Health and Wellbeing Board

Item 10c)

Report title:	**Winter in Norfolk and Waveney- The Top 5 for Prevention: an update from the Prevention workstream of Norfolk and Waveney STP**
Date of meeting:	**31st October 2018**
Sponsor (H&WB member):	**Dr SJ Louise Smith, Director of Public Health, STP Prevention Workstream Senior Responsible Officer**

Reason for the Report

This report sets out the top 5 priorities of the Sustainability & Transformation Partnership (STP) Prevention workstream which are focussing on system delivery outcomes to help the system be sustainable this winter. It seeks commitment from HWB members to support and contribute to these priorities.

Report summary

Analysis of the STP Prevention workstream work programme suggested that there would be more benefit to having fewer, more specific priorities that were more closely linked to system delivery outcomes that will help the system be sustainable. This led to the development of the 'Top 5 Prevention priorities', a plan with achievable actions addressing areas which could make the biggest difference across the system this winter.

The approach has been to work with local leads of existing groups to agree a small number of high impact but achievable actions to be delivered within a short timescale.

The top 5 prevention priorities include a focus on infection control (flu and norovirus) and prevention work around respiratory and cardiovascular conditions, which are the highest preventable causes for admissions during the winter. There are also specific priorities for working with District Councils and voluntary, community and social enterprise (VCSE) organisations around Homes and Health and Social Prescribing.

Work continues with partners to develop project plans for each of the priorities and impact will be monitored via a data dashboard.

This work fits with the strategic priorities of the Joint Health and Wellbeing Strategy: Prioritising prevention, Tackling Inequalities in Communities and Integrated Ways of working.

Recommendation

The HWB is asked to:

- **Support the 'Top 5 for prevention' priorities developed by the STP Prevention workstream**

1. Background

1.1 The STP Prevention workstream was established in early 2018 and originally covered thirteen different projects areas. Analysis suggested that there would be more benefit to having fewer, more specific priorities that were more closely linked to system delivery outcomes that will help the system be sustainable. This led to the development of the 'Top 5 Prevention priorities' which have been discussed and refined through consultation with stakeholders.

1.2 The Senior Responsible Officer (SRO) for the Prevention workstream is the Director of Public Health. Following the recent STP governance changes the Prevention workstream now reports to the Primary and Community Care Programme Board. Diabetes and Cancer prevention workstreams now also report to their own separate groups.

2. Winter in Norfolk and Waveney: The Top 5 for prevention

2.1 The top 5 prevention priorities include a focus on infection control (flu and norovirus) and prevention work around respiratory and cardiovascular conditions, which are the highest preventable causes for admissions during the winter. There are also specific priorities for working with District Councils and VCSE organisations around Homes and Health and Social Prescribing.

2.2 The approach has been to work with local leads of existing groups to agree a small number of high impact but achievable actions to be delivered within a short timescale. A summary of the agreed actions is detailed below. Further detail, the rationale and the potential impact are included in **Appendix A**.

- **1. Infection Prevention and Control** – A STP wide infection control winter resilience group is overseeing a co-ordinated approach to influenza planning and infection control. This work includes:
    - Establishing care home influenza outbreak response teams across all CCGs
    - An influenza vaccination campaign for 'at risk' groups and supporting areas with low uptake
    - Ensuring NHS Trusts and Care organisations meet staff vaccination targets
    - Communication campaigns to prevent the spread of gastrointestinal and flu-like illness

- **2. Respiratory conditions** – This builds on the work being led by the STP wide Right Care Respiratory group and Public Health campaigns. The actions include:
    - Promoting Stop Smoking through local Stoptober campaigns and promoting e-cigarettes as a safer alternative to smoking tobacco.
    - Promoting SOS packs for COPD patients – (packs containing emergency medication) as part of medication reviews and empowering patients to use them
    - Introducing easier access to Stop Smoking specialist advice for clinics in Acute Hospitals (including opt-out rather than opt-in referrals in Respiratory clinics)

- **3. Cardiovascular conditions** – This builds on the work being led by the STP Right Care Cardiovascular Disease prevention group. The actions include:
    - Improving the diagnosis and treatment of Atrial Fibrillation in flu clinics to reduce the risk of stroke (which increases in the cold weather).

- Re-running the successful “Get Checked” campaign to help identify and treat people living with undiagnosed high blood pressure (and subsequently reduce their risk of heart attacks and strokes).
- Support people with Heart Failure – including looking at the possibility of SOS packs for Heart Failure (as already established for COPD), and implementing a workforce development project to improve tissue viability in people living with heart failure.

- **4. Homes and Health** – builds on the work being led by the District Council’s Group (a separate paper on this topic with more detail is included on the agenda today) and Adult Social care. The actions include:
  - Warm and Healthy Homes – promoting winter wellness, installing Central heating systems and offering energy and money saving advice
  - Integration with MDTs – district council officers attending MDT meetings in GP practices so that housing and home safety support are an integral part of supporting people with frailty.
  - Supporting discharge from hospital – supporting people being discharged from hospital to return home or access suitable accommodation prior to discharge and reduce readmissions – by maximising the learning from existing projects and pilots and expanding to other settings such as mental health and community hospitals.

