The Role of the NHS in Prevention

Discussion paper

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FACULTY OF PUBLIC HEALTH

About this discussion paper

The Faculty of Public Health (FPH) has received a grant from the Health Foundation to undertake a policy development and research project examining the role of the NHS in the prevention of ill-health. Our project began in August 2018 and will end in the first half of 2019. This is the first phase of what we hope will be a larger project exploring NHS investment in prevention.

The Role of the NHS in Prevention project aims to:

- Build a better understanding of how the NHS currently delivers prevention
- Understand what 'good' prevention in the NHS looks like
- Explore the enablers and barriers for NHS organisations seeking to take a more preventative approach
- Determine initial priorities for increased investment and focus

This discussion paper draws together the key themes that have begun to emerge from our work so far. It also points to further ideas to be explored, issues that will need to be resolved, and steps that will need to be taken in order to achieve our project objectives.

This paper is aimed at FPH members and other public health professionals working within or in partnership with NHS organisations, other front-line NHS staff or managers with an interest in prevention, even if it's not formally part of their role, and policy-makers at local and national levels.

It is the first of three papers that will be published as this project progresses. The cumulative findings from our work will be released in a final report in mid-2019.

What evidence did we gather to inform this paper?

We undertook a diverse programme of evidence-gathering to produce this discussion paper, including interviewing experts, commissioning a rapid evidence review, doing a review of the grey literature, and hosting a policy workshop. We have also used evidence generated over the past few years by FPH's various policy committees. These committees are made up of expert members in all the domains of public health practice.

Rapid evidence review

We commissioned an evidence review which examined over 400 studies of prevention programmes within NHS settings. We looked for type of activity, benefits, and barriers and enablers to implementation. Sources spanned 18 bibliographic databases and covered all four nations. We also undertook a companion grey literature review.

Policy workshop

We convened a policy workshop which brought together over 40 experts in prevention, including from NHS England, Public Health England, local government, charities such as Cancer Research UK, FPH's Health Services Committee and the Health Foundation. Workshop participants helped us to assess our evidence base and determine priority areas for this project to focus on.

Expert interviews

We followed up the workshop with a series of interviews with a range of practitioners and experts, including from Public Health Wales, NHS Trusts, and FPH's Primary Care and Public Health Special Interest Group. These interviews helped to both clarify and expand on issues raised during the workshop and identify potential future case studies for our work programme to explore.

FPH expertise

We have also relied on evidence generated by FPH's Academic and Research Committee (ARC), Health Services Committee, and Policy Committee, which includes position statements and survey results.

Introduction

The Secretary of State's Prevention Vision makes the case that prevention is everyone's business and cannot be delivered by any one institution, sector, or specialist; we all have a role to play. This shared responsibility is the basic strength of the prevention approach and is a principle we think needs to be at the centre of the forthcoming Prevention Green Paper.

But we are hearing from our members working in different public health roles in different places that this broad applicability can also work as a weakness. If prevention is everyone's business, there is the risk that it's seen as nobody's core business. This framing can lead to confusion over roles, responsibilities, and obligations. Common questions tend to emerge: Who leads? Who is accountable? Who gets the 'benefit' – both financially and in terms of improved outcomes – and at whose expense?

Our consultation has revealed that it would be more useful to say that while prevention is everyone's business, it is so in different ways, at different times, and at different levels within a complex system. This makes the kind of cross-sector action discussed in the Prevention Vision challenging to operationalise effectively and at the scale required to make desired population level change in health outcomes and reduce health inequalities.

Bearing that in mind, our focus here is specifically on how prevention is the NHS's business.* We want to get a better sense of how different NHS organisations deliver good prevention interventions and where front line staff think the NHS can add the most value to system wide prevention action or priorities in the future. Ultimately, we want to help the NHS shift from a demand driven system to a prevention driven one.

We think the NHS has a pivotal role to play in the prevention of ill-health and reducing health inequalities and should be better supported in those aims. This is not a new concept. There has long been widespread consensus that the NHS should be actively involved in the prevention agenda - from Wanless (2002), to Marmot (2010), to Stevens (2014). Yet, this consensus has not translated into meaningful changes to investment or service delivery patterns.

