

**FROM PREHAB TO POPULATION
HEALTH**

**TARA RAMPAL
CLINICAL DIRECTOR-MEDWAY PREHAB**

BAH,
H
U
M
B
U
G



Our Population

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared

| Domain | Indicator | Period | Local count | Local value | Eng value | Eng worst | England range | Eng best |
|-------------------------------------|--|---------------------|-------------|-------------|-----------|-----------|---------------|----------|
| Adults' health and lifestyle | 12 Smoking prevalence in adults | 2016 | n/a | 19.0 | 15.5 | 25.1 | | 4.1 |
| | 13 Percentage of physically active adults | 2015 | n/a | 53.3 | 57.0 | 44.8 | | 69.8 |
| | 14 Excess weight in adults | 2013 - 15 | n/a | 65.6 | 64.8 | 76.2 | | 46.5 |
| Disease and poor health | 15 Cancer diagnosed at early stage | 2015 | 546 | 51.6 | 52.4 | 39.0 | | 63.1 |
| | 16 Hospital stays for self-harm† | 2015/16 | 577 | 201.1 | 196.5 | 635.3 | | 55.7 |
| | 17 Hospital stays for alcohol-related harm† | 2015/16 | 1,396 | 545.7 | 647 | 1,163 | | 374 |
| | 18 Recorded diabetes | 2014/15 | 15,408 | 6.9 | 6.4 | 9.1 | | 3.1 |
| | 19 Incidence of TB | 2013 - 15 | 46 | 5.6 | 12.0 | 85.6 | | 0.0 |
| | 20 New sexually transmitted infections (STI) | 2016 | 1,308 | 721.4 | 795 | 3,288 | | 223 |
| Life expectancy and causes of death | 21 Hip fractures in people aged 65 and over† | 2015/16 | 232 | 593.6 | 589 | 820 | | 312 |
| | 22 Life expectancy at birth (Male) | 2013 - 15 | n/a | 78.4 | 79.5 | 74.1 | | 83.1 |
| | 23 Life expectancy at birth (Female) | 2013 - 15 | n/a | 82.0 | 83.1 | 79.1 | | 86.1 |
| | 24 Infant mortality | 2013 - 15 | 38 | 3.6 | 3.9 | 8.2 | | 0.8 |
| | 25 Killed and seriously injured on roads | 2013 - 15 | 188 | 22.9 | 38.5 | 103.7 | | 10.4 |
| | 26 Suicide rate | 2013 - 15 | 83 | 11.7 | 10.1 | 17.4 | | 5.6 |
| | 27 Smoking related deaths | 2013 - 15 | 1,310 | 346.2 | 283.5 | | | |
| | 28 Under 75 mortality rate: cardiovascular | 2013 - 15 | 511 | 79.6 | 74.6 | 137.6 | | 43.1 |
| | 29 Under 75 mortality rate: cancer | 2013 - 15 | 1,019 | 159.3 | 138.8 | 194.1 | | 98.1 |
| | 30 Excess winter deaths | Aug 2012 - Jul 2015 | 344 | 16.7 | 19.6 | 36.0 | | 6.9 |

Our need is the real creator...
Plato's Republic

Infrastructure

CPET bikes
Hand dynamometer
Weights
Patient literature

Human Resources

Exercise Supervision
Surgery School
Nutritional Support
Psychology Input
Administrative Personnel

Patient pathways

Surgeons
Cancer nurses
Patients

Media Strategy

Awareness
Hearts and Mind
Engagements

WHAT CAN PUBLIC HEALTH OFFER US...

Our Relationships

Medway
Kent and Medway NHS
NHS and Social Care Partnership Trust

South East Coast Ambulance Service NHS
IMAGO
Medway NHS
NHS Foundation Trust

MCH
Medway Community Health
NHS
Medway
Clinical Commissioning Group

NHS
Swale
Clinical Commissioning Group

Kent
County Council

Swale
BOROUGH COUNCIL

healthwatch
Medway

Transforming
health and social care
in Kent and Medway

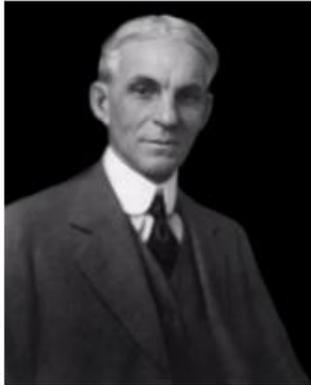
NHS
Kent Community Health
NHS Foundation Trust

healthwatch
Kent

MVA
Medway Voluntary Action

SCUS
Swale Community & University Services

virgin care



Coming together is a **beginning**,
staying together is **progress**,
and working together is **success**.

- Henry Ford

Goalcast

HUMAN RESOURCES



FUNDRAISING



FROM HOSPITAL TO



COMMUNITY...





