number 1

Health Improvement Action in Hospital Settings:
Context for Delivery

hphs
health promoting health service

CEL (1) 2012 Annual Report Summary Briefings – Year 1

This paper is part of a series of briefing papers summarising national health improvement action within the hospital and community hospital setting, reported to Scottish Government as part of the formal governance requirements for delivery of CEL (1) 2012. Information within these reports has been extracted from Year 1 Annual Reports submitted on 30 April 2013 and, therefore, reflects reported health improvement action from January 2012–April 2013.

NHS Boards received individual feedback on their annual report submissions and these can be read alongside the briefings series in order to support local-level discussion.

Briefing papers within this series include: 1 Context for Delivery (Core Actions 1–5); **2** Tobacco; **3** Alcohol (covering selected performance measures not reported through the ADP Governance Framework); **4** Breastfeeding; **5** Healthy Working Lives; **6** Sexual Health; **7** Physical Activity; and **8** Active Travel.

NHS Boards received feedback on Action 18.4 Food and Health within their individual feedback.

To view the entire briefing series, and for all other secondary care health improvement support, please visit our NES Knowledge Network Portal at:
www.knowledge.scot.nhs.uk/home/portals-and-topics/health-improvement/hphs.aspx

Core Actions 1–5

1. Chief Executives are asked to delegate responsibility for implementation to the appropriate committee and governance structures and to provide a report to the Board on progress, at least annually, in each of the next three years.
2. The attainment of generic health improvement competences should be supported through provision of an appropriate professional development programme.
3. Local expertise on improvement methodology should be made available to jointly support all hospital and public health staff to test, adopt and spread good practice.
4. Patient Focus and Patient Involvement (PFPI) and patient experience leads should enable patient, carer and volunteer participation in developing and implementing the action plan.
5. Medical Directors and Directors of Public Health should jointly support and encourage all hospital Clinical Directors to take account of involvement in health improvement actions through the annual appraisal cycle for hospital consultants.

Background

Context for delivery

In support of CEL (1) 2012 aspirations to sharpen local leadership and accountability of the HPHS agenda, five core actions were required from all NHS Boards in order to support infrastructure creation and development. These actions were complimented by 'Appendix A: Implementation Guidance' disseminated in December 2012, accompanied by the final Monitoring and Evaluation Framework. This guidance explicitly stated that the requirements of CEL (1) 2012: Action in hospital settings encompassed all hospital settings; which included acute, community, paediatric and mental health hospitals.

The core actions within CEL (1) 2012 set out to create appropriate conditions for operational and strategic engagement in this agenda, and ensure efforts for continuous improvement were in place. Therefore, guidance for effective implementation of CEL (1) 2012 highlighted the importance of: joint-working and collaboration across the hospital setting; the role of health improvement action to advance equality and tackle health inequalities; and the importance of embedding mental health improvement throughout the hospital setting.

Joint-working and collaboration

In order to nurture the culture change required to embed health improvement within patients, visitors and staff experiences of Scottish hospitals, NHS Boards were encouraged to ensure engagement in this agenda far beyond public health and clinical teams alone. Local level strategic/governance groups were advised to include representation from relevant topic leads/ service managers, organisational development, communications teams and appropriate support services in order to facilitate operational and strategic progress.

Advancing equality and reducing health inequalities

NHS Boards were provided with guidance to support implementation of CEL (1) 2012 that promotes equality and reduces inequality. Although there is proportionately greater use of hospital services by patients from deprived communities, to successfully provide equity of access to health improvement interventions hospitals may be required to offer targeted support at varying levels. This will be specific to the clinical setting and patient demographics within each local area. NHS Boards were strongly recommended to conduct inequalities impact assessments to better understand needs and effective interventions across the local population to avoid widening inequalities.

To support this action, NHS Boards were directed to contact their local equality lead, and signposted to the NHS Health Scotland Equality Team: **www.healthscotland.com/ Equalities/index.aspx** and their Health Inequalities Impact Assessment approach: **www.healthscotland.com/equalities/eqia/health-inequalities.aspx**

Mental health improvement action

The importance of promoting staff and patient mental health and wellbeing within all hospital settings has been highlighted by key stakeholders throughout the consultation process, and CEL (1) 2012 Implementation Guidance reflected this.

