Appendix A: CEL (1) 2012 Implementation Guidance

This appendix forms a technical guidance package for staff leading, delivering or reporting on the actions and associated activities within HPHS/ CEL (1) 2012. The contents cover:

1. Context for Delivery

2. Implementation Guidance detailing:

- Any amended actions and/ or performance measures
- Qualification of any terminology or language in CEL(1) 2012
- Performance Management Context
- Delivery guidance

Please note: Where actions and performance measures are not referenced, no amendments or qualifications are required.

2.1	Core Actions
2.2	Action 18.1 Smoking
2.3	Action 18.2 Alcohol
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3. Health Inequality Impact Assessment (HIIA) screening summary

Appendix B Monitoring and Evaluation Framework (Year 1)

Appendix C Framework Consultation Summary

HPHS Knowledge Network: the one-stop shop for information and support on health improvement in secondary care

1. Context for Delivery

1.1 Terminology clarification: hospital settings

The Health Promoting Health Service (HPHS) policy is framed for 'Action in hospital settings' and should also include community hospitals as per CEL (1) 2012. Boards are reminded CEL (1) 2012 policy requirements encompass all hospital settings, which should include paediatric and mental health hospitals. Throughout, there is reference to the following terms below, and these should be considered interchangeable to include all hospital settings:

- hospital sites/settings
- acute settings/ services
- community hospitals
- secondary care
- NHS premises/sites

1.2 Health Promoting Health Service: key delivery themes

Within the consultation process, three key themes were identified as important to address throughout all HPHS interventions in order to achieve the aspiration of '*every health care contact is a health improvement opportunity'*, and meet the Quality Strategy ambitions of a Person-centred, Safe and Effective health service. These were:

- The requirement of joint-working and collaboration across the hospital setting
- Embedding and developing practices that advance equality and tackle health inequalities and,
- Promoting the importance of mental health and wellbeing throughout the hospital setting

1.2.1 Joint working and collaboration

It is recognised that, in order for the vision of Health Promoting Health Service to be achieved, collaboration across the whole hospital setting is required far beyond public health and clinical teams alone.

Whilst the CEL (1) 2012 specifically requests Managed Clinical Networks (MCNs) and Area Clinical Fora (ACFs) to act as champions for this agenda, Boards are strongly encouraged to engage with all appropriate service managers, support services and organisational development in order to influence and nurture the cultural change towards health improvement being embedded within patients, visitors and staff experiences of Scottish hospitals.

1.2.2 Advancing equality and tackling health inequalities

It is recognised that within CEL (1) 2012 the health improvement actions are universal interventions, and details on specific targeting is not provided. There are references within the policy document describing *'additional needs'* or *'vulnerable'* or *'deprived groups'* and/ or *'those at risk of* both *health outcomes'*, and where these terms occur in relation to specific topics, clarification has been provided in section 2.

Whilst the CEL (1) 2012 interventions are universal, it is recognised and understood that structural inequalities will impact on opportunities for patients to engage fully with health improvement interventions. People experiencing poor housing, with low literacy, on low incomes and issues such as gender, race and disability will all impact on the effectiveness of health improvement interventions and must be delivered within this social context.

Given the proportionately greater use of hospital services by patients from deprived communities, hospital settings offer a major opportunity for primary and secondary prevention as part of routine person-centred care to those least likely to engage with preventative action delivered in the community setting. However, to successfully provide equity of access to health improvement support, hospitals may be required to offer targeted support that is specific to the clinical setting and patient demographics, beyond the requirement of CEL (1) 2012. At present, there is not sufficient understanding of whether some people/population groups benefit more or less than the population as a whole through health improvement intervention delivered within the hospital setting. To address this:

- NHS Health Scotland and Scottish Government would strongly recommend carrying out a health inequalities impact assessment locally to understand needs and effective interventions across the local population to avoid widening inequalities. In addition, NHS Boards have a legislative requirement to undertake equality impact assessments under the Equality Act 2010 (Specific Duties) (Scotland) Regulation as well as ensuring compliance with the Human Rights Act (1998). Your local equality lead will be able to provide advice on this. Health Inequalities Impact Assessment brings together equality, health and human rights considerations into the impact assessment process.
- The Equality Team, NHS Health Scotland, can provide additional capacity and practical support to work with you to facilitate the impact assessment process using your local or the Health Inequalities Impact Assessment approach www.healthscotland.com/equalities/eqia/health-inequalities.aspx. If you would like to discuss this further, then please contact Health Scotland's Equality Team: www.healthscotland.com/Equalities/index.aspx
- NHS Health Scotland is supporting our understanding of tackling inequalities through the hospital setting through current qualitative research into the delivery of CEL (1) 2012 actions of Sexual Health and Tobacco to better understand what practitioners understand by health inequalities, what actions are being taken to identify patients experiencing inequalities specifically and describe what interventions are or could be implemented to promote equity through the hospital setting. This report will be published in April 2013.

Implementation guidance

Boards are encouraged to:

- Provide evidence on a piece of hospital-based innovative and emerging practice that demonstrates targeted interventions or actions that advance equality or tackle health inequalities.
- Use quarterly reporting opportunities with the HPHS National Network to describe and share targeted interventions delivered to patients, visitors and/or staff.

