Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Health Improvement Partnerships Board: Thursday 6 February 2025

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Title:	**OUH Prevention Programme**
Status:	**For Information**
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Board Lead:	**Chief Medical Officer**
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Confidential:	**No**
Key Purpose:	For Information

OUH Prevention Programme Update

1. Purpose

1.1. The purpose of this paper is to summarise recent work on prevention at Oxford University Hospitals NHS Foundation Trust (OUH).

2. Background

National Context

2.1. Prevention should be at the heart of everything the NHS does. This has been emphasised in the NHS Long Term Plan and in the Secretary of State's Prevention Vision, both of which stress the core role of the NHS in preventing disease and improving population health. The Long Term Plan highlights the importance of preventing disease as a route to better health and lower inequalities, and to controlling demand management and maintaining sustainable finances.

2.2. Lord Darzi's rapid, state of the NHS review, focusing on assessing patient access, quality of care and overall performance of the health system, and the subsequent development of the Governments 10 Year Health Plan reinforces three shifts to Community, Digital and Prevention supporting the drive for prevention.

2.3. Prevention is a stated strategic priority for the Shelford Group, a collaboration of the ten largest research and teaching NHS hospital trusts in England, which includes Oxford University Hospitals NHS Foundation Trust.

Local Context

2.4. The Oxfordshire Health and Wellbeing Board is the partnership vehicle in Oxfordshire for delivering whole systems approaches to health and wellbeing.

2.5. The Oxfordshire Health and Wellbeing Board has developed a Prevention Framework setting out how partners can work together across the system to prevent ill health. OUH is a member of the Board, a key delivery partner for the delivery of the Health and Wellbeing Strategy and the Prevention Framework.

3. Prevention at OUH

3.1. OUH has the opportunity to make a significant contribution to preventing disease and improving the health and wellbeing of the Oxfordshire population through its 15,522 members of staff, 1 million patient contacts, and substantially more visitors to its sites every year. This is being achieved through activities such as acting as an 'anchor institution', by making best use of its digital and analytical potential, by acting both independently and in partnership to orientate services towards prevention and through its membership of Oxfordshire Integrated Care Partnership and wider Buckinghamshire, Oxfordshire and West Berkshire Integrated Care System (ICS).

3.2. The importance of prevention has also consistently been reflected in the Commissioning for Quality and Innovation schemes in previous years, including alcohol and tobacco screening and advice, and staff flu vaccinations.

3.3. Preventing disease and improving population health is a national NHS priority. Some patients, often the most vulnerable in society, may access health care in acute healthcare trusts more frequently than in community settings. Acute trusts therefore have an important contribution to make in supporting preventative work, improving healthy life expectancy and reducing inequalities, as part of the care and treatment of their patients.

3.4. The Trust's potential health-promoting influence extends to the families of staff, patients and visitors, and to the wider local community, for example through employment, procurement, and transport infrastructure.

3.5. The vision of OUH is to 'be an exemplar in healthcare delivery that is compassionate and enabled by the highest levels of research and innovation.' The following strategic objective has been agreed and is central to the development of the 3-year plan:

3.6. To work in partnership at Place and System level for the benefit of our patients and populations with effective collaboration to reduce health inequalities and fulfil our roles as an anchor institution.

OUH Prevention programme

Here for Health

3.7. Here for Health offer a free health and wellbeing service to staff, patients and visitors to OUH trust. As part of the lifestyle consultation, physical activity is discussed, and people are regularly referred to Move Together.

3.8. Here for Health supports services and their patients through recommendation of Nicotine Replacement Therapy (NRT) and providing

behavioural change support to inpatient smokers and onward referrals to community stop smoking services. On average of 138 patients per month are supported. Patient Education sessions are delivered for Oncology, ERAS, Urology, Colorectal, Dermatology and Hepatology averaging 35 patients per month.

3.9. The Here for Health (H4H) approach is based upon improving psychological capability through increasing awareness, knowledge and emotional wellbeing support; providing support opportunities through referral pathways; and influencing motivation for behavioural change through behavioural medicine

3.10. During 2024, 5156 lifestyle medicine conversations were completed by Here for Health (H4H) team. These included 2996 remote consultation, 373 face to face consultations, 863 Inpatient ward visits, 815 promotion stand conversations and 400 education session attendances.