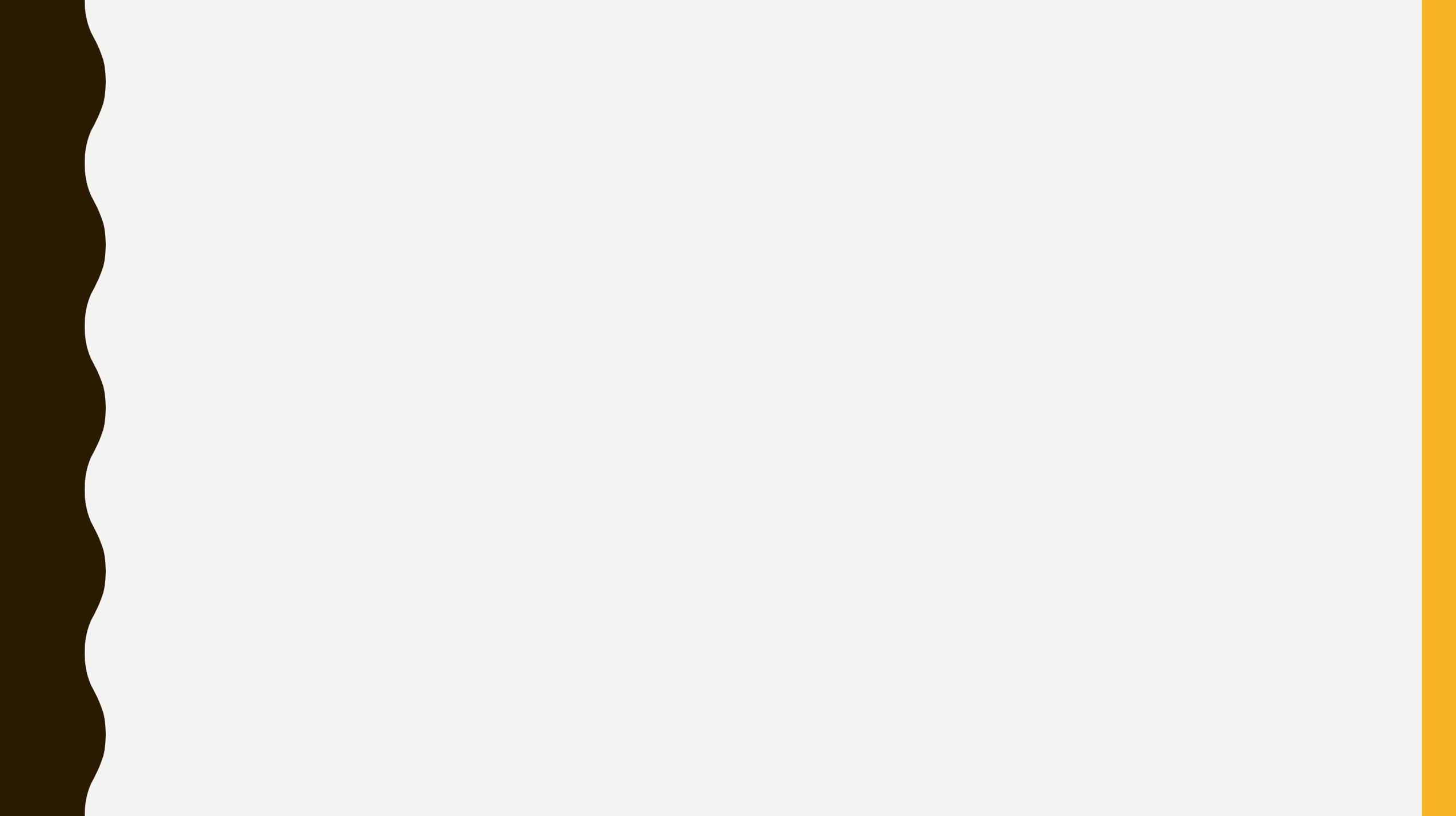
email.nhs.net



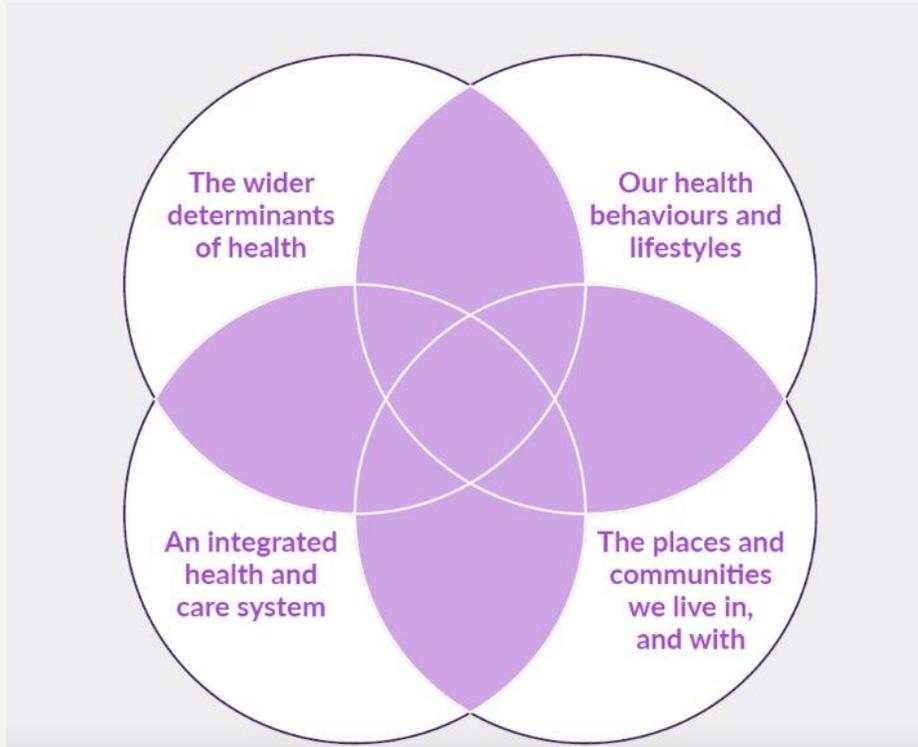
inpatient care.

KMCA is providing funding so that Medway's prehab pilot can be extended, providing evidence about the value of prehabilitation interventions for cancer patients and scoping the potential to expand prehab services across the county.





POPULATION HEALTH MANAGEMENT



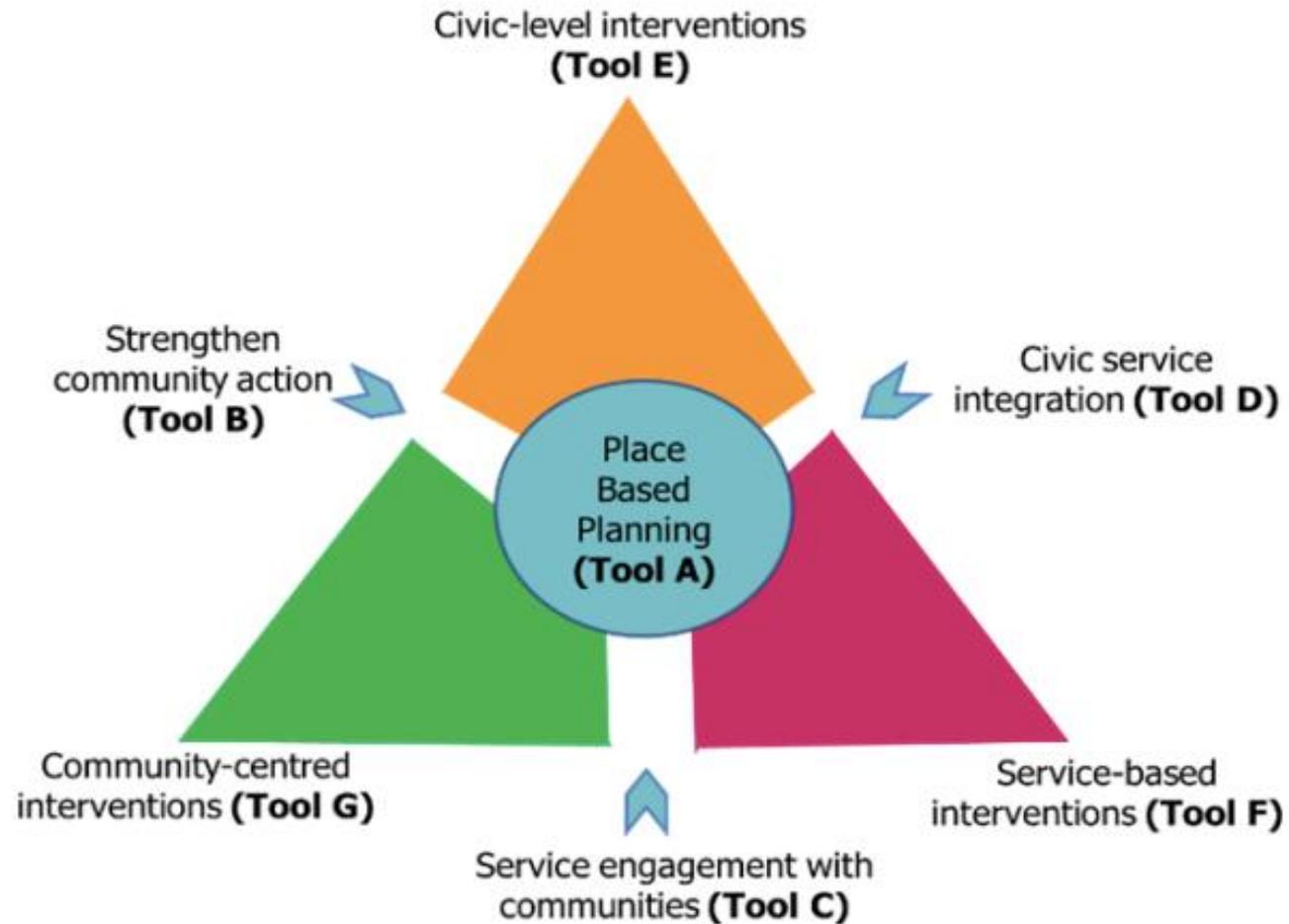
Broadly defined as specific policies, programs and interventions directed at improving health of sections of populations

Population health management provides a useful rationale for patients, providers, payers, and policymakers to move collectively away from the traditional system of individual, siloed providers to a more integrated, coordinated, team-based approach, thus creating a holistic view of the patient population