NHS Boards were advised of the alignment between CEL (1) 2012 and the *Mental Health Strategy for Scotland: 2012–2015* in achieving the Quality Ambitions. Through providing hospital-based care with respect for an individual's needs and values (demonstrating compassion, continuity, clear communication and shared decision-making) mental wellbeing can be supported and improved. Specific detail was also provided on the increased risk of poor mental health for those with long-term conditions and older people. It was additionally highlighted that those who experience severe and enduring mental health problems have poorer physical health outcomes and often do not have equal access to health improvement interventions.

Specific work programmes supporting this agenda include Choose Life, Scottish Recovery Indicator-2, Steps for Stress, dementia-friendly environments and mentally healthy workplace training for staff and managers. NHS Boards were directed to **www.wellscotland.info** for all mental health improvement professional support.

Core actions

During the governance framework consultation process, Core Actions 2 and 5 were the subject of significant discussion. Responses on Core Action 2 led to a revision of the action to focus on up-skilling staff through appropriate provision of health improvement professional development programmes. The ongoing challenge on acute staff to undertake professional development courses beyond statutory and mandatory training is recognised by Scottish Government. However, supporting staff to gain skills in generic health behaviour change through existing development opportunities is encouraged and should be enabled with the support of clinical and professional leads.

Following consultation on Core Action 5, it was evident that there was a lack of shared understanding of 'health improvement action' from medical consultants. Implementation guidance advised that actions should focus on interfaces with patients as means of evidencing delivery. Examples of this were suggested as descriptions of 'how status of smoking, alcohol and/or physical activity levels are routinely recorded; how patients receive appropriate health improvement education/information; and/or what processes are in place for onward referral and/or signposting to further support mechanisms'.

Summary of data provision

Core actions data

No NHS Boards are exempt from the core actions. Annual report submission were received from all 14 delivery NHS Board areas and the Golden Jubilee Hospital Trust, therefore, unless specified n=15.

All NHS Boards submitted some evidence of delivery for elements of the core action requirements, and the majority did submit evidence against all five actions. Where NHS Boards have not submitted evidence against specific actions, details are provided below.

Innovative and emerging practice

NHS Boards were required to submit examples of innovative and emerging practice as evidence of CEL (01) 2012 performance measures 16–18. Guidance advised NHS Boards to take a thematic approach to these submissions, and they were encouraged to report on examples of collaboration, actions to advance equality and/or tackle health inequalities and action to promote mental wellbeing of staff, patients and visitors.

In total, 40 examples of innovative and emerging practice were submitted from 13 of the 15 eligible NHS Boards. The most common theme was actions for physical activity promotion, followed by strategic action to support the HPHS agenda and thirdly by the promotion of wellbeing. Additional examples submitted were on food and health, Healthy Working Lives, health inequalities, sexual health and smoking.

The reach of these projects was widespread, targeting patients, staff, members of the public, visitors, volunteers, older people in the community, carers and third sector organisations.

Summary of findings

Strategic leadership

Core Action 1: Chief Executives are asked to delegate responsibility for implementation to the appropriate committee and governance structures and to provide a report to the NHS Board on progress, at least annually, in each of the next three years.

Required evidence: Submit local governance and implementation structures and evidence of NHS Board reports/minutes on progress achieved.

All NHS Boards evidenced that local governance structures were now in place for CEL (1) 2012. These structures varied, and the majority of NHS Boards have multiple reporting streams in place either hosted by specific HPHS groups or by embedding HPHS into existing groups with responsibility for a related agenda e.g. Health Improvement and Inequalities Group.

Responsibility for CEL (1) 2012 had been deputised by Chief Executives to Medical Directors (two NHS Boards), Director of Public Health (six NHS Boards), Area Clinical Fora (three NHS Boards), Nursing Director (one NHS Board), unspecified Executive Director (one NHS Board), Chief Operational Officer (one NHS Board) and one NHS Board elected to have individual leads for each of their specific hospital sites, governed by their senior management team.

