Cheshire and Merseyside NHS Prevention Pledge Evaluation Report

Dr Tammy Boyce
Institute of Health Equity
April 2022

Contents

Executive Summary

The NHS Prevention Pledge (PP), commissioned by the Cheshire and Merseyside Health and Care Partnership (HCP) through the Champs Public Health Collaborative, encourages NHS Provider Trusts to shift from treating illness to adopting a disease prevention approach which will reduce the impact of ill-health on NHS services in the medium and long term. The Health Equalities Group (HEG) deliver the PP and offer guidance and tools to support Trusts to implement the PP.

To date, nine NHS Trusts in Cheshire and Merseyside have committed to adopting the PP, with funding made available for two trusts to start adoption in 2020-21, and another seven across 2021-22.

The evaluation assesses the nine Trusts in Cheshire and Merseyside that are implementing the PP, analysing whether the PP is an effective mechanism to increase the level of prevention activity undertaken by NHS Trusts and specifically considers the role and capacity of the PP in supporting the delivery of prevention activities as part of the future Marmot/ Institute of Health Equity programme and in supporting NHS organisations to become Anchor Institutions and implement social value approaches.

Methods

This research uses qualitative methods. The research is a purposive sample of 11 interviews of 20 participants, including the nine Trusts implementing the PP in Cheshire and Merseyside, the Health Equity Group and with a stakeholder working on prevention in Cheshire and Merseyside. The interviews were analysed using an interpretive approach derived from the research questions. All interviews were completed in March 2022.

Findings

Trusts report that the PP is a useful mechanism to collate and present their actions on prevention and has helped them focus their actions on prevention, inequalities and social value. Trusts reported that attitudes towards inequalities, prevention and social value had shifted since the start of the pandemic, and that Trusts were keen to implement actions to promote prevention, reduce inequalities and address social value. They were also keen to state that prevention was an issue for everyone in the NHS and not only public health colleagues.

Trusts stated the PP allowed them to better understand the level of prevention work they'd already been doing and helped them to better guide future work and push the Trust to go further. The process of collecting information for the PP provided Trusts an opportunity to share their good practice and acknowledge the work staff had been doing and the leadership some of their staff had shown – in relation to actions related to prevention.

The PP focuses on traditional ill-health prevention actions, health inequalities and social value and Trusts reported the PP could help to implement the inequalities and social value approaches. The PP had encouraged Trusts to integrate prevention approaches in their work, by working better with external partners and thinking in the long-term.

On the whole, Trusts were satisfied with the individual support and tools provided by HEG. Some wanted the HEG to be more ambitious, many requested HEG provide more direction in terms of what actions to take and in providing examples of good practice in addressing ill-health prevention, reducing health inequalities and implementing social value approaches.

Overall, the PP has strengthened senior leadership support for preventative approaches in Trusts across Cheshire and Merseyside and future evaluations should take place after an adequate length of time, to monitor the short, medium and long-term impacts of the PP.

Introduction

In 2020, Health Equalities Group (HEG) was commissioned by the Cheshire and Merseyside HCP through the Champs Public Health Collaborative to develop a prevention pledge to support NHS Provider Trusts to better incorporate prevention into secondary and tertiary care services and physical environments. The Prevention Pledge (PP) encourages Trusts to shift from treating illness to adopting a disease prevention approach which will reduce the demand of ill-health on NHS services in the medium and long term. The PP seeks to secure organisational and clinical support and commitment to prioritise prevention activity. The PP supports a whole system approach, by aligning operational strategies, policies and plans and encouraging Trusts to work in partnership, internally and with external stakeholders.

The PP was collaboratively produced with local Cheshire and Merseyside NHS stakeholders (Trusts, Public Health Teams, Clinical Commissioning Groups) and the voluntary and community sector, Public Health England and the National Institute for Health and Care Excellence. At the core of the PP are 14 commitments to be implemented using a staged approach. The commitments were revised in late 2020/early 2021 in the context of the COVID-19 pandemic, focussing more on inequalities, recovery from COVID-19, social value and anchor institutions. The 14 commitments encourage changes to diet, physical activity, smoking, alcohol and promote mental wellbeing, amongst Trust workforces, patients, and wider communities (see Appendix 1 for full list of commitments).

The PP was piloted in Liverpool University Hospitals NHS Foundation Trust and Warrington and Halton Teaching Hospitals NHS Foundation Trust over a 4 month period from late 2020 to early 2021 (the original intention to undertake a 9 month pilot was deemed unfeasible by Trusts due to COVID-19). The second phase commissioned a further seven Cheshire and Merseyside Trusts to implement and adopt the PP by 31 March 2022. Most of the Trusts in phase two began working on the PP in October 2021. The seven Trusts in the second phase are:

- Alder Hey Children's NHS Foundation Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- The Clatterbridge Cancer Centre NHS Foundation Trust
- Countess of Chester Hospital NHS Foundation Trust
- Liverpool Heart and Chest NHS Foundation Trust
- Mersey Care NHS Foundation Trust
- The Walton Centre NHS Foundation Trust

First evaluation

HEG evaluated the pilot phase in 2021 and concluded adoption of the prevention pledge required the following:

- Commitment of a senior officer to lead the programme and maintain momentum.
- Identification of clinical champions to advocate the programme across different trust directorates.
- Internal communication across different trust committees and Boards to gain endorsement for the programme and agree governance arrangements.
- Establishment of a working group to drive programme implementation forward across the trust and review progress.
- Completion of a baseline audit to benchmark current activity against the pledge commitments, identify gaps and priorities for future action.
- Development of an action plan detailing the tasks, outcomes, accountable leads, and timescales to achieve each of the 14 pledge commitments.
- Development of a performance monitoring system with agreed data metrics and indicators to monitor progress.
- Formal adoption of the prevention pledge and programme implementation.
- Completion of a 6-12-month audit to track progress, identify any barriers or unintentional consequences, create solutions, and inform future delivery (1).

