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Healthcare Public Health

Welcome to the first Healthcare Public Health newsletter edition for 2019, we trust you have had an enjoyable start to the year and like us, you have had an opportunity to reflect on the successes of 2018 and to consider what is on the horizon for the year ahead. Building on last year's Prevention Vision from the Secretary of State for Health and Social Care, we have now welcomed the NHS Long Term Plan with a significant focus on prevention at its core. The plan provides a platform for many opportunities for increasing the health outcomes of local populations, that many partners reading this newsletter will be perhaps already engaged, or planning to collaborate on during the next couple of years.

This newsletter is produced on a quarterly basis by the national Healthcare Public Health team at Public Health England (PHE). The team is very interested to hear your thoughts on whether it is of value to your work locally and any suggestions you may have for additional content. We welcome your feedback and suggestions via this survey which runs until Friday 15 March 2019.

Should you wish to discuss any element of this edition of the newsletter with a member of the team, please contact us on HealthcarePublicHealth@phe.gov.uk

Eleanor Wilkinson - Population Health Services Manager – Health Care Public Health Team, Public Health England

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Foreword from the Health Care Public Health Team

Dr Allison Streetly OBE - Deputy National Lead, Healthcare Public Health, PHE

Earlier this month the NHS launched their Long-Term Plan, which sets out a vision we welcome; we look forward to working together with the NHS and other our partners to make this vision a *system wide* practical reality. Whilst this is a vision for the NHS, all partners across the system will need to come together to achieve the desired step change contained within this vision.

We welcome the strong focus on prevention and in particular a clear focus on reducing health inequalities. The plan also discusses much needed population health models that will seek to improve health outcomes alongside efficiencies by bringing together local primary and community health services which have, since the inception of the NHS, been overseen and funded separately. This could make it considerably easier and reduce transactional costs in achieving not only joined up services at a local level but also provide a joined-up vision on key health outcomes. Whilst this is described as a 'long term' plan, delivery of this vision is a significant challenge and in order to achieve this, the plan discusses a needed redesign of service models to ensure a 'bottom up' approach aiming to bring a clearer focus on local systems and working together at local level. It also makes a change from the emphasis being on commissioning and provision as two separate parts and a mention for the first time of the importance of the NHS as an "anchor institution" as "part of local community resources". Monitoring of progress of health outcomes and evaluation will be essential in ensuring we are doing the best we can within the time and resources available and ensuring that we are reducing variation in delivery of services and improving health outcomes as new service models are implemented. It will be important to avoid getting lost in the detail of many different aspirations within the plan.

We welcome the clear ambitions set out for obesity, smoking and alcohol services, noting again that this will need to be joined up with existing local government services to optimise the effectiveness of this. Commitments for reducing 150,000 cardiovascular related deaths by improving the treatment for the three high risk conditions (atrial fibrillation, high cholesterol and hypertension) are particularly welcome given our involvement in developing the PHE CVD prevention programme. Following the publication of the Familial Hypercholesterolemia Implementation Guide, which aims to support the Implementation of existing NICE guidance we are delighted to see NHS commitment to increasing detection of carriers of FH from its current low base in England to 25% within the next five years, achievable now in England with the roll-

out of the new genomics centers. We look forward to continuing to work with key partners including NICE, voluntary sector stakeholders and clinical partners in primary care to ensure this ambition is achieved as a model of genomics being mainstreamed outside of specialist units.

Given our teams strong links with the Academic Health Science Networks (AHSNs) over the years, we are delighted to see ‘innovation’ embedded within the plan. There is a strong focus on better joined up, patient centered services. Continuing partnership working between the AHSNs, Getting It Right First Time (GIRFT) and NHS Right-Care will be essential to ensure changes and service improvements occur in partnership to achieve progress with reduction in already well described variations. It goes without saying that this plan will remain only an ambition without adequate investment in existing NHS staff members and the many vacancies. Supporting NHS staff with training, career progression opportunities and focusing on improving their health and wellbeing – both physical and mental, will be essential to ensure optimal capability and capacity is achieved – and can of itself directly contribute to softer influence in the NHS itself of the value of not simply being a treatment service. This is particularly important international in reports such as the 2018 Commonwealth fund report which highlighted the excellent efficiencies in the NHS compared to our international partners, however also noted that we have the second poorest health outcomes, only behind America. This long term plan is a welcome opportunity to refocus on common objectives and outcomes for population health.