Several NHS Boards also detailed mechanisms in place to provide updates to their corporate management team/senior management groups, clinical governance committees, healthcare governance groups, quality and performance groups as well as finance and performance committees, in respect of HEAT target-related topics.

Workforce development

Core Action 2: The attainment of generic health improvement competences should be supported through provision of an appropriate professional development programme.

Required evidence: Submit the proportion of staff undertaking and completing generic health improvement professional development programmes.

All NHS Boards submitted some evidence on their provision of appropriate development programmes supporting health improvement capacity-building.

Monitoring of staff numbers and groups participating in heath improvement-related professional development appears to be a challenge for the majority of NHS Boards, based on the CEL (1) 2012 annual report submissions. Two NHS Boards provided comments that, whilst significant numbers of their staff had received relevant training, only 12% and 10% respectively represented hospital-based staff. One NHS Board reported efforts to increase recording mechanisms for staff accessing and attending training were being pursued.

Courses sited in relation to delivery of Core Action 2 included:

- generic health behaviour change (10 NHS Boards)
- self-management
- working in partnership
- raising the issue (two NHS Boards)
- developing effective practice
- promoting health
- using asset-based approaches to improve health and wellbeing
- working with cultural diversity and health
- group work and facilitation skills
- the impact of homelessness on health

Clinical staff attending courses were predominately linked to workstreams that included alcohol, child healthy weight, Keep Well and physical activity. Whilst some NHS Boards reported a conscious shift towards generic training, most reported that the highest attendance was still on topic-specific training, specifically for tobacco, weight and alcohol.

Support continuous improvement

Core Action 3: Local expertise on improvement methodology should be made available to jointly support all hospital and public health staff to test, adopt and spread good practice.

Required evidence: Submit a named lead and description of what planned and/or operational improvement processes are in place.

One NHS Board reported their improvement methodology workstreams were being driven by their modernisation and planning team, one from their local quality improvement hub, two from within the public health directorate, two from organisational development and two NHS Boards reported the named topic/hospital lead for CEL (1) 2012 actions were leading on this individually.

Six NHS Boards did not provide a name lead for application of improvement methodologies within hospitals sites.

A wide range of examples of applying improvement methodologies to advance health improvement action in hospital settings were reported.

Specific examples included:

- Examination of long-term condition pathways to consider how these may be improved to incorporate lifestyle changes.
- Review of smoking cessation pathways in alignment with new targets for organisation tobacco policy.
- Applying asset-based approaches to develop a health improvement self-assessment tool to support an acute hospital new build project.
- LEAN methodology was applied to three theatres and two pharmacy departments, establishing a three-year work programme.
- Developing a positive corporate culture through Healthy Working Lives work is being taken forward by employee relations and occupational health leads.
- Supporting the Scottish Patient Safety, Releasing time to Care and Patient Experience Improvement Programmes to develop and share experiences and capability in the application of improvement methodology across clinical services.
- Two NHS Boards are working together on the Transforming Clinical Services Programme with a view to establish a strategic approach to ensure ongoing sustainability.

Generic examples included:

- Application of the NHS Health Scotland Change Acceleration Process (CAP) training within Public Health and by the AHP Clinical Improvement Board to take forward health improvement work.
- Improvement methodology expertise within the public health and health improvement teams are being used to support the development of good practice.
- Improvement approaches are captured within service improvement plans for all topics covered in CEL (1) 2012, supported by an organisational development consultant.

Capacity building activities to increase improvement methodology use was also reported by six NHS Boards, who did not report current projects. These activities included:

- Development of a local Quality Improvement Hub aligned to Healthcare Improvement Plan.
- Targeted training in quality improvement methodologies, including some targeting of senior staff.

- Promoting national quality improvement website support materials and tools.
- Identifying clinical leads through Area Clinical Forum engagement.
- Creation of a post to coordinate availability of the local expertise on improvement methodology for hospital and public health staff.
- Plans to expand inequalities focused work based on improvement methodology.
- Intention to identify health improvement lead for all wards and health improvement development programme being offered.