The evaluation concluded that the second phase would be an opportunity to scope or implement the recommendations, including:

- Using the Pledge as a mechanism to re-shape and re-design existing services to embed prevention within a post COVID-19 context.
- Embedding Marmot Principles and prevention of ill-health into Trust strategies.
- Supporting NHS providers to develop their role as Anchor institutions.
- Using the PP to support:
    - Sub-regional public health workforce development programme;
    - Tobacco dependency programme in acute settings;
    - Sub-regional physical activity strategies and programmes delivered by Merseyside Sports Partnership & Active Cheshire;
    - Use of Quality Standards as KPI's in driving a quality improvement approach to prevention (1).

Aim of current evaluation

This evaluation explores the experiences of the nine Trusts in Cheshire and Merseyside in implementing the PP and assesses whether the PP is an effective mechanism to increase the level of prevention activity undertaken by NHS Trusts. It draws on the conclusions of the first evaluation and explores how the PP is able to support the delivery of prevention activities as part of the future Marmot/ Institute of Health Equity programme in Cheshire and Merseyside (2) and the role of the NHS Prevention Pledge in supporting NHS organisations to become Anchor Institutions and adopting social value approaches (3).

Method

This research uses qualitative methods to explore the experiences of Trusts implementing the PP in in their own workplace.

The sample

The research is a purposive sample of 11 interviews of 20 participants, all participants were selected as they were involved in delivering the PP. Nine interviews were held with key individuals delivering the PP in each of the nine NHS Trusts implementing the PP, an interview with the HEG and another with a stakeholder working on prevention in Cheshire and Merseyside. HEG suggested participants to be interviewed from each Trust. Interviews were conducted via Teams in March 2022. Interviews lasted between 40 and 75 minutes.

Ethics

This is a service evaluation of an NHS project, as such, formal ethics approval was not needed. The interviewer followed ethical principles and at the start of each interview stated the purpose of the interview, that interviewees could stop at any point without repercussions or questioning and asked if recording the interview would be possible. All interviewees agreed to be interviewed and all agreed for the interview to be recorded.

Questions

Semi-structured interview guides were employed during the interviews. Guides were developed based on questions supplied by CHAMPs and analysis of Prevention Pledge documents. The interview guide was used to ensure relevant topics were covered in each interview. The interviewer raised themes from the interview guide if interviewees did not freely talk about them.

Data Analysis

All interviews were recorded, by agreement. Notes were taken and a rough transcription created using the Teams tool. The interviews were coded and thematically analysed using an interpretive approach derived from the research questions and issues emerging from initial research (4) (5).

'Participants' refers to the interviewees and quotes from participants are identified by an interview number. HEG staff are referred to as 'HEG'.

Findings

Responses from the two Trusts involved in the first phase are presented alongside responses from the seven Trusts in the second phase of the PP. In March 2022 Clatterbridge Cancer Centre contacted HEG to inform that they would like to pause working on the PP until a point in 2022 when additional resource could be found within the Trust to facilitate this work. They stated that they 'are just too many competing priorities for our limited resources at this time'. Regardless of their decision to pause this work, their comments are included in this evaluation. Throughout their interview they stated the Clatterbridge Cancer Centre was keen to increase their work on prevention, but were concerned about their capacity to meet the 'artificial' deadlines they'd been set.

> I could cobble together an action plan on my own…but we're not ready, I haven't got the resource to do it, it's reality of my team… of course, this is something we should sign up to, but it doesn't mean we're all on the same path at the same speed.[1]

It is unfortunate that this Trust, supportive of the aims of the PP, has been unable to commit to completing the intended work plan for 2021-22. In the future it is important for the PP timings be flexible enough for NHS Trusts be able to adopt the PP in line with their current capacity.

On the whole, Trusts spoke of the PP as a useful mechanism to collate and present their actions on prevention. In addition, all Trusts spoke of the PP helping them to focus action on prevention and inequalities and social value.

A Prevention Pledge is an accelerator

The PP has been a useful mechanism allowing Trusts to step back and reflect on the work related to prevention. Trusts referred to the PP as an 'umbrella' or a 'hanger' with which to collate their prevention work.

> It's giving us a framework to achieve everything that we want to achieve around prevention. The reason I wanted to adopt the pledge in the first place is because I view the pledge as both a catalyst but also a coat hanger….We've got some fantastic people doing fantastic things, but what we didn't have was a home for bringing all that together, so that we can ensure both that we're in maximising our impact, but also that we are telling our story and influencing the world both internally and externally. (Participant 9)

> (PP) enables us to demonstrate that we understand our new collaborative duty…a previous culture might say we only care for people who arrive at our front door…We now get it, we understand it. The PP has been a coat hanger for us to put our coat on and say actually 'we're wearing this, not just talking about it'. (Participant 8)

> (PP) is a helpful way of just bringing, bringing yourself categorising and bringing all that work together under a common umbrella. (Participant 7)

For many Trusts the PP was helping them to 'carve out time' to address prevention, particularly as the NHS recovers from the impact of the COVID-19 pandemic.

> It's making sure there is protected carved out time (for prevention) regardless of whatever is going on because there's clearly still huge focus on recovery, which could easily get in the way. (Participant 9)

In collating information for the PP, Trusts frequently stated they'd under-estimated the level of prevention work they'd already been doing and that the PP helped them to focus on future work and to push the Trust to go further.

> What we don't do is celebrate our achievements very well, they tend to be done and dusted and taken over by other events, day to day and firefighting takes precedence…It amalgamates the

[1] Participant number not included to preserve anonymity

> work that we're doing. It also shows us where the gaps are as well…we can demonstrate activities that have happened or will happen under the PP, it's a helpful way of categorising and bringing that work together. (Participant 7)

> (PP) gives another reason to drive (prevention) and maybe slightly steer to a different audience. It's not to say this wouldn't have been happening anyway, just under a different badge. It's helped us to rise it up the agenda…and gives a reason to drive it… adds value…gives us impetus to do the work… I do think it's not just a 'nice to do now', it's 'we should be doing this'. (Participant 1)

> (PP) is like giving someone with poor eye sight a pair of glasses, it helps to see what we doing and see it more clearly…. It helps us to say this is where we're going and what we are going to achieve. (Participant 4)

For a Trust that had a number of prevention activities and novel approaches, the PP didn't prompt them to do new work but was useful to understand what they were doing and to inform their senior team about their work.