3.11. Of the contacts in 2024, 31.4% were with individuals whose ethnicity was BAME, 51% identified as a man and 49% as a woman and <1% were non-binary or preferred not to say.

3.12. In 2024 H4H made 184 referrals to Move Together/You Move. Discussing the benefits of being more active can have significant benefits on reducing stay in hospital, mental health, progression of disease and can help manage long term conditions. Therefore, being able to discuss this with everyone seen helps to improve people's wellbeing and self-management.

3.13. Move Together and You Move is a physical activity pathway which can offer free or low-cost physical activities for adults, children and young people respectively. This can include home based, community or leisure type activities.

3.14. Here for Health also deliver **Making Every Contact Count (MECC)** and the Power of Healthy Conversations skills training which aims to increase healthcare professionals' skills in discussing topics such as physical activity, minimising harmful substances, weight, healthy eating and self-care. Within these training sessions H4H regularly signpost to Moving Medicine, a free resource, which healthcare professionals can access, for advice on conversation frameworks, on how to discuss physical activity as well as providing the benefits of exercise for a variety of long-term conditions.

3.15. **Tobacco Dependency Advisors**

Tobacco Dependency Advisors (TDAs) have been employed at the Trust since April 2023, and provide behavioural support, as well as

recommending an appropriate level of Nicotine Replacement Therapy (NRT), to all inpatient smokers who are referred to the service.

3.16. Referrals are automatically generated when smoking status is clerked on the Electronic Patient Record (EPR). As of December 2024, there is a dedicated proforma for recording smoking status, with a reminder being placed on the patient tasks until it has been completed. Before this time, smoking status could be recorded via completion of the KIPI tool, but completion of this was found to be low. Since the change, the number of inpatient referrals has increased threefold.

3.17. NHS England's Core20Plus5 approach focuses on five clinical areas all of which are exacerbated by smoking. The work being undertaken by TDAs directly contributes and positively impacts upon potential health inequalities in the Oxfordshire and OUH's patient population.

3.18. **Emergency Department Based Services**

3.19. Over the last decade, several complementary services have been developed to provide care and support for an identifiable yet heterogenous cohort of patients attending OUH Emergency Department (ED). They include the High Intensity Use Service (HIU), Community Safety Practitioners (CSP), Alcohol Care Team (ACT), Embedded Housing Workers (EHW), and the Hospital Navigator Programme (HN). Some of these services are the result of specific initiatives and some are nationally mandated (e.g. ACT and HIU). All the individual teams have become valued partners across the Trust and within a network of external organisations. They have not only proven to be beneficial to the needs of a typically marginalised group, but many have shown an ability to reduce pressures on the acute hospital. Although they work with a similar patient population, the various teams are all inherently different, and they each provide a unique service. That said, they often work in unison and support each other when more specific problems arise.

3.20. While the nature of Emergency Department care is typically reactive to urgent medical need, the services mentioned above have given additional value in their ability to play a preventative role in health improvement, both at patient and population level. Although all the services contribute towards this aim, an example of primary prevention is the work of the ACT. Additionally, secondary prevention is a major goal across the various teams, i.e. the prevention of future biopsychosocial crises. Within this remit all the services work closely with the OUH Safeguarding Teams.

3.21. **High Intensity Use Service (HIU)**

3.22. Prior to establishing the HIU service, OUH and Oxford Health NHSFT had a Frequent Attender Programme which focused on devising management plans for patients regularly attending our Emergency Departments. It is widely recognised that this population has complex physical and mental health needs, which are not easily met in the acute care environment. Yet, they often return to the ED, which is where a focus on prevention is required. A 2021 Red Cross report found that High intensity ED use is associated with homelessness, joblessness, drug and alcohol misuse, criminality, loneliness and social isolation. (*A symptom of unmet need: Learning more about people who frequently attend Accident and Emergency services*. A report for the British Red Cross by Imperial College Health Partners. November 2021, North West London)

3.23. In 2019/20 a formally commissioned HIU service was established. This service recognised the need for providing support outside of the ED environment, with the patient as a partner in goal-setting, and the aim of making a real change to their lives. The HIU service has recently been paused, so the model will be described as it existed when fully operational.