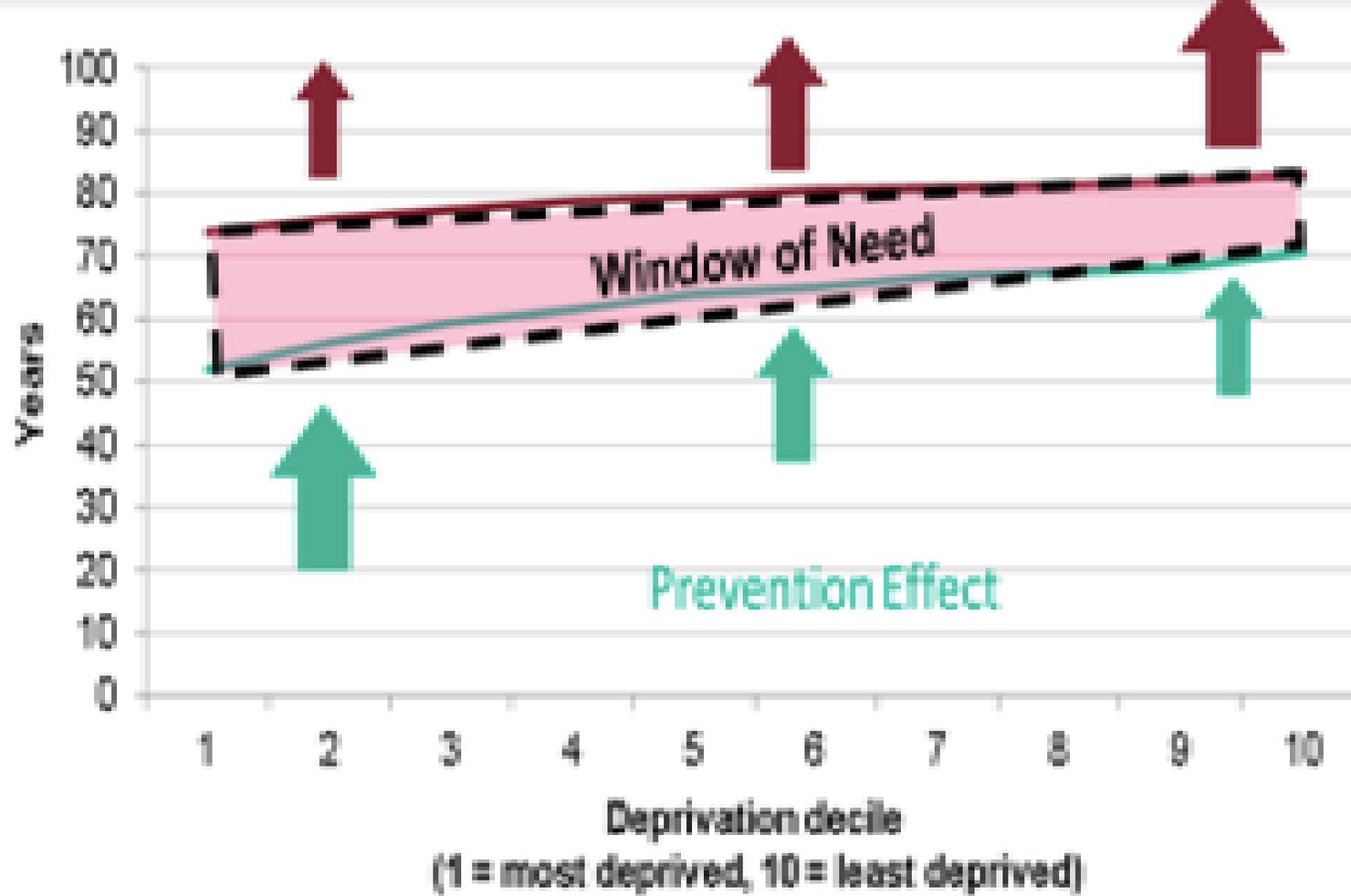
TRIPLE AIMS OF HEALTHCARE

- Improving the patient experience of care (including quality and satisfaction)
 - Improving the health of populations
 - Reducing per-capita costs of care.
-
- Attained through a patient centred team approach, coordination of care, effective communication, robust data analysis and continuous quality improvement
 - The Perioperative Medicine has the potential to achieve the Triple Aim, including improving the health of the surgical population.

Place Based Approach to Reduce Inequalities

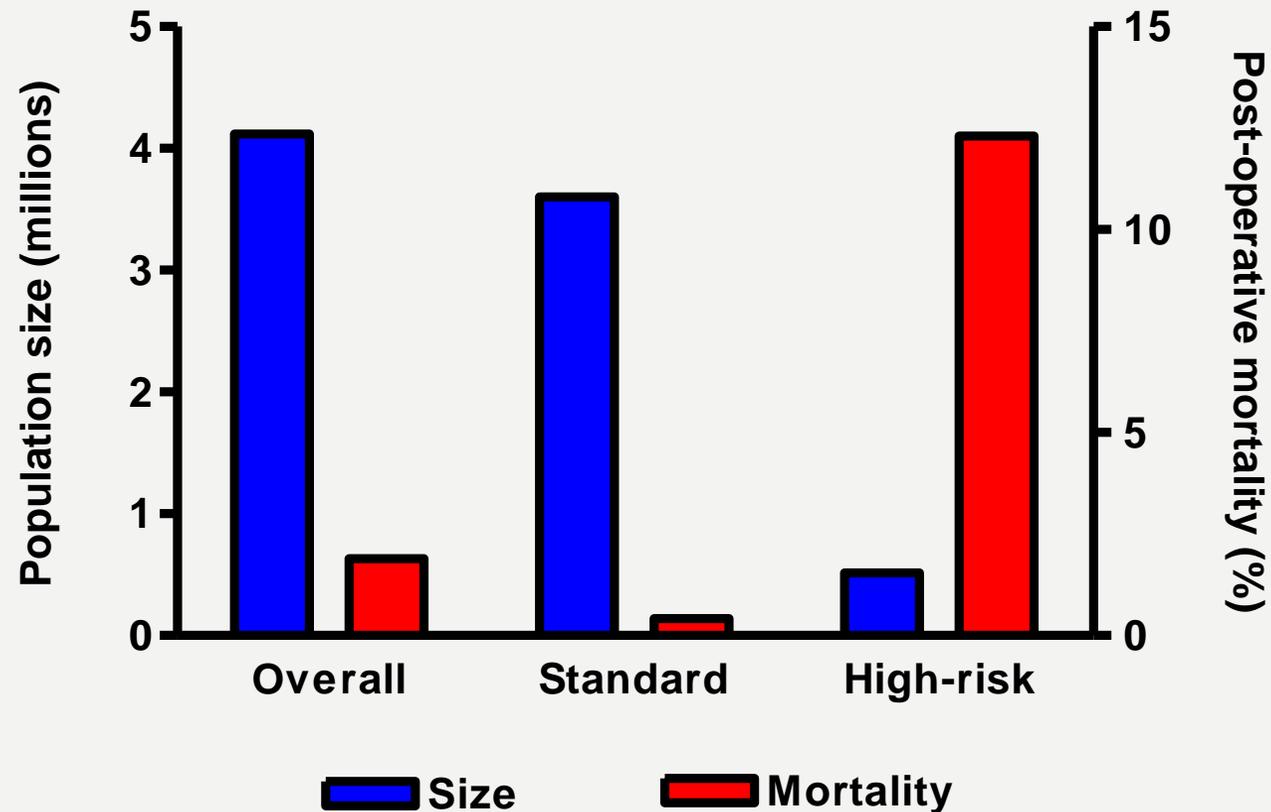


Treatment and Care Effect



— Life expectancy — Healthy life expectancy

FACT- HIGH RISK PATIENTS ACCOUNT FOR 80% OF SURGICAL DEATHS



Critical Care 2006; D 80-251

FACT

- Post operative complications increase mortality and impair quality of life

thebmj

Research ▾

Education ▾

News & Views ▾

Campaigns ▾

Archive

Clinical Review

Managing perioperative risk in patients undergoing elective non-cardiac surgery

BMJ 2011 ; 343 doi: <https://doi.org/10.1136/bmj.d5759> (Published 05 October 2011)

Cite this as: *BMJ* 2011;343:d5759

Article

Related content

Metrics

Responses

Rupert M Pearse, reader¹, Peter J E Holt, clinical lecturer², Michael P W Grocott, professor^{3 4}