> PP brings all of our of (prevention work) under an umbrella, which is quite nice. That's one of the real attractions for me, is that it brings all the activities that we're doing. I'm not sure we have necessarily come up with anything that we're going change as a result of the PP, no new governance created, …(we) already had a lot of work going on. (Participant 2)

In the next year, Trusts will be expected to go further than presenting current work and will be required to show how all 14 commitments will be addressed, which will require them to develop new actions and approaches.

Delivering the PP

Trusts have had since November to develop action plans covering a minimum of six or seven commitments within the PP framework, during Delta and Omicron outbreaks. In this short period Trusts have; identified leads, presented to Boards; created working groups and/ or clinical groups and actions plans with trackers aligned to core commitments; developed governance structures; and secured senior leadership. Most Trusts had prevention in their existing strategic objectives or have updated these to include prevention in their Trust's objectives / strategies.

Whilst the aim of this evaluation is not to assess the state of action plans, all interviews were questioned as to the status of their action plan. The Trusts had been expected to have the action plans approved by the end of March 2022 and most were in the process of finalising the action plan with their Boards or had recently finalised it. None were worried about the process, even if the March 2022 date would not be met.

> It is slightly early yet… our Trust 5 year strategy came before the PP, it talks about improving health and wellbeing lives…. the commitment is there in our Trust 5 year strategy and the PP is one of those components and factors used to demonstrate prevention work. (Participant 7)

In addition to needing time, Trusts stated they needed funding to be able to implement the PP and related work on prevention, inequalities and social value. Some were in the process of securing this additional funding.

> Resources, resources, resources. That's the only thing with this stuff. (Participant 9)

> PP has enabled us to put bids to our Board, for service development that I don't think ordinarily would have been possible. (For example) we're currently working on a bid to do some work with schools. (Participant 8)

> Proper funding to do prevention better is needed, it needs people on the ground to bang that drum, doesn't it? (Participant 5)

Two Trusts suggested the PP could be linked to the work of the Care Quality Commission, stating this would be an opportunity to embed prevention work into each NHS organisation.

> There's an opportunity to do better and be pushed by good practice across Cheshire, Merseyside… what I'd like to see with the PP, is it linked to CQC. How does it improve your Care Quality Commission report? Because it should do, there should be a link into CQC. (Participant 2)

HEG agreed:

> This is providing a framework that is then something that can pull all of this together. They can use this strategically. They can talk about it externally. This is really good for external communications as well. It's good for CQC stuff. It's good in terms of ICS stuff. (HEG 1)

Senior leadership buy-in

In all Trusts, senior management are involved in the PP process, either as executive sponsors, or delivering the PP itself. HEG concluded after the first evaluation that senior leadership buy-in was necessary for the success of the PP and this was proved correct in interviews, involving senior management has helped to push prevention up Trusts' agendas.

> One of the key things that that we needed to meet as part of the prevention pledge was making sure that prevention was prioritised by an organisation at the appropriate level, this required there to be an executive lead. (Participant 6)

> We've had such good feedback and communication and support from our executive team and from the Board… We provide an update to the Board and provide an update to the weekly exec meetings, they support it fully, completely.(Participant 8)

> Used (PP) to push senior leads and get (prevention) further up the agenda. (Participant 1)

In addition to clinicians who were already personally interested in prevention, Trusts made very similar lists of the senior team members supporting the PP work, including: medical and nursing directors; human resources; estates; finance; pharmacy; education; procurement and contracting; patient experience; health and wellbeing teams; communications and quality improvement and innovation.

All but one Trust had a named clinical champion/s. All Trusts stated that the clinical champion/s were not the only senior member of staff who they were working with and in more than one Trust they stated they had already gone to departments and services and asked for named individuals to be PP champions or divisional champions (Participants 2,4,8,9).

Some Trusts had organised a working group but most had not and instead had a group of supportive clinicians they could contact, and other Trusts were putting together this group of supportive clinical staff. One Trust had a monthly working group meeting:

> We meet and then we decided that what we want to do is go off in pairs and wander around different parts of the hospital, partly to find out what it is that people would like….(For example) do they need changing facilities? And if we built changing facilities, would they get used? Is there any point putting in bike racks for 50 bikes if only four people are going to cycle to work?...We want to show that we can actually affect change, we want to show that we can actually deliver. (Participant 3)

The COVID-19 pandemic has highlighted the importance of addressing health inequalities and of the value of prevention activities. HEG stated that led to 'buy in from very senior level inside the NHS organisations (and) is a sea change from what it was two years ago'. On the whole, Trusts spoke of consistent and genuine support from the senior teams and Boards.

> Our (Board) chair is really interested in (prevention) and the outcome measures around the prevention pledge and how we really demonstrate outcomes within some of this work. We are getting challenged, which is great. (Participant 2)

> Our chief executive is fully supportive and in fact it's her who's driven this, if I'm honest.(Participant 3)

A number of Trusts discussed the importance of getting prevention and the PP into governance structures, in order for their senior teams to take the issue seriously.

> We need to align ourselves to a committee…we need to get this into our governance structure. (Participant 1)

> (PP) is quite helpful in terms of an initial assessment around what we're already doing, where some of those gaps might be and helped us to think about where we should govern. (Participant 6)

Only one Trust questioned the emphasis on senior support, stating the support of staff was just as important:

> Do you want Board level sign up? Because I could do that by Tuesday. But the bit about every single person in the organisation having prevention at its very heart - that's harder. (Participant 5)

Merely a tick box?