3.24. Since its inception the HIU team consisted of multi-disciplinary professionals, including clinical coordinators of various backgrounds (in the first year we had a physiotherapist and since then seconded ED nurses and EDPS practitioners), ED and psychiatry consultants, and a psychologist. While hosted by OUH, the core HIU service is provided by both OUH and Oxford Health, the two major Trusts in Oxfordshire.

3.25. The HIU programme is founded on the principle that complex patients need a complex response to improve their ability to self-care and enable them to be healthy and functional members of society. This is not a homogenous group of individuals, but rather a number of distinct groups whose needs and risks require different approaches to ensure they receive a coordinated and consistent response to address their health and social challenges. Such a response involves system-wide working with multiple partners, both statutory and voluntary, both primary care and secondary care. Indeed, the networks created by the HIU service has enhanced its potential as a key stakeholder in the health improvement and prevention space.

3.26. In an independent evaluation done by Imogen Blood and Associates in 2023, the Oxfordshire HIU service was described as "looking after a houseplant; the traditional NHS approach looks at the water given to a plant, but plants also need soil, an appropriate size pot, light and clean air,

which the NHS alone is not designed to do; to look at someone's whole problem needs an analogously broad approach. Overall, 30 other organisations were mentioned in the HIU data as sources of onward referral or further support".

3.27. From a healthcare cost perspective, the report estimated a return on investment of more than £4 for every £1 spent. This is simply a monetary quantification of preventative impacts. As stated in the report it "could well be an underestimate, as many patients have complex histories of mental health and long-term physical health conditions which could be prevented from becoming worse if they are supported into more appropriate care, preventing inpatient treatment for their condition becoming necessary."

3.28. The HIU service sub-contracted Elmore Community Services, a local third sector organisation, to provide a direct referral pathway which prioritises a brief 3-month intervention, with the premise that increased ED attendances signifies a crisis period.

3.29. The Oxfordshire HIU service model involves working with patients directly, identifying opportunities to prevent health deterioration, and enabling numerous services to deliver care in a coordinated way, rather than in silo. It has received regional and national recognition, and aspects of our model were referred to in the recently published Royal College of Emergency Medicine guidance on services for patients who frequently attend EDs.

3.30. **Alcohol Care Team**

3.31. The Alcohol Care Team (ACT) has been operational since October 2018. Over time we have extended our scope of practice, and our primary focus is on the improvement of alcohol withdrawal management within the OUH. The ACT was restricted to the inpatient setting due to funding and resource. However, the evidence suggests that ACTs can be most effective when operating in Emergency departments.

3.32. A 18-month grant was awarded by Oxfordshire County Council to help develop and introduce a 5-day ACT into the two ED Departments at the OUH. This was to help understand the unmet need and collect local data which would help to highlight the issues around alcohol related presentations. This model is to provide equality of care to our patients including safe detoxes, interventions in ED and EAU and teaching/training. The project commenced in September 2023. The current funding for the service will end on the 31st March 2025.

3.33. The project has been extremely successful. During the first 12 months of the project the ACT reviewed 804 patients in ED across both sites (JR and HGH). On average the ACT have been able to support 67 patients a

month. This has included initiating and advising medical management for alcohol withdrawal plus supporting patients with complex social needs. The ACT have identified that many patients in the Oxfordshire area are already known to community drug and alcohol services but may have sporadic engagement. In our role we have been able to bridge this gap and encourage patients to re-engage and access timely support in the community. The ACT have referred 516 patients to community alcohol services with 209 of these being new referrals. During the first 12 months of the project the ACT averted 112 admissions from ED. This has been calculated as a financial saving of £310,464 over the first 12 months.