Additionally, in support of the Monitoring and Evaluation Framework development, NHS Health Scotland conducted a Health Inequalities Impact Assessment screening (section 3). Some implementation guidance within the topic-specific sections (section 2) has been provided in support of these findings.

NHS Health Scotland will coordinate a full Health Inequalities Impact Assessment of the NHS Health Scotland HPHS programme as part of business delivery 2013/14.

1.2.3 Mental health and wellbeing

The importance of promoting staff and patient mental health and wellbeing has been highlighted throughout the consultation process. Although mental health is not explicitly mentioned in the CEL (1) 2012, consideration of positive mental health is integral to the successful delivery of the HPHS by enabling people to take more responsibility for their own health and wellbeing. As exemplar for public health, NHS settings should promote the importance of wellbeing as part of routine person-centred care.

The Mental Health Strategy for Scotland 2012-2015 acknowledges the importance of the Quality Ambitions where patient care is delivered with respect for an individual's needs and values, demonstrating compassion, continuity, clear communication and shared decision-making. Providing patients with health improvement advice and interventions at a time of high motivation to change is a key principle underpinning the HPHS approach. It is recognised that mental health and wellbeing is implicit in much of the HPHS activity and will be affected through delivery of the actions specified within CEL (1) 2012. The evidence base suggests some actions provide greater opportunity to enhance mental health and wellbeing. For example:

- The opportunity to support patients' experience of achievement through the motivational behaviour change offered from smoking cessation
- Breastfeeding and importance of promoting maternal and infant mental health with support for bonding and attachment within the hospital maternity settings
- Recognising and promoting the significant benefits of physical activity and the outdoors to short and long-term mental wellbeing
- The harmful and hazardous use of alcohol and the increased risk of depression, self-harm, suicide and other common mental health problems
- The potential risk to mental wellbeing within the termination setting for victims of rape or abuse, those experiencing repeat terminations

NHS practitioners have a responsibility to ensure that patients are provided with appropriate and accurate support on an equitable basis, recognising that:

- Those with long-term conditions are at increased risk of poor mental health and this should be considered within their treatment in acute settings
- Older people are at increased risk of poor mental health and are a significant proportion of the hospital users
- 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

Implementation Guidance

Boards are encouraged to:

- Provide evidence of a piece of hospital-based innovative and emerging practice that demonstrates mental health benefits to patients e.g. money advice services as part of a cancer-diagnosis care package

- Use the quarterly reporting opportunities with the HPHS National Network to capture mental health benefits to patients, visitors and staff as products of interventions being delivered.

Further support and resources to promote mental health and wellbeing in the hospitals setting can be found in Healthy Working Lives section 2.6.

For all professional facing information about Mental Health Improvement please visit: www.wellscotland.info including links to information on:

- **Choose Life** suicide prevention training programmes
- Applying the principles of recovery for the whole person through adoption of the **Scottish Recovery Indicator 2** (SRI-2) tool
- Taking the **See Me** Pledge to tackle stigma and discrimination
- Promoting **dementia-friendly environments**
- **Mentally Health Workplace** training to staff and managers
- **Steps for Stress** resources

2. Implementation Guidance

2.1 Core Actions

2.1.1 Any amended actions and/ or performance measures *(noted in italics)*:

Core Action 2
Ensuring that generic health improvement competences are embedded in professional development requires action at national level. Local Board KSF leads therefore have responsibility to implement the HR processes around the NHS KSF, and therefore the AMENDED ACTION is:

The attainment of generic health improvement competences should be supported through provision of appropriate professional development programmes.

2.1.2 Performance Management Context

In response to the amended Core Action 2, the required evidence for submission in the annual report is: *'The proportion of staff undertaking and completing professional development programmes'*

Core Action 4 should be evidenced with details on the level of engagement by PFPI leads within the CEL (1) 2012 delivery plans.

Core Action 5 requires hospital consultants to deliver health improvement actions, with a focus on interfaces with patients as a means of evidencing delivery. This can include demonstrating how: patients' status of smoking and alcohol and physical activity levels are routinely recorded at their first consultation; patients receive appropriate health improvement education/ information; and what processes are in place for onward referral and/or signposting to further support mechanisms.

2.1.3 Delivery Guidance

Whilst all Boards have formed their own governance procedures for HPHS, it is recommended that a clear link to ACF and MCNs would be very beneficial within the evidence of delivery for Core Action 1.

The challenge for acute care staff to undertake professional development training beyond statutory and mandatory training is recognised. Whilst topic-specific training is still relevant to specific staff groups, generic Health Behaviour Change (HBC) skills offers a more efficient and effective approach to workforce development for health improvement. Mechanisms of monitoring HBC development opportunities will be explored for year two, but can currently be evidenced against Core Action 2. National approaches to providing accessible and relevant mechanisms to raise staff awareness and knowledge in health improvement amongst hospital staff groups continues to be explored.

Professional Profiles, resources showcasing health improvement clinical champions and their practice, and how it links to their KSF evidence, can be found on the HPHS Knowledge Network.