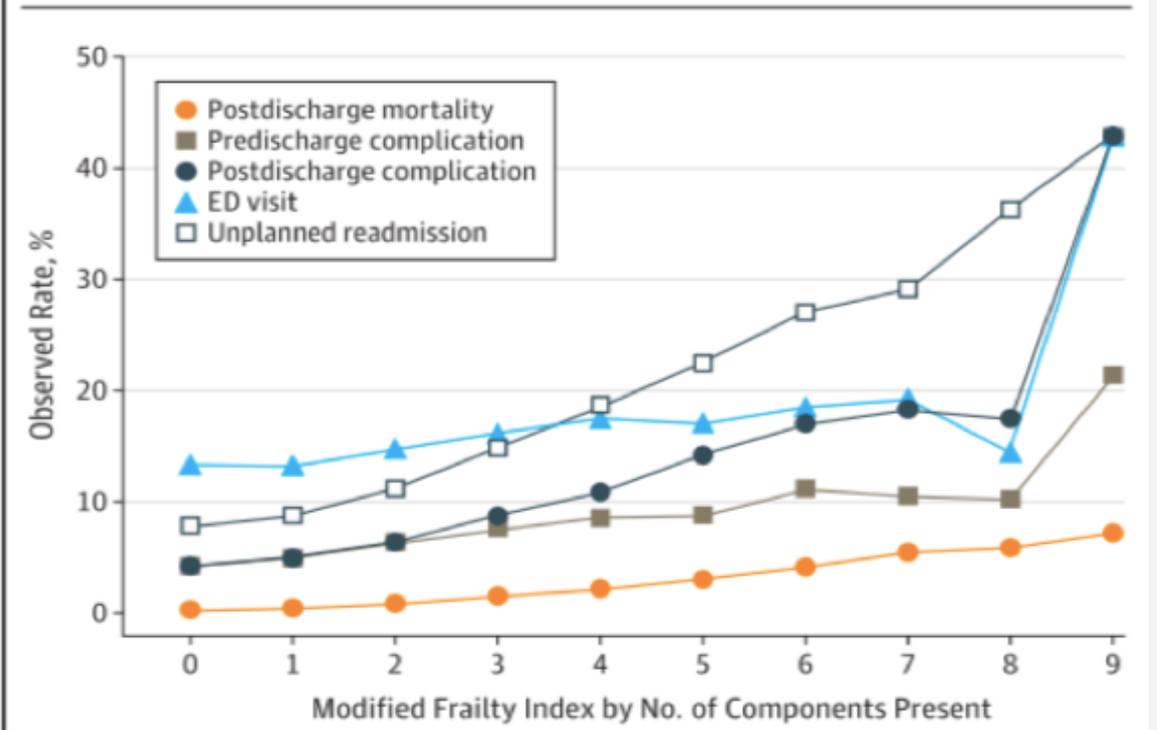
FACT

- There is a gradual increase in surgical procedures being offered to high risk patients

The Charlson Comorbidity Index (CCI) as a Mortality Predictor after Surgery in Elderly Patients.

Anat Laor, Sari Tal, +2 authors Eli Mavor • Published in The American surgeon 2016

Figure 2. Observed 30-Day Postoperative Outcomes by Frailty Component Burden



INTEGRATED CARE SYSTEMS

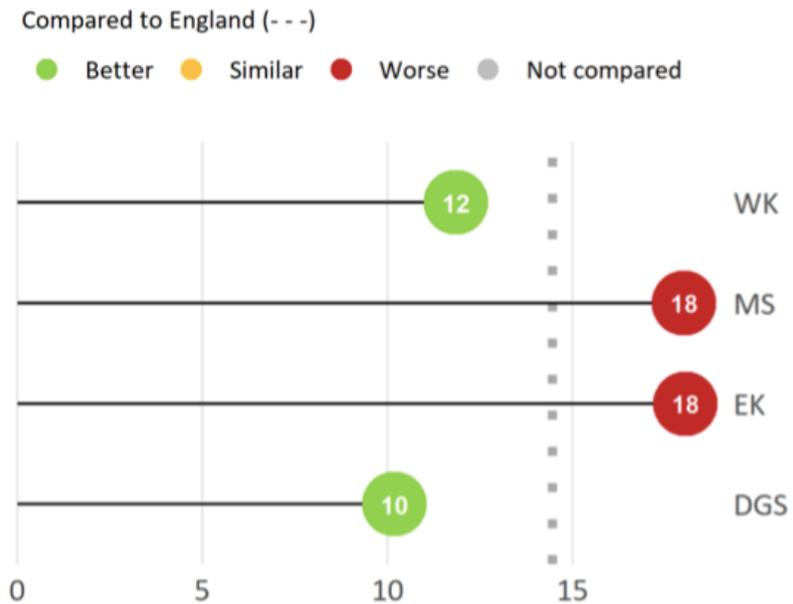


Requires improvement

| Domain | Indicator |
|------------------------------------|--|
| Prevention and Health Inequalities | Smoking Prevalence in adults (18+) - current smokers (APS) |
| | Percentage of adults (aged 18+) classified as overweight or obese |
| | Cancer screening coverage - bowel cancer |
| Best start in life | Smoking status at time of delivery |
| | Breastfeeding initiation |
| | Under 18s conception rate / 1,000 |
| Major health conditions | Hypertension: QOF prevalence (all ages) |
| | Diabetes: QOF prevalence (17+) |
| | Under 75 mortality rate from cancer |
| | Unplanned hospitalisation for chronic ambulatory care sensitive conditions |
| | Depression: Recorded prevalence (aged 18+) |
| Ageing well | Suicide rate |
| | Estimated dementia diagnosis rate (aged 65 and over) |

Smoking Prevalence in adults (18+) - current smokers (APS)

| | | |
|-----------------------|-------------|-----------------|
| <h1>18</h1> | | <h2>14</h2> |
| | | England |
| ICP: Medway and Swale | | <h2>15</h2> |
| Medway Swale | | Kent and Medway |
| <h2>15</h2> | <h2>21</h2> | 2018 |



The rate in Medway and Swale is worse than England.

Value type: Proportion - %

● MS — England

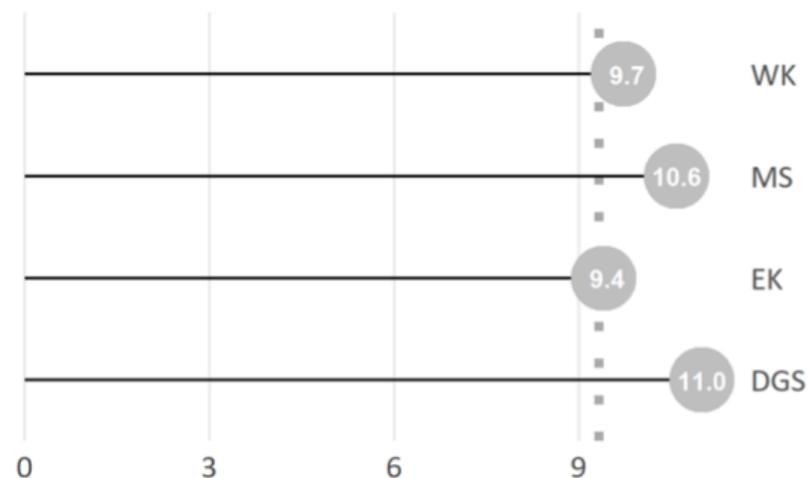
Air pollution: fine particulate matter

| | | |
|-----------------------|-------|-----------------|
| 10.6 | | 9.3 |
| | | England |
| ICP: Medway and Swale | | 9.9 |
| | | Kent and Medway |
| 11.3 | 9.9 | 2016 |
| Medway | Swale | |

MS — England

Compared to England (- - -)

● Better ● Similar ● Worse ● Not compared



Medway and Swale cannot be compared to England statistically.

Hospital helping patients quit smoking this Stopober

Date: 21 October 2019



Even though smoking is in terminal decline, it remains the nation's biggest killer. Although there are now almost two million fewer smokers than in 2011 nationally, there remain around six million adults who are still subject to the devastating harm tobacco causes.

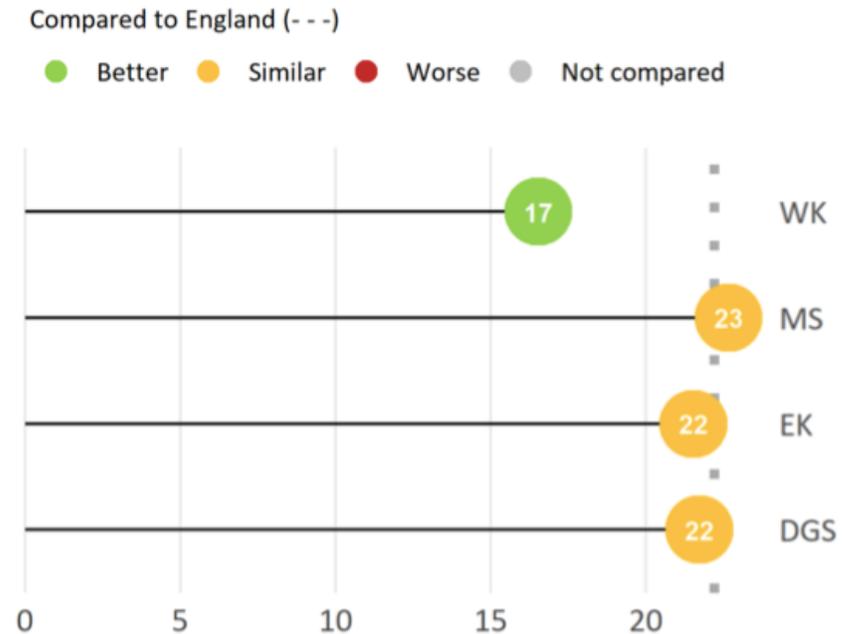
Requires improvement

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| | Unplanned hospitalisation for chronic ambulatory care sensitive conditions |
| | Depression: Recorded prevalence (aged 18+) |
| Ageing well | Suicide rate |
| | Estimated dementia diagnosis rate (aged 65 and over) |

Percentage of physically inactive adults

| | | |
|-----------------------|-------|-----------------|
| 23 | | 22 |
| | | England |
| ICP: Medway and Swale | | 20 |
| | | Kent and Medway |
| 23 | 22 | 2017/18 |
| Medway | Swale | |

MS — England



The rate in Medway and Swale is similar to England.