Early in the evaluation process, the first two interviews raised concerns that the PP could be a tick box exercise.

> We can pick and choose which pledges (we adopt), so we could potentially pick and choose six or seven pledges that we know we're doing already…Or we can pick things that we know we're not addressing anywhere and we want to be able to put a focus on the spotlight on them and drive some improvement in those areas…It's open to be used any way that anybody wants to, isn't it? And that's probably one of the flaws of it. (Participant 1)

> My concern is the PP is perceived like a tick box exercise tick it, so we've done prevention. Well actually, you never really 'do' prevention, it's always there, you're always continually having to look for it, it's never done, the work is never finished. That's the mindset you need to be having rather than I've got the award now. (Participant 2)

As a result of these comments, in subsequent interviews Trusts were asked if the PP was a tick box exercise or in danger of becoming a tick box exercise and if the 'bar had been set too low'. All Trusts pushed back, stating this was not how they perceived it to be.

> We could treat this as tick box exercise… but we saw (PP) as an opportunity to do something a little different, we wanted to use it to change and get out into the community and the Trust deputies quite like working together and looking for a project. (Participant 3)

> It's not just about monitoring the progress and holding people accountable…it's giving people that empowerment to take those initiatives forwards as well…They know there's the backing at senior levels, people have that permission to bring initiatives forward and to develop them. (Participant 6)

> (The PP) could actually make a real impact to people locally, we could reduce our length of stay, we could reduce our readmissions, we could reduce mortality and we could just be doing the right thing. (Participant 1)

> Culturally, (PP) has been really helpful, it's certainly not tick box. PP is about… breaking down barriers…we have a lot of barriers and now have duty to collaborate and get prevention on the daily agenda. (Participant 8)

One Trust stated the PP would 'not be embedded by the end of March' and stated 'we need to be real and not use this as a performance management tool':

> We're in danger of the prevention pledge becoming almost a performance tool. How many water coolers did you put in? I've no idea and I'm not going to go back to my contracts to tell you. What we *can* do is say we developed a health and wellbeing offer post COVID that's aligned to our PP,

> around things like flexible working, improved environments, we've been planting trees across the organisation not just for our green agenda but for the wellbeing of staff. (Participant 8)

Being able to 'own', to 'pick and choose' their prevention strategies and not simply adopt the same PP in each Trust avoids the PP becoming a 'performance tool'.

> What the pledge shouldn't be is a steamroller that says everybody has to do it this way. But what it should be is a framework and enabler bringing together of minds and thoughts...I've been comfortable with it as a pledge, but I've set out very clearly from the start, this will be Trust's prevention pledge. We will use the framework, we will play the game with everybody, absolutely. This has got to be meaningful for us…we've got our own culture. We know what we need to make things land and we have to be the guides for that and (HEG) really got that. (Participant 9)

Very few comments such as below, stated unsure what of the value of the PP.

> As an organisation, as a team, we've been talking about trying to do more in this area and we would have been doing that without a Cheshire and Merseyside PP. I can see a value to the health and care partnership perhaps. I don't know that there's one for us. (Participant 5)

Giving the NHS an opportunity to shine

At a time in NHS' history, after years of added pressures from the COVID-19 pandemic, the PP has given Trusts an opportunity to share their good practice. Most of the interviewees spoke of being surprised at how much work was going on already, and that the PP was a useful mechanism to acknowledge the work staff had been doing.

> One of the main benefits for me that I've seen straight off, is it's refreshing (seeing) some of the work that we do that perhaps we take for granted…we're just not very good at telling people that we're doing because we're getting on and doing the doing (Participant 4)

> The (PP) has helped to celebrate our work on prevention, raise the profile, given people permission (to work on prevention), prompted and enabled and raised importance of prevention. (Participant 1)

> What we don't do in this organisation is celebrate our achievements very well because they tend to be done and dusted and then forgotten about and overtaken by events… firefighting always, always take precedence, which is a shame really.(Participant 7)

> Our trust has always been a little bit shy and a little bit anonymous…We should be going out to publicise ourselves, what we do. (Participant 3)

> It's probably brought up projects together that we're maybe not everyone knew about... previously (actions) sat with different people…that's one of the real attractions for me. (Participant 2)

Three Trusts said the PP way a useful mechanism to highlight the work of individuals within their Trusts who had been leading good practice, many leading good practice for years that had previously gone unnoticed:

> When we shared that we were prevention pledge pilots with some of those clinicians, they were really excited. They felt that that this was an opportunity for them to get recognition, to get support …. having a forum to document what's happening, to promote those activities, encourages other clinicians to think a bit differently as well. (Participant 6)

This newly gained information is being used by PP leads to demonstrate to their senior teams that prevention work has been going on within Trusts already, and that Trusts should be better supporting these innovative clinicians.

> There were things that I didn't realise until I actually started to ask the questions that people are doing in more detail and that's helpful that we can start to highlight these actions higher (up). Certain communications across the organisation probably wasn't happening and I think the PP

> will help address that…it's important that execs …across the organisation (know about these people), to get a sense of what's happening. (Participant 2)

An inclusive understanding of prevention: health inequalities and social value

Initially the PP concentrated on traditional ill-health prevention actions, the shift to including the concepts around health inequalities, social value and anchor institutions was as a result of the pilot work and conversations with people in the region.

> Originally the intention was to focus on key lifestyle risk factors and then the brief kind of evolved as we started to do that initial consultation, in interviews that we carried out with key stakeholders. We started to get a sense that this was more about anchor institutions and health inequalities. (HEG 3)

This led HEG to shift the PP to address the wider determinants of health as well as health behaviours and lifestyles. One Trust showed a particularly strong understanding of the relationship between the PP and inequalities.

> The language of thinking about health inequality is the language of prevention and the willingness to think outside of traditional pathways. The willingness to think outside of the traditional clinic room walls…There's stuff about what we can do internally to address the impact of health inequalities for those that we already see and then there's a whole bundle of stuff about how we work with partners externally to raise the profile of work around health inequalities and influence at policy level as well. (Participant 9)

For most other Trusts, the PP was a useful method to assess and consider current and previous prevention activities and to see these with an inequalities lens.