For further support on Health Behaviour Change, please contact NHS Health Scotland Learning and Workforce team at: nhs.HealthScotland-HBCLWD@nhs.net

2.2 Action 18.1 Smoking

2.2.1 Any amended actions and/ or performance measures *(noted in italics)*:

Action A
Performance Measure 1 amendment

Increased quit attempts and successful quits amongst hospital in-patients, o*ut-patients, day surgery cases and pregnancy.*

Performance measure 3 amendment

Evidence of *training and/or support* in the delivery of brief advice for smoking cessation in secondary care;

Performance measure 3 amendment

Evidence of *specialist smoking cessation support (or health behaviour change equivalent)* available within or to all secondary care sites within Boards

Action B

To commit to the development *(or maintenance)* and implementation of a comprehensive organisational tobacco policy.

2.2.2 Qualification of terminology or language in CEL (1) 2012

The definition of smoking cessation referral set by the National Smoking Cessation Coordinators Network is:

A referral into the smoking cessation services from a hospital based health professional not limited to specialist smoking cessation staff

To commit to the development (or maintenance) and implementation of a *comprehensive* organisational tobacco policy.

In achievement of a '*comprehensive'* policy guidance within CEL (1) 2012 advises that consideration should be given to going beyond current legal requirements and moving towards the goal of being completely smoke-free. However please see details in Delivery Guidance for further support with regards to organisational planning and how the policy is embedded throughout the system.

2.2.3 Performance Management Context

NHS Boards are expected to submit the data already recorded on the ISD National Smoking Cessation Database as part of the monitoring annual reports. Requests for amendments to the ISD dataset identified through the consultation have been shared with ISD to support national consistent and prevent duplication of effort.

Smoking cessation delivery provided by single-service models are understood to be focused on community engagement and therefore it is recognised that there may be a decrease of hospital referrals, due to successful primary care engagement. This will be discussed in respect of the monitoring data produced.

A standardised format of local tobacco policy details will be provided as part of the Evidence of Delivery within the annual report template.

2.2.4 Delivery Guidance

Action 18.1 A
The amendment of performance measure 1 to extend the requirements beyond 'in-patients' to also include outpatients, day surgery cases and maternity services has been agreed with the Scottish Government following consultation with the National Smoking Cessation Network. This addition has been made in order to provide more comprehensive representation of the hospital and community hospital setting contribution to smoking cessation support. The inclusion of maternity smoking-cessation quit attempts links with the national HEAT target to reduce smoking prevalence in pregnant women. Opportunities to record smoking status, deliver brief advice and signpost to specialist services exist over the course of the pregnancy at routine appointments with maternity services.

We recognise that Boards may not have mechanisms in place to report from all named settings due to varying sizes of Boards and models of delivery, however this should be provided wherever possible. Boards should provide details of any of the settings omitted from their monitoring data during quarterly reports.

It is recognised that patients who wish not to engage with the service following brief advice/ sign-posting may not be included in the baseline data for interventions being delivered. Additionally, it is appreciated that the total sum of brief advice offered in relation to smoking cessation by clinicians across the hospital setting will not be fully represented in this data capture; however the data provided by Boards will be helpful to exemplify the extent of opportunities within hospitals and this national consistent approach will enable comparisons to be drawn.

Action 18.1 B
Guidance within CEL (1) 2012 on achievement of the Action B advises that, wherever possible, consideration should be given to going beyond current legal requirements and moving towards the goal of being completely smoke-free. The consultation process has highlighted further legislative support to achieve smoke-free status is required. NHS Health Scotland and Scottish Government are working together to provide alignment with CEL (1) 2012 and the new Tobacco Control Strategy for Scotland 2012 to support a unified national approach. Leadership from MCNs to align with smoking cessation ICPs is also being explored nationally.

Planning and implementation of smoke-free sites within the NHS aligns with various workstreams including Scottish Patient Pathway Safety work, Healthy Working Lives and Health & Safety legislation, and therefore requires cross-organisational representation. Recommended staff groups accountable for achievement of this action include: Facilities, Health and Safety, Communications, Smoking Cessation, Clinical staff and Management. It is essential that facilities management of smoke-free policies is aligned to in-patient NRT and cessation support services.

For further information please visit:
NHS Health Scotland's tobacco webpages at:
www.healthscotland.com/topics/health/tobacco/index.aspx

Please refer to page 7 of CEL (1) 2012 for additional support on key policy drivers.

2.3 Action 18.2 Alcohol

2.3.1 Any amended actions and/ or performance measures *(noted in italics)*:

Performance Measure 2 is amended to align with Action 18.2 wording
The number of A&E attendance screening for *harmful or hazardous drinking* and the % screening positive i) with % eligible for ABI and ii) % eligible for referral to treatment services

2.3.2 Performance Management Context

The monitoring and evidence dimensions against Action 18.2 have been aligned with the revised Alcohol and Drug Partnerships (ADPs) Governance and Accountability arrangements to minimise any duplication of effort.