Patient, carer and volunteer engagement

Core Action 4: Patient Focus and Patient Involvement (PFPI) and patient experience leads should enable patient, carer and volunteer participation in developing and implementing the action plan.

Required evidence: Submit details of how and what PFPI leads have influenced in the development and implementation of the local delivery plan.

Several approaches have been taken to enable patient, carer and volunteer participation in implementing CEL (1) 2012. Only one NHS Board submitted no evidence for this requirement, with the 14 submitting NHS Boards providing a range of descriptions varying in detail.

HPHS strategic groups include patient representatives or PFPI leads within six NHS Boards. Additional mechanisms to involve patients, carers and volunteers included differing levels of consultation on HPHS action plans/specific activities with PFPI leads, patient experience leads, patient panel groups and volunteer forums.

Specific examples collated from submissions on engagement and/or planned engagement included:

- PFPI groups influencing priorities and actions for Long-Term Conditions agenda, advocacy services and screening programmes.
- Public participation with the Managed Clinical Networks (MCN) actions for nutrition.
- Healthy Working Lives engaging with the public through external organisations employee wellbeing survey.
- Reviewing patient involvement strategy and carer policy.
- Implementing dementia-friendly environments.
- Patient representation on HPHS subgroups (i.e. food and health, smoke-free policy).

Medical leadership

Core Action 5: Medical Directors and Directors of Public Health should jointly support and encourage all hospital Clinical Directors to take account of involvement in health improvement actions through the annual appraisal cycle for hospital consultants.

Required evidence: Hospital consultants have demonstrated involvement in health improvement action.

Evidence submissions on hospital consultants' leadership in health improvement actions were varied and generally lacked detail. However, four NHS Boards described 'a number' of consultants were supportive of the agenda, and this was helpfully demonstrated through current activities, which included:

- Embedding a smoking cessation pathway into all care pathways.
- Embedding an opt-out smoking cessation pathway into specific departments (respiratory x1, pre-operative assessment x2).
- Using hospital greenspace as part of patient rehabilitation.
- Championing smoke-free grounds.
- Promoting healthy eating options for staff.

Two NHS Boards reported involvement through their MCNs. These activities included the Respiratory MCN support for smoking cessation services, the Coronary Heart Disease MCN support for physical activity interventions and Heart Disease and Stroke MCN promoting physical activity through a third-sector collaboration.

One NHS Board has now incorporated health improvement action into the consultant job plan. Six NHS Boards reported Medical Directors are at various stages of considering these requirements as part of the medical appraisal and revalidation processes and/or consultant job plans. This will ensure consultants consider health improvement contributions of doctors in their annual appraisals.

One NHS Board reported that quality improvement activities were an essential part of the existing consultant appraisal documentation and were discussed during the appraisal process, submitted to the appraisal lead and Medical Director.

Two NHS Boards reported that discussions were planned with their Clinical Directors Group. One NHS Board reported their Director of Public Health is committed to advancing this work area.

One NHS Board reported that the Area Clinical Fora and clinical services management team, including representation from hospital consultants, now have HPHS as a standing agenda item.

One NHS Board submitted no evidence towards Core Action 5.

Summary of report action

CEL (1) 2012 set out to enhance local leadership and accountability of the HPHS agenda. Through implementation of Core Actions 1–5, all local delivery NHS Boards have strategic-level leads to enable preventative action across hospital settings throughout Scotland over a range of clinical and environmental areas. The formation of local-level implementation groups has improved the collaborative engagement for this cross-cutting programme of work and generated critical debate on the roles and responsibilities for HPHS progress at both national and local level.

Clarity on progress within community hospital settings, an additional requirement from CEL (14) 2008, has not been clear from the report submissions due to the incomplete and/or combined data submitted by NHS Boards.

All CEL (1) 2012 annual reports failed to represent paediatric hospital settings, apart from one reported example of pilot work being undertaken for physical activity promotion. Mental health hospitals were also not clearly represented within any of the submissions.

For all support on implementation of CEL (1) 2012, please contact the HPHS national support programme at NHS Health Scotland by emailing:
nhs.HealthScotland-hphsadmin@nhs.net