3.34. **Community Safety Practitioners**

3.35. The Community Safety Practitioner Service (CSP) has been running in its current format since 2021, with three Band 7 ED Nurses sharing 1.8 whole time equivalent. They are funded by Public Health and are embedded within the Emergency Departments (ED) in the OUHFT John Radcliffe and Horton Hospital.

3.36. The patient cohort that we are referred, are those that are discharged or who left the Emergency Departments following an attendance where alcohol, illicit substance use, homelessness, community violence (either as a victim or perpetrator) and violence / assaults on Emergency Workers in the ED's. Patients who frequently attend the ED will often be referred onwards to the HIU service and managed collaboratively. Other individuals will require specific input from the ACT or homelessness services, in which case the teams will work in parallel. Notably, CSP does not primarily provide a patient-facing service, but is active at the interface of hospital-based and community services.

3.37. CSP is based on The Cardiff Model for information and data sharing and forms a vital multifaceted interface between stakeholders and tertiary services within the community setting and the Emergency departments.

3.38. CSP have initiated and developed patient pathways with probation services, His Majesty's Prisons and Police to improve transfer and communication and information sharing between the custody setting and the Emergency Departments and to improve patient safety. These have been implemented locally within the ED and some more Trust wide.

3.39. CSP has seen an overwhelming increase into the service since we have been working within our current model which has increased by over 450% since 2016 and continues to grow.

3.40. CSP continue to be increasingly impactful on reducing health inequalities and health improvements especially with the increasing misuse and cost of alcohol and illicit substances within our communities and the NHS.

3.41. CSP has developed from an in-house support service to a proactive, innovative and respected team within the wider OUH Trust and our partners and stakeholders, empowering a positive change to the experience of both patients and staff and our communities.

3.42. **Hospital Navigator**

3.43. The John Radcliffe Hospital Navigation Scheme, initiated in July 2024, is part of the Thames Valley Violence Prevention Partnership's broader initiative under the Home Office Violence Reduction Scheme. The program targets people aged 15–25, which allows it to focus on children and young people, thereby augmenting the work done by other ED-based services. The scheme addresses issues such as physical and sexual assault, gang-related violence, exploitation, mental health crises, and substance misuse. With a part-time employed ED Coordinator, the scheme relies on volunteers to provide support and guidance to at-risk individuals in the Emergency Department (ED). These volunteers build trust, offer emotional support, and connect young people with relevant community resources, aiming to prevent future ED visits and promote positive outcomes.

3.44. The program's primary goal is to intervene during critical "reachable moments" when young people are open to assistance. Volunteers receive referrals from ED staff and engage in tailored signposting to local agencies, follow-up communications, and mentoring sessions. Specific cases illustrate the scheme's impact, including supporting victims of violence, addressing family dynamics, and fostering re-engagement with education or work. Navigators often collaborate with safeguarding teams, social workers, and mental health professionals to address complex needs comprehensively.

3.45. While the program has proven invaluable, challenges such as volunteer sustainability and safety concerns during offsite visits have emerged. Despite these obstacles, the initiative has made a measurable difference, with 120 referrals since its inception. The scheme emphasizes the importance of expanding its scope to include community navigation and enhancing partnerships with external organizations. Its success underscores the need for long-term sustainability and development to maximize its impact on young people and their families.

3.46. **Oxfordshire Health and Homelessness Inclusion Team**

3.47. A multidisciplinary team comprising a mixture of short-stay respite accommodation and statutory / clinical in-reach into hospitals and community services. For people aged 18 and over, experiencing, or at risk of, homelessness or rough sleeping within Oxfordshire.

3.48. Core aims are to:

- Facilitate planned, safe and timely discharges from hospital; avoiding discharges to street and associated re-admissions;
- Increase access to services; reducing inequalities and avoiding admissions to hospital where a person's needs can be better met in the community;
- Improve patient experience and outcomes;
- Prevent rough sleeping and homelessness.

3.49. The service has assisted in generating flow, creating capacity and changing lives. 611 supported discharges with 267 to step down facilities. This has shown 24% reduction in emergency admissions, 56% reduction in presentation to ED and 155% increase in elective outpatient visits.