- **5. Social Prescribing** – working with District Councils and VCSE organisations to drive forward the implementation of the five social prescribing schemes that are now established across Norfolk (and seek assurance on progress on neighbouring Suffolk County Council scheme in Waveney). The actions include:
  - A communications strategy to ensure all stakeholders are aware of social prescribing and how to refer into the schemes
  - Create links with Social Prescribing and the Social Isolation/loneliness delivery in each locality
  - Evaluate the impact using common evaluation framework

3.0 Next steps

3.1 Work continues with partners to develop a more detailed project plan for each of the priorities and impact will be monitored via a data dashboard.

Officer Contact

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FOR DISCUSSION

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Winter in Norfolk and Waveney:

The Top 5 for Prevention

1. Infection Prevention and Control

AIM: To reduce staff sickness absence, increase bed capacity and improve care home availability.

Respiratory and gastrointestinal viruses put additional pressure on NHS services over the winter. These illnesses impact on bed capacity by increasing demand at the same time as leading to ward and care home closures. They also contribute to increased staff sickness.

In Norfolk there were 33 respiratory outbreaks in care homes between September 2017 and April 2018. This compares to only 12 in the same period the previous year. The number of gastrointestinal outbreaks was less variable: 68 in 2016/17 compared to 72 in 2017/18. Norfolk reported 13% of all respiratory outbreaks in the East of England between September 2017 and April 2018, and 23% of all gastrointestinal outbreaks.

Staff uptake of influenza immunisation in 2017/18 met the national target of 70% across 5 out of 7 trusts in Norfolk and Waveney. The target for the next influenza season has increased to 75%, which means 3 trusts need to increase uptake next year.

Influenza vaccination uptake meets national targets in school-aged children, but not in the over-65s, under-65s at risk, pregnant women or preschool children. Uptake needs to be increased by 7 percentage points to meet the target for under-65s at risk and pregnant women.

ACTIONS

- Ensure a coordinated approach to influenza planning is in place.
- Establish care home influenza outbreak response teams across all CCGs.
- Run an influenza vaccination campaign aimed at the general population and targeted at general practices with low uptake.
- Ensure NHS trusts and care organisations meet staff influenza vaccination targets.
- Run communications campaigns aimed at the general public, care homes and schools to prevent spread of gastrointestinal and flu-like illness.

AMBITIONS:

- Meet national targets for influenza vaccination coverage.
- Meet 75% target for the vaccination of health care staff in all NHS trusts.
- Prevent and control outbreaks of flu-like illness and gastroenteritis in care homes, schools and hospitals.

IMPACT:

- Vaccine coverage of 48% in full-time care home staff can prevent 5 deaths, 2 hospital admissions, 7 GP consultations and 9 cases of flu-like illness per 100 residents during periods of moderate flu activity.
- Vaccination of 75% of the risk population could avert 9402 cases of flu in Norfolk. This could mean 148 fewer deaths and save £707,427 in healthcare costs.

Lead: Anna Morgan, STP Lead Nurse, Director of Nursing and Quality, NCHC

2. Respiratory conditions

AIM: To reduce ambulance calls, A&E attendances and emergency admissions due to respiratory conditions.

The incidence of respiratory illness increases as the outdoor temperature drops, leading to a high impact on health and care services in the winter. In 2014/15, pneumonia was the leading cause of emergency admissions to hospital. Smokers are more likely than non-smokers to develop respiratory conditions. They are also more likely to becomes seriously unwell and require hospital admission.

ACTIONS

- Promote e-cigarettes as a safer alternative to smoking tobacco, through a Stoptober publicity campaign supported by all STP organisations.
- Promote SOS packs for COPD patients.
- Introduce specialist stop smoking provision into respiratory clinics in all acute trusts.

AMBITIONS:

- No smoking on the premises of any STP organisation.
- Nicotine replacement products made available on NHS sites.
- NHS organisations recognise e-cigarettes as being safer than smoking tobacco.
- Opt out referral system to stop smoking services in place in respiratory and antenatal clinics.
- COPD care pathway in place.

IMPACT:

- For every 100 hospital inpatients offered smoking cessation advice and pharmacotherapy, 6 would avoid readmission at 30 days compared to those receiving only written advice. 12 would avoid readmission over a year. 5 people would avoid an emergency department attendance at 30 days and 6 deaths would be avoided over a year.

LEAD: Rosa Juarez, Lead for Right Care Respiratory, Head of Planning, Norwich CCG

3. Cardiovascular conditions

AIM: Improve early detection and treatment of hypertension, atrial fibrillation and heart failure, to prevent stroke, exacerbations of heart failure, myocardial infarction and death.

The incidence of stroke and myocardial infarction increases when the outdoor temperature drops below 8 degrees Celsius, leading to an increased impact of these conditions on services in the winter. Cold weather also leads to an increase in admissions to hospital for congestive heart failure.