Health care public health – a lookback exercise
Dr Edmund Jessop - retired public health consultant

In the 1980s I worked in Colchester. The title then was Director of Community Medicine and the community we served was people living in North East Essex. General practice was expanding away from single handed practitioners towards well-staffed group practices with nurses and other ancillary staff. We were also in the early stages of the first health strategy for Britain – 'Health of the Nation' with its five key areas of cardiovascular disease, cancer, mental health, accidents and HIV. Primary care is fundamental to all five and so, rather than tackle each one separately, we focused on strengthening primary care capacity by running team building workshops. We were fortunate to have a very experienced facilitator who understood life as a GP – an increasingly rare thing!

My next job, after a short interlude at a regional headquarters, was in West Surrey. We were the richest district in England on almost any measure (second only to Solihull on some) so the basic public health indicators were fine – lowest cardiovascular mortality in England, lowest teenage pregnancy rate etc. Primary care was strong and our energy was consumed by the secondary care system. The key task was to encourage co-operation between four acute and no less than seven community hospitals all crammed into a small geography. This was organisational complexity at its worst! Initial efforts were hampered by a government trying to introduce market economics by emphasising competition; but the winters of the 1990s, characterized by huge spikes in influenza and chaos in A&E departments, changed the emphasis to collaboration.

The next reorganisation landed me in the Department of Health with what at the time was called 'national' commissioning but is now 'highly specialised' – commissioning services which need planning, funding and monitoring at national level. Within the new doctrine of place based commissioning these services have the whole of England as their 'place'. Our core belief is that volume drives expertise: the more you see, the better you get. So we are hugely centralizing because that's the only way to ensure that patients can be seen by teams which are fully expert in their disease. That drive to concentrate expertise creates an obligation to study geography carefully – are people living distant able to access the service readily?

NHS England was established in April 2013 with a strong ethos of evidence-based policy which has been heavily dependent on public health expertise. There has also been the challenge of developing clinical policy for some hugely expensive (but also hugely effective) treatment for the ultra-rare diseases. All in all, a varied and enormously rewarding four decades in healthcare public health.

An update on eye health
Dr Leonora Weil, Public Health Registrar, Public Health England

In November 2018, PHE held a Collaborative Workshop in Eye Health supported by DHSC and NHSE. The workshop focused on three areas; uptake of eye checks, eye health data and information, and child vision screening. These key areas were identified through interviews over six months with stakeholders to understand the scope to improve efficiency and outcomes in eye health from the perspective of public health. Approximately 50 people attended the workshop from a range of organisations including national bodies (DHSC, NHSE, NHS Digital, NHS Rightcare), colleges (Royal college of Ophthalmologists, College of optometrists), eye health sector (LEHNS, LOCSU, GOC) and the third sector. The key messages from the workshop were shared in a report and are outlined below. The findings were also presented at the APPG on Eye Health and Visual Impairment in Parliament on December 10th 2018. Note that the views expressed in this document are the views of those in the workshop and not necessarily the views of PHE, DHSC or NHSE.

Key Messages:

Reducing inequalities and increasing uptake of all eye health checks;

- **Public Health Campaign:** A need for a coordinated, unified, targeted national Public Health campaign to engage, motivate and support people to make positive changes, to clarify that an eye test is a health check and highlight the preventative actions, treatment and support services available
- **Making every contact count:** prompts from all health professionals and those working with the elderly to encourage eye tests
- **Assist local commissioners:** Developing a series of tools and guidance documents including support on including vision loss in Joint Health Needs Assessments would be useful to understand need and reduce inequalities.
- **Hard to reach groups**: should be specifically targeted for any campaigns
- **System Leadership**: A need for greater system leadership arena of eye health

Improving access and sharing of data and health information;

- **Quality data:** There is already good quality data available, but it is not always clear how to find or use it or detailed at the local level.
- **An evidence review**: to assess the scale of eye health disorders and their public health impact and identify effective interventions

- **Connectivity:** It would be useful to have greater connectivity between primary and secondary care data
- **Taking advantage of upcoming opportunities:** including the PHE/Right Care Atlas of Variation for Eye Health and the NHSE Connectivity Programme.