Value type: Proportion - %

Medway & Swale Integrated Care Partnership

| Health & Well being Priorities | Driver Diagram - 5 Year Plan - Interventions and Outcomes | | |
|--|---|---|--|
| | Primary Drivers | Secondary Drivers | Action |
| Smoking Aim; To decrease smoking prevalence to below the national average To prevent young people from starting to smoke tobacco and other substances | Peer pressure | CV team are working practices AF + anti coag - Right care CVD | Commissioning for outcomes - lit review |
| | Highly addictive product | National expectations of 75% of people on a Learning Disability register to have an annual health check | Track use of appts for MH patients referred for smoking cessation |
| | | Availability of smoking areas in public | Ensuring all patients >65 have an annual pulse check |
| | | | Healthy ways programme |
| | | | Project need -Trusted assessors |
| | | | Trusted assessors workforce passports |
| | | | MECC - 3 levels of training |
| | | Dehydration - UTT's for homebound patients | |
| Obesity Aim; to reduce the prevalence of obesity by 10% in all age groups To reduce the prevalence of type 2 diabetes and Stroke in all age groups | Ease of access to high calorie, low value low cost nutrition | Social deprivation | Pre-diabetes weight loss + PH programmes |
| | Lack of exercise / activity | Poor motivation | Diabetes improvement programme |
| | Genetic predisposition (few) | Lack of knowledge of nutrition | Education on nutritional value and cooking at school to include parents / guardians / carers |
| | | Inability to cook | All vending machines to sell low sugar, low fat products |
| | | | Prehab |
| Wider Determinants of Health | Social deprivation | | |
| | Lack of opportunity | | |
| | Low educational attainment (<5 GCSEs, no maths or English) | | |
| | Excessive car use / lack of public transport routes at low cost | | |
| | | | |

Medway & Swale Integrated Care Partnership

Driver Diagram - 5 Year Plan - Interventions and Outcomes

| Health & Well being Priorities | | | |
|--|--|--|--|
| | Primary Drivers | Secondary Drivers | Action |
| <p>Aim; to reduce the number of admissions to hospital of people with ambulatory care sensitive conditions (ACSC)</p> | Insufficient Primary Care capacity | Lack of knowledge of self-care options | Reduction in incidence of hypertension |
| | Over reliance on care from consultant led teams | Lack of rapid response to deteriorating conditions | Rapid response teams through single point of contact |
| | Presentations at times when senior decision makers are not available | Outpatient appointments not flexible to patient need (XS fixed follow up appointments) | 24H pharmacy |
| | Social deprivation factors | Patients self referring to ED | Online pharmacy |
| | | | PAM IAPT social prescriber |
| | | | Meds optimisation strategy |
| | | | GAP - Lifestyle coach (LTC) |
| | | | Prehab |
| | | | Shared Care plans Patient / Carer / health professional. |
| | | | |

COLLABORATIONS- DIABETES

WhatsApp 12:19
nursingtimes.net — Private



New diabetes nurse clinic helping patients prepare for surgery

13 NOVEMBER, 2019 | BY REBECCA GILROY



A nurse-run diabetes clinic in Kent is advising patients on achieving better blood glucose level



Diabetes focus group for the black, asian and minority ethnic community

Saturday 8 February 2020, 10am to 12pm
Common Room, Education Centre
Medway Maritime Hospital, Gillingham, ME7 5NY

Diabetes in the Surgical patient- place for Prehab intervention?

Roberto Laza-Cagigas, Daniel Sumner, Tarannum Rampal
Department of Anaesthetics. Medway NHS Foundation Trust



Introduction

Around 8 million procedures are performed in the UK with 10-15% of patients having diabetes. These patients are subjected to greater numbers of complications and length of stays. Furthermore, as the population of the UK ages, the likelihood of patients presenting for major oncological surgery while also having either type 1 or type 2 diabetes (T2D) increases, implying an overall greater mortality when compared to those without diabetes.

We identified that a number of patients referred to our Surgical Prehabilitation Service (SPS) suffered from T2D. We explored whether we could offer a multimodal, targeted intervention to make a significant impact on their T2D management. This is particularly relevant in patients presenting for expedited surgery which does not allow time for traditional interventions to have a clinical impact.

We hypothesised that supervised exercise and dietary changes in T2D patients awaiting elective surgery would improve their diabetes management in a short period of time.

Methods

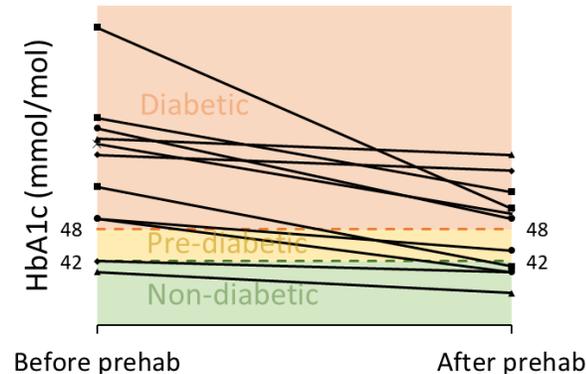
Patients referred to our SPS for optimization before elective surgery who suffered from T2D were offered to enrol in our Prehabilitation Programme.

We measure glycosylated haemoglobin (HbA1c) before and after Prehabilitation to assess changes in T2D management.

The dietary approach included our usual counselling; 1) cutting down on processed foods, 2) reaching a minimum daily protein intake of 1.5 g/kg of ideal body weight, and as a novelty we asked patients to consider 3) an *ad libitum* low-carbohydrate high-fat diet. To provide support for the later, we explained patients how to detect high-carbohydrate sources.

Patients also performed 2 weekly in-hospital sessions of either 30-minute aerobic interval training on a cycle ergometer or 30-minute resistance training. Patients were offered anxiety coping strategies at group sessions as part of the Prehabilitation Programme.

Figure 1. Individual changes in HbA1c



Results

Ten oncology and 1 orthopaedic patients (3 females) with T2D referred to our SPS for optimization before elective surgery accepted to adopt some dietary changes in form of carbohydrate restriction. After an average span of 6 weeks, HbA1c (Figure 1), weight, and BMI showed reductions (Table 1). Every patient reduced their HbA1c.

| | Pre-prehabilitation | | Post-prehabilitation | |
|--------------------------|---------------------|--------------|----------------------|--------------|
| | Mean | Range | Mean | Range |
| Age (years) | 71 | (55-86) | - | - |
| Prehab weeks | - | - | 6 | (2-9) |
| Weight (kg) | 104.9 | (73.3-125.5) | 99.7* | (72.6-117.0) |
| BMI (kg/m ²) | 36.5 | (25.7-44.8) | 34.7* | (25.4-41.1) |
| HbA1c (mmol/mol) | 59 | (40-86) | 48** | (36-62) |

Table 1. Pre- and post-prehabilitation data. Values are presented as mean (range). Paired-sample t-test: *P=0.001, **P=0.003

Conclusion

There was demonstrable HbA1c improvement in our 11 patients awaiting elective surgery. These improvements were observed in as short as 2 weeks and allowed patients to eat to satiety while only reducing high-carbohydrate foods intake. Currently, we continue recruiting eligible patients to further assess the reproducibility of our approach.

More focussed studies are required for establishing the efficacy of Prehabilitation interventions on T2D patients.