Performance measures 1 and 2 form part of two core indicators provided on an annual basis to support local ADPs' core outcomes, as part of their planning and reporting arrangements. Extraction of A&E data is required locally as part of HEAT 4 requirements. The NHS is a member of these local ADPs and the A&E component will be fed into these indicators. These indicators will be submitted to Scottish Government in June every year, with the next available at end of June 2013. Further details available: www.scotland.gov.uk/Resource/0039/00391796.pdf

Performance Measure 3 is collected by ISD and shared with Scottish Government and NHS Health Scotland. Publication of these figures currently takes place annually.

2.3.3 Delivery Guidance

It is recognised that there are multiple challenges in the delivery of ABIs in A&E settings including training, the low percentage of 'screen positive' cases and high DNA rates for further assessment. Consultation feedback has indicated Boards are continuing to identify wider settings within secondary care that they feel are more appropriate for ABI delivery. This should be detailed within the evidence provided.

For further support please visit:

- Alcohol Brief Interventions: Communications and Guidance webpage: http://www.healthscotland.com/topics/health/alcohol/alcohol-brief-interventions-communications-and-guidance.aspx#data

- ABI HEAT Standard National Guidance 2012/13: http://www.healthscotland.com/documents/5662.aspx

Please refer to page 8 of CEL (1) 2012 for additional support on key policy drivers.

2.4 Action 18.3 Breastfeeding

2.4.1 Any amended actions and/ or performance measures *(noted in italics)*:

Amendment of Performance Measure 2

All mothers are signposted to available breastfeeding support programmes in the community. Those with additional needs who are least likely to breastfeed, or breastfeed only for a short time, are supported to access and engage with services through an appropriate referral process.

Additional Performance Measure 4

All women returning to work from maternity leave are advised of the breastfeeding support policy 4 -6 weeks prior to returning to work.

2.4.2 Qualification of any terminology or language in CEL (1) 2012

In respect of Performance Measure 2 '*signposting*' should be understood as detailed within the UNICEF BFI guidelines: 'Identify sources of national and local support for breastfeeding and ensure that mothers know how to access these prior to discharge from hospital.' Appropriate national resources are provided in 2.4.4 below.

2.4.3 Performance Management Context

Data collection for signposting can be challenging given the other demands of data collection for maternity and early years, and therefore Boards should provide proportionate baseline data as part of Year 1 reporting. As some Boards have indicated, their existing practice encourages that all women are routinely signposted to breastfeeding support and this can be demonstrated in monitoring values provided (i.e. 100%). This measure may be amended in Year 2, and exploration of referral pathways for those requiring additional support will be considered.

2.4.4 Delivery guidance

Action 18.3 aligns with a number of other work streams around maternity services and early years, including the Early Years Collaborative, Leading Better Care, Maternity Care Quality Improvement Collaborative, Quality Measures for the Maternity Care Framework and Indicators for the Maternal and Infant Nutrition Framework. This action is not intended to duplicate effort but to evidence the full contribution of hospitals across departments and settings.

Maternity units are encouraged to link with community breastfeeding initiatives and programmes in order to fully achieve success of breastfeeding outcomes. Challenges around continuity and consistency of breastfeeding support for women from islands and rural areas are being explored in order to identify appropriate support.

Patients can be signposted to the national breastfeeding website, for information on both local and national support, at: Feed Good Factor

Off To A Good Start- all you need to know about breastfeeding for your baby

For further support please visit:

- UNICEF BFI professional guidance: www.unicef.org.uk/BabyFriendly/Health-Professionals/
- Professional maternal and early years: www.maternal-and-early-years.org.uk/

Please refer to page 11 of CEL (1) 2012 for additional support on key policy drivers.

2.5 Action 18.4 Food and Health

2.5.1 Amended actions and/ or performance measures *(noted in italics)*:

Performance Measure 1
Number of sites with hospital caterers from all sectors with Healthyliving Award (or Healthyliving Award Plus for those caterers who have already achieved the Healthy Living Award) as a proportion of total sector delivery units. *It is noted that for performance measure 1 some sites have more than 1 unit, and this should be specified within the annual report.*

2.5.2 Performance Management Context

The monitoring and evidence measures required for Action 18.4 are recorded by Boards as part of their Healthliving Aware (HLA)and healthyLiving Programme (HLP) requirements on a quarterly basis. These measures should be included within the HPHS annual report.

2.5.3 Delivery Guidance

Staff with responsibility for Contracts and Procurement in the hospital setting should be made aware of the requirements within CEL (1) 2012, and the details of the HealthyLiving Award and the Scottish Grocers Federation Healthy Living Programme criteria.

HealthyLiving Award and healthyLiving Programmes can offer support and guidance during periods of contract re-negotiation. For support with contract negotiations or any other queries please contact: nhs.HealthScotland-hphsadmin@nhs.net

Boards are reminded that PFI hospitals are to be included in the delivery of CEL (1) 2012 requirements, although the route by which contracts are negotiated may be slightly different.

National support and recommendations in response to the challenges with non-NHS retail units and/or existing long-term contract agreements identified through the consultation are being explored within Scottish Government.

For more information please use the links below:

- The HealthyLiving Award: http://www.healthylivingaward.co.uk/
- SGF healthyliving Programme: www.fhascot.org.uk/Resource/scottish-grocers-federation-healthyliving-programme
- The Scottish Food and Health Alliance: http://www.fhascot.org.uk/Home/

Please refer to page 13 of CEL (1) 2012 for additional support on key policy drivers.