Improving vision screening for 4-5 year olds

- Whilst the 4-5 child vision screening is a national programme in England as part of the 0-19-year programme, it is commissioned by LAs and not all localities provide vision screening in schools. The main issue is the lack of consistency of commissioning vision screening for children.
- **The Interim advice from the PHE screening team**: take children for an NHS sight test offered as part of the General Opthalmic Service. Some optometrist practices might need more support for this.
- **Importance:** The 4-5 child vision screening programme is valued
- **Barriers for local authority:** outlining costs savings and benefits to local authorities could help with local support
- **Inequalities:** where school screening it is not offered, children in the most deprived families or hard to reach groups might miss out and this could increase the risk of inequalities
- **Messages for parents:** more information is needed around testing children's vision and where to go for tests.

Many thanks to DHSC, NHSE and Miss Parul Desai for their support and input into the workshop.

Evaluation & Monitoring- Five Year Forward View CVD Prevention Programme

Dr Nayab Nasir - Evidence and Evaluation Lead CVD Prevention – National Cardiovascular Intelligence Network, Public Health England

2018 has been a dynamic, exciting and successful year for prevention. Following the publication of Next Steps of the NHS Five Year Forward View, the PHE CVD prevention team initiated a national Cardiovascular Disease (CVD) Prevention Programme at scale in collaboration with NHS RightCare and local health economies. Within the same year PHE convened an inaugural of CVD Senior Leadership Forum brought together 35 partnerships on one platform to align priorities and enable system leadership on CVD prevention.

The initiation, implementation and delivery of the yearlong project is underpinned commitment to scale up the CVD prevention work with system partners on the three high risk conditions through CVD ambitions for England. The programme aims to improve premature CVD mortalities and reduction in health inequalities through effective diagnosis and optimal management of atrial fibrillation, hypertension and dyslipidaemia showing the greatest return on investment.

PHE's National Cardiovascular Intelligence Network is conducting a formal evaluation while the national CVD prevention team has an oversight of the delivery of the project. The evaluation approaches are set up in a way to examine, monitor and evaluate the various stages of the project to produce high standard recommendations for setting up national projects of like in the world of prevention work, both nationally and internationally. The evaluation and monitoring mechanisms provide evidence based recommendations from interviewing stakeholders, surveys, examining qualitative information from high level strategic documents, case studies and analysis of high standard reporting.

The study has been a stepping stone in identifying the enablers and barriers in the health care system. The initial findings of the evaluation are suggestive of the importance of clear, system level work which is possible through setting up governance structures, clinical leadership and collaborative work. I am hopeful that some case studies will intensify powerful example of leadership approaches in improving outcomes for patients in a complex health care system. More than 86% STPs have shown commitment to prioritise at least one or more CVD high risk conditions. It is likely that at the close of March 2019 this number will increase further.

For more information, contact Dr Nayab Nasir, Evidence and Evaluation Lead, National Cardiovascular Intelligence Network at Nayab.nasir@phe.gov.uk

Is cardiac rehabilitation a new sentinel service?

Nevila Kallfa MD MPA FFPH, Consultant in Public Health, Public Health England

Dr Vaughan Lewis, Medical Director Specialised Commissioning NHS South & Interim SE Regional Medical Director

Cardiac rehabilitation (CR) is an evidence-based and NICE-recommended service which is clinically effective and both cost-effective (adding 'life to years' and 'years to life') and cost- efficient (in reducing hospital re-admissions). The NHS Specialised MD and PHE lead engaged during 2017 with local complex cardiology clinicians as part of its transformational QIPP. Clinicians highlighted challenges in this tertiary prevention service. The South West Public Health team took the lead in understanding the service barriers and bridging the gaps. PHE SW worked in collaboration with the clinical community (Cardiologist, Nurses and Clinical networks), commissioners, Local Authority CVD leads and the British Heart Foundation (BHF) including the National Audit of Cardiac Rehabilitation (NACR)[1].

We identified significant; noncompliance with national standards of care, gaps in early access, variation in methods of care delivery and outcomes. The following report on CR services across the SW presents the case for action to commissioners: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/744462/cardiac_rehabilitation_in_the_south_west.pdf. The findings were shared with partners with the addition of two bespoke events organised jointly by BHF and PHE. Following this commissioners and providers committed to a series of pledges on improving; care, the mechanisms for quality assurance and patient flows. These pledges were also shared with executives as well as NHS England and Directors of Public Health.

