Selected interventions

1: Implement a holistic approach to workplace health and wellbeing – employers adopt the Workplace Wellbeing Charter to put in place a structured, evidence-based approach to employee health and wellbeing. Aims to improve employee wellbeing and reduce avoidable sickness absence cost effectively, thereby increasing lifetime productivity, with a focus on the NHS, LAs and SMEs where there is the greatest potential for improvement.

Seeks to achieve this through the Workplace Wellbeing Charter (WWC) by providing employers with a structured approach to workplace health and wellbeing. As part of the WWC, organisations implement workplace policies to

a) manage absence
b) ensure health & safety of staff
c) identify and support those with mental health issues
d) reduce harm from smoking
e) encourage physical activity coming to or at work
f) educate about and provide access to healthy food and g) identify and support those with substance misuse issues. WWC also links to risk reduction services (e.g. NHS Health Checks) and other resources (e.g. One You) campaign.

Coventry-based manufacturing company Edgetech introduced stress management training and return-to-work processes as part of their WWC accreditation and observed a decrease of staff turnover from 8% (pre-WWC) to under 5% and a year on year decrease of absence rates of between 1% and 3% over the last 3 years.
Workplace health (continued)

Evidence

Effectiveness: NICE estimated the effectiveness of workplace mental wellbeing programmes, recommended as part of the WWC, to be between 0.02 and 0.04 Quality-Adjusted Life Years (QALY) gains per worker per intervention. This translates into 2 additional depression-free days (DFD) over a 35 day observation period (bringing it to 33 DFD), compared to those who didn’t receive support.

Costs: NICE estimates the total cost to companies of implementing staff stress management programmes to be between c£140 and c£370 per participant per intervention.

Net savings: NICE estimates that the net-benefit to employers of implementing interventions to promote the mental wellbeing of employees ranges from £130 to £5,020 per participating employee through reductions in absenteeism and presentism.

Other WWC interventions such as promoting physical activity or diet improvements are also considered cost effective by NICE.

– Can be commissioned by CCGs, other NHS organisations and Las.
– Can be delivered by LAs in collaboration with public and private sector organisations, supported by Job Centre Plus (Fit for Work); providers can deliver workplace wellbeing for NHS staff

Progress indicators

Local implementation and uptake of the Workplace Wellbeing Charter and staff wellbeing surveys.
Rates of sickness absence, regionally and through the Health and Social Care Information Centre for the NHS Associated CQUIN by NHS acute trusts.

Public Health Outcomes Framework 1.08 (% employment disability gaps).
Workplace health (continued)

References and further information
Bryson et al., Does Workplace Wellbeing Affect Workplace Performance, NIESR, 2014
Chapman, Meta-Evaluation of Workplace Health
PHE Evidence reviews: Productivity, Physical Environments – Impact on workplace health
NICE Public Health guidance 22 ‘Mental Wellbeing at work’
Workplace Wellbeing Charter

2: Increase collaboration in delivery of health-related employment support – CCGs commission NHS providers work with Job Centre Plus to co-locate employment advice services and individual placement support.

3: Integrate multi-disciplinary occupational health and vocational occupational therapy advice into care pathways – CCGs encourage collaboration between primary care, secondary care and patients to ensure work becomes a positive and achievable clinical outcome for those with chronic disease and in recovery from acute health events.

4: Create health and care premises that actively promote healthy choices and behaviours – CCGs and LAs require all providers to implement food standards (e.g. Government Food Buying Standards) – see diet and obesity slides for further detail.

5: Support recruitment and retention of staff with/who develop health issues or disabilities – NHS and LA employers encourage this by role-modelling practices and through the use of Government grant schemes (e.g. Access to Work).
Individual placement and support

Aims to reduce unemployment amongst individuals with common and severe mental problems through greater integration of clinical and employment support services in primary and secondary care settings. Seeks to achieve this through co-locating dedicated employment advisors (EA) in local mental health services to provide tailored employment support for service users in line with the 8 principles of Individual placement and support (IPS). This includes raising awareness amongst clinical staff about availability of and referral pathways to employment advice services. EA will work with referred service users to

a) identify the required level of support; and depending on need;
b) develop job-search action plan and application support;
c) provide 1:1 coaching sessions;
d) sign-posting to benefits; and
e) support with interview preparation.

A pilot in Sussex saw implementation of full IPS across 17 sites, focussed on improving employment outcomes for services users with severe mental illnesses. After 12-months support, 24.9% of IPS participants had taken up competitive employment compared to 14.3% of individuals before IPS was implemented.

Evidence

Effectiveness: IPS participants are twice as likely to gain employment compared with traditional vocational rehabilitation alternatives (55% v. 28%). In addressing employment issues of people with common mental health issues, RAND estimates that 1 EA leads to 35 additional IAPT users finding work per year.

Costs: The cost of IPS are viewed as being similar to traditional vocational services in mental health settings. RAND estimates that attaching one EA to an IAPT service costs c£75k p.a. (£40,000 for salary, pension and benefits costs; £35,000 for indirect costs such as overheads).
Workplace health (continued)

**Net savings:** RAND estimates that the net savings from employing one EA are £44,000 p.a. (ROI of 1.59). Savings accrue to the Exchequer from moving individuals from Job Seekers Allowance and Statutory Sick Pay to employment (£3,900 & £1,225 per person per year respectively); and to the NHS from fewer GP visits and limited use of secondary care (£300 per person per year).

- Can be commissioned by CCGs, LAs and NHS England
- Can be delivered by secondary care (especially Mental Health) providers in partnership with Job Centre Plus

**Progress indicators**

Public Health Outcomes Framework (PHOF) 1.08i (% employment gap for those with long-term health conditions).

PHOF 1.08ii % employment gap for those with learning disabilities.

PHOF 1.08iii % employment gap for secondary mental health service users.

Local ESA Off-Flows across DWP Districts.

**References and further information**

Delivering Brief Health Interventions through Job Centre Plus Social Justice Coaches, 2016

Centre for Mental Health, Individual Placement and Support (IPS), 2016


PHE, Public Health Outcomes Framework, 2015

Steadman et al., Investing in a workforce fit for the future, The Work Foundation, 2015