2.6 Action 18.5 Health Working Lives

2.6.1 Any amended actions and/ or performance measures *(noted in italics)*:

Action amendment

Action: Continue to work to attain Healthy Working Lives Awards for all acute services, working towards the Gold award

Removed: *'work to attain the Healthy Working Lives Mental Health Commendation Award'*

Performance Measure 3 removed: *NHS Boards should work to attain the Healthy Working Lives Mental Health Commendation Award.*

2.6.2 Performance Management Context

It is recognised that within Boards, some, hospital units/departments may have achieved the HWL Award, but not the whole hospital. Boards should provide details of the hospitals units and/ or sites reported on within their HPHS Annual Report.

2.6.3 Delivery Guidance

Boards are encouraged to engage with Staff Side Groups, Area Partnership Forums, Occupational Health, Health & Safety and Staff Governance workstreams on appropriate staff health and wellbeing issues. Contributions from key staff groups, e.g. AHPs, in improving health and wellbeing of staff and supporting attendance through their contribution to occupational schemes should be fully explored.

Additionally, in line with the Delivery Context Section 1.2.3 (Mental health and Wellbeing) within CEL (1) 2012, the Healthy Working Lives award offers a key mechanism to embed mental health improvement within the hospital setting. The protection and promotion of staff mental wellbeing is essential to achieving a motivated and productive workforce that is positioned to consider the mental health and wellbeing of patients, relatives and colleagues.

Challenging stigma and discrimination of mental health ill-health is a core national priority within the Mental Health Strategy for Scotland 2012-2015 and it is essential that NHS staff are leaders in improving the mental health literacy of the general population and put processes in place which facilitate inclusion and support a culture which appreciates and values diversity.

Whilst the HWL Commendation Award is being embedded within all HWL Awards criteria, the standards underpinning this award for good practice in promoting positive mental health and wellbeing ensures that staff participate in mental health awareness activities with specific support for managers and organisations undertake stress risk assessment and produce an annual action plan to tackle any organisational issues and implement a workplace mental health and well-being policy.

For information and support on HWL please visit:

- www.healthyworkinglives.com/award/index.aspx

Please refer to section 2.8 for linking HWL workstreams to Actions 18.7 and 18.8. For further advice and support www.healthyworkinglives.com/advice/workplace-health-promotion/physical-activity.aspx

Please refer to page 15 of CEL (1) 2012 for additional support on key policy drivers.

2.7 Action 18.6 Sexual Health

2.7.1 Qualification of any terminology or language in CEL (1) 2012

'vulnerable women who are at risk of poor sexual health outcomes'

Due to the current challenges in having a consistent definition of "vulnerability" (including 'drug and alcohol problems') and a robust reporting mechanism, for year 1 (2013/14) of the framework, vulnerable women will be recorded as:

i) under 20 years of age (i.e. up to19 years and 364 days) and
ii) from SIMD groups 1 and 2.

This interim definition has been agreed with the Scottish Government.

Long acting reversible contraception (LARC): this is defined here as those contraceptives that are the most effective at reducing unintended pregnancies: this includes intrauterine devices/systems (IUS/IUDs) and implants.

2.7.2 Performance Management Context

Challenges to reporting on the monitoring and evaluation data for sexual health were raised by a small number of Boards**.** Should Boards require further advice and support on reporting mechanisms for any of these measures please contact the HPHS team for sign-posting support at: nhs.HealthScotland-hphsadmin@nhs.net

2.7.3 Delivery Guidance

The Scottish Government recognises that sexual health improvement interventions are a new requirement to the HPHS CEL (1) 2012, and therefore the implementation process is at a developmental phase that may require additional support.

Further work at a national level will take place to develop more robust definitions and reporting processes to support data reporting that identifies women who are at risk of poor sexual health (including victims of gender-based violence, sexual abuse, those at risk of suicide and self-harm, and those with 'drug and alcohol problems' will be undertaken for year 2 (2014/15) reports of CEL (1) 2012.

Boards are encouraged to consider all appropriate sexual health improvement interventions in maternity and termination clinics within hospitals. This should include information and advice of preventing transmission of sexually transmitted infections (STIs) as well as unintended pregnancies through the provision of LARC, where appropriate.

There is a range of information sources for both professionals and women on long acting reversible contraception and the prevention/management of STIs.

To access information, go to:
www.sexualhealthscotland.co.uk/longer-lasting/contraception or to order email publications-healthscotland@nhs.net

For further information on sexual health policy and practice in Scotland please visit: www.sexualhealthscotland.co.uk/

For information on NHS Health Scotland Wellbeing in Sexual Health and HIV (WISHH) Network please visit:
www.healthscotland.com/topics/health/wish/index.aspx

Faculty of Family Planning and Reproductive Health Care
www.fsrh.org/

Clinical Effectiveness Unit
www.fsrh.org/pages/Clinical_Effectiveness_Unit.asp

ISD Key Clinical Indicators report on LARC
www.isdscotland.org/Health-Topics/Sexual-Health/

Please refer to page 17 of CEL (1) 2012 for additional support on key policy drivers.

2.8 Action 18.7/ 18.8 Physical Activity and Active Travel

2.8.1 Any amended actions and/ or performance measures *(noted in italics)*:

Performance Measure i) has been amended to the statement below

Evidence of brief *advice and/or* interventions for the routine provision of information and advice to patients on physical activity. This should include defined pathways for the delivery of brief advice.

2.8.2 Qualification of any terminology or language in CEL (1) 2012

Brief Advice

Brief Advice is a short (< 3 minutes), structured conversation used to raise awareness of physical activity. Brief advice is less in-depth than brief intervention. Each practitioner will develop their own approach to delivering brief advice. A suggested structure is to reiterate the physical activity recommendations, highlight the benefits, explore barriers, and identify solutions with the patient.

Brief Intervention

Brief Interventions lasts approximately 3 – 20 minutes, and goes a step beyond brief advice. They aim to motivate and support, taking into account the individual patient's needs, preferences and circumstances. Additional techniques, such as motivational interviewing, can be employed. Each practitioner will develop their approach of delivering a Brief Intervention. As with Brief Advice, a suggested structure might be to highlight the benefits, explore barriers, and identify solutions with the patient. A practitioner must remain non-judgmental and positive throughout the Brief Intervention.

2.8.3 Performance Management Context

Patient physical activity

The framework consultation has indicated the challenges of reporting on achievement of performance measure i) in response to physical activity action 18.7. The Scottish Government recognises that physical activity is a new requirement to the HPHS suite of interventions, and therefore the implementation process is at a developmental phase that requires identifying and supporting appropriate infrastructure for delivery.

To support this context for Year 1 reporting, Boards are asked to submit monitoring evidence focused on the proportion of staff and/ or staff groups who are committed to deliver brief advice and/or interventions routinely in their practice.

However, it is anticipated that the Year 2 annual reporting will require evidence of the number of patients routinely receiving brief advice/ interventions. Therefore, preparatory steps for this phase should be developed during Year 1 i.e. the addition of routine patient questions on a) current level of physical activity and b) advice/ intervention being delivered.

Boards should anticipate future requirements (for Years 2 and 3 of CEL (1) 2012) to identify all areas of practice where patients are asked about their smoking and alcohol habits, and include the National Physical Activity Pathway at these points of patient contact. This aligns with the Chief Medical Officers of England, Scotland, Wales, and Northern Ireland *Start active, stay active* report, which can be read in full here using this link:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128209

Therefore:

- All admission pro-formas should be changed to record level of physical activity at the point of re-print/ revision.

- All patient forms with self-reported questions on smoking and alcohol should be amended to include physical activity levels

National reporting mechanism in support
Exploration of developing national reporting mechanisms for physical activity within the hospital settings will be conducted by NHS Health Scotland and Scottish Government in consultation with Boards in 2013/14.

Staff physical activity
The measurement of staff physical activity levels and engagement with physical activity schemes is already included in Healthy Working Lives workstreams so these should be utilised wherever possible to support reporting.

Boards are advised that staff physical activity champions, already identified through staff health and wellbeing activities and HWL initiatives, should be identified and encouraged to support physical activity promotion from within their role.

2.8.4 Delivery Guidance

A National Physical Activity Pathway has been developed by NHS Health Scotland. This is intended for universal use across Scotland so that all NHS staff become familiar with it as part of their practice. NHS Health Scotland is conducting a feasibility study on implementing a Physical Activity Pathway delivering Brief Advice and Brief Interventions in primary care in Scotland between January and March 2013. For specific information on this study, please contact the Physical Activity Heath Alliance team via email at: nhs.healthscotland-paha@nhs.net

The National Physical Activity Pathway has been adapted to support the delivery of Brief Advice and Brief Interventions in Secondary Care to support CEL (1) 2012, and audit and improvement locally will be encouraged. This resource will be published on the HPHS Knowledge Network portal, and shared through the HPHS National Network as soon as it is available.

Leadership and collaboration
Boards are asked to identify an appropriate hospital-setting physical activity lead. This may be the lead for HPHS, AHPs or HWL, the existing Board physical activity lead or another appropriate individual who can influence change in the hospital setting. It is recognised that the active travel/ staff physical activity dimensions of CEL (1) 2012 and those targeting patients and visitors may require separate leads.

Hospital physical activity leads should proactively promote the National Physical Activity Pathway to staff managers/ leads in order to gain local buy-in and increase

capacity for raising the issue and delivery of brief advice on physical activity. It is recognised that opportunities for brief interventions may be lesser within the acute setting and initial work should focus on raising the issue and delivering brief advice.

It is understood that health improvement staff with existing remits for physical activity promotion currently focus activities in primary and community care. Their knowledge and experience should be used to identify any applicable practice approaches that could be adopted/ developed for secondary settings, and identify any opportunities for collaboration between staff and resources/ contacts through either formal (HPHS delivery groups) or informal (buddying) mechanisms.