3.50. £1,587,000 freed up preventing re-admissions and £1,984,647 costs avoided maintaining accommodation

3.51. The service contributes towards preventing admission, avoiding rough sleeping and increasing access.

3.52. **Prevention Work in Palliative Care**

3.53. The Palliative Care Service across Oxfordshire and South Northamptonshire aims to improve the quality of life of patients who have a non-curable, life-limiting illness, and of their families.

3.54. Our Living Well service supports patients with a life-limiting illness to improve their wellbeing and manage their symptoms. As more people choose to be cared for in their own home at the end of their lives, OUH Palliative Care services offer personalised care to more people in their own homes, through integrated and enhanced palliative care and support plus early supported discharge from hospital, where this is the choice of patients and their families. They complement existing services provided by a wide range of valued hospices and care providers (rather than replacing them). This initiative has meant that our patients have cumulatively spent >12,000 days at home each year instead of in hospital in their last year of their life.

3.55. Palliative Care Bereavement Support is offered to friends and family members of palliative care patients. This support serves an important

preventative function in helping with mental health and wellbeing at a critical time of change in people's lives. In addition to 1:1 support, we also offer a Bereavement Cafe, which provides social engagement with others who are bereaved.

3.56. Voluntary Services within Palliative Care also provides an opportunity for social engagement. We have over 100 volunteers, with an average age of sixty.

3.57. The Palliative Medicine Department has made a significant commitment to Equality, Diversity, and Inclusion (EDI), hiring an EDI Officer funded by Sobell House Hospice Charity to better understand and address health inequalities in palliative care. There was a significant unmet need for palliative care among individuals experiencing homelessness, who are more likely to die premature deaths. Together with the Lived Experience Advisory Forum, they held focus groups to understand what matters most to people on the homeless pathway when they or a friend are dying. In response to those results, they initiated a Homelessness Outreach Project with funding from St. James' Place Charitable Foundation and Sobell House Hospice Charity. A Community Nurse Specialist (CNS) has been seconded to work directly with partner organisations on their sites, in a location where patients would be comfortable, reducing barriers to our service. Five months on, the CNS has worked closely with Homeless Oxfordshire, Luther Street Medical Centre, Turning Point, and Connection Support, among others. The patient caseload of individuals experiencing homelessness has doubled, and the team have been able to support patients' dignity and choice through the end of their lives.

3.58. **Prevention Work through Sexual Health clinics**

3.59. Prevention work undertaken by Sexual Health clinic incorporates sexual health promotion and risk reduction. This would include preventative measures for blood borne virus, sexually transmitted infections and unplanned pregnancy.

3.60. Our Terence Higgin Trust outreach team do specialist health promotion/ safer sex & risk reduction work, focussing on young people, but also adults.

3.61. Within the clinical outreach team, we do health promotion workshops and visits to community groups, Turning Point and Hostels. This is to reduce stigma and promote easier access to testing, condoms and contraception to reduce infections and unplanned pregnancies.

3.62. **Maternity**

3.63. The maternity lifestyle team was established in January 2024 and offers the following maternity services. The tobacco dependency in pregnancy service offers a bespoke maternity in house programme throughout pregnancy and the postpartum period. Offering behavioural support, NRT and swap to stop vape vouchers.

3.64. The maternity immunisation service which has two hubs, one at the JR and one at HGH. Launched in September these offer RSV, Pertussis and seasonal flu and covid to pregnant individuals alongside antenatal appointments. Outreach pop up clinics are planned for hard-to-reach communities.

3.65. Several initiatives aim to tackle inequalities in maternity care, including the Equal Start Oxford program, place-based outreach clinics for asylum seekers, and efforts to improve language support and resource equity.

3.66. Community Partnerships: Equal Start Oxford (ESO) collaborates with community midwifery teams in the most diverse and deprived areas of Oxfordshire to improve maternal and perinatal health outcomes through advocacy and support for non-health needs such as immigration and welfare benefits.

3.67. Outreach Clinics: Place-based outreach clinics have been established for asylum-seekers in dispersal accommodations to ensure timely access to maternity care, addressing barriers like language and transportation.

3.68. Language Support: Efforts are being made to improve language support for rare languages, including Tetum, to enhance patient experience and communication.