The NHS remains first and foremost a treatment service, with the wider health system across the UK spending only around 5% of its total budget on prevention. FPH's investigation into the progress of Sustainability and Transformation Partnerships (2016) found that most are falling short of translating their prevention aspirations into achievable targets and commitments and that engagement with public health expertise and local public health priorities was variable and uneven. There is now widespread acknowledgement that 'the promised radical upgrade in prevention has yet to be delivered.'

So why have we struggled to make progress on something everyone seems to agree on?

We have been challenged by this question numerous times already. With this paper we hope to start the process of responding to that challenge. In order to do that, this paper grapples with three main issues.

First, we look at the current evidence base for prevention and assess some of the challenges that we see in translating this evidence into action. We've heard that while we have good evidence for particular interventions, situations, or decision-makers, overall the evidence base has been described as mixed in terms of areas and populations, limited in scope and reach, and sometimes unhelpful for making population level or system change. For example, there is a considerable gap in evidence about mental health interventions and also about the impact of different preventative approaches on outcomes, the use of health services, and costs. This means that decision-makers often need to 'go beyond' the published evidence when making decisions about where or how to invest in prevention.

Then we look at what prevention in different NHS organisations looks like in order to get a better sense of the roles that the NHS is playing when it delivers prevention. At the moment our members are telling us that the NHS role in prevention is often poorly defined, poorly understood and, as a consequence, can also be poorly delivered. We heard that understanding this is essential in order to support the NHS to take a more preventative approach.

We think that the opportunities for the NHS to shift from a demand driven system to a prevention driven one can be characterised in two broad ways. The first is via the NHS's role in the direct delivery of services. We know that between 10-20% of our health outcomes are directly attributable to our access to health services and that approximately half of the prevention interventions that people receive occur within healthcare settings. We think the NHS can make the most of those interactions by building prevention into clinical pathways and working across organisations to ensure services are joined up.

The second is via the impact that NHS organisations can have indirectly on the social determinants of our health in their capacity as local employers, procurers, and 'anchor' institutions. This includes supporting the health and wellbeing of its own workforce and providing a healthier space for visitors, as well as patients.

By looking at that activity in the round, we think the NHS is currently fulfilling five prevention roles, albeit unevenly and in different ways: leader, partner, employer, advocate, and researcher. We're now looking to test whether or not stakeholders believe these roles are legitimate roles for the NHS to be engaged in and if we can better understand which roles will help NHS organisations sustainably shift to prevention.

Lastly, we examine priority areas for action and focus over the next 3-5 years. In particular, we start to engage in the debate between those who think the main focus should be on supporting NHS organisations to take a systems approach to prevention (and what that might mean in terms of immediate actions and priorities) and those who advocate the NHS investing its resource and focus in delivering interventions that we already know can work if implemented well. Above all, in grappling with what the priority areas should be we want to start to focus the conversation on what will enable big change to happen.

We very much hope that this discussion paper will lead to lots of additional conversations with our members, partners and those interested in this issue. We raise a number of questions for further exploration that we will need your help in answering. These questions are all listed on page 19 of this paper.

Please do offer your thoughts via email to policy@fph.org.uk. We look forward to hearing from you and keeping you updated as the work progresses.

* By 'prevention' we mean the prevention of ill-health and not the wider prevention agenda, which can also include the prevention of: demand, admissions, escalation of care, waste, or cost.

Summary of emerging themes

This paper addresses three main themes that have emerged so far from our research, evidence gathering, informal interviews, and our first stakeholder workshop.

1. What is the evidence telling us?

We have mixed evidence about 'what works' for prevention interventions in NHS settings.

While we have good evidence about specific interventions that are useful for particular decision-makers in particular contexts, overall the evidence base for prevention is limited in scope and often doesn't meet the needs of local decision-makers. This means that those working in or with the NHS often need to 'go beyond' the published evidence when making decisions about how to implement prevention activity or when they are making the case to others.