References

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- Barker, P., Creasey, P. E., Dhatariya, K., Levy, N., Lipp, A., ... & Woodcock, T. (2015). Peri-operative management of the surgical patient with diabetes 2015: Association of Anaesthetists of Great Britain and Ireland. *Anaesthesia*, 70(12), 1427-1440.
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- McKenzie, A. L., Hallberg, S. J., Creighton, B. C., Volk, B. M., Link, T. M., Abner, M. K., ... & Phinney, S. D. (2017). A Novel Intervention Including Individualized Nutritional Recommendations Reduces Hemoglobin A1c Level, Medication Use, and Weight in Type 2 Diabetes. *JMIR diabetes*, 2(1), e5-e5.

COLLABORATIONS- FRAILITY MANAGEMENT



Making Every Contact Count at the Medway Prehabilitation Service

Making Every Contact Count (MECC) is an approach to patient behaviour change that uses the millions of day-to-day interactions that organisations and people have with other people to support them in making positive changes to their physical and mental health and wellbeing [1]. The Five Year Forward View calls for a radical change in approach to prevention and public health. It outlines the importance of increasing the support available to help people manage and improve their own health with the aim of achieving long-term sustainability for the health and care system [2].

One of the approaches to make every contact count is a brief intervention. This involves an initial discussion or engagement with a patient and further support following it. It is also possible to offer further interventions, depending on the patient's response, or more intense support. In all interventions, the care professionals require the necessary skills and knowledge. They are often carried out as and when they present, often triggered by taking more than a five-minute discussion and advice [3]. For such interventions to be successful, the message needs to be tailored to suit the one behaviour where necessary [4].

These opportunities need to be recognised and a 'head-to-head' approach where the patient has an opportunity to receive a positive behaviour change for a brief intervention, an ongoing session and physical activity [5].

We are the Prehabilitation Team at Medway NHS Foundation Trust. As well as interventions such as surgery, radiation, and chemotherapy, we have introduced a prehabilitation approach for making an overall healthy living. Our approach views an illness as a medical condition, not a disease, and we are looking to prevent, not cure, it. High salt, sugar, fat, and alcohol intake, sedentary lifestyle, and tobacco use are all risk factors for chronic diseases, such as heart disease, blood pressure, diabetes, and cancer. We are looking to prevent, not cure, it. We are looking to prevent, not cure, it. We are looking to prevent, not cure, it.

References

1. Public Health England. Making Every Contact Count (MECC). London: Public Health England; 2015. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/461000/making-every-contact-count-2015.pdf
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5. Public Health England. Making Every Contact Count: A Practical Guide. London: Public Health England; 2015. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/461000/making-every-contact-count-2015.pdf

Thomas Roper
Marina Shah
 Consultant Dietitian

Robert Lane-Cox
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Medway NHS Foundation Trust

References

1. Public Health England. Making Every Contact Count (MECC). London: Public Health England; 2015. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/461000/making-every-contact-count-2015.pdf
2. NHS. Five Year Forward View. London: NHS; 2014. Available from: <http://www.nhs.uk/5-year-forward-view/>
3. Behaviour Change in Health: A Practical Guide. London: Public Health England; 2015. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/461000/behaviour-change-in-health-a-practical-guide-2015.pdf
4. Health and Safety Executive. Making Every Contact Count: A Practical Guide. London: HSE; 2015. Available from: <http://www.hse.gov.uk/making-every-contact-count/>
5. Public Health England. Making Every Contact Count: A Practical Guide. London: Public Health England; 2015. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/461000/making-every-contact-count-2015.pdf

Structured Prehabilitation For High Risk Surgery: Getting the surgeons on board

D Cottam, T Rampal, R Laza-Cagigas, M Shah
Medway NHS Foundation Trust



Introduction

- Prehabilitation may improve outcomes and hasten return to pre-operative functional levels following major surgery^{1,2}.
- Due to contradictory evidence³, surgeons may desire local trials to encourage referral for prehabilitation.
- Medway Maritime Hospital is a 588-bed district general hospital where high risk patients are reviewed by consultant anaesthetists and undergo cardiopulmonary exercise testing (CPET); however no formalised process existed for patients who may benefit from intervention to increase surgical fitness.
- We describe the implementation of a prehabilitation programme, assessing the impact on predicted perioperative mortality and aiming to promote surgical engagement.

Methods

- An 81-year-old male with a background of cerebrovascular disease, pulmonary embolism and bladder transitional cell carcinoma was referred to the prehabilitation unit following CPET assessing fitness for cystectomy.
- We provided nutritional information, home-based respiratory muscle training instructions, and supervised cycle ergometer interval training (twenty-four 30-minute sessions over eight weeks), and assessed the impact on CPET, laboratory tests and 30-day post-operative mortality estimation⁴.
- Presentation of case data along with CPET demonstrations to surgeons and Trust wide educational presentation, we have established links with Surgical schedulers to increase the potential benefit to all major surgical patients.
- We continue to invite surgeons and GPs to Patient education evenings and regular promotions in social media and newsletters.



CPET/training bike set up

References: 1. Gillis C, et al. Prehabilitation versus rehabilitation: a randomized control trial in patients undergoing colorectal resection for cancer. *Anesthesiology* 2014; 358:937-47; 2. Li C, et al. Impact of a trimodal prehabilitation program on functional recovery after colorectal cancer surgery: a pilot study. *Surg Endosc* 2013; 358:1072-82; 3. Cabian C, et al. The effectiveness of prehabilitation or preoperative exercise for surgical patients: a systematic review. *JBI Database System Rev Implement Re*; 13:146-87, 2015; 4. J. B. Carlisle; Assessing fitness, predicting outcome, and the missing axis. *BJA: British Journal of Anaesthesia*, Volume 109, Issue 1, 1 July 2012, Pages 35-39

Results

The intervention was well tolerated by the patient. Pre- and post-intervention spirometry, CPET and laboratory data are summarised in table 1. BMI reduced from 30.9 to 29.7 with 3 kg of weight loss. Spirometry values improved post-intervention with increases in FVC, FEV1 and PEF, while CPET demonstrated increases in VO2 Max, minute ventilation and maximum load. Serum creatinine reduced, while albumin and haemoglobin increased post-intervention. The patient's predicted 30-day mortality fell from 11.5% to 6.14% within 8 weeks.

| Parameter | Pre-Intervention | Post-Intervention |
|---|------------------|-------------------|
| FEV1 (L) | 2.41 | 2.49 |
| FVC (L) | 3.62 | 3.82 |
| PEF (L/min) | 411 | 488 |
| FEV1/FVC (%) | 67 | 66 |
| VO ₂ /kg Anaerobic Threshold (ml/min/kg) | 10.3 | 11.0 |
| VO ₂ /kg Max (ml/min/kg) | 14.1 | 17.6 |
| Maximum HR (bpm) | 138 | 151 |
| Ventilation (L/min) | 64 | 84 |
| Maximum Load (W) | 90 | 118 |
| BMI (kg/m ²) | 30.9 | 29.7 |
| Creatinine (µmol/L) | 126 | 121 |
| Albumin (g/L) | 39 | 41 |
| Haemoglobin (g/L) | 130 | 139 |
| Predicted Mortality (%) | 11.5 | 6.14 |

Table 1: Summary of Pre- and Post-intervention spirometry, CPET and laboratory data.

Conclusions

A structured prehabilitation programme may have the potential to reduce perioperative risk in high risk patients in a hospital with no pre-existing set-up. Following the presentation of the initial proof of concept and collaborative educational sessions for surgeons, we have increased the referral rate into our programme. We have enrolled further patients and continue to review the impact on perioperative mortality.

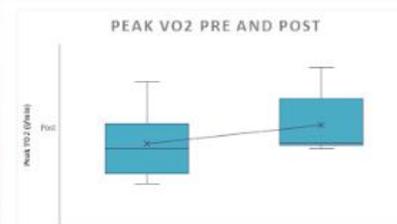


Figure 3: Boxplot of peak VO₂ pre and post prehabilitation. The box shows the 25th quartile, median, and the 75th quartile. The 'x' marks the mean, with a line connecting the two means to show the change in mean between the two observations (n=7).