3.69. Data Quality and Resource Equity: Ongoing initiatives include improving the accuracy of ethnicity and social determinants data in digital health records and matching community midwifery resources to areas of high need.

3.70. Community Engagement: Maternity services have expanded community engagement to Blackbird Leys, holding monthly sessions with diverse groups of women to gather insights and share information.

3.71. Digital Inclusion: Maternity services have become a registered hub for digital support, providing free SIM cards and mobile devices to pregnant women experiencing digital poverty, benefiting over women so far.

3.72. Anti-racism Training: Anti-racism and anti-discrimination training for maternity staff has been completed and mandated by senior leadership, with a focus on strong staff attendance.

3.73. **Moving Medicine & Physical Activity**

3.74. In 2024 Oxfordshire became a pilot site for the place based physical activity clinical champions programme. A physical activity coordinator was recruited who is working with Oxfordshire Active partnership to deliver training to all staff about physical activity in primary and secondary prevention. Physical Activity coordinator is working across the ICB and with the Sport and Exercise Medicine team of Specialist Registrar's to deliver training across the system.

3.75. The active Hospital project which was piloted in Oxford in 2018-20 continues. OUHFT Active Hospitals:

3.76. The Sport and Exercise Medicine team lead a Public Health England commissioned and Sport England funded Pilot to integrate physical activity interventions within secondary care.

3.77. Five pathways were developed in peri-operative transplant service, cardiology service, complex medical units (CMU), maternity service and prosthetics service. Since the Pilot, further pathways have been developed and implemented in Accident & Emergency, Hepatobiliary medicine, Paediatric services, Renal Dialysis and Acute Medical Admissions. Physical activity training has been delivered to over 400 healthcare providers during the Pilot.

3.78. On the CMU wards a dedicated team of trained rehabilitation support workers assess and deliver physical activity interventions for over 800 inpatients per year, aimed at maintaining functional status and reducing hospital deconditioning. Audit data demonstrates that this service is safe, that there has been no increase in falls rates and is highly valued by patients, families, and staff members.

3.79. Since launch the maternity service has assessed and delivered brief advice regarding physical activity to over 32,000 pregnant women.

3.80. **Staff Active Travel:**

3.81. Here for Health deliver health promotion campaign awareness stands throughout the year, one of which being National Bike Week in June 2024. This led to a partnership with OUH travel & transport to hold a cycle to work day on 1st August 2024 at JRH and travel & transport Horton day on 17th October 2024.

3.82. This led to a staff cycling initiative in collaboration with OUH travel and transport and Joyriders Oxford (local cycling volunteer group) to deliver a 10-week pilot cycle training programme for staff who wanted to learn/improve ability to cycle. 31 staff members signed up and 21 attended at least one session. Participants went from being absolute beginners to being able to balance and pedal on a bike independently. 75% of staff

who participated lived in OX3 and OX4 postcodes. 60% participants were from clinical roles and 20& administrative. 84% were from BAME backgrounds and 95% participants were female. Feedback was that staff wanted more sessions, more time to practice and the pilot to continue.

3.83. Here for Health were successful in securing £8k grant money through Active Oxfordshire and OCC active travel grant in Dec 24. This will allow the project to be further developed to provide 2 further 10-week training programmes at JRH and CH/NOC site to increase reach of project. OUH T&T will also be supporting extra funding to further develop this project.

3.84. Here for Health has also been exploring with colleagues from the Nuffield Orthopaedic Centre to develop walking routes connecting places across and around sites to encourage both patients and staff to walk more when accessing the Headington hospitals. This is in early stages but includes support from OUH charities and partnership with Go Jauntly, a community, based walking app encouraging connection with nature.

3.85. Staff also have access to the cycle to work schemes and discounted gym memberships through staff pay and rewards schemes.

4. Conclusion

4.1. The paper summarises the current areas in which OUH seeks to support the prevention of ill health, with particular reference to inequalities.

5. Recommendations

5.1. The Committee is asked to note and support the commitment of OUH to health improvement and the prevention of ill health described in the paper.