2. Defining the role of NHS organisations in ill-health prevention

We heard that there was a need to clarify and better understand the various roles that NHS organisations are currently playing in prevention. Based on our evidence gathering, we think the NHS is currently fulfilling five prevention roles, albeit unevenly and in different ways: leader, partner, employer, advocate, and researcher. We're now looking to test with stakeholders whether or not they believe these roles are legitimate roles for the NHS to be engaged in when doing prevention and explore in more detail what these roles look like in practice.

3. Action and focus for the next 3-5 years

We heard that a collection of individual interventions alone will not achieve the change we're looking for at a population level. This requires a systems approach. But there is also a need to prioritise the delivery of prevention interventions that we already know are impactful, cost-effective, and deliverable within current structures if implemented well.

This requires clarity and alignment on priority areas for action and approaches that should be agreed via consultation. Alongside that, we need a simplicity and clarity of approach and communication that can enable big change to happen. While this is clearly very complicated, presenting a case that requires a generation of political effort and many billions more in funding may simply lead to the challenge remaining on the 'too difficult' pile.

1. What is the evidence telling us?

We have mixed evidence about 'what works' for prevention interventions in NHS settings. While we have good evidence about specific interventions that are useful for particular decision-makers in particular contexts, overall the evidence base for prevention is limited in scope and often doesn't meet the needs of different decision-makers. This means that those working in or with the NHS often need to 'go beyond' the published evidence when making decisions about how to implement prevention or when they are making the case to others.

Background

We think that any action to improve the health of the public should be informed by high quality research evidence telling us 'what works.' To get a better sense of this for prevention interventions in the NHS and to inform the direction our work would take, we commissioned a rapid evidence review that explored three main questions:

1. **What are the main types of prevention work researched in NHS settings?**
2. **What are the benefits of prevention programmes in the NHS?**
3. **What helps or hinders prevention in the NHS?**

We also undertook a review of the literature published in non-commercial form - the 'grey literature' - to serve as a supplement to the commissioned review. You can read the full results of the review by clicking here, or see the shaded box to the right for a summary of the main findings.

Throughout the course of our project so far, we've been interrogating the published evidence that we've gathered and asking people to respond to the main findings. While we discuss the specifics of the findings throughout this paper, there are some core themes which have emerged from a general discussion of the state of the evidence base that we think need to preface the findings laid out in this discussion paper.

Overview of the Evidence Review

Over the past decade, the NHS has taken a more proactive role in helping people to stay healthy and well and prevent the onset or further deterioration of conditions. Prevention programmes implemented in the NHS vary widely in scope and scale, ranging from universal screening programmes to individual falls prevention exercises. Most prevention work that is researched is based in general practice or in the community; there is much less research on prevention done in hospital settings

There is a lack of long-term evaluation of prevention programmes delivered by the NHS, making their impact difficult to assess. For example, the long-term impact of prevention programmes on health outcomes, on the use of health and care services, and on cost-effectiveness is uncertain. There are several different approaches to delivering prevention, but there are no clear trends about which are the most beneficial.

There are a wide variety of enablers for prevention work, with good staff training and cross-sector partnerships highlighted as particularly important. However, there are significant system-level barriers that need to be overcome in order to further prioritise prevention in the NHS. These include a lack of integration into core services, the isolation of staff undertaking prevention roles, and lack of infrastructure and resources.

What have we found?

1.1 We heard that the evidence base for public health interventions in NHS settings is difficult to translate into action – which is a common problem for a variety of disciplines in many health and care settings. This means that even if we know 'what works' we often don't always know how or why it works. This is a fundamental challenge for policy-makers and clinicians, which complicates decision-making and serves as a persistent barrier to improvement.

1.2 We also heard that in addition to being challenging to operationalise, the public health evidence base is also limited in scope and reach. This is largely because most of the available evidence about 'what works' in health and care settings is generated by research methods that are typically designed for assessing the effectiveness of clinical interventions, often at an individual or group level. These methods are less appropriate for designing interventions for achieving change at a population level or for addressing public health challenges, which tend to be the result of many complex factors. This means that while we may have good evidence about a range of interventions that deliver specific benefits in terms of cost-effectiveness, return on investment, or health outcomes for particular groups, that evidence base is less useful for taking action holistically on prevention.