Following on from the recommendations of this report the PHE SW is continuing to support commissioners through its work with the National Cardiovascular Intelligence Network (NCVIN) and NACR by developing a methodology for identifying the eligible population that could benefit from CR. Using NACR activity data cross-referenced to the eligible population data, gaps in service provision at CCG and STP level have been identified. This will be used to inform local

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[1] NACR Quality and Outcomes Report 2018: https://www.bhf.org.uk/informationsupport/publications/statistics/national-audit-of-cardiac-rehabilitation-quality-and-outcomes-report-2018

commissioning. The eligible population cohort is also being used to identify current re-admission levels and costs to provide a baseline for evaluating one of the anticipated service impact.

A further recommendation was to review the current provision and data capture mechanisms against the 7 NACR quality standards as well as funding arrangements.

Next steps

- Complete the development of the cost savings model based on system optimisation by extending provision to all those who can benefit from CR.
- Inform the strategic commissioning of CR in the South West.
- Work with providers to improve the quality standards focusing on data completeness/quality and outcomes (e.g. based on completion of CR rather than initiation).
- Explore potential for using a database for commissioning to measure activity and outcomes

Dr Vaughan Lewis says… Cardiac Rehabilitation and the companion of primary/secondary prevention are key to better cardiovascular health which is actively promoted in the NHS Long Term Plan. If a new technology offered the same improvement in health, the demand from patients and clinicians would be unrelenting. These interventions are available now and offer real value to patients, healthcare systems and the wider economy and should be actively promoted by providers, commissioners and STPs and demanded by patients and their families.

Faculty of Public Health – What is the role of the NHS in prevention?

Feedback can be provided by email to policy@fph.org.uk

In August 2018, the Faculty of Public Health (FPH) set out to explore what the role of the NHS is in prevention. Carried out in partnership, the Faculty are keen that stakeholders feed into discussions. In December an initial discussion paper was published raising many important questions that readers may also wish to reflect on and contribute to the discussion. Feedback can be provided by email to policy@fph.org.uk. The discussion paper focuses on three key pieces of work:

What is the evidence telling us?	Defining the role of NHS organisations in ill health prevention	What should be the main actions and areas of focus for the next 3-5 years?

What is the evidence telling us?

The paper highlights the challenges faced by the limitations in the existing evidence available alongside limitations in the current potential reach of population health due to a focus on specific interventions. It also discusses that there is an urgent need to grow the public health evidence base within and outside of health and care and to address the 'negative feedback loop' that currently exists with some public health programmes.

Questions posed for readers by the Faculty PH include:

- Do readers agree with the analysis of the current state of the public health evidence base? Are there overarching points that have been missed?
- How do local decision-makers leading prevention in the NHS bridge the research-to-action gap effectively? Are there effective means of expediting the 'evidence into practice' time lag?
- What tools, methodologies, or approaches do readers use that allows them to 'go beyond' the evidence any current evidence limitations that they may face?

Defining the role of NHS organisations in ill health prevention

The paper discusses how there is a need to better define this role and based on the evidence carried out by FPH they have identified 5 main roles: **Leader, Partner, Employer, Advocate and Researcher.**

The main questions that this raises are:

- Do the above outlined roles that the NHS is playing in prevention chime with your experiences?
- Has anything been missed?
- Are these roles legitimate for the NHS to be fulfilling?

The third and final part of the scoping work was carried out in a workshop format, attended by Allison Streetly and Mandy Harling from the Healthcare Public Health Team.

What should the main actions and areas of focus be for the next 3-5years?

In a workshop with over 40 organisations present, key priority areas were debated, these were then grouped into 26 topic areas under 5 themes of common risk factors, clinical and/or patient pathways, population group or life stage, NHS as an employer, enablers for prevention activity, and universal prevention programmes. Using a variation of nominal group process, participants debated and reviewed the list of priority areas and after much discussion this resulted in 11 key areas which were agreed as a shortlist as the areas of focus over the next 3-6 years:

Shortlist of 11 areas of focus (in no particular order):

A systems approach to prevention	**Better governance for prevention**	**Realising the potential of the community**	**Tackling inequalities**	**Tackling multi-morbidities**	**NHS staff health and wellbeing**
Mental health and wellbeing	**Smoking**	**Alcohol**	**Early years**	**Health promotion**	

