Meeting the Prevention Challenge in the East Midlands
A Call to Action

A Joint Report from Public Health England East Midlands and the East Midlands Clinical Senate
About Public Health England

Public Health England exists to protect and improve the nation’s health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

About East Midlands Clinical Senate

The East Midlands Clinical Senate provides independent strategic advice to commissioners and other stakeholders to support them in making the best decisions about health care for their populations. They do this by bringing together a range of health and social care professionals, with patient representatives.

Public Health England

Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

East Midlands Clinical Senate

Fosse House
6 Smith Way, Grove Park
Enderby, Leicester LE19 1SX
Tel: 0113 824 9584
www.emsenatescn.nhs.uk
Twitter: @EMSenate


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Executive Summary

The NHS Five Year Forward View (2014) was published in October 2014. It sets out the challenges the NHS faces and calls for a “radical upgrade in prevention and Public Health”. This report from Public Health England (PHE) East Midlands and the East Midlands Clinical Senate aims to support the delivery of the prevention challenge in the East Midlands. It highlights the projected rises in demand for health and care services, provides a practical framework for prevention in the East Midlands and identifies areas for intervention with case studies highlighting local good practice.

Traditionally efficiencies have been delivered through more efficient delivery of care, but meeting the NHS’s current efficiency goals requires a new solution and a focus on stemming demand through delaying or preventing the onset of need. This report develops the concept of a window of need during which the individual is suffering the effects of one, or as is often the case a number of health conditions, and demands are being made on health and care resources. The report highlights that treatment and care effectively extend the time an individual spends in the window of need, whereas prevention offers the potential to delay an individual’s entry into this window improving outcomes for the individual and reducing the resource demands on services. The model also highlights the added potential to impact on health inequalities through prevention due to the significant inequalities seen in Healthy Life Expectancy across the social gradient.

The report aims to provide practical support to provider and commissioning organisations to support the required shift towards prevention focused health and care system. The following page outlines the top 10 recommendations for each type of organisation.
Prevention top tens

Commissioning organisations

1. To embed Prevention within corporate governance structures, appoint a board level champion for Prevention and Public Health and develop Prevention Impact Assessment for all policies, plans and programmes.

2. To mainstream commissioning for Prevention, ensuring a whole pathway approach to maximise primary, secondary and tertiary prevention within all pathways. E.g. to aim for 100% take up of Cardiac Rehabilitation.

3. To embed Making Every Contact Count (MECC) within all contracts and commissioning, ensuring data collection and contract management reflects MECC outcomes.

4. To work in partnership through Health and Wellbeing Boards to develop clear prevention and lifestyle service pathways with a single point of access.

5. To tackle variation across clinical services, and reduce exception reporting within QOF.

6. To adopt Proportionate Universalism and target prevention activity where it is most needed.

7. To develop the role of the organisation as an advocate for prevention and health improvement within local and national policy debates.

8. To work with Health and Wellbeing Boards and other partners to commission collaboratively, incorporating prevention into pathways and removing barriers to access.

9. To develop a Corporate Social Responsibility strategy with prevention at its heart to maximise the organisation’s impact for prevention across its staff, estates and corporate activity.

10. To consider system, scale and consistency in the organisation’s approach to prevention to ensure delivery of an equitable population level impact.
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Provider organisations

1. To embed Prevention within corporate governance structures, appoint a board level champion for Prevention and Public Health and develop Prevention Impact Assessment for all policies, plans and programmes.

2. To systematically adopt a Making Every Contact Count (MECC) approach within the delivery of all services supported by necessary staff training and IT infrastructure to record activity and outcomes.

3. To develop holistic approaches to history taking to address lifestyle and other risk factors and use this information in care planning and include in discharge summaries.

4. To share information on clinical and lifestyle risks in referral and discharge summaries to ensure that prevention is addressed at all points in pathways and that patients are included on relevant disease registers as early as possible.

5. To ensure healthy food provision within all premises, removing sugary snacks and beverages from vending machines in public sector buildings.

6. To develop estates management and transport policies with prevention at their heart, reducing the impact on local communities and promoting active travel and providing high quality infrastructure to support this.

7. To maximise the organisations impact on the health of staff and their families by ensuring a living wage and implementing occupational health and workforce wellbeing strategies that meet best practice.

8. To adopt a comprehensive Corporate Social Responsibility strategy maximising the positive prevention impact of the organisation within the local economy.

9. To consider how service delivery can support the prevention agenda and how adoption of a proportionate universalism approach can maximise the impact amongst communities with the greatest need.

10. To consider system, scale and consistency in the organisation’s approach to prevention to ensure delivery of an equitable population level impact.
Introduction to prevention

Foundations for report

The NHS Five Year Forward View (2014) was published in October 2014. It set out the challenges the NHS faces and why change is needed, what that change might look like and how it can be achieved.