1.3 This state of play has led FPH's Academic and Research Committee (ARC) to suggest that there is an 'urgent need' to grow the public health evidence base at all levels (individual, group, population) within and outside health and care organisations.

1.4 There is also a gap in understanding and/or disagreements over what kinds of evidence different parts of the system need. For example, commissioners might need to see big-picture population health outcomes, whereas front-line clinicians often need or rely on experiential evidence to tell them an intervention is working or is worth investing time and resource in.

1.5 We heard that a lot of prevention in NHS settings is delivered in small-scale, short-term, or independent projects or is embedded into routine practice informally or otherwise – all of which can be difficult to evaluate. Not being able to evaluate the outcome of routine interventions, such as Make Every Contact Count or social prescribing, has led to what some are calling a 'negative feedback loop' whereby front line staff only get feedback from the patients when the intervention doesn't work. This leads to a perception amongst staff that prevention isn't worth it.

1.6 Research on prevention interventions tends to focus on understanding or impacting a single part of a larger system or tries to strip out system context entirely. There is a lack of evidence on how to achieve systems change in NHS organisations or how specific interventions in one part of a system might impact on another part.

1.7 Due to gaps raised in the above and challenges of the public health evidence base, stakeholders working in NHS organisations delivering prevention often see their role as 'going beyond' the published evidence to make decisions when a range of factors are uncertain. This may include using a range of less robust evidence, such as case-studies.

Key questions for further exploration:

1. Do you agree with our analysis of the current state of the public health evidence base? Are there overarching points that you think we've missed?
2. How can local decision-makers leading prevention in the NHS bridge the research-to-action gap effectively? What tools, methodologies, or approaches do they use that allows them to 'go beyond' the evidence they have?

2. Defining the role of NHS organisations in ill-health prevention

We heard that there was a need to clarify and better understand the various roles that NHS organisations are currently playing in prevention. Based on our evidence gathering, we think the NHS is currently fulfilling five prevention roles, albeit unevenly and in different ways: leader, partner, employer, advocate, and researcher. We're now looking to test with stakeholders whether or not they believe these roles are legitimate roles for the NHS to be engaged in when doing prevention and explore in more detail what these roles look like in practice.

Background

There is a consensus that the NHS has a pivotal role to play in prevention and needs to do more to address population health challenges. This principle has been most recently articulated in the NHS Long Term plan process, the Prevention Vision, and the Government's 2018-2019 mandate to NHS England.

But what is meant by 'pivotal' is less clear. This is confounded by the confusion over what is meant by 'prevention' – as there is no one single understanding of it – and also by 'NHS' as there are many different NHS organisations that can mean different things in different places. This makes the role of the NHS in ill-health prevention difficult to describe.

For the purposes of our project, we have defined ill-health prevention as activities where the primary purpose is to avoid disease and risk factors (primary prevention) or to mitigate the progression of the effects of existing disease (secondary prevention). But this definition is not universally used and leaves out tertiary prevention activity as well as, potentially, wider upstream activity. This working definition may be revisited as our work progresses, depending on stakeholder feedback.

Outside of its Section 7A services, NHS England has been pushing a 'triple prevention' strategy, which can be broadly categorised as:

1. **Targeted prevention programmes: for patients at risk of specific long-term conditions, for example the Diabetes Prevention Programme and the RightCare CVD prevention programme**
2. **Workplace wellness: aimed at protecting and maintaining a healthy and productive NHS workplace**
3. **Healthy ecosystems: providing a model healthy environment for NHS staff, visitors, and patients**

While ambitious in scope, and often innovative, the delivery of 'triple prevention' has been hindered by the immediate financial pressures faced by NHS organisations and exacerbated by fragmented pools of funding that are allocated on an annual basis, restrictive payment mechanisms, and a lack of upfront investment. Itemising spend is also difficult as many programmes straddle agencies and are delivered in partnership with others.

This too often masks the wide range of regional and local prevention activity that individual organisations are carrying forward, some of which were referenced as priority areas in the Government's most recent mandate to the NHS. A lack of explicit resourcing for prevention means we have no comprehensive picture of where, how much, or to what collective effect this work is being done. This lack of transparency means that there is also no clear consensus about what

proportion of health system spend for prevention is required in order to move towards even a moderate upgrade, let alone a radical one.