The main questions that this raises are:

- What does a system wide approach to prevention across the NHS look like?
- Do you agree with the prioritised short list of 11 prevention areas selected at the workshop? If so why? If not, why not and what would you change?
  In terms of individual prevention areas:
- Are these aiming for the areas with the biggest impact (short, medium, or long-term)?
- Are these able to have the greatest impact regarding cost-effectiveness?
- And if so, do health benefits (outcomes) count equally as well from your perspective as direct financial benefits/savings?
- Are these areas the most deliverable? And does this mean deliverability in terms of how the NHS functions, political deliverability, or workforce deliverability?

We encourage you to join this discussion and consider the questions that this raises. Feedback can be provided by email to policy@fph.org.uk. For initial discussion with the Healthcare Public Health team, please contact Healthcarepublichealth@phe.gov.uk.

An introduction to the Provider Public Health Network
Mandy Harling –Healthcare Public Health Team, Public Health England

Established in 2014 by Sir Muir Gray and Dr Jane Wells, the Provider Public Health network provides a space for public health leads who are working to maximise population health outcomes in services based within acute, community and mental health trusts, to come together to share practice, ideas and to access peer support.

The network includes members from a variety of roles, including Directors of Public Health, Assistant Medical Directors, Public Health Consultants and Public Health Specialists and Practitioners, plus Public Health Registrars who are undertaking placements in provider trusts as part of their training. Increasingly the network also includes leads from local authority public health teams who have a role in supporting 'healthcare public health' within a local provider setting.

In addition to supporting professional and local practice, for example with workshops on relevant tools or initiatives, network members have the opportunity to engage in a number of national projects. Previous examples have included: working with NHS England's Strategy team on the provider-based 'sugar tax pilots', input to the development and QA testing of the *Preventing ill health CQUIN* and its support products, engaging with NHS RightCare Delivery Partners; and the Health Foundation on their work on 'Anchor institutions' and engaging with the NHS Sustainable Development Unit.

Meeting face-to-face in spring and autumn, the October 2018 meeting included a session from PHE's Local Knowledge and Intelligence Service with a walkthrough of tools to support local planning and practice, including the SHAPE tool.

For further information on the Provider PH Network, please contact either janecwells@yahoo.co.uk or mandy.harling@phe.gov.uk

Events, CPD and Opportunities

Have your say

Health Care Public Health Newsletter
Please provide us with your thoughts on how you currently use the newsletter and how we can improve this resource moving forward by completing this survey.

Faculty of Public Health Discussion: What is the NHS role in prevention?
We encourage you to join this discussion and consider the questions that this raises. Feedback can be provided by email to policy@fph.org.uk. More information in the article above.

Familial Hypercholesterolemia (FH)
Following the publication of the co-authored FH Implementation guidance, we are very interested to understand how this is being adopted and implemented across the country. Given the new NHS commitments to increase detection of carriers to 25% in England, we are very interested in hearing from you about what you are doing. If you would be willing to discuss this then please contact Eleanor.Wilkinson@phe.gov.uk.

RSPH and PHE Everyday Interactions: seeking your feedback
In 2017, the Royal Society for Public Health and Public Health England produced 11 impact pathways to help healthcare professionals measure the public health impact of the 'healthy conversations' they have as part of their work. These cover a variety of topics, including smoking, mental wellbeing, alcohol and obesity, and were part of a report called 'Everyday Interactions'.
To help us to evaluate the usefulness of the impact pathways and to understand how they are being used, we have put together a short survey. We welcome responses from all healthcare professionals, regardless of whether you have used these impact pathways before.

Click here to access this survey **closes at the end of February**

Events

PHE CVD National conference
Please hold the date for the *Cardiovascular Disease Prevention Conference 2019: Saving Hearts and Minds Together*, which will take place on **Thursday 14 February 2019** in Manchester - **www.phe-events.org.uk/NHShealthcheck2019**.

Opportunities

Vacancy: Consultant in Public Health – Northumberland County Council

An opportunity to join the Public Health team in Northumberland, described as the most beautiful county to live and work. With a supportive Director of Public Health, innovative programmes of work and opportunities to engage both in international work and local collaboration across the region, including with acute trust providers. For further details click here. **Closing date 11th February 2019.**