At its core, it argues that the time has come to create a health system geared towards promoting health and reducing health and social inequalities, rather than just delivering health services. The report identifies the burden of long-term illness on the NHS, now accounting for 70% of its budget, and calls for a radical upgrade in prevention and public health. It identifies the need for the NHS to become more active in bringing about health-related social change and address health inequalities such as smoking and obesity which cascade down generations and are strong risk factors for chronic disease.

The Five Year Forward View starts the move towards a different NHS, and in light of this key recommendation, calls for a “Radical upgrade in prevention and Public Health”. This report identifies areas for intervention providing a practical framework for the East Midlands with case studies highlighting good practice.

Why prevention matters

It is well recognised that the UK has a growing and ageing population, and that this is creating pressure on services across health and social care. The King’s Fund estimate that rising demand for NHS services will lead to a £30bn funding gap by 2020/21. The government have committed to fund £8bn, with the other £22bn requiring delivery through efficiency savings as set out in the Five Year Forward View. Similarly, the Local Government Association (LGA) project a £15bn funding gap in social care as demand rises against a backdrop of reduced funding.

Traditional models of care have focussed on meeting demand within the population, and efficiencies have been achieved through improvements in service delivery. However much of the potential for efficiencies in delivery has been exhausted and further gains are unlikely to be made at the scale and pace required to fill the projected funding gap. A new solution is required
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that focuses on stemming demand through delaying or preventing the onset of need. This report develops the concept of a window of need during which the individual is suffering the effects of one, or as is often the case a number of health conditions, and demands are being made on health and care resources. The report also highlights that treatment and care effectively extend the time an individual spends in the window of need, whereas prevention offers the potential to delay an individual’s entry into this window.

Reducing the window of need

The window of need for any given individual is the time between the onset of ill health and the resolution of that ill health. With the vast majority of morbidity in the UK now stemming from progressive chronic diseases, resolution is often not possible other than at the point of death. This enables us to consider the window of need for a population as being the gap between Healthy Life Expectancy and total Life Expectancy, or the gap between the time lived in a healthy state through to death during which many will be living with multi-morbidity and complex needs.

Figure 1 Window of need

Whilst both prevention and treatment and care approaches will lead to an increase in overall life expectancy, only prevention offers the opportunity to provide this in a way that extends the period of healthy life expectancy. This approach has the benefit to delay entry into the ‘window of need’ and hopefully to deliver a reduction in the level of care required at the onset of morbidity, and the total time spent with need during the life course.

The above model also highlights the potential for impact on health inequalities of treatment and care and prevention approaches. The graph shows the gap between Healthy Life Expectancy and Life Expectancy for women in England by deprivation decile (2009-2011). It can be seen that the gap is largest within the most deprived population groups and demonstrates a clear
gradient by deprivation. Treatment and care interventions tend to favour those with the least complex conditions who are best able to access and adhere to treatment, on the whole those who are less deprived. Prevention interventions are also more likely to be taken up by the least deprived, but when systematically applied at population level offer the greatest benefit to those with the highest risk exposure, on the whole those from the most deprived communities.

A true prevention approach is not just about the prevention of the onset of disease (primary prevention), but also the prevention of the progression and impacts of disease (secondary and tertiary prevention) through early intervention with high quality treatment and care as described below. This report aims to support the achievement of the right balance in approach through the lifecourse and across disease pathways. Shifting the balance towards prevention in this way should maximise both healthy life expectancy and life expectancy, support the reduction of health inequalities and at the population level reduce the person time spent in the ‘window of need’.
Definition

**Primary Prevention**
Primary prevention is taking action to reduce the incidence of disease within the population before the disease occurs. This is achieved through universal measures that reduce lifestyle risks or by targeting high-risk groups. Such measures include immunisation programmes, which may be open to all or targeted to high risk groups, or healthy diet, fitness and smoking cessation campaigns.

**Secondary Prevention**
Secondary prevention aims to reduce the impact of a disease, by detecting and treating it as early as possible in its course. The intervention is often during the asymptomatic phase, in an effort to delay or reduce symptoms and negative effects. This can be implemented through screening programmes, which aim to identify pre-symptomatic disease for early treatment, or through measures such as diet and exercise programmes or daily low-dose aspirin to prevent further heart attacks.

**Tertiary Prevention**
Tertiary prevention is undertaken to reduce the negative impact of established disease, aiming to minimise the impact of disease on life quality and life expectancy. This is done by reducing complications and disability, through interventions such as cardiac or stroke rehabilitation programmes.
Current and future projections

Ageing population and healthy life expectancy

The East Midlands population is ageing. It is estimated that there are around 836,000 people in the East Midlands aged 65 or over. By 2035 this is projected to rise by almost half a million to over 1.3 million resulting in over a quarter of the population being 65 or over.

![Figure 2 ONS 2012 sub-national population projections for East Midlands by age and sex](image)

One of the reasons for the ageing population is a long term trend in improved life expectancy. By contrast the length of time people live in good health (healthy life expectancy) has not kept pace meaning that people are living longer in poor health. This is exacerbated by deprivation; where people living in the most deprived areas live longer in poor health and still dies earlier than those in the least deprived areas.

Men in the most deprived areas of England living on average 21.4 “unhealthy” years before death compared to 12.2 years in the least deprived areas. For women the gap is even larger with those in the most deprived areas living 26.4 “unhealthy” years before death compared to 14.2 years for those in the least deprived areas.
A significant proportion of deaths in the East Midlands could be avoided by the presence of timely and effective healthcare or public health interventions. In fact, across the East Midlands in 2013, a total of 9,532 people died from causes considered avoidable which equates to approximately 23% of all deaths (Figure 5). Whilst the avoidable mortality rate has dropped over the years (mostly due to improvements in cardiovascular disease) there is still work to be done.
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The WHO Global Burden of Disease Study shows us that the leading causes of the years people have to live in disability are obesity, tobacco, drug use, alcohol use, occupational risks, poor diet and high blood pressure. The radical upgrade in prevention called for in the NHS Five Year Forward View needs population-level approaches, but it also needs ongoing behaviour change support and medical treatment for individuals during their repeated contacts with NHS.

Figure 6 Years Live with Disability per 100,000 populations by risk factor and cause UK, Global Burden of Disease 2010\textsuperscript{vii}

Figure 5 Age standardised avoidable mortality rates per 100,000 population England and East Midlands 2001-2013\textsuperscript{vi}
Local health issues

Local health issues are similar to those seen across England with overweight and obesity, smoking, alcohol consumption, healthy eating and physical inactivity all being key issues. Whilst there is variation across the East Midlands they are issues that affect all areas.

Figure 7: % people aged 16+ consuming at least 5 portions of fruit and vegetables per day modelled estimates 2006-08

Figure 8: % people who had a limiting long term illness or disability that affected their daily life 2011

Figure 7: % people aged 16+ that binge drink, modelled estimate 2006-08

Figure 9: % population aged 16+ with a BMI of 30+, modelled estimate 2006-08
Figure 10: Prevalence (%) of smoking among persons aged 18 years and over 2013

Figure 11: % of adults aged 16 years and over who are classed as inactive 2013
The consequences of inactions

As the data from the Global Burden of Disease study shows, the consequences of these risk factors are already with us.

In particular:

- Cancer Research UK have estimated that 42% of cancers in the UK are preventable
- 80% of NHS spending on diabetes is incurred in treating potentially avoidable complications
- In more than 90% of cases, the risk of a first heart attack is related to at least one of nine potentially modifiable risk factors
- Two thirds of premature deaths could be avoided through improved prevention, earlier detection and better treatment
- It is estimated that if Atrial Fibrillation was adequately treated, around 7,000 strokes would be prevented and 2,100 lives saved every year
- The National Audit Office suggest that 47% of type 2 diabetes cases in England can be attributed to obesity
- Despite reductions in levels of smoking 17% of deaths in adults over 35 are attributable to smoking
- The incidence of liver disease is increasing with a 40% increase in Liver deaths from 2001 to 2012. Whilst approximately 5% of liver disease is attributable to autoimmune disorders most liver disease is due to three main risk factors: alcohol, obesity and viral hepatitis
- 80% of NHS spending on diabetes goes on managing complications, most of which could be prevented

And from modelling of obesity and diabetes we can see the risks for the future:

- Diabetes prevalence in the East Midlands is expected to increase from 7.7% to 9.3% by 2030 partly linked to increasing level of obesity (Figure 12)
- Modelling on obesity suggests that by 2050 over 60% of adult men, 50% of adult women and about 25% of all children under 16 could be obese
- Obesity is also a major contributor to liver and cardiovascular disease, some cancer and musculoskeletal conditions
- The NHS costs attributable to overweight and obesity are projected to double to £10 billion per year by 2050

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1 Further modelling on diabetes is expected in late 2015.
Figure 12: % of the population with diabetes, modelled estimates projected to 2015, 2020 and 2030
Delivering prevention

System, scale and consistency

Often prevention measures are delivered in an *ad hoc* way through small scale, short term, and independent projects. To achieve the ambitions set out for prevention in the NHS Five Year Forward View it is important to ensure a systematic approach is taken. Prevention measures should not be undertaken in isolation, but should be built into all health and care pathways and applied systematically to ensure maximum benefit is achieved.

Prevention measures also need to be delivered at scale to achieve the aim of delivering a population level impact. A small impact may not be noticeable at the level of an individual, but a small impact to everyone across a population can deliver significant gains in health and reductions in need across that population.

It is also important to be consistent in the approach taken to prevention ensuring consistency in Public Health messaging and the delivery of interventions across disease pathways. In adopting prevention approaches public sector organisations should be consistent across the full sphere of their operations. Prevention does not only apply to the delivery of care and front line services, but also needs to be evident in the way that organisations carry out their business. The principles of prevention can be applied to facilities management, employee health and wellbeing, the commissioning of services and the procurement of goods. These organisational activities can have an impact on the environments in which patients and the public live, influencing the wider determinants of health such as employment, income, education, housing, air quality and social capital and connectedness, and in some cases directly influencing lifestyles and the key risk factors of smoking, diet, physical activity and excess alcohol consumption.

System, scale and consistency should be considered when applying any of the following approaches and interventions to ensure that the intended population level outcomes are delivered.
Leadership for prevention

Meeting the requirement for a “radical upgrade in prevention and public health” identified in the NHS Five Year Forward View will require strong local leadership. The Public Health system, through local authority Directors of Public Health and their teams working alongside PHE East Midlands, has a major role to play in leading and supporting the prevention agenda, but for maximum impact Health and Wellbeing Boards and each local health and care system will also need to strengthen their leadership on the prevention agenda.

Directors of Public Health and their teams provide strategic leadership on prevention and public health. As the Public Health advisor to Health and Wellbeing Boards and through their role within local authorities and their duty to provide public health advice and support to CCGs Directors of Public Health are able to set the vision for prevention, and to provide support for the local system to deliver that vision.

Public Health England East Midlands has a remit to protect and improve the public’s health. PHE has a duty to provide public health advice and support to NHS England, and works closely with the East Midland’s Partnership Organisations, Directors of Public Health and wider stakeholders to provide system leadership and support with respect to all three domains of public health, each of which contribute to the prevention agenda.

Achieving the ambitions set out in the NHS Five Year Forward View requires all organisations within the health and care system to make prevention a focus and ensure that a shared vision can be delivered. To facilitate this it is recommended that all health and care organisations identify a board level champion for prevention and public health and incorporate into the governance structures the assessment of the prevention implications and opportunities of policies, plans and programmes.

Organisations will need to embed prevention within their organisational cultures, and should also consider the policies, infrastructure and organisational

PRACTICE EXAMPLE

Enhancing cancer screening uptake in patients with severe mental illness

Chris Packham, Associate Medical Director – Nottinghamshire healthcare
Chris.Packham@nottshc.nhs.uk

We use NHS England/PHE screening registers from the screening hubs and merge these with lists of our most severe and vulnerable patients with severe mental illness. We use a third party pseudoanonymisation site for this (in our case the Arden & GEM CSU for East Midlands). We then get lists of our patients and approach them to facilitate their genuine choice about their wish to take up screening. We take very careful regard about true informed consent and capacity, and use tools our services already work with to help communication messages. We have strong support from our stakeholders – GPs, PHE and involvement centre. We have negotiated improved access to bowel screening kits to assist our teams in this process.
and workforce development requirements to support this and ensure appropriate leadership for prevention exists at all levels within the organisation.

**Immunisation and screening services**

NHS England commissions a number of national immunisation and screening programmes based on effectiveness and cost-effectiveness evidence. As primary and secondary prevention services respectively these programme either aim to prevent the development of disease, or to identify disease early to enable effective management and where possible prevent or delay the progression of illness.

Commissioners and providers of health and care services should ensure that staff are aware of current programmes relating to their clientele and promote the uptake of relevant programmes through their contacts. This is particularly important amongst groups where uptake is known to be low.
Making Every Contact Count (MECC)

The Making Every Contact Count (MECC) approach recognises the large number of contacts that health and care services have with the public each day. There is significant potential to use these contacts to promote health and support individuals, their friends, families and carers to make small changes to lifestyles and behaviours. With the NHS alone having over a million patient contacts every 36 hours these small individual changes can add up to large improvements in population health.

The Global Burden of Disease study highlights high body mass index, tobacco smoking, drug use, alcohol use, occupational risks and dietary risks as the top six risk factors contributing to years lived with disability in the UK. Using health and care service contacts to re-inforce health promotion messages and support change in the modifiable risk factors highlighted above can reduce their impact and the years lived with disability, and therefore spent in the ‘window of need,’ in the UK population.

The core of MECC is primarily focussed on health and care staff that are trained to:

- Deliver to patients, service users and colleagues a ‘very brief’ or ‘brief’ evidence based advice intervention for lifestyle behavioural change; the core elements of which are stopping smoking, increasing physical activity, reducing alcohol consumption and maintaining a healthy weight and diet
- Be competent and confident to deliver this intervention; and
- Be knowledgeable about local services and how to signpost/refer people to enable them to access them

To achieve maximum effect at population level and on health inequalities MECC approaches have to be applied systematically, and should be embedded within pathways and supported by
clinical systems and processes. The following three aspects of MECC are essential for high quality delivery of the approach, and where possible should be measured and reported:

- Systematic identification of individuals requiring lifestyle discussion
- Recording of discussions taking place and communication of outcomes to others involved in the care pathway
- Services available to recommend / refer to where further support needs are identified

Adopting the MECC approach will enable health and care providers to move upstream from the delivery of care to meet the needs created by lifestyle risk factors to the delivery of proven interventions to tackle lifestyle risks and prevent or delay the onset of the health needs that they cause. Delivery of MECC at this scale could support the development and building up of the groundswell for a social movement for healthier lifestyles and help to shift us towards the ‘fully engaged’ scenario described by Derek Wanless in his 2002 report, ‘Securing our Future Health: Taking a Long-Term View’.

As well as addressing the core lifestyle risk factors contributing to years lived with disability, a MECC Plus approach can be adopted to identify and meet wider social needs such as housing support, debt advice, parenting support and social isolation. Some areas are adopting this approach and linking it to ‘social prescribing’ schemes based on the model developed in Bromley by Bow. This has been shown not only to support individuals to meet their social need, but also to reduce demand for clinician time within the practices involved enabling them to focus on clinical issues knowing that their patients’ wider needs are being met elsewhere.

**Lifestyle and social support services**

To complement the adoption of the MECC and MECC Plus approaches described above it is important to ensure that appropriate pathways are in place for those requiring further help. A CASE STUDY EXAMPLE illustrates how this approach works in practice.}

**CASE STUDY EXAMPLE**

Leicestershire County Council’s My Health, My Life Service

Julian Mallinson – Consultant in Public Health, Leicestershire County Council

Julian.Mallinson@leics.gov.uk

The My Health, My Life service builds on the Council’s First Contact approach and provides a single point of access through which professionals and members of the public can access a wide range of lifestyle and social support services. The service provides triage assessment, brief advice, motivational support and signposting to self-help resources and onward referral to community support and specialist provision. It also provides access to Health and Wellbeing Advisors who can offer telephone follow up to support clients to make change.

The service has been designed to meet the needs of the population across a wide range of issues:

- Healthy lifestyle (Smoking, Alcohol, Healthy eating, Healthy weight, Physical activity, Sexual health)
- Feeling positive
- Preventing falls
- Money
- Work, learning and activities
- Looking after yourself
- Relationships and support
- Caring for others
- Where you live
- Feeling safe
support beyond the brief interventions provided through MECC. There are a plethora of services available to meet lifestyle and social needs. Provision of these services varies, with involvement from the public, private and third sectors.

Commissioners should work together through Health and Wellbeing Board structures to ensure that local MECC initiatives are supported by and linked to appropriate lifestyle and social support services, and that sufficient capacity is commissioned to meet the needs and deliver the MECC objectives.

With the plethora of lifestyle and social support services in existence it is often difficult for frontline health and care practitioners to keep up to date with the full list of services available. This can be a barrier to making recommendations and referrals due to a lack of confidence that the information is current. It is therefore recommended as good practice to streamline referral pathways for such services through the development of a single point of access.

**Early identification and management of clinical conditions and risk factors**

The aim of primary prevention interventions is to delay or prevent the onset of clinical conditions. Where conditions do develop secondary prevention approaches should be adopted to minimise the impact on health and wellbeing and support independence. Such approaches often rely on the early identification of a clinical need followed by timely access to appropriate care. The primary care Quality and Outcomes Framework (QOF) incentivises the management of a wide range of conditions and clinical risk factors such as diabetes, asthma and hypertension where there are well evidenced approaches to management.
Case finding and the identification of disease and risk factors occurs through a variety of programmes and in a range of settings. This can range from formal programmes, such as national screening programmes and NHS Health Checks, to the ad-hoc identification of disease through routine care to late symptomatic presentation. Where strong evidence exists for improved outcomes from the early identification and management of conditions services should adopt systematic approaches to case finding, and ensure robust processes exist to get those patients identified as having a need onto the relevant disease register so that their care can be monitored.

The adjacent case study identifies the approach taken by the Cardiovascular Disease Clinical Network to improve the diagnosis of Atrial Fibrillation in the East Midlands. This included the identification of unmet need, developing training to improve diagnosis and management of atrial fibrillation, developing a focus on variation, and the delivery of a systematic approach to tackle variation.

Clinical Commissioning Groups and NHS England should consider adopting the CVD Clinical Network’s approach to other disease management pathways. Where strong evidence exists for the potential for good management to reduce morbidity, mortality and health and care use commissioners and quality leads should work together to tackle variation in clinical practice, and to support practices to improve their ability to diagnose and manage disease.
Advocacy for prevention

The delivery of the prevention challenge set out in the NHS Five Year Forward View requires more than just a contribution to the prevention agenda from NHS and Social Care organisations. Those organisations and their senior managers need to become advocates for prevention within the wider system too. As respected health and care organisations and leaders and as members of Health and Wellbeing Boards there is a significant opportunity to provide constructive challenge and to influence partners within the wider system to adopt policies and approaches that support prevention.

As advocates for prevention health and care organisations should: -

- identify Board level ‘Prevention Champions’ with a clear remit to provide executive leadership and prevention focussed scrutiny and challenge
- consider their public stance on key issues including sign up to the declaration on tobacco and declaration on alcohol, and for Acute Trusts sign up to the WHO Health Promoting Hospitals standards.
- review their internal policies and procedures with regard to prevention
- consider their position with regard to local and national policy debates and advocate for change where appropriate
- work to integrate prevention approaches within local pathways through collaboration with Health and Wellbeing board partners
- consider their corporate impact on prevention and health inequalities (see Corporate Social Responsibility and Prevention section of this report)

PRACTICE EXAMPLE

Stress awareness training for managers

Sue Collington, Occupational Health Lead Nurse - UHL
sue.collington@uhl-tr.nhs.uk

3 hour session for managers to learn:
- to recognise stress in themselves and others,
- how to undertake a stress risk assessment
- follow the Trust’s risk assessment process in making positive proactive changes to working practices
- onward referral to support services such as counselling or Occupational Health services if required.

2 hour session for all new staff who wish to book onto the session which covers:
- Mental health issues
- Proactive self-management of mental health
- Managing enforced change
- 10 point strategy for building resilience

Clinical and financial benefits were realised through training 100 managers and 150 staff in 1 year.
Corporate social responsibility and prevention

Corporate Social Responsibility (CSR) is about ensuring that organisations are making a positive impact on society and in the communities in which they operate. The Health and Care sector has the opportunity to make a significant positive contribution to society, not just through the delivery of services, but also through its wider employment, estates, procurement, retail and community activities.

Health and Care organisations should develop CSR strategies such as the Public Health Strategy developed by Nottinghamshire Healthcare Partnerships NHS Trust with its aims of “improving the health of the public and reducing inequality through the work of the trust”.

CSR approaches are often assessed using the ‘Triple Bottom Line’ approach assessing the impact on People, Planet and Profit. This enables organisations to monitor their impact on their staff, clients and the communities they operate in and their sustainability and environmental impact alongside the monitoring of their finances.

Areas that organisations should consider within such strategies include:

- Workforce wellbeing and employment practices

The health and care sector is a major employer with organisations often drawing staff from their local communities. Staff wellbeing programmes and wider employment practices provide an excellent opportunity to impact on both the health of staff and through them of their families and wider communities. Employment itself is known to have an association with improved health outcomes, but by ensuring a living wage, providing appropriate occupational health services, supporting work life
balance and promoting active travel and healthy lifestyles employers can maximise their impact on employee health.

**Estates and travel management**

Health and care organisations have significant estates, often with significant flows of staff, patients, and goods. Management of these estates and the travel and transport flows to and from them can have significant impacts on the health and wellbeing of users of the estates and members of the wider community surrounding them. Smoke free sites send a clear message with respect to the health impacts of smoking whilst also reducing smoking amongst users of the sites and influencing social norms within the community. The NHS and Local Authorities should ensure all sites are smoke free. Similar impacts on health and social norms can be achieved through the promotion of active travel and low emission travel options such as public transport, and the use of electric and low emission vehicles within organisational fleets.

Health and care organisations should also develop Sustainable Development Management Plans with a focus on reducing carbon emissions and their wider environmental impact. Again, through monitoring their progress, and openly publishing details in their annual reports organisations can not only minimise their impact, but can act as catalysts for other local organisations from other sectors to adopt similar strategies.

**Procurement and commissioning practice and influencing along supply chains**

Health and Care organisations don’t just have the ability to influence their own practices, but as major buyers of goods and services can use their own procurement and commissioning practices to influence along their supply chains. Local health outcomes are inextricably linked to the local economy and employment opportunities, and organisations should ensure that
procurement and commissioning policies allow for consideration of the impact on local economies when balancing cost and quality, promoting the retention of funds and the development of jobs within local economies. Similarly, policies should allow for assessment of the impact on population health of the relevant suppliers and providers. This should ensure the consideration of suppliers and providers policies covering payment of a living wage, workplace wellbeing, sustainability, recruitment, staff development and apprenticeships. It should also consider the wider activities of the suppliers and providers and their impact on population health enabling organisations with a primary interest in health and care to give a negative quality weighting to suppliers and providers who sell or promote substances harmful to health such as tobacco.

Commissioners of health and care services should also develop guidance to support commissioning for prevention. Ensuring consideration of the whole care pathway in all commissions to identify how each service within a pathway can contribute to the prevention agenda can ensure appropriate KPIs are developed. For example ensuring that all providers of care are integrating the MECC approach into their provision and systematically monitoring and reporting on it has the potential to significantly impact on population health, and support consistent messaging from all health and care professionals.

Commissioners should ensure that pathways are integrated, and that barriers to accessing preventative support are removed. Proven lifestyle services such as cardiac rehabilitation should be commissioned as an integrated part of the service, as opposed to being seen as an additional offer on discharge from care. Equal weight should then be placed on promoting high uptake of such interventions as is placed on ensuring adherence to pharmacological interventions.

Retail and catering offers

Public sector organisations involved in health and care services routinely provide and sell food and drink and other goods to their patients and clients. Ensuring the availability of free drinking water and healthy food offerings and at the same time reducing the availability of less healthy products such as tobacco, sugar sweetened beverages and high calorie, low nutritional content foods can influence the behaviours of staff and members of the public using facilities and the social norms within the wider community.
Prevention and health inequalities

Health Inequalities are preventable and unjust differences in health status experienced by certain population groups. Public sector organisations including Local Authorities, NHS Bodies and Health and Wellbeing Boards have statutory duties to tackle Health Inequalities and to have regard for inequalities in access and outcomes with respect to the services they commission and provide.

The ‘Window of Need’ graph (Fig 1, p6) highlights the inequalities gradient seen by deprivation for both Life Expectancy and Healthy Life Expectancy highlighting the potential for a focus on prevention to also deliver reductions in health inequalities. For this potential to be realised it will be important however to consider how prevention interventions are implemented.

The Marmot review ‘Fair Society, Healthy Lives’ recognises that inequalities exist not just between the extreme ends of the social gradient, but between all points across that gradient, as demonstrated in Fig 1. Due to this fact the review recommends that actions to tackle inequalities are universal, but that recognition is given to the need for implementation to be proportionate to the level of need and the level of input that may be required. The review states,

“To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the...
level of disadvantage. We call this proportionate universalism. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem.”

(Marmot M, 2010)

Proportionate Universalism is an important concept in the implementation of both preventative and treatment and care interventions, and commissioners and providers should consider how resources are allocated to maximise the overall impact on outcomes and on health inequalities through the use of Health Impact Assessment tools. Careful consideration of how interventions are implemented is important for the avoidance of Intervention Derived Inequalities, whereby health inequalities are worsened through the failure to give due regard to them when delivering programmes and services.
Appendix 1 – Useful links

For the latest links and data go to: http://datagateway.phe.org.uk/

**Lifestyle factors**
Tobacco - http://www.tobaccoprofiles.info/
Obesity - http://www.noo.org.uk/visualisation
Alcohol - http://www.lape.org.uk/

**Health profiles**
Local authority – http://www.healthprofiles.info
Local health (neighbourhood) - http://www.localhealth.org.uk/
National General Practice profiles - http://fingertips.phe.org.uk/profile/general-practice

**Cancer**
http://www.ncin.org.uk/

**Cardiovascular disease**
National Cardiovascular Intelligence Network
Cardiovascular (CVD) intelligence packs

**NICE local government briefings**
- Alcohol: http://www.nice.org.uk/advice/lgb6
- Behaviour change: http://www.nice.org.uk/advice/lgb7
- Body mass index thresholds for intervening to prevent ill health among black, Asian and other minority ethnic groups: http://www.nice.org.uk/advice/lgb13
- Encouraging people to have NHS Health Checks and supporting them to reduce risk factors: http://www.nice.org.uk/advice/lgb15
- Health inequalities and population health: http://www.nice.org.uk/advice/lgb4 (this contains some really good case for investment stuff)
- Judging whether public health interventions offer value for money: http://www.nice.org.uk/advice/lgb10
- Physical activity: http://www.nice.org.uk/advice/lgb3
- Preventing obesity and helping people to manage their weight: http://www.nice.org.uk/advice/lgb9
- Tacking the causes of premature mortality: http://www.nice.org.uk/advice/lgb26
- Tobacco: http://www.nice.org.uk/advice/lgb24
Appendix 2 - Case studies

- A public health strategy for the Trust
- Enhancing cancer screening uptake in patients with severe mental illness
- Implementing public health guidance 48 in our Trust (mental health)
- Physical healthcare enhancement on patients with severe mental illness
- Reducing cardiovascular disease mortality and morbidity in prisoners
- Developing and implementing a high quality physical healthcare service model for prison services in Nottinghamshire NHS Foundation Trust
- Enhanced physical health clinic within mental health in-patient settings
- Livewell – an integrated lifestyle services commissioned by public health, provisioned by Derby City Council
- Provision of physical healthcare for patients in long term segregation
- Stroke prevention in Atrial Fibrillation in the East Midlands
- Flo Simple Telehealth evaluation report 2013/2014
- Smoker identification on electronic in-patient tracking system coupled with targeted intervention by commissioned dedicated bedside smoking cessation service
- Using technology to support self-care and care planning – Flo Simple Telehealth
- Stress awareness training for managers and emotional resilience training for new staff delivered in University Hospitals of Leicester NHS Trust.
References


Public Health England Public Health Outcomes Framework http://www.phoutcomes.info/ last accessed 15/05/15

Years spent not in good health


smoking/tobacco use, poor diet, high blood cholesterol, high blood pressure, insufficient physical activity


NICE CG180 Atrial Fibrillation 2014 https://www.nice.org.uk/guidance/cg180


Public Health England Liver Disease Profiles http://fingertips.phe.org.uk/profile/liver-disease last accessed 22/06/15


Public Health England *Diabetes prevalence model for local authorities and CCGs*
Acknowledgements

We would like to thank the following people who contributed to our report:

- Ben Anderson, Consultant in Public Health, PHE
- Shirley Devine, Specialist Public Health Manager, JSNA – Derbyshire
- Molla Ahmed, Specialist Registrar in Paediatrics, UHL
- Sandra Whiston, Dental Public Health Consultant for the East Midlands, PHE
- Habab Mekki, Specialist Registrar in Paediatrics, UHL
- Semina Makhani, Consultant in Dental Public Health, PHE
- Martin Cassidy, Senior Quality Improvement Lead, East Midlands Strategic Clinical Networks
- Andy Sirrs, Nottinghamshire NHS Clinical Lead for IAPT, Nottinghamshire Healthcare FT
- Bernadette Armstrong, Physiotherapist, Northamptonshire Healthcare FT
- Isabel Perez, Consultant in Public Health Medicine and Assistant Director Public Health, Lincolnshire County Council
- Karren Staniforth, Biomedical Scientist Infection Prevention and Control, NUH
- Dave Rowbotham, Professor of Anaesthesia and Pain Management, East Midlands Clinical Senate Co-Chair, UHL
- Alun Elias-Jones, Consultant Community Paediatrician, Leicestershire Partnership NHS Trust
- Andrea Kerr, Consultant Ophthalmologist Training Programme Director, Health Education East Midlands
- Karen Scholes, Clinical Psychologist and Clinical Lead, NHS Hardwick CCG
- Tasso Gazis, Consultant Endocrinologist and Diabetologist, NUH
- Sanjay Agrawal, Consultant in Respiratory Medicine and Intensive Care and Associate Director, UHL
- Steve Ryder, Consultant Hepatologist and Clinical Director of East Midlands Strategic Cancer Network, NUH/NHS England
- Keith Spurr, PPI rep
- Richard Prettyman, Honorary Senior Lecturer/East Midlands Strategic Clinical Network Clinical Lead, Lincolnshire Parternship NHS FT
- Tracy Means, Clinical Team Leader/Complex Case Manager, Lincolnshire Community Health Services
- Waqqas Khokhar, Speciality Registrar in General Adult Psychiatry, Derbyshire Mental Health Services NHS Trust
- Julie Hall, Executive Director of Forensic Services, Nottinghamshire Healthcare NHS Foundation Trust
- Kirit Mistry, East Midlands Clinical Senate Patient Rep, East Midlands Clinical Senate
- Nigel Beasley, ENT Consultant and Deputy Medical Director, East Midlands Clinical Senate Co-Chair, NUH
- Julian Mallinson, Consultant in Public Health, Leicestershire County and Rutland
- Gareth Harry, Chief Commissioning Officer, NHS Hardwick CCG
- Jane Scullion, Respiratory Consultant Nurse, UHL
- Helen Ross, PH (Commissioning and Procurement), Nottingham City Council
- Gisli Jenkins, Reader in Pulmonary Biology, Clinical Lead for Interstitial Lung Disease Unit, NUH
- Rowan Harwood, Consultant Physician and Professor of Geriatric Medicine, NUH and University of Nottingham
- Sue Collington, Lead Occupational Health Nurse/Service Manager, UHL
- Liz Marder, Consultant Paediatrician and Pathway Lead Clinician for Children and Young People, Nottingham
- Mark Batt, Consultant: Sport and Exercise Medicine, Nottingham
- Ann Goodwin, Programme Manager, PHE
- David Clark, Senior Programme Officer (Health Improvement), Public Health Lincolnshire County Council
- Alison Whitham, Head of Midwifery and Gynaecological Nursing, Sherwood Forest Hospitals NHS Trust
- Andrea Brown, Director of Programme Delivery, NHS Mansfield and Ashfield CCG
- Alison Challenger, Consultant in Public Health, Public Health Nottingham City
- Chris Packham, Associate Medical Director, Nottinghamshire Healthcare
- Angela Odell, Public Health Manager, Derby City Council