Hypertension is one of the biggest risk factors for premature death and disability in England. For every 10mmHG increase in blood pressure, an individual has a 33% increased risk of stroke. The risk of suffering a stroke is increased by nearly 500% for patients with atrial fibrillation (AF). Identifying those at risk and intervening is one of the most effective ways GPs can reduce the widening gaps in life expectancy and health outcomes.

Myocardial infarctions and strokes can be prevented by identifying and treating people with undiagnosed hypertension and AF. Nearly a third of the Norfolk adult population has hypertension, with nearly half of them being undiagnosed. Exacerbations of heart failure can also be prevented by aggressive management of risk factors.

ACTIONS

- Diagnose atrial fibrillation at flu clinics using AF monitors.
- Re-run a local "Get Checked" campaign to detect hypertension.
- Complete a mapping exercise for heart failure services.
- Review the evidence for heart failure SOS packs.
- Implement a workforce development project to improve tissue viability and heart failure management skills.

AMBITIONS:

- Diagnose and treat hypertension, atrial fibrillation and heart failure early.

IMPACT:

- In Norfolk and Waveney undiagnosed AF is estimated at 10,600 people. Treating an extra 2,300 AF patients could prevent 390 strokes and 185 deaths over 5 years.
- Treating an additional 24,321 people with undiagnosed hypertension could prevent 195 deaths, 363 strokes and 243 heart attacks over 5 years.
- Controlling hypertension in an additional 3,543 patients who are already diagnosed could prevent 28 deaths, 53 strokes and 35 heart attacks over 5 years.

LEAD: Mark Lim, Lead for Right Care CVD, Programme Director – Clinical Commissioning, Great Yarmouth and Waveney CCG

4. Homes and health

AIM: Increase bed capacity, through timely discharge and prevention of emergency admissions caused by housing problems.

In 2013, 21% of houses in England did not meet the standards recommended for decent housing. There is a contrast between owner-occupied and rented accommodation, with private rented accommodation being less likely to meet standards than owner-occupied and housing association houses. Housing is a key determinant of good health and in total, inadequate housing costs the NHS £1.4 billion per year. Houses that are cold, damp or hazardous increase the risk of respiratory disease, cardiovascular disease and falls. This means people in inadequate housing are more likely to become unwell and to use healthcare services. In addition, problems with housing are a key reason for delayed discharge from hospital.

In Norfolk, 11% of households live in fuel poverty. This means that due to low income, high fuel costs and poor insulation, they cannot afford to heat their houses adequately. The proportion of households in fuel poverty is higher in Norfolk than the East of England and England averages. 9000 houses in Norfolk do not have any central heating, with Great Yarmouth having a particularly high proportion of houses without central heating. It is estimated that 10% of excess winter deaths are attributable to fuel poverty.

ACTIONS

- Develop multi-disciplinary teams (MDTs) involving district council housing officers and other community organisations to prevent hospital admissions.
- Implement the 'district direct' and other related schemes in all trusts, including mental health, community and acute trusts: district council housing officers working in hospital MDTs to facilitate discharge from hospital.
- Use the Warm Homes Fund to install central heating systems and offer benefits and advice for those in fuel poverty across all districts.
- The 'Warm and Well' campaign, delivered by Community Action Norfolk. Proactive energy switching campaigns.

AMBITIONS:

- Reduce delayed transfer of care.
- Prevent emergency admissions to hospital.
- Prevent the acute events that lead to crisis admissions.
- Reduce excess winter deaths.

IMPACT:

- Implementing the 'district direct' scheme for a full year could save 1653 bed days and £330,690.
- Residents aged over 60 who receive housing improvements could see a 39% reduction in emergency admissions for cardiorespiratory conditions and injuries compared to those receiving no improvements.

LEAD: Matthew Cross, Deputy Chief Executive, Broadland District Council

5. Social prescribing

AIM: Reduce demand for primary care; prevent unnecessary hospital admissions and A&E attendances.

Social prescribing is listed as one of the ten high impact actions in the General Practice Forward View. A considerable amount of primary care time is spent on the consequences of social problems or medical problems exacerbated by social problems. An estimated 20% of GP appointments are not related to any clinical condition.

Social prescribing involves linking people with social, emotional or practical needs to a range of non-clinical services to improve their health and wellbeing and to reduce avoidable appointments.

ACTIONS

- Implement social prescribing in each locality to meet the needs of the community.
- Evaluate the impact of social prescribing using an agreed framework.
- Develop a communications strategy to ensure primary care staff are aware of social prescribing and how to refer patients to it.
- Create and develop links between Social Prescribing and Social Isolation and loneliness delivery in each locality.

AMBITIONS:

- Ensure all general practices, libraries and adult social care have access to social prescribing.
- Achieve approximately 5000 social prescribing referrals per year across Norfolk and Waveney.

IMPACT:

- Modelling suggests that among patients referred to social prescribing we could achieve:
  - A 13% reduction in the average number of GP appointments.
  - A 20% decrease in the number of hospital admissions 12 months following referral.
  - A 20% reduction in accident and emergency attendances.
  - A 20% reduction in the number of outpatient appointments.
  - A reduction in prescribing of antidepressants.

LEAD: Rob Cooper, Head of Integrated Commissioning, Norfolk County Council / South Norfolk CCG