There may also be opportunities to collaborate with community and voluntary sector organisations who lead and support physical activity schemes e.g. Paths for All, Sustrans, Living Streets etc. and these should be explored wherever possible. This may include identifying opportunities to provide walking groups for in-patients who wish to access the outdoor space within hospital grounds, as well as identifying opportunities within the community that are appropriate following discharge.

Action 18.7 A- Defining Pathways

As part of the Year 1 monitoring data on the proportion of staff/ staff groups who are delivering brief advice and/or interventions routinely in their practice, leads for hospital based physical activity promotion are advised to target specific clinical settings and groups where there is strong evidence that physical activity will be of benefit to the patient for their current treatment and/or future complications or where there is locally identified readiness and enthusiasm due to external factors e.g. the AHP physical activity pledge.

National recommendations for initial areas of engagement include: paediatrics, oncology, mental health, respiratory, cardiology and orthopaedics. However it is recognised that some degree of physical activity will benefit the vast majority of patients, and therefore physical activity promotion should be cascaded throughout the hospital setting.

The AHP Physical Activity Pledge offers a key mechanism to deliver the requirements of CEL (1) 2012 and all AHP Directors should produce delivery plans for their Board area. This will include various leads within each of the professional groups who can cascade information, and support colleagues. Key commitments within the pledge in support of CEL (1) 2012 include:

- Agree a form of questioning and brief intervention for each patient, every time and embed this in all AHP services
- Establish in each Health Board at least one partnership with local authority leisure services and exercise coordinators promoting community physical activity
- Explore a national “physical activity” challenge for teams of NHS staff

National work is ongoing to demonstrate the impact of the fulfillment of the pledge and HPHS leads should link with the AHP Directors and/ or AHP professional group physical activity leads in order to prevent duplication of effort. To read the Pledge in full please use the link below: www.paha.org.uk/Announcement/ahp-directors-physical-activity-pledge

Action 18.7 B and 18.8- Maximising opportunities
Hospital in-patients who have no mobility issues should be routinely encouraged to use the outdoor space and walking routes in hospital grounds during their stay and can do so without a referral by a member of staff. The benefits to mental wellbeing and opportunity to socialise should be promoted, as well as the benefit to physical health.

For performance measure 4 under Action 18.7, Boards should use a range of promotional materials to promote physical activity considering the range of accessibility and mobility requirements of staff, patients and visitors. This should include mixed-media approaches to sharing messages on the opportunities to be physically active and the benefits of doing so (e.g. active travel information on appointment cards and waiting rooms LCD screens, motivational posters/ stair-walking tools, advice and sign-posting messages on patient information boards, identifying greenspace/ walking routes/ bike storage on site maps, and providing information on physical activity providers and opportunities within patient information centres (or equivalent).

Staff training and support tools:

General awareness raising:

- **23 ½ hours:** http://www.paha.org.uk/Feature/23.5-hours

This educational film takes 10 minutes to view and is suitable for all staff levels. This can be used at weekly/monthly education meetings, or in staff rest areas. It is strongly encouraged that this is embedded into at ALL staff inductions.

Professional development

- **Free e-module "raising the issue of physical activity"** http://elearning.healthscotland.com/course/view.php?id=315

2.8.5 Supporting Evidence

It is recognised that at present there is no evidence on the effectiveness **or** ineffectiveness of brief advice and/ or interventions on physical activity being delivered within acute care directly as this is an emerging area of practice. The Scottish Government aims for Scotland to be a world leader in the promotion of physical activity and therefore pioneering practice is required based on the principles of plausible theory. For the Scottish population to have continuity of messaging on the importance of physical activity it is essential that health professionals are exemplar champions in the benefits of an active lifestyle. This requires that physical activity is promoted across the entire healthcare system so that there is better understanding at a general-population level of the impact it has on in both quality and length of life.

As part of the implementation of physical activity advice/ interventions into the hospital setting, Boards are encouraged to embed evaluative approaches into practice in order to support our shared understanding of effective practice and increase the evidence base to inform future actions. The CEL (1) 2012 quarterly HPHS National Network Meetings will be used to identify shared experience of enablers and barriers in support of this. National support to develop an evidence

base will be explored as part of the ongoing support for HPHS provided by NHS Health Scotland.

Please refer to page 19 of CEL (1) 2012 for additional support on key policy drivers.

2.9 Innovative and Emerging Practice

2.9.1 Performance Management Context

This requirement relates to CEL (1) 2012 Performance Measures 16-18.

A pro-forma will be developed with the HPHS National Network in order to support Boards report on this topic within the annual report.

Quarterly monitoring of this area is not required, but may be discussed should examples of good practice be relevant to specific meeting themes.

Boards are encouraged to take a thematic approach to reporting in order to take a pragmatic approach to reflection *some* of the wider health improvement activities being undertaken by staff within the hospital settings.

Examples of opportunities to report on innovative and emerging practice identified through the monitoring and evaluation consultation process include:

- Demonstrating specific actions to advance equality and/ or tackle health inequalities
- Demonstrates mental health benefits to patients, relatives or staff

2.9.2 Delivery Guidance

Opportunities to provide health improvement interventions within current practice and/or identified areas of needs within hospital settings aligns with Performance Measures 16-18, noting the specific CEL (1) 2012 actions are minimum set of actions to be delivered by Boards.