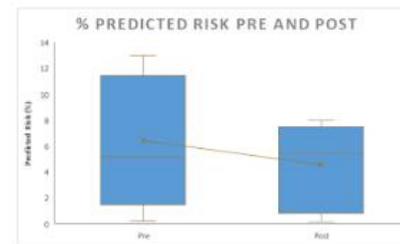


Figure 4: Boxplot of % predicted mortality risk pre and post prehabilitation. The box shows the 25th quartile, median, and the 75th quartile. The 'x' marks the mean, with a line connecting the two means to show the change in mean between the two observations (n=7).

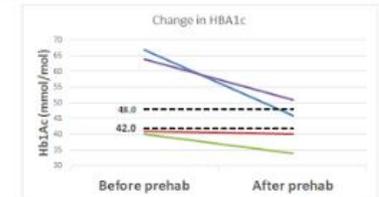


Figure 5: change in HbA1c for the 4 diabetic patients before and after completing 6 weeks of prehabilitation.

Achievements and Aspirations

Through very early on in our journey, we have been encouraged through favourable feedback from our Trust Executive Board and Senior Public Health Figures. The team have presented their work at the World Prehabilitation Conference (June 2018) and Perioperative Exercise Testing and Training Society meeting (July 2018).

Earlier this year we won the Inaugural Chief Executive's Scholarship to visit Franco Carli's pioneering Prehabilitation unit at McGill University, Montreal (Photo 5 below). We have just returned from an inspirational trip which has given us the opportunity to see the inner workings of their unit, to learn about their challenges and journey over the last 7 years and share good practice. It has given us impetus and ideas to continue developing our service in the future, as well as the opportunity for future collaborative research.



COLLABORATIONS - SOCIAL ISOLATION



The NHS as an anchor

28 March 2018

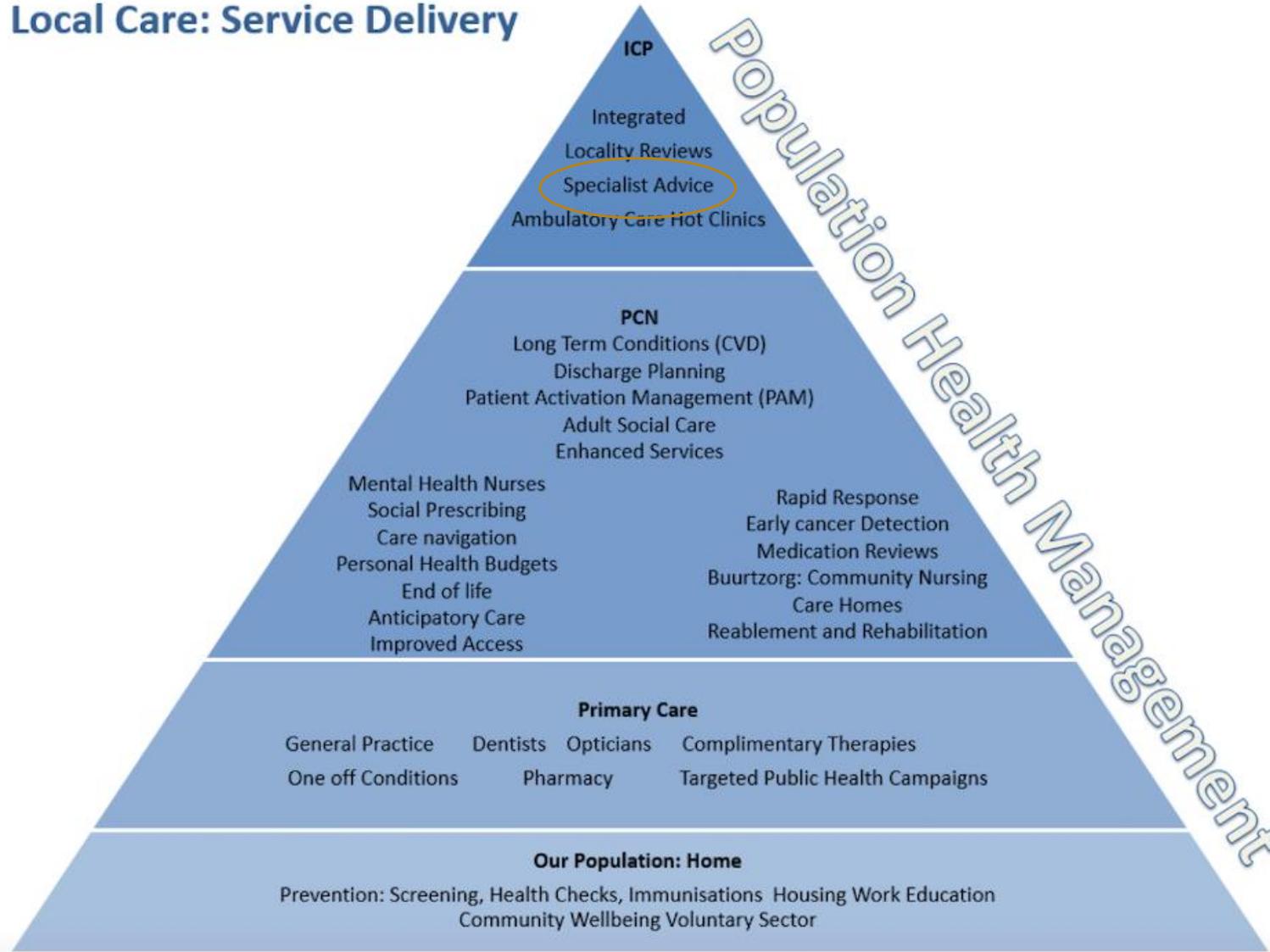
 [Sarah Reed](#)

 [Newsletter feature](#) / [Public health](#) / [Quality improvement](#)



How can health care organisations maximise their resources to improve population health?

Local Care: Service Delivery





Medway innovation Hub @healthovation · 13 Dec 2019

Still reflecting on our 2019 end of year hub expertly chaired by @TaraR54704426 from @Medway_NHS_FT where we reviewed all of the innovators, our vision and our roadmap for 2020. Cross system innovation requires listening, inclusivity and a creative environment: watch this space!



Medway innovation Hub @healthovation · 28 Nov 2019

Such an honour for the #MiH to be awarded pilot site status by @rcgp for their Innovators Mentorship Programme #bringontheinnovators @NHSMedwayCCG @KMhealthandcare