This is particularly relevant now as the NHS Long-Term Plan considers how to best allocated funding for prevention. During the NHS Long-Term Plan process, Public Health England stressed that the NHS could ensure that we all live a longer, healthier life by prioritising the prevention of smoking, cardiovascular disease, and obesity. Other priorities include: alcohol, antimicrobial resistance, air pollution, a healthy NHS workforce, and mental health.

The Prevention Vision also highlights many of those areas, but prioritises the location of care by emphasising the role that primary and community services can play and signalling that those settings will be better supported to deliver prevention in the Long-Term Plan.

What have we found?

We have heard that, following the 2013 reforms in England, there is a sense that the NHS role in prevention beyond its remaining core public health functions has been poorly defined and also poorly understood by NHS staff and their delivery partners. This has been exacerbated by national policy mandates, which may be out of step with local priorities or local need. 'Reinventing the wheel' (e.g. Healthy New Towns) and 'dropping the ball' (e.g. PrEP commissioning and STP investment in prevention) were two phrases that have come up repeatedly.

We have also heard that the role of the NHS in addressing people's non-medical needs and also reducing inequalities needs to be more clearly defined. Stakeholders were near-unanimous that the NHS does have a role in reducing health inequalities as is outlined in the Health and Social Care Act (2012) and the Equality Act (2010), but there is a difference in opinion about the shape or extent of that role.

Some believe that because prevention and health inequalities are closely related, most prevention interventions should have the added benefit of reducing inequalities – especially if there is a consistent focus during implementation on reaching disadvantaged groups. Published research on prevention interventions, however, demonstrate that there tends to be lower uptake from 'harder to reach' groups, potentially widening health inequalities.

Others told us that the NHS should pay a much larger regard to reducing health inequalities in all of its activities, but particularly in its capacity to influence the wider determinants of health. Related to that, some stakeholders also pointed out that there is no consensus over how far upstream the NHS and/or the larger Integrated Care System boundary or remit should extend.

What does prevention in the NHS look like?

Added to this sense of uncertainty or confusion, however, is also a sense that most NHS organisations are involved in ill-health prevention and reducing inequalities in really significant ways, but the evaluation challenges mentioned earlier in this paper mean that the combined extent of this work and its impact are often difficult to quantify or describe.

We found that most NHS prevention activity targets three broad groups - individuals, populations, and organisations/professionals - and occurs across four main 'spaces' - primary, community, hospital, and cross-sector partnerships.

Regardless of the group or setting, activity can typically be classified into 11 different approaches: increasing knowledge, supporting behaviour change, reducing risk factors, identifying risk, reducing risk, targeting availability, staff roles, staff training, organisational policies, reviewing provision/contracts, and the use of (usually electronic) support tools. There is no consensus about which approach is most beneficial.

The most commonly researched programmes are those that take place in primary care or community care settings, usually targeting individuals and populations. This kind of activity includes:

- **Screening programmes, such as the NHS Health Check**
- **Individual support programmes, such as counselling or falls prevention**
- **Group education, such as group weight loss support**
- **Stop smoking services**

There is much less research published on prevention in hospitals, but we can look to the grey literature for a comprehensive overview of the kind of prevention work that is going on there. Particularly, we've found recent publications from Public Health England East Midlands and the Provider Public Health Network provide illuminating examples of the kind of work that provider organisations are leading. Some of this activity includes:

- **Building public health capacity by appointing consultants in public health to define and deliver public health ambitions**
- **Creating Board level champions for prevention and developing strategic prevention plans**
- **Launching smoke-free sites**
- **Prioritising staff wellbeing in a variety of ways, including through staff wellbeing strategies, healthy food programmes, and the promotion of the NHS Health Check for staff over 40**
- **Reducing alcohol harms**
- **Behaviour change approaches, such as Make Every Contact Count (MECC), health promotion assessments, and health chats**
- **Promoting equity of care**
- **Screening programmes**
- **Action to tackle the wider determinants of health, such as programmes to support unemployed young people, providing work experiences, and procuring services locally**

We also know of examples of NHS organisations working in partnership with local authorities, statutory organisations, commercