

Gloucestershire Hospitals



NHS Foundation Trust

**Patient
Health and
Wellbeing
Strategy**

2016



Foreword

We recognise that beyond fulfilling the core role of an Acute Hospitals Trust, of diagnosing, treating and caring for our patients, we also have the opportunity to contribute to the wider health and wellbeing (H&WB) of the people of Gloucestershire and to the Countywide H&WB Strategy, 'Fit for the Future'.

H&WB or our patients – in partnership with a wide range of countywide health, social care and other stakeholders.

This Strategy will be underpinned by a detailed work programme for the year ahead and beyond. It will be overseen and monitored, on behalf of the Trust Board, by the Trust's H&WB Committee.

At the end of 2014, we produced our own over-arching Health and Wellbeing Strategy to describe how we could make this broader contribution.

We realised that there are three key groups with which we come into contact: our staff, our patients and the wider community. Since we also realised that our contribution to the H&WB of each of these groups is different, we committed to focus on each of these groups in turn.

In 2015, in conjunction with our Staff Side, we developed a more detailed Staff H&WB Strategy and accompanying action plan.

In 2016, the focus is on our patients. This strategy, 'The Health and Wellbeing of our Patients' has been developed by the members of our H&WB Committee, which has oversight of H&WB activities in the Trust.

Building on what we already do, this strategy considers more closely the further opportunities we have to improve the



Sally Pearson
Director Clinical Strategy



Tony Foster
Non-executive Director



Introduction

Our health and wellbeing vision

To be recognised as a health-promoting Trust, one that makes an active contribution to promoting and improving the wider health and wellbeing of those with whom we come into contact.

Our ambitions

Our overarching Trust H&WB strategy sets out the three broad ambitions, reflecting the three groups of people with which we come into contact – our staff, our patients and the wider community. These ambitions will underpin our vision and be reflected in our annual work programmes.

- **Our staff:** every employee will be supported to maintain and improve their health and wellbeing and every employee will be expected to take reasonable steps to improve their health and wellbeing
- **Our patients:** every patient contact will count for promoting health and wellbeing
- **The wider community:** the wider community will also benefit through our involvement in the broader countywide health and wellbeing agenda



What is a health promoting hospital?

“A health promoting hospital does not only provide high quality comprehensive medical and nursing services, but also develops a corporate identity that embraces the aims of health promotion, develops a health promoting organisational structure and culture, including active, participatory roles for patients and all members of staff, develops itself into a health promoting physical environment, and actively cooperates with its community.”

World Health Organisation (WHO)

The wider context

Links with our values and corporate objectives

Our Trust’s mission is to improve health by putting patients at the centre of excellent specialist patient care.

By using the contact which we have with patients to promote healthier lifestyles and prevent ill health, we can make an additional contribution to our patients’ more general health and wellbeing.

Two of our current Trust objectives particularly reflect the H&WB agenda:

- To implement the patient H&WB strategy
- To contribute to the countywide obesity strategy.

This Strategy will also bring benefits to us as a provider of NHS specialist services, and contribute to our wider organisational objectives to make more effective use of resources – for example by reducing length of stay and unnecessary admissions.

Health promotion in action:

- Smoking cessation can reduce complications at birth and improve the outcomes for pregnant mothers and their babies
- Provision and signposting of support for mental health or alcohol addiction in our emergency department can assist in reducing admissions
- A holistic and proactive approach to assessing our elderly care patients can speed a safer return home or reduce unnecessary admissions
- Providing advice about diet and wellbeing can have a huge impact on many areas of our patients’ lives.

Five Year Forward View

The Five Year Forward View, launched by NHS England in 2014, gives a powerful message:

“If the nation fails to get serious about prevention then the recent progress in healthy life expectancies will stall, health inequalities will widen and our ability to fund beneficial treatments will be crowded out by the need to spend billions of pounds on wholly preventable illness.”

Our Trust Strategy is consistent with a responsibility to support the wider prevention agenda.

Working together in Gloucestershire to improve health and wellbeing

Within the county, the wider H&WB agenda is led by the Gloucestershire H&WB Board.

Its ambitions and plans are informed by the local [Joint Strategic Needs Assessment \(JSNA\)](#) and are set out in the [Countywide H&WB Strategy](#) and its [associated action cards](#).

We recognise the importance of a shared sense of direction and take the countywide Strategy as the context for our own activities.

Key priorities for the county are:

- Achieving a healthy weight
- Reducing harm caused by alcohol
- Improving mental health
- Improving health and wellbeing into old age
- Tackling health inequalities



Our county:

In Gloucestershire:

- Overall, in Gloucestershire we enjoy better health than average for the country, but this is not so for some groups and areas in our county
- 82 out of every 100 people over 65 are in good health – higher than the national average
- Cancer, cardiovascular disease and respiratory disease are the three leading causes of death in the county
- 1 in 4 adults are obese
- At Year 6, 31% of pupils have excess weight levels
- Gloucestershire has an ageing population, By 2035, people aged over 65 will increase from 19% to 28% of the population
- 18,300 children are living in poverty according to official figures
- There are still 900 deaths from smoking-related diseases each year
- Over a quarter of people are estimated to have harmful or hazardous drinking levels



Our patients: Every contact will count for promoting health and wellbeing

Every year we come into contact with a significant proportion of the local population.

Making Every Contact Count is an approach which is now widely recognised across the country and within the county of Gloucestershire. This is also overarching ambition for this Strategy.

We already take the opportunity 'to make our contacts count' in many areas of our hospitals – but we want to build on this and extend this approach more widely.

Groups of our staff have been involved in the countywide training initiative which enables them to gain the skills and confidence to raise health and lifestyle issues with patients and we also want to build this capacity more generally across our staff.

The Five Year Forward Plan for the NHS talks of the opportunity for NHS staff to serve as ambassadors for health and in their communities – for the NHS and its staff to lead by example and act as models for promoting health more widely.

We are well placed to influence our patients. We often have access to groups which are more likely to be suffering from preventable illnesses. Even where people have an established illness, there are still steps that they can take to improve or delay progression through adopting healthier lifestyles. There may be other preventive services which may help and which we can signpost or refer our patients to.

People in hospital may be more receptive to messages about promoting health and to information from healthcare

professionals. There is evidence that the majority of hospital patients think that it is appropriate for hospitals to take a role in promoting health.

Health promoting and prevention initiatives can lead to quicker healing and recovery, fewer complications, fewer admissions or lower lengths of stay, risk reduction and increased independence. As well as improving the health and wellbeing of our patients, this also contributes to the improved use of increasingly pressurised NHS and social care resources.



Every year
we see:

65,600
day cases

6,300
Hospital births

65,200
emergency
admissions

13,000
planned
inpatients

675,000
consultant
outpatient
appointments

Our organisation:

Gloucestershire Hospitals NHS Foundation Trust is one of the largest hospital trusts in the country and provides high quality acute, elective and specialist health care for a population of more than 850,000 people.

Some services are run on both our sites while other specialist services are focused at just one to optimise the use of specialist staff, skills and equipment.

- We are the second largest employer in Gloucestershire, with more than 7,400 employees. Our success depends on the commitment and dedication of our staff. Many of our staff are world leaders in the fields of healthcare, teaching and research and we aim to recruit and retain the best staff possible.
- Our patients are cared for by more than 2,100 registered nurses & midwives and 800 doctors. In addition, we employ more than 600 estates staff, 190 healthcare scientists and 425 health professionals, such as physiotherapists and speech therapists.

Achieving a healthy weight

Background

Currently 64% of the county's adults are overweight or obese. Adult obesity is a major cause of early death and avoidable ill health and is linked to diseases including cardiovascular disease, type 2 diabetes, cancer and poor mental health. In the county's schools, at Reception, just under a quarter of children have excess weight levels. By Year 6 this has increased to around 32%.

The causes of obesity are often complex, requiring action across the wider community. It is not as simple as eat less and exercise more. Psychological and environmental issues are very important and help with them is often needed.

What we do now: some examples

- Our Specialist Weight Management Service supports adults with complex weight management issues. Our ambition is to be able to offer an equivalent service for children.
- We have developed a Food and Drink Strategy and action plan. We run training and awareness raising activities during Nutrition and Hydration Week.
- LEAP, a programme for people with hip or knee joint osteoarthritis, offers supervised exercise advice on weight management, pain relief and self-management strategies.
- Our dietetic team receives referrals from primary care and the hospital. The team works closely with clinical teams and their patients, including those with long term conditions.
- We support a range of local and national campaigns, including Diabetes Awareness Week, raising

awareness and highlighting the link between overweight and diabetes

- We have a weekly stall in the canteen selling fresh, locally sourced, vegetables.

Areas for action:

- Contribute to the development of the countywide Obesity Strategy, by engaging in countywide initiatives to:
 - develop options for supporting children and young people who are overweight or obese and establish specialist weight management services for children
 - implement recommendations of the adult care pathway review and strengthen links between tiers of care
 - undertake a three-year programme of work, supported by Leeds Beckett University, to co-develop a whole systems approach to addressing obesity in the county
- Make healthy choices easier by working with catering teams, commercial outlets and suppliers to offer and promote healthy options and improve nutritional labelling.



Patient case study: Specialist Weight Management

The Specialist Weight Management Service (SWMS) is a small team of psychologists and dietitians. The bulk of their work is supporting patients to manage their weight more effectively but they also provide the pre-surgery preparation for patients eligible for bariatric surgery, and post-surgery follow up.

Patient story:

"I am a 55 year old woman and was in control of all aspects of my life except my weight. That was until I was referred to the Specialist Weight Management Service. Today I am in a much happier place and am more than five stones lighter.

"I have had an ongoing battle with my weight all my adult life; losing weight (and sometimes in great quantities) but eventually always putting it all back on, and more to boot. Every time I started a new diet, I was convinced this was the one that I was going to succeed with and each time I failed. I went to various slimming clubs in the hope that as we were all suffering the same deprivations, we could console each other in mutual misery. But it wasn't enough to overcome the complex issues of overeating I had or understood. I became convinced that I would never gain control of my weight and it would always control me.

"My weight continued to increase and in desperation when I felt I wouldn't be able to continue with my job for much longer, I turned to my GP who referred me to the Specialist Weight Management Service. I knew it wasn't going to be a quick fix solution but I was prepared for the long haul.

"The first session was a very tearful occasion as my counsellor gently coaxed me to reveal

details about my situation. I found myself able to open up and say things that I had never been able to admit even to myself. As the sessions continued I felt as though I had a big knotted ball of string in the pit of my stomach that my counsellor was managing to tease apart and unravel. I filled in various questionnaires and seeing how I felt on paper was a terrible shock and made me feel incredibly sad for me. But my counsellor made me feel valued and positive about my future.

"Through my sessions she gave me 'tools' to use in various situations and I found myself using them in situations where I was likely to overeat. I realised that diets set us up to fail and I was always going to fail because the root cause is never addressed, just the outcome. My attitude began to change with my counsellor's support and I stopped dieting altogether. Instead I became conscious about what I was eating, picking healthier options and stopping to ask myself if I really wanted what was in front of me.

"I learned to like myself again. I started to lose weight, but more importantly than losing weight, my relationship with food began to change and it became far less significant in my life. My life took on new meaning as I started to be able to do things that my weight had prevented me from doing in the past. I have come a very long way."



Smoking cessation:

What do we do now

Although local smoking rates are lower than in many other areas of the country, smoking remains a major risk for many diseases, including lung cancer, chronic obstructive pulmonary disease and heart disease.

Smoking is associated with a significant number of hospital admissions and it is estimated that up to a half of all smokers will die from a smoking related condition.

Smoking in pregnancy has detrimental effects on both the health of the mother and the growth of the baby. It can bring higher rates of miscarriage and still birth. Illnesses among children caused by exposure to second hand smoke are responsible for higher levels of admission to hospital than for other children.

Supporting the service

Our Smoking Cessation Group provides the focus for smoking cessation in the Trust.

- We work closely with advisers from GSSS, the Gloucestershire specialist NHS Stop Smoking Service. This collaboration has brought a range of initiatives – including the establishment a network of trained Smoking Cessation Champions with representation on every ward and department.
- GSSS has worked especially closely with our midwifery team to provide tailored training and to implement an opt out referral scheme for pregnant women who smoke.
- As part of the countywide StopB4op initiative, patients undergoing pre-admission assessment are encouraged to give up smoking before they come into hospital – this is known to speed the rate of healing and recovery and reduce

length of stay. We also provide NRT to inpatients who are finding it challenging to be in hospital without cigarettes. Stop smoking advisors are able to see patients on our wards and can continue to support them after discharge.

- E-learning modules have been developed and undertaken by many of our staff, encouraging them to raise smoking cessation with their patients.
- We support national and local stop smoking campaigns.

Areas for action:

- Intensify our efforts to reduce smoking amongst pregnant women – a high priority for the county in the year ahead.
- Reinforce our smoke free site status by replacing the external smoke free notices and messages across our sites.
- Continue to work with NHS specialist stop smoking services and our specialty teams to introduce smoking cessation effectively in a wider range of care pathways.
- Continue to promote events such as National No-smoking Day.



Case studies: referring patients from hospital

Our teams are ideally placed to refer patients on our wards and in surgical pre-assessment to specialist stop smoking advisors from Gloucestershire Stop Smoking Service.

Patient stories:

Patient Graham*, who has COPD (Chronic Obstructive Pulmonary Disease) reflected on his experience:

“I had been approached before about being referred, but it was when I went on holiday to visit relatives that I was inspired to take up the offer. They had arranged a very busy itinerary and I realised quite quickly that I was unable to keep up due to COPD.

“The service I received from the Gloucestershire Stop Smoking Service was great – my advisor was upbeat and positive and my questions were always answered cheerfully and quickly.

“I know that the damage to my lungs is permanent, but there are so many positives to having quit. I no longer have coughing fits, my house and clothes no longer smell and my friends and family find visiting me a more pleasant experience. I found E-cigarettes very useful in managing my cravings as a big part of the challenge is what to do with your hands.

Brian* and Terry* were both referred following repair of aortic aneurysm (AAA).

Brian says: “I didn’t want to quit, but I was in hospital and they asked if I needed any help with not smoking while I was an inpatient.

“I was prescribed nicotine replacement therapy while I was on the ward, which helped to manage my cravings. I certainly wasn’t fit enough to go outside to smoke, so it really helped.

“The nurse also asked if I would like to be

referred to the stop smoking service, and I agreed to see an advisor.

“When I smoked I coughed all the time, and it’s been remarkable to me that this has stopped entirely since I quit.

“I would say to anyone who is in my position, do give it a go, they are very helpful and you will feel better.

“Don’t be deluded into thinking that you can have just one ciggy as it’s easy to slip back. You will get cravings, but they will get better and the products they offer you really can support you.”

Terry says: “Following a near-critical aortic aneurysm, I have been advised to give up smoking, lose weight and take statins. I am taking all of this advice!

“I was able to begin my stop smoking journey in hospital. The specialist advisor prescribed me medication, which I would say has made my attempt much easier as it has really reduced my cravings.

“Now, my breathing is better, food tastes better and I have fewer headaches. Like many other former smokers, I wish I had done this years ago! I would encourage anyone to contact the service and get some help to quit and not to wait until they are hospital to do so.”

* names have been changed



Reducing harm caused by alcohol

Background

Alcohol misuse is a major cause of early death and dysfunction for individuals. It is the biggest risk for cancer after smoking, the most frequent cause of liver disease and the cause of a range of other diseases, mental ill health and antisocial behaviour. Alcohol is estimated to cost the NHS £3.5 billion each year.

Within our Trust, we have contact with both alcohol-specific admissions (where alcohol is the sole cause of the health condition) and also alcohol-related admissions which combine to give the broader picture that alcohol makes to ill health locally.

It is estimated that in Gloucestershire about 28% of the population have harmful or hazardous drinking levels.

What we do now: some examples

Our Trust provides comprehensive services including a dedicated alcohol team with specialist nurses trained in mental health, addiction and liver disease.

- As well as supporting Public Health England's Dry January campaign each year, mainly through social media, 2015 also saw a focus on this area during Alcohol Awareness Week which occurs in November. This proved a great success within the hospitals, giving the team a chance to highlight their work.
- Around Christmas and the New Year period we regularly see higher levels of alcohol-related attendances at our Emergency Department. We use the local media to draw attention to the impact on the hospital and encourage people to drink sensibly.

Areas for action:

- We are investigating what investment in a local fibroscanner could add to care for groups of patients such as those with fatty liver and hazardous drinking levels. This type of ultrasound would help our doctors to understand how much scarring is in a patient's liver, increasing awareness in the patient and allowing staff to plan treatment and follow-up.
- The Alcohol Liaison Team would like to increase out-patient referrals from ED and hopes that new training provided by one of the Lecturer Practitioners will help raise awareness of their service and encourage staff to signpost more patients to the service.
- We are exploring the possibility of being able to refer a greater number of patients to the correct services through access to the alcohol liaison service outside office hours. It is felt that currently, opportunities may be missed to provide some patients with adequate support and follow-up.
- We will continue to support implementation of the County's Alcohol Harm Reduction Plan



Patient case study: liver transplant

Ken's story:

Ken, 68 has been a patient at our hospitals for more than 16 years. Two years ago, Ken had a liver transplant from which he has made a remarkable recovery.

Previously a heavy social drinker, he had experienced health issues caused by drinking alcohol. When advised by a consultant to quit drinking is he wanted to see his grandchildren grow up, Ken complied immediately and his condition stabilised.

He says: "I didn't drink every day and never drank at home, it was always in a social situation. I didn't feel any ill effects from drinking, but one day I noticed that my skin and eyes had become quite yellow. The doctors at the hospital advised me that I should stop drinking and I did. That was 15 and a half years ago."

More than ten years after he had stopped drinking, Ken's liver began to fail and he developed regular accumulation of fluid in the abdominal cavity, called ascites. Ascites is common in people with cirrhosis and it usually develops when the liver is starting to fail. In general, the development of ascites indicates advanced liver disease and patients may be considered for referral to liver transplantation.

"This is the message that I'd like people to know, that I never did" said Ken. "The damage that drinking can do to you will probably not be obvious at the time, but it can all catch up with you so many years later."

Ken was seeing Liver Nurse Debbie Durrant for weekly drainage of his ascites – paracentesis. This was becoming a regular appointment where up to a gallon of liquid was being drained.

Ken commented: "Debbie was wonderful and I got to know her so well during this time. Because I was coming in so often, I was grateful to be able to benefit from the fact Debbie had introduced the drainage as a day procedure rather than having to be admitted for a night every time."

As his health issues became insurmountable, he was referred by our hepatology team for a liver transplant at University Hospitals Birmingham.

There is a strict assessment process that decides who can have a liver transplant, as donated livers are scarce, both in the UK and worldwide. Ken was able to meet the criteria – to have ceased drinking and also to be ill enough to warrant inclusion on the transplant list but also to be well enough to survive this major surgery.

Liver transplants take about 8 hours and require the patient to be well enough to withstand the operation and the recovery period afterwards. As well as extensive physical assessments, there is a lot of psychological help and support.

Ken was put on the transplant list in January 2014 and received his transplant later that year. Six months after the transplant, Ken felt that he had recovered from the trauma of the operation.

In his words:
"It was like being born again."



Improving mental health:

Background

Mental health problems are common. Each year one in four people may experience a mental health problem. Risk factors include deprivation, substance misuse, poverty, relationships, isolation and discrimination.

There are also strong links between physical and mental health problems. Many people with a long term-physical health problem also have a mental health problem. Within the hospitals, joint working with mental health colleagues is central to identifying and managing these problems.

For many it is difficult to talk about mental ill health. One in ten people who experience mental health problems say they face stigma and discrimination.

Examples of what we do now

- Collaborative working is central to improving the mental health of our patients. The mental health liaison team (MHLT) and other mental health support at our hospitals is provided by colleagues from 2gether Trust.
- For young people who self harm, we now have rooms which provide a safe environment during their stay in the our Children's Unit. We have developed a leaflet which explains about their admission to hospital and what may happen next.
- The alcohol liaison team or ALT provide specialist assessment and intervention to those patients undergoing treatment for alcohol withdrawal, or for whom high risk alcohol consumption has been identified as a factor during their admission.

- Older age liaison specialise in the assessment and treatment of patients over the age of 65 years with conditions including dementia, delirium, depression and anxiety.
- All of the services benefit from having direct access to the supervision and expertise of a senior Consultant Psychiatrist.

Areas for action:

- We will to work towards increasing staff awareness of mental health in our patients by including this more widely in training and development.
- We will also develop a mental health section on the intranet to brings together resources and pathways for any member of staff who may wish to refer a patient
- A specialist young persons' assessment room will be created in our Children's Emergency Area to allow young people to be assessed by specialist mental health experts



Case studies: Mental health care plans

The mental health team undertake specialist assessments of the mental health needs of patients who are in receipt of care from GHNHSFT. They work in conjunction with medical and nursing staff, patients and carers to develop individualised discharge plans which engage patients with community mental health services if required.

Patient A:

Patient A was brought to hospital by ambulance following an overdose of paracetamol and admitted to ACUA for IVI Parvolex (a medicine used in paracetamol overdoses), monitoring and observation. An assessment of risk on admission identified that the patient posed a high risk to themselves in the immediate future. ACUA staff followed the mental health risk assessment policy and 1:1 care was implemented overnight. This ensured that Patient A received appropriate supervision and a high quality of individualised care during a period of acute distress and anxiety.

The mental health team undertook a comprehensive face to face biopsychosocial assessment with patient A the following morning. This identified a long standing depressive disorder which had been exacerbated by acute stress (marital separation and moving out of the family home) and excessive alcohol use.

A comprehensive package of care was developed with Patient A, his GP and the Crisis Team with onward referrals for Alcohol Outpatient work in A&E and Turning Point in the community. Patient A went on to make a full recovery.

Repeated attendances at ED

In 2015, a frequent attender manager was appointed to the MHLT. This post was

created and manages circa 50 patients who were attending our Emergency Departments on a very regular basis. Anecdotally, many regular attenders have combinations of mental health, substance misuse and social care issues.

Key to the role is looking at each patient individually, and putting together packages of care designed to reduce dependence on hospital services.

Patient Z:

Patient Z attended the ED on a weekly basis, specifically 49 attendances in 2014 (29 admissions) and 51 attendances in 2015 (18 admissions).

Looking at the case, it was identified that a multi agency approach including A&E, GP, mental health and the ambulance trust (SWAST) would provide a forum to develop a care plan.

A plan was developed for Patient Z which provided better support for the patient and also encompassed alternative advice for pain relief provided by the Pain Management Team. This plan better supported the patient in meeting their complex needs in a more proactive way, reducing A&E/SWAST attendances.

The effect of this has been to reduce the prescribing of regular opiates given by ED, ward and the ambulance service. This strategy has been very successful – since June 2015 when it was put in place, Patient Z has only been admitted to hospital on a single occasion.



Improving health and wellbeing into old age

The number of older people aged 65+ in Gloucestershire has grown steadily. This rise is projected to rise more steeply in the decades ahead and at a higher rate than for the country as a whole. Older people often have multiple health conditions, resulting in a range of health-related and social care needs. Many of our older patients are also frail.

Over 9,000 people aged over 65 are estimated to be living with dementia in Gloucestershire. This is forecast to rise by two thirds to almost 15,000 by 2030.

What we do now

- OPAL is our older person's assessment team. With early specialist assessment and planning, our aim is to prevent or minimise hospital stays, wherever possible, to maximise independence and enable patients to return to their usual place of residence.
- A number of our older patients experience a degree of memory loss or are living with dementia. Early assessment, diagnosis and individualised treatment and support can improve quality of life.
- We have developed a Trust dementia care strategy 'What Does Good Dementia Care Look Like in our Hospitals' and we work in partnership with others to deliver the Countywide Dementia Strategy.
- We have developed and trained a network of Dementia Champions across the Trust to promote and support best dementia care.
- We have enhanced our care environment with new signage to help our older patients find their way more easily – we have introduced visual prompts

and pictograms, clocks and calendars, and coloured crockery. In addition, a programme of weekly cognitive stimulation sessions are held on our general and old age medicine wards.

- Over a third of people over 80 fall each year. The Falls service offers a detailed assessment of risk factors and personalised treatment plans to minimise risks.
- Our Food & Drink Strategy highlights the importance of managing malnutrition and dehydration in older patients to minimise reduced cognitive function, falls or poor diabetes control.
- Our lecturer practitioners have been involved in the development of a course for the Care of Frail Older People with the University of Gloucestershire.

Areas for action:

- Continue to progress elements of the Frailty Programme, including working with Glos CCG to establish two community-based consultant posts to reduce or prevent admission of older people and support their earlier discharge
- Continue to support implementation of the Countywide and the Trust's Dementia Strategies and also lead a countywide group to improve communication with patients and the public to assist people to live well with dementia.
- Over time, as more staff across the Trust undergo Making Every Contact Count (MECC) training, we will work to encourage younger people to adopt healthier lifestyles which may delay the onset of ill health in older age.

Case study: older people

OPAL – older persons' assessment and liaison team

For older people, hospital is not the best place to be for a long term stay. The unfamiliarity of a hospital environment can often trigger or worsen existing confusion and patients are at risk of falls and injury. It can also make them more vulnerable to hospital acquired infections such as pneumonia, C. difficile and MRSA. Longer stays in hospital can lead to loss of muscle mass, where patients may struggle to regain their previous level of mobility and independence.

Our older persons assessment and liaison team, or OPAL, aims to provide the best expertise to enable patients to avoid long stays in hospital. The objective of this specialist team is to provide a comprehensive assessment when an older person comes to hospital via the emergency department. They will consider what other support the person may require to continue living independently at home.

Their comprehensive assessment looks at all aspects of physical and social wellbeing, giving an indication of the individual's frailty to allow us to plan and involve the appropriate services at an early stage. The team comprises an elderly care consultant, registrar, GP trainee and Nurse practitioners, working alongside an Integrated Discharge Team.

June's story: June* was admitted following a fall at home. She had been found by carers on the floor, having fallen on the way to the bathroom.

When June was admitted to our Emergency Department, the OPAL team were called to assess her. The reasons for June's fall were assessed, through speaking to her but also to relatives and care staff. Carers are often able to give the team a more comprehensive and detailed account of the patient's previous levels of function and mobility.

June's injuries were assessed and the team looked at possible medical reasons for her fall via blood tests, ECG and X-rays. As she had a head injury and seemed confused, a CT scan was ordered. June was also found to have an infection for which IV antibiotics were required, necessitating an admission to hospital.

During June's admission, more detailed assessments of her functioning and cognition were undertaken. Her confusion improved substantially following treatment for the infection.

A medication review was a crucial aspect of her assessment as many medications can contribute to falls. June's carers were able to gain a better understanding of the medication she was taking and the possible side effects.

After 48 hours, June was discharged home with additional support in place. Her carers and relatives were also involved and were given the following advice to help safeguard June against future falls:

- Wearing suitable footwear and keeping active and mobile as much as possible
- Regularly discussing and rationalising medications with the GP
- Regular eye checks and using her mobility aids as advised by professionals
- Wearing her lifeline at all times

* name has been changed



Tackling health inequalities:

Background

Health inequalities are preventable and unjust differences in health experienced by certain groups in the population. They may be linked to wider factors influencing health such as housing, environment, social background, income, employment and education.

Other factors which contribute to health inequalities are differences in individual lifestyle behaviours, isolation and poor access or use of healthcare. Those with poorer health and wellbeing may come from deprived areas, from black or ethnic communities, have a physical or learning disability, mental health problems or be homeless.

Examples of what we do now

- Our midwives work closely with health visitors and Children's Centres as part of the Midwifery Partnership Teams initiative providing support to families and their children.
- Concerned about the fate of homeless people leaving hospital, one of our Consultants joined with a number of local groups and secured government funds to set up the Time to Heal project. This aims to ensure that homeless people are not discharged from Gloucestershire Royal Hospital without planned housing or support.
- We have set up a network of trained Learning Disability (LD) Champions in the Trust. The Champions work closely with specialist LD liaison nurses from Together and have developed a 'traffic light assessment' tool for our patients with LD.

- A range of initiatives have been undertaken to increase sensory awareness and good practice in the Trust, to improve and support patients with hearing and sight loss – through listening devices, training, special signage and use of pictograms, supporting Deaf Awareness Week and other campaigns.

Areas for action:

Although many actions to tackle health inequalities lie with other agencies and the wider community, we will work with them in a range of areas for action highlighted in the Countywide 'Tackling inequalities Action Plan', including:

- contributing to the development of multi-agency plans to improve breastfeeding rates in those least likely to breast feed
- increasing referrals of pregnant women who smoke to specialist smoking cessation support
- supporting initiatives to increase coverage of cervical and breast screening
- improving outcomes for patient groups who have trouble in accessing the health service in a traditional way
- increasing the number of professionals undertaking Making Every Contact Count (MECC) training.

Case study: supporting families

Midwifery Partnership teams

Though the image of Gloucestershire is of a rural and a relatively affluent county, there are areas of significant deprivation. In these areas, families may be classed as 'hard to reach' for a number of social reasons.

Midwifery Partnership Teams are an initiative in Gloucestershire that provides practical and emotional support to families through pregnancy and their children's early years.

By working together, midwives, health visitors and Children's Centres share information and training, meaning that they can offer a more flexible service and intensive support to families. This can include joint home visits, enhanced antenatal education to support women to have a healthy pregnancy and a normal birth and access to midwifery appointments within Children's Centres in these areas.

The midwives are trained in Motivational Behaviour Change techniques to support healthy lifestyles and smoking cessation.

This service provides midwifery support in a more intensive way and for an extended period in the postnatal period for vulnerable women and babies, supporting parenting and prolonged breastfeeding as well as supporting attendance and take up of Children Centre support.

Outcomes:

- Maintenance of higher than normal breastfeeding rates for this cohort of women through to 6 weeks
- High levels of smoking cessation in pregnancy compared to Gloucester comparator group and Gloucestershire as a whole
- Higher numbers of home births compared to Gloucester comparator and Gloucestershire as a whole.

- Providing contraception services to vulnerable women including long acting options.
- Early labour home assessments to avoid unnecessary antenatal admissions

Families who used this service benefitted from more support with emotional wellbeing, increased levels of breastfeeding, decreased levels of smoking and support to feel more confident as parents.

Having begun in Hester's Way, Cheltenham, the service has now been extended to Children's Centres in Matson, Bartongate, Linden and Cinderford.

Feedback includes:

"It was great to know that there is always someone there to help. I can rely on them. If my Mum can't help I know they can."

"Much more confident knowing that there is support available if I need it."

"It was reassuring having a familiar face with a good understanding of my circumstances. It helped not having to repeat my story to lots of different midwives. My partner was much happier too – he felt reassured."

"I liked being able to text midwife or go to the drop-ins."



Screening programmes

Background

Screening is the process of identifying healthy people who may be at increased risk of disease or a condition. A series of national screening programmes have been introduced over the years. A number of our Trust's clinicians were involved in the early stages of establishing some of these national schemes. A range of the programmes are provided by staff linked to the Trust, for local people living in Gloucestershire or nearby.

Abdominal aortic aneurysm screening programme

Available for all men aged 65+, a simple ultrasound to identify an expansion or weakening of the main blood vessel in the body. Some men will be referred for surgery.

Bowel cancer screening programme

Men and women aged 60-74 are sent a home test kit every 2 years to check for the presence of blood in a stool sample, a possible early sign of bowel cancer. People with abnormal tests are referred for further assessment and if necessary, further investigation with a colonoscopy.

Breast screening programme

Eligible women 50-70 are invited for x-ray screening every 3 years. Women with abnormal changes in breast tissue are referred for further assessment and treatment if required.

Cervical screening programme

Women aged 24-64 are invited for screening every 3 or 5 years. Abnormal tests may be referred to colonoscopy for further investigation or treatment.

Diabetic eye screening programme

Early identification and treatment of diabetic eye disease can reduce sight loss. This is for people with type 1 and type 2 diabetes aged 12+. Some people will be referred for further assessment or laser surgery.

Antenatal and new born screening programmes

Offered to women in pregnancy, or after a child is born, these are designed to help detect a range of abnormalities and conditions, infectious diseases, physical and hearing problems.

Areas for action:

- Support wider initiatives associated with the Reducing Inequalities Action Plan, to increase coverage of cervical and breast screening.
- Continue the roll-out of the Bowel Scope screening programme in the county – an additional programme offered to men and women at the age of 55
- Explore the potential for some screening staff to undertake MECC training to enable them to raise healthy lifestyles factors with those attending for screening.

Case study: AAA screening

The Gloucestershire & Swindon Abdominal Aortic Aneurysm (AAA) Screening Programme has been screening men aged 65 and over for a potentially fatal expansion and weakening of the main blood vessel in the body in Gloucestershire since 1990. In July 2012, the Programme expanded to include men in Swindon.

Abdominal aortic aneurysms are formed when the main blood vessel in the body weakens and expands. Nationally, around 5,000 people, most of them older men, die every year after large aneurysms burst.

Bob's story: Bob lives in Highworth in Swindon and was diagnosed and treated at Gloucestershire Hospitals. This is his story:

"In October of 2012 I got a telephone call out of the blue from my local surgery asking would I like to come along for an AAA scan as I met the criteria and that people of my age were more at risk of having one.

"Well, along come November 20th 2012 which I remember as a bright sunny day. I remember vividly walking out of our front door and saying to my wife: "Why did I agree to this? There is nothing wrong with me, I feel just fine, my diabetes and angina are all under control and I have better things to be doing", so off I went smugly confident that they would tell me what I already knew: "All OK, no problems."

"At the surgery I was called into the scanning room where they took some details and asked me lay down on the couch where they explained what would happen. One of the team came in and explained to me that I did have an aneurysm and that they would be referring me for further tests. They even told me at this early stage that surgery would be needed.

"In under two weeks I had a CT scan and was referred to Mr Poskitt, the Consultant

Surgeon at Cheltenham General Hospital. I had my first consultation with Mr Poskitt where he spent time explaining to me exactly what I had and what the possible options were. Whilst I will admit to being a bit frightened by the diagnosis, I came away from the consultation confident that I had someone professional, caring and would listen on my side.



"I agreed with Mr Poskitt to proceed with the full open operation as, yes there was a risk involved it would be silly not to realise it however the 'Do Nothing' option would leave me forever wondering if today was the day it would burst.

"I was admitted to Avening Ward at Cheltenham General Hospital on 25th March and was met by Mr Poskitt and his team who talked me through the procedure and checked that I was still ok to go ahead. Although apprehensive I had made my decision and the operation was carried out the next morning. Mr Poskitt's team and the nursing staff on the ward as well as the multitude of other departments involved in my care were excellent and I was finally discharged home.

"I would urge anyone who has the opportunity to have the AAA scan to do so. For me it was the right and most sensible thing to do and I owe the service a debt of gratitude along with all the other professionals and staff treatment and care shown during the time I spent both pre-op and post care."

Delivering the strategy: enablers

Training for staff – MECC

The ambition behind this strategy is that “every contact will count for promoting the health and wellbeing of our patients”. We want our staff to feel confident in raising health and wellbeing issues with patients and will increase the number of staff undertaking the “Making Every Contract Count” (MECC) training, provided within the county.

Working together with others

We will continue to work in close collaboration with other stakeholders in the county in areas where we can contribute to the Gloucestershire H&WB Strategy. This will involve joint working on a day to day basis, and playing an active part in countywide strategy and planning forums, in the Healthy individuals Programme Group and other CCG Programme Groups, and in and new projects and initiatives.

Electronic health records

A major project is underway in the Trust to introduce, over the next two years, an electronic health record system. Over time this will provide opportunities to capture more health and lifestyle data, to prompt staff to raise health and lifestyle issues, and to introduce swift electronic means of referring or signposting patients to appropriate support and advice.

NICE guidance

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care NICE. The H&WB Committee

will continue to review relevant guidance relating to health and lifestyle to identify gaps and areas for potential action.

Staff H&WB

We recognise that the NHS and its staff have a responsibility to lead by example. Our Staff H&WB Strategy was launched last year and has an on-going work programme, designed to improve the health and wellbeing of our staff and encourage and support them in this. In line with the 5 Year Forward View, we will explore how we can model healthy behaviours more clearly and become effective health champions in the wider community.

Media and communications

Wherever possible we promote healthy lifestyle issues in a range of ways – on our website, through the local press, by supporting national and local awareness campaigns, and, through the use of social media.

We recognise that in an increasingly digital world there is the potential for extending our use of social media. This is a key area on which we shall be working.



Delivering the strategy - monitoring

Work programme

The strategy will be underpinned by a work programme, which will be updated at least annually and monitored quarterly.

Where relevant, it will reflect elements of the Countywide H&WB Strategy's Priority Action cards or other emerging H&WB related plans. We will work to develop better metrics for monitoring progress in implementing this Strategy.

Oversight and monitoring

Responsibility for overseeing and monitoring the Strategy rests with the Trust's H&WB Committee, which reports directly to the Trust Board.

The Committee is chaired by one of our non-executive Directors. Its core membership is drawn from across the clinical and corporate Divisions and includes Occupational Health and Staff side colleagues and Trust Governors.

Representatives from the local CCG, the county's Public Health Team and specialist NHS stop smoking

services are co-opted members of the Committee – reflecting our shared commitment to collaborative working.

Strategy review

The Strategy will be reviewed at least every two years, and more frequently if required.

Risks to implementation

Many benefits associated with H&WB and public health activities are only seen in the longer term – health promoting activities may be perceived as a lower priority in the context of short-term service delivery pressures.

Insufficient financial resources and staff time and capacity.

An uncoordinated approach to H&WB across the county will diminish our ability to maximise the progress which we can make together.

Equality Impact Assessment

An equality impact assessment has been undertaken.



Glossary of terms

Term	Definition
CCG	Clinical Commissioning Group
Commissioning/Commissioners	Our commissioners are the Gloucestershire Clinical Commissioning Group. Commissioning is the process of assessing the needs of a local population and putting in place services to meet those needs. Commissioners are those who do this and who agree service level agreements with service providers for a range of services
Disadvantaged groups	Sometimes called 'marginalised', 'hard-to-reach' or 'seldom-heard' groups, these are people who experience inequalities in health, healthcare and employment, but who are not specifically protected by the Equality Act. They can include homeless people, sex workers, people who misuse substances, people with low socioeconomic status, and people living in rural isolation
Equality Impact Assessments	Process used to ensure the impact upon all protected characteristics has been considered prior to any service changes being introduced.
Foundation Trust	NHS providers who achieve foundation trust status have greater freedoms and are subject to less central control. Foundation Trusts are part of the NHS and have to meet the same national targets and standards
Foundation Trust Governors	The Board of Governors are elected by Foundation Trust members. Over half our members are local people or service users, other membership includes staff members and local partner organisations. Governors advise a Foundation Trust on how it carries out its work so that this is consistent with the needs of members and the wider community
GCC	Gloucestershire County Council
Gloucestershire Health & Wellbeing Board and Strategy	The Board is a partnership between local council representatives, the NHS and the wider community to improve the health of everyone in the county. Its plans and ambitions are set out in the county's HWB Strategy
Health	A complete state of physical and mental health and wellbeing and not merely the absence of disease and infirmity
Health promotion	The process of enabling people to increase control over, and to improve, their health
Healthwatch	Healthwatch was established in April 2013 and is the new consumer champion of the health and social care in England, giving children, young people and adults a powerful voice
JSNA	Joint Strategic Needs Assessment, a high level overview of need in the county
Long term conditions (LTC)	Chronic health conditions which cannot at present be cured, but which can be controlled by medication, and other therapies and action. Among the most common LTC's are: diabetes, coronary heart disease, stroke, heart failure, respiratory diseases and asthma, severe mental health conditions and epilepsy
MECC	Make Every Contact Count - an initiative and associated training which encourages staff to raise issues about healthy lifestyle behaviours with their patients
NICE	The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care
Public Health	The science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society
Screening	The process of identifying healthy people who may be at increased risk of disease or a condition
Service users	Those who use services or those who may use them. Service user involvement can be directly or through representatives
Stakeholder engagement	A process by which an organisation or Local Health Community learns about the perceptions, issues and expectations of its stakeholders and uses these views to assist in managing, supporting and influencing any planned changes/improvements in service delivery
Stakeholders	Any person or group of people who have a significant interest in services provided, or will be affected by, any planned changes in an organisation or Local Health Community
Wellbeing	Wellbeing is a subjective concept, often associated with people feeling comfortable, secure and fulfilled in their lives, or with improving economic, social and environmental factors.