Plan Delivery

2019/2020

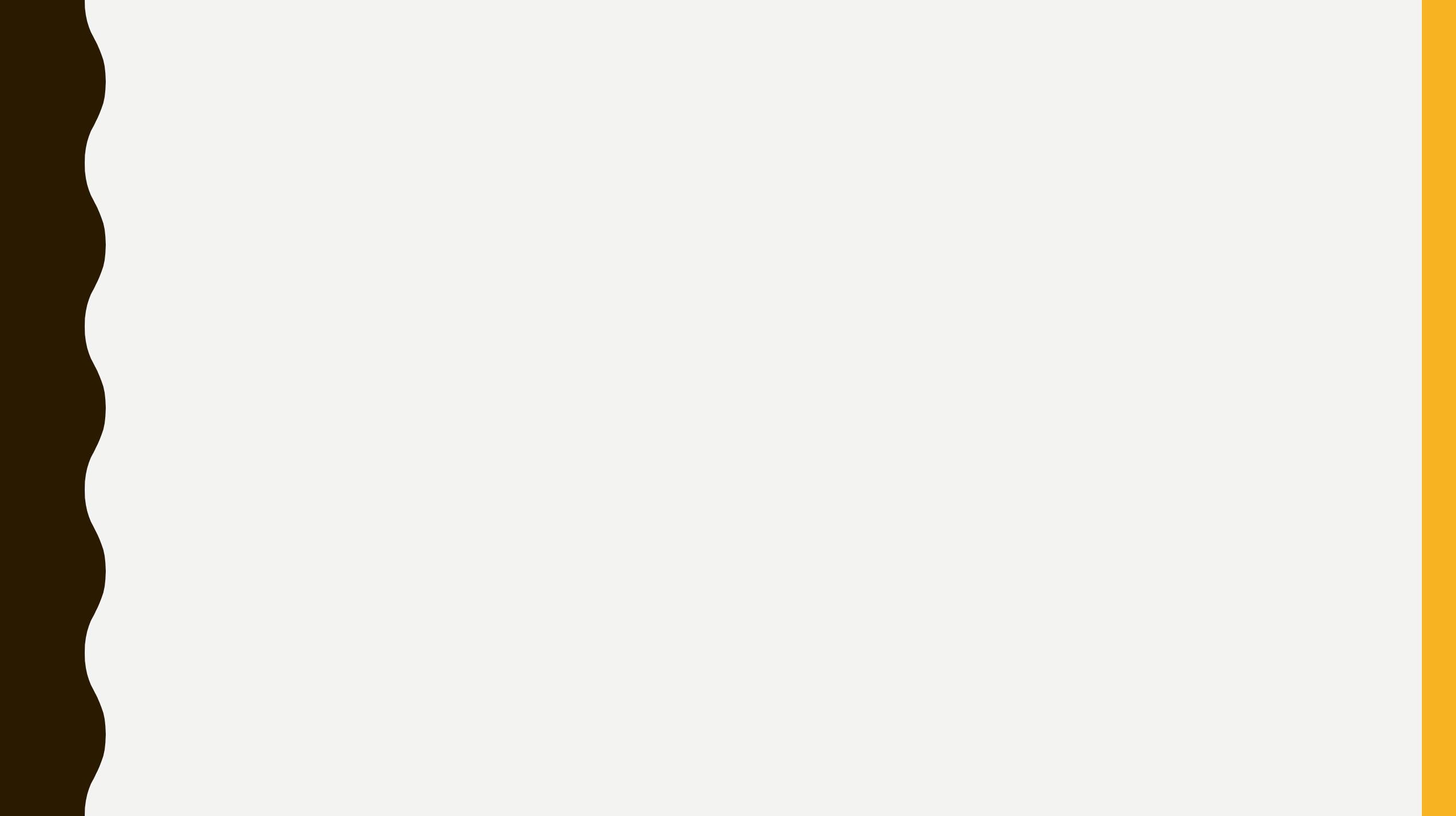
- Primary Care Networks Established
- New roles in PCNs
- Integrated Locality Reviews (ILRs)
- Care Navigators
- Central coordination function commenced
- Training Hubs
- Patient Activation Measures (PAM) programme
- Mobilisation of community services to localities: Plateletomy
- General Practice Forward View Initiatives
- Care Home Programme
- Improved Access

2020/ 2021

- PCN Development
- Local Enhanced Services
- Anticipatory Care- Risk Stratification: PCN reviews
- Mental Health Primary Care Nurses
- Early cancer diagnosis
- Ambulatory Care / Hot Clinics
- Time to Care: Quality Improvement
- Medication Reviews
- Rehabilitation and rehabilitation, discharge planning
- Community Nurse review: Budgeting, alignment to PCNs, clinics
- Investment in case manager roles
- 2 hour rapid response
- 80% Tier 1 services and 50% Tier 2 Services aligned to PCNs

2021/ 2022

- Neighbourhood Inequalities
- Improved Access and extended Access aligned
- Rollout of Care Manager role
- Implementation of agreed community funding model
- 100% alignment of services to primary care networks
- 48 hour reablement



New care models



**How to meet population health needs
through workforce redesign**

FACT

There is increased demand on healthcare resources

Original Articles

Multidimensional principal-agent value for money in healthcare project financing

Roberto Moro Visconti 

Pages 259-264 | Published online: 11 Jun 2014

 Download citation  <https://doi.org/10.1080/09540962.2014.920198>

A Primer on Population Health Management and Its Perioperative Application

Boudreaux, Arthur M. MD; Vetter, Thomas R. MD, MPH [Author Information](#) 

Anesthesia & Analgesia: July 2016 - Volume 123 - Issue 1 - p 63-70

doi: 10.1213/ANE.0000000000001357

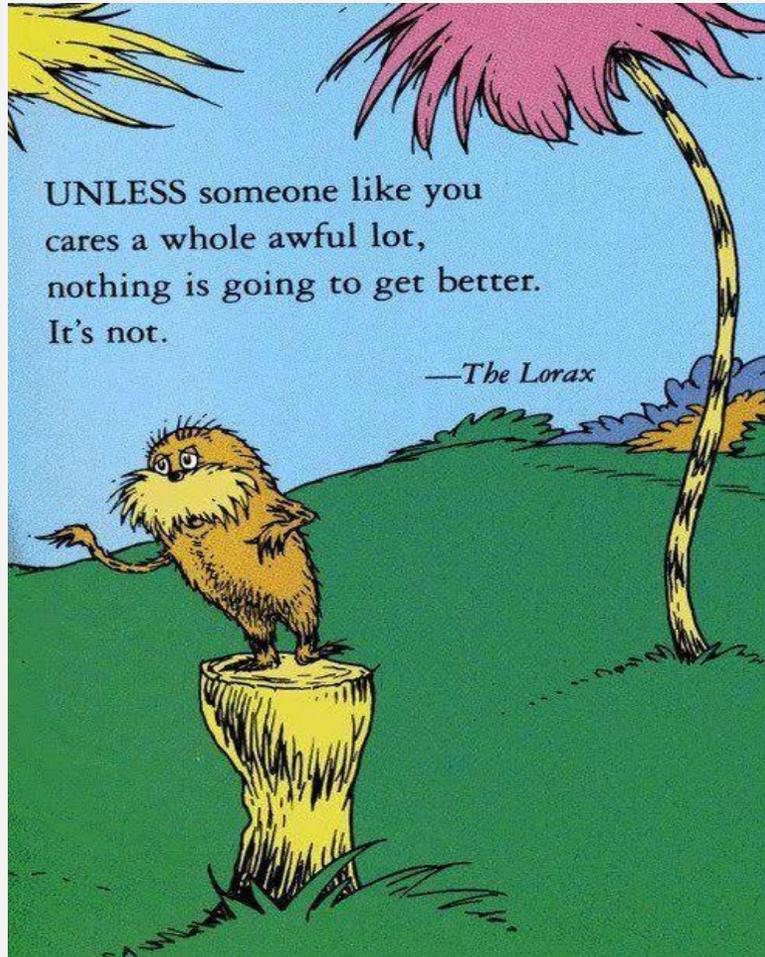
Delivering a Healthier Future for Londoners: Policy Landscape & Workforce Considerations

16th January 2020

Venue: Edwards room, The King's Fund, 11-13 Cavendish Square, London W1G 0AN

The King's Fund is hosting this conversation on behalf of the London Public Health Academy (part of Health Education England) and partner organisations. The aim of this one-off workshop is to explore key considerations such as the opportunities, priorities and actions for delivering a strong Population Health focused workforce in London. There are lots of great efforts already underway for aspects of this, and this day provides participants with an opportunity to come together, supported by Population Health experts Durka Dougall and David Buck from the King's Fund, to join up and strengthen efforts.

| Time | Session | Who |
|-------------|---|--|
| 09:30-10:00 | Registration and Coffee | |
| 10:00-10:05 | Welcome & Introductions | Rachel Wells |
| 10:05-11:15 | <p>Context for Population Health in London & Significance of Future Drivers</p> <p>3 x 15 min presentations providing an overview of key work and policy developments:</p> <ul style="list-style-type: none"> • The King's Fund's Vision for Population Health • The Needs of Londoners & Vision for London • Workforce Now & For the Future <p>Followed by 15min Q&A session with the panel the future drivers work in the current landscape (20 min).</p> | Elizabeth Hughes Paul Plant Durka Dougall David Buck |
| 11:15-11:30 | Tea break | |
| 11:30-12:45 | <p>Mapping Our Individual and Collective Priorities</p> <p>Interactive exercise using King's Fund's Framework for Population Health to review current priorities of partner organisations to deliver population health in London. Work to identify areas of shared interest and priority focus needed as a London system for population health.</p> | Durka Dougall David Buck |
| 12:45-13:30 | NETWORKING LUNCH | |
| 13:30-14:45 | <p>Workforce</p> <p>Short presentations about workforce in three key areas: specialist public health workforce, clinical workforce, wider workforce. This will be followed by a discussion about how to unlock the tremendous potential of these and practical actions that are needed.</p> | Rachel Flowers Ruth Hutt Shirley Cramer Tarannum Rampal Kenye Karemo |



UNLESS someone like you
cares a whole awful lot,
nothing is going to get better.
It's not.

—*The Lorax*



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