The Innovative and Emerging Practice reporting dimension offers Boards to share good practice and comprehensively represent the contribution of the hospital setting and highlighted achievement in targeted approaches, in addition to health improvement topics specified within CEL (1) 2012.

This dimension has been agreed with the HPHS National Network.

3. Health Inequalities Impact Assessment Screening Summary

As part of the development of the Monitoring and Evaluation Framework, NHS Health Scotland conducted a Health Inequalities Impact Assessment screening. This section provides a summary of these findings. Any recommendations resulting from this process, following identification on potential inequity in delivery, have been detailed within the respective topic section. Additionally, ABIs Interventions and the Health Works programme have been subject to individual assessments and these are available on request from: nhs.HealthScotland-hphsadmin@nhs.net

To further support this process, NHS Health Scotland will be coordinating a full Health Inequalities Impact Assessment of the HPHS programme of work as part of business delivery 13/14.

For further support and information on advancing equality and tackling health inequalities, please refer to section 1.2.2. Colleagues are also advised to contact their local Equality lead for support in ensuring printed materials meet the needs of local populations and an up-to-date list of local leads can be found at: www.healthscotland.com/Equalities/index.aspx

Action 18.1 Smoking
Smoking cessation support should be offered and available to all smokers within the hospital settings. All smokers should be informed about the cessation support by practitioners during their hospital treatment, and be provided with a written resource or another appropriate means, detailing cessation support contact information. Patient-facing smoking cessation information and self-referral information should also be provided in patient information (*or equivalent*) points through staff, free phone numbers, waiting room posters and department signage.

Sensitivity towards personal and cultural beliefs and knowledge on the impact of tobacco should be considered when informing patients about the harmful impact of smoking, and the cessation support available.

The implementation of smoke-free sites should be enforced in a consistent and equitable approach to support all patients, visitors and staff benefit from the provision of a safe smoke-free site.

Action 18.2 Alcohol
The challenging and changing environment of A&E to screen and deliver ABIs was recognised as a potential source of inconsistent provision of Action 18.2. Health improvement actions reliant on individual autonomy are not evidenced to be the most effective in reducing health inequalities. However, ABIs should be delivered to all appropriate patients in a consistent approach recognising that those experiencing harmful or hazardous drinking may challenge practitioner perceptions in terms of age, ethnicity, gender and mental/ physical disability, for example.

Action 18.3 Breastfeeding
The UNICEF Baby Friendly Initiative does not fall under the jurisdiction of the UK Equality Act 2010 and therefore may not have been equality impact assessed. Potential inequity in the provision of onward community referral support for those in remote and rural areas has been identified. Barriers to engagement may include cost of travel to support groups or access to public transport. Some local areas are already implementing virtual social networking support, and national work to consider appropriate mechanisms of support is being explored.

Staff knowledge and understanding of those who may require additional support should be developed to identify those least likely to breastfeed and how to then best support them.

Action 18.4 Food and Health
As the action relies on individual autonomy, there is potential for inequity of benefit, without support for patients, visitors and staff to understand healthy options. The use of prominent positioning of food options in retail units/ storage cabinets, signage, including HLA and HPA award resources, to highlight healthy options within the catering and retail units should be provided. It is recognised that healthy options should be competitively priced so that cost does not impact individual's opportunities to make healthy choices.

Action 18.5 Health Working Lives
The Healthy Working Lives programme has been subject to a recent HIIA. The award criteria has been redeveloped to account for any potential negative impacts and recommendations will follow.

Action 18.6 Sexual Health
The age-based service provision within Action 18.6 was challenged during the screening process, particularly in respect of those at risk of poor sexual health outcomes under the age of 16. However, the legal and medical rationale provided for these parameters means that this is not in conflict with the Equality Act 2010.

Scottish Government National Guidance on 'Under-age Sexual Activity: Meeting the Needs of Children and Young People and Identifying Child Protection Concerns' advises *'The law continues to make clear that society does not encourage sexual intercourse in young people under 16, as it can be a cause of concern for their welfare. It does not follow that every case has child protection concerns and it is important to ensure that a proportionate response is made and that only appropriate cases are brought to the attention of social work and the police.'*

Additionally, the importance of considering a holistic approach to identifying all potential poor sexual health outcomes should be undertaken. This means that the provision of effective contraception should also include sexual health improvement in order to reduce unintended pregnancies and STIs. In addition, staff need to be aware of the needs of women of varying ages, ethnicities, socio-economic status and mental/ physical disability, who may require additional written and/or verbal support.

Action 18.7 and18.8 Physical Activity Active Travel
The risk of inequity in opportunities to be active within the hospital setting is consistent with national evidence for inactive groups including those experiencing mental ill-health, physical or learning disabled people and those with long-term conditions (particularly those with co-morbidities).

All information on the national physical activity recommendations, and opportunities to be active within the hospital grounds, including travel to/ from, should be considerate of the physical and financial barriers in making an active-travel choice. The importance of using different mechanisms to communicate these messages through written, verbal and interactive approaches across the hospital should be borne in mind.