> One of our surgeons used to go out to schools but he tended to go out to the private schools to encourage students to become doctors. What we'd like to do is start with our local schools, the local Liverpool schools. (Participant 3)

> Our schools program hasn't started yet, but we have a number of schools who are signed up who are from those areas are greater deprivation or health inequalities…we've asked those schools, would they be interested in working with us...We're wanting to be a trust that makes a difference. (Participant 8)

For all Trusts, they stated the PP had pushed them to think more about inequalities.

> What is increasingly obvious is the way that we traditionally do things creates health inequalities, in terms of access and those hard to reach communities. There are things that we want to do with the PP, if you're not actually reaching certain target communities, you're not in a position to make every contact count because you've not got any contacts. (Participant 9)

Similarly, they stated the PP was pushing them to think more about social value.

> Whenever we now go out to market to procure things, the prevention approach, the green approach is at the forefront of policy, if you were going to market and you looked at a number of suppliers, we would choose a local and we now know that 90% of all our procurement is undertaken locally. (Participant 8)

Despite a great deal of action and support on social value and anchor institutions available to Trusts, some stated some of their staff were still unclear what these concepts meant and why they were important for the NHS.

> Not everyone realises that what they are doing is about social value. (Participant 4)

However, it was more common for Trusts to state they understood the impact social value approaches could have on their local communities and in reducing health inequalities and how the PP could help to implement these social value approaches.

> What we've done recently is we've tried to kind of describe what we mean by anchor and what does it mean for us as an organisation. We've set up three areas of work within our anchor program and they are addressing health inequalities, delivering social value, green plan…(PP) is helpful to bring this all together, helps in keeping profile high. (Participant 6)

> We're a major employer, we spend a lot of money. We want to treat our patients well…If you're trying to make things like procurement and purchasing decisions on the basis of social value then there is going to be cost implications…slow process to get people to think like that, to think about procurement and social value… that's indirectly prevention behaviour. In areas of high deprivation getting people into good employment is important… we are in the heart of community where patients are based, we are an employer of ** people…it might only be a drop in the ocean, but we do what we can, can't we? (Participant 5)

Cheshire and Merseyside's Anchor Institute Charter includes the requirement for NHS Trusts to have adopted the PP. In a short interview with a representative from the HCP, they stated this as a 'natural fit…we've said (prevention) should be in there, as a principle'. Future evaluations should assess the value of including the requirement to be signed up to the PP in the anchor framework.

The PP has encouraged Trusts to make links and look at the causes of health inequalities, and that they have a role in reducing health inequalities and to assess their previous and future prevention activities.

B Cultural shift in prevention

All interviewees – Trusts and HEG – stated attitudes towards inequalities, prevention and social value had shifted since the start of the pandemic, so much so that one Participant stated they were:

> Pushing an open door. (Participant 4)

Another Trust stated:

> I have many, many more conversations about health inequalities and prevention and what we should be doing in that space now than I did three years ago. Many, many more. (Participant 9)

HEG reflected on the impact the pandemic has had on the PP.

> This piece of work has risen up the agenda massively in in the space of 18 months…This piece of work is so much more relevant now. Trusts are pretty much mandated in terms of making this happen because of the recognition of the social determinants of health, the efficiency savings that they now need to achieve in terms or prevention within their own trust. The level of buy in and engagement at top level, at director level, that we are now getting this time round in terms of the PP is so far away from the first time round.(HEG 1)

When HEG put out the expressions of interest in 2020, asking for pilot sites, they had two applications but in 2022, they easily identified the second set of sites to work with. Trusts agreed, and many referred to the cultural shift in how the NHS views prevention. Trusts were keen to state that they had a role in prevention, in reducing inequalities and that this was an issue for everyone in the NHS and not only public health.

> Prevention isn't the job of GPs and public health…At the very least we should be trying to prevent ill health in our own workforce and to which there are good sound business arguments as well…realistically what we need to do is encourage more and more people to think about (prevention) as part of the day job. (Participant 5)

> A great deal of what we're trying to influence to be different is stuff that is considered the purview of local authorities or public health, or it's somebody else's job or education or whatever it is. We don't think like that…we want to fix the stuff that we can do ourselves but we also want to be part of fixing what we can as a collective…Sometimes people feel that we're stepping onto their territory, but it's leading to things changing. (Prevention) should be all of our territory because if we can support upstream work then ultimately we got fewer (patients) coming through our doors, the whole thing is a virtuous circle if you get it right. (Participant 9)

> Prevention's everyone business, to label prevention as a public health programme I think is a mistake…Please don't tell me that prevention belongs to somebody else. We have the ability to do it and to lead and we take that seriously and are doing something about it. (Participant 8)

> The trick is to embed (prevention) and turn it into a business as usual activity for the organisation. (Participant 7)

Part of the cultural shift to a better approach to prevention is valuing partnership working as integral to having an effective approach to prevention, inequalities and social value. The PP aims to developing a place-based approach to prevention and to work with partners, internal and external. As most Trusts had only worked on the PP for 4 months, they had not yet started to work with external stakeholders, outside the of ones they already had established:

> I think it is a bit early. Last year we developed our Trust five year strategic plan and one of the key components is that wider working outside of these four walls and engaging with our community. (Participant 7)

But Trusts were keen to state that the PP had made them realise they needed to spend more time working in partnerships and for those who had extensive external networks, they were keen to state the PP would easily fit into this existing work.

> Our PP has opened up lots of other opportunities. (Participant 8)

> (PP) links us to other organisations that we perhaps weren't familiar with previously, who've been really helpful…(PP) has really helped to accelerate some of our work on prevention…As part of an action tracker they ask have you worked with primary care local? Are you working with primary care local authorities and VSO's? That's a good thing. (Participant 6)

> There's loads of value in it, it's the first thing I would say…It helps us work differently with people outside the organisation, which is what the whole kind of ICS world is about. (Participant 9)

> We're a partnership organisation…already working externally, unsure if PP will help with this work … I don't know if the PP will help us to establish any new external partnerships. (Participant 2)

Longer term strategies

One of the ways the PP pushed the prevention agenda was encouraging Trusts to think over the longer term.

> If you want to do (prevention) properly, people will have to be given the time to do it. I've spoken to the clinical director and they're willing to give this new research time to do it. That's often the problem in the NHS, we're busy and people don't think they've got time. There's a cost to that and the cost is time. But I think that the trust, if it wants to do it properly, it has to accept that. (Participant 3)

> There's a number of programs within our prevention pledge that we won't deliver this year, it does make you think longer term. (Participant 8)

The HEG agreed that the PP was encouraging Trusts to view prevention as a long-term goal.

> (Trusts) are not looking to this finish this next month…they're very clear about the embedding process, about looking at this in the longer term, looking at metrics in six months and in 12 months time. (HEG 2)

A cultural shift in specialist hospitals

Four specialist Trusts in Cheshire and Merseyside were included in the second phase of the PP: Alder Hey Children's NHS Foundation Trust; Liverpool Heart and Chest Hospital NHS Foundation Trust; The Clatterbridge Cancer Centre (CC) NHS Foundation Trust and the Walton Centre NHS Foundation Trust. All

of the specialist Trusts stated their support for the PP and adopting a more active approach to prevention, three of the four specialist Trusts admitted they had previously not prioritised work on prevention:

> This isn't our bread and butter…cautiously trying to enhance our role in prevention, it isn't our core business.[2]

One of the specialist Trusts has actively worked on prevention activities for many years and the senior team are leading on work around health inequalities and social value. For the other three specialist Trusts, the PP has helped them to focus their work, one also stated that it had helped to bring the four specialist hospitals together:

> Participant: Joint collaborative pieces that we do with the other specialist trusts, the learning and cross-fertilisation of all this is also taking place at the moment.
>
> Interviewer: Was that happening before the prevention pledge?
>
> Participant: It was, but not around prevention, prevention was not part of that program…(Specialist Trusts) decided that we wanted to do prevention and so the four Trusts are doing this at the same time.
>
> Interviewer: PP has prompted you to work together?
>
> Participant: Yes, (PP) helped focus the Specialist Trusts to have their own work programme…The prevention group looks at how we can improve our delivery…we look at our compliance against the national ambitions to be able to try and understand if we're having any impact.

Another Trust agreed, stating the PP had encouraged them to acknowledge the causes of ill-health in each of their Trusts was often the same.

> We're talking as a group of specialist trusts…different ways to work together. Prevention was always on the list, what prevents coronary heart disease also prevents cancer also prevents…At the start of it is those lifestyle factors. You've interventions for preventing all of those things…we got wind of the PP thing and just said wouldn't it be good if we all signed up to this thing as a group? And I don't know if we knew what the thing was when we said yes to it.

The NHS Long Term Plan does not include actions for Specialist Trusts to take to adopt upstream prevention approaches, as such, the PP is an opportunity to demonstrate the effect of implementing ill-health prevention approaches in Specialist Trusts, and for Cheshire and Merseyside to be seen as leaders (6). Future evaluations should examine the effectiveness of a coordinated approach by the Specialist Trusts.

C The value of HEG support tools

On the whole, Trusts were satisfied with the individual support and tools provided by HEG. Most were very happy with HEG's approach and the approachability and accessibility of the HEG team.

> The guidance and the tools that they gave to us were very, very useful. (Participant 1)
>
> The tools that they provided are good, we get a lot of communication from them…They're always on hand... I know that if I have good question… they'll get back to me by the end of the day, they are really reliable. (Participant 8)
>
> Audits, all the tools, those were brilliant at the at the start to kind of assess where we are and I've tried that and adopted the audit tool to make our kind of action tracker, that was really helpful. (Participant 6)

Some wanted the HEG to be more ambitious and to push Trusts and provide more direction:

[2] Participant identification is removed in this section to reduce likelihood of Trusts being identified.

> How do we re-enliven Making Every Contact Count? How do we refresh and re-energise people around that evidence base? I would like a bit of that from the HEG and I'm not sure we've really got that from the pledge team. (Participant 9)

> I would rather (HEG) come in and say these are the programs of work we want you to all do, this is what good looks like, this is the ambition. I think that's a better approach for me rather than just saying here's the pledge and everyone has to find something. They're trying to be very flexible, but that means you can choose your own path…Can they kind of help us around our journey to do this and how do we get push us? (Participant 2)

> Need specific guidance on where to focus because there's a billion things you could do and claim it's a preventative measure, but actually, what are the most impactful ones? (Participant 5)

People stated they wanted to know 'what to do', examples of good practice in addressing ill-health prevention, reducing health inequalities and implement social value approaches.

> Seeing examples of other organisations ahead of us, their actions plans, it's as good…Clearly still work for us to do, starting to crystalise what the shape of our work going forward will look like. (Participant 7)

> The group is starting to show a bit more value, with relationships and links to other organisations we're not familiar with…For instance they hooked us all in with the strategic sport groups and Active Cheshire and Merseyside Sports Partnerships. They will be really helpful in providing some of that advice and guidance to improve active travel or how do you get some funding. (Participant 6)

> It would be interesting to perhaps get some feedback on projects that other people have been successful with, some quick wins. (Participant 3)

> Availability of other pledges, share ideas to support networking, more regular meetings, some key milestones to aim for – to think longer-term and what the PP could deliver. (Participant 1)

In addition to wanting examples of best practice and/or quick wins, a few Trusts stated they wanted advice on working with the voluntary sector.

> Some acute hospitals probably would probably never reach out and work with voluntary organisations, how do you encourage working with housing associations and how do we get them on Board involved? I would have preferred something ambitious like that that would really pushed organisations to do go further. (Participant 2)

> What sorts of things are already going on, the voluntary sector groups who are already doing this sort of work, that we could tie in with and help support them or use them to support us. We do need to look at the voluntary sector…we could maybe get some help from (HEG) on this. (Participant 3)

A few stated the PP was admin-heavy:

> We have 10 areas…to then have to find metrics to justify those 10 is a little tiresome. (Participant 8)

> I found the PP stuff not clear, there are 14 commitments and I don't think one of them is shorter than three lines of text, some are nice quick wins and some are impossible tasks – e.g. Board level sign up and then making a person in organisation having prevention at its heart….What are you actually asking us for? What are we signing up to here? (Participant 5)

One of the mechanisms that improved the effectiveness of the PP was having good connections with the specialist registrar in CHAMPS and the Director of Partnerships at the ICS. They stated having support from people with knowledge of preventative public health, who understood the purpose of the PP and the connections that needed to be made helped improve the success of the PP.

> We now have momentum, we have some tangibility in terms of how this can work together…We had the Director of Partnerships for the ICS, Dave Sweeney, who is in the background saying, this is something which is actually really helpful for our NHS trusts, this is something which is helping to deliver on the social value awards, he saw the bigger picture and he saw that this was one element in a wider array of frameworks that the NHS needs to work towards. (HEG 1)

> We got a great deal of support from Dave Sweeney in terms of the communications that went out to the organisations to let them know that this piece of work was happening. (HEG 3)

D Future evaluations

Many questioned why an evaluation was taking place so soon. Many had participated in the first evaluation and often mentioned this in the interview. Others stated the evaluation was too early as they were being evaluated on work they had only started in November and that this would limit the effectiveness of the evaluation and that they were limited in what they could say. That the evaluation was taking place too soon was often one of first things mentioned in interviews.

> People need to be given the time to do it...we do need to run some pilots to work out what works and what doesn't work and how we're going to do this.(Participant 3)

> Is this a good time to evaluate? It's early for us because COVID has had significant impact on organisation. (Participant 7)

Trusts were happy to be part of an evaluation but wanted this to take place later.

> It does give an opportunity to shape it though. The reason I'm really happy to commit to it and put be part of the conversation is if some of this stuff gets fed back. Come back and ask me in a year! Are you going to evaluate the end of phase two? That's interesting to me, something that we could perhaps answer better in a year or two years. People are very much at the start. (Participant 9)

> Evaluating (PP) four months after people have been asked to do it?... Surely evaluation would be when something had a chance to be changed because of the intervention? (Participant 5)

> It would be good (evaluate) once we've implemented this…evaluation post implementation, after a year… It's still early days for us…in a year's time it will might be clearer.(Participant 2)

HEG agreed a more useful time to evaluate the programme would be in spring 2023.

> When things are fully embedded within Trusts and we can show what change has taken place once this framework has been embedded for a 12 month period, the indicators are being used to gather data and show change. We can then actually have a proper public facing evaluation of this programme and we can show hopefully that (the PP) is something which is perhaps a bit of a trailblazer in terms of NHS trusts adopting a specific framework around prevention. (HEG 1)

> You will talk to people who will make generally enthusiastic noises about it. You'll get some evidence…It can only take you so far down this line, not least because of the latest wave of the pandemic that's come on board. So we think there's been pretty good progress made, but we won't be able to say anything tangible about outputs and around impact…that's 12 months down the line. (HEG 2)

For many, because of the Omicron outbreak, they had only spent two months on the PP. Only two Trusts stated the COVID-19 pandemic had not affected the delivery of the PP and one Trust stated the increased attention the pandemic brought to prevention, helped:

> In all seriousness, if it had been in 2019, early 2020, I'm not sure we would have been able to get (PP) off the ground in the same way because people's energies, focus, just wasn't here…People would still want to do it, but the capacity to do it would not have been there. (Participant 9)

For the remaining seven Trusts, COVID-19 did impact the delivery of the PP and in some places, this continues to have an effect, although this is often due to a combination of factors increasing pressures on

Trusts. Two hospitals were also dealing with the introduction of electronic records and others were dealing with CQC inspections or preparing for imminent CQC inspections. One Trust stated the winter of 2022 was difficult, that staff are:

> Participant 7: …exhausted because they've all been working their butts off for the last few years, especially the last few months…. staff absences…waiting lists are looming over everyone's head.
>
> Interviewer: Is there any time to think about prevention?
>
> Participant 7: The easy answer is no, but it's obviously when is? Is there ever going to be a right time to do (prevention)….during the winter months, from November through to March, the traction that we're able to get in the organisation is very limited…In an ideal world we would do (PP) from April/May onwards…but if we're serious about it, we need to do it now. (Participant 7)
>
> There were some challenges obviously because it was and still is during a COVID pandemic which meant that actually a lot of our governance as an organisation was paused…COVID – has taken a lot of capacity and people are exhausted. (Participant 6)
>
> It's easy to blame COVID but it did impact the delivery of what we would do…Lot of changes and exec changes and organisations change and regulatory strains and pressure. (Participant 1)

The pandemic also impacted the HEG's development of the PP. The pandemic hit at the same time as the PP consultation process, the first pilot was meant to start in March 2020. HEG stated they did not have many opportunities to liaise with Champs or the Director of Public Health chairing the HCP's Prevention Board, they understood the pressures they were under and got on with developing the 14 commitments.

Conclusions

This evaluation assesses the views of nine Trusts in Cheshire and Merseyside who have adopted the PP (though one Trust subsequently dropped out temporarily). This early evaluation of the second phase of the PP found all Trusts report that the PP has acted as an accelerator and rejected that the PP was a tick box or performance management exercise. The PP has strengthened leadership support for preventative approaches in Trusts across Cheshire and Merseyside as well as support from senior teams to better address health inequalities and implement social value approaches.

Trusts stated they valued the opportunity the PP gave them to tell positive stories about the efforts of individual staff who had taken their own initiative to address prevention and inequalities.

By the end of March 2022 Trusts had either created their own PP action plan or were in the process of producing it. All had secured senior buy-in, and found it easy to secure the support of their senior teams.

It is too early to assess the effectiveness of the PP. What this evaluation was able to explore is how the nine Trusts view the PP as a tool to better embed prevention into existing strategies and build support amongst their senior team and in their wider workforce. Future evaluations can monitor:

- In the short and medium term if:
    - The PP helps to increase actions undertaken by the NHS across Cheshire and Merseyside to preventing ill health;
    - Levels of better health and wellbeing (e.g. decreased smoking and obesity levels, increased physical activity) have occurred.
    - Staff absences reduce.
    - Social value approaches to employment and procurement are implemented.
- In the longer term if:
    - Services have transformed from treating illness to proactively and consistently implementing prevention approaches;
    - Inequalities have reduced;
    - Preventable and chronic disease levels and inequalities have declined as a result of these approaches and actions;
    - Demand on the NHS related to preventable disease have reduced.

Appendix 1

Cheshire and Merseyside NHS Prevention Pledge Commitments

STRATEGIC CORE COMMITMENTS – those commitments that all NHS organisations can pledge support for:

By signing up to the Cheshire and Merseyside NHS Prevention Pledge …X… NHS Trust Commits to:

1.Prioritise a long-term focus on well-being, prevention and early intervention ensuring health in all policies; embedding prevention within our governance structures, appointing an Executive Sponsor for prevention (including MECC), and making 'prevention everybody's business'.

2.Create the conditions to support service managers and staff teams to take a quality improvement approach to review and transform services to embed prevention.

3.Guided by Marmot principles; develop approaches to prevention, working with our partners 'at place', to address inequalities and deliver local priorities and prevention ambitions set out within the NHS Long Term Plan and in COVID recovery plans.

4.Work in partnership in the utilisation of common prevention pathways across Trusts, supporting secondary and tertiary prevention that reduces the impact of established disease through lifestyle advice and cardiac or stroke rehabilitation programmes.

5. Establish key anchor practices that contribute to a successful application for the Cheshire and Merseyside Social Value Award; to positively impact on the wider determinants of health and the climate 'health' emergency when making decisions on procurement, purchasing and through our organisation's corporate social responsibilities.

6. Systematically adopting and embedding a 'MECC approach' from commissioning contracts to service delivery, increasing the number of brief or very brief interventions with patients supporting them to eat well, be physically active, reduce harm from alcohol and tobacco and promote mental well-being.

7.Work with primary care, local authorities and VCSO's to systematically refer to sources of non-clinical support through social prescribing, aligned with community capacity building to reduce impact on GP consultation rates, A and E attendance, hospital stays and re-admission, medication use, and social care.

8.Support workforce development, providing training and/or resources to frontline staff to offer brief advice and/or referral in supporting patients to eat well, be physically active, reduce harm from tobacco and alcohol and promote mental well-being.

9.Ensure a smokefree environment, linked to support to stop smoking for patients and staff who need it.

10. Provide workplace health programmes for NHS staff and foster an organisational culture that promotes workplace resilience and creates opportunities for staff to eat well, be active, reduce harm from tobacco and alcohol and promote mental well-being.

11a. Review food and drink provision across all our NHS buildings, facilities, and providers in line with Hospital Food Standards and the NHS Standard Contract, to make healthier foods and drinks more available (including vending and onsite catering), convenient and affordable and limit access to less healthy foods and drinks such as those high in fat, sugar and/or salt.

11b. Increase public access to fresh drinking water on NHS sites (keeping single use plastics to a minimum) and encouraging re-useable bottle refills.

12.Support the sub-regional physical activity strategy; to promote and create opportunities for staff, patients, and visitors to be physically active both on and off site and in line with active travel and sustainable management plans.

13.Sign up to the 'Prevention Concordat for Better Mental Health for All' and to embed the Prevention Concordat across health and care policies and practices.

14. Monitor the progress of the pledge against all commitments and to publishing the results of our progress at regular intervals.

ORGANISATIONAL COMMITMENTS - Examples

1.Adopt a robust approach to ensure patients have a positive experience of care; working with clinical champions to engage patients, families, and carers in providing feedback, promoting person-centred care, and empowering individuals and communities to manage their own health.

2.Develop a communication strategy that will promote a cultural shift across the organisation to embed prevention and health improvement within our work; maximising the opportunities provided by national programmes and resources such as 'All Our Health'.

3.Develop ambassadors across our organisation to encourage and support the workforce to develop skills and confidence to increase interactions, using a 'MECC approach', with patients.

4.Train workplace physical activity champions to offer peer support to staff and identify opportunities to be physically active.

5.Support midwifery teams to offer carbon monoxide (CO) monitoring and brief advice for all pregnant women and where appropriate refer for specialist stop smoking support.

6.Reduce the length of hospital stay and provide patients with a better care experience by ensuring they are discharged from hospital without unnecessary delay, whilst working with therapeutic teams to prevent de-conditioning during their stay.

Bibliography

1. Health Equalities Group (2021) Cheshire & Merseyside NHS Prevention Pledge: Summary & Evaluation Report, Phase 1.

2. UCL IHE Collaboration with Cheshire and Merseyside HCP (2022) Available from: https://www.instituteofhealthequity.org/about-our-work/latest-updates-from-the-institute/ucl-ihe-collaboration-with-cheshire-and-merseyside-health-and-care-partnership.

3. Cheshire and Merseyside HCP (2022) Our role as a social value accelerator site. Available from: . https://www.cheshireandmerseysidepartnership.co.uk/about-us/our-role-as-a-social-value-accelerator-site/.

4. Guba EG, Lincoln YS (1989) Fourth generation evaluation. Sage Publications Ltd: Newbury Park.

5. Braun V, Clarke V (2006) Using thematic analysis in psychology. Qualitative Research in Psychology. 7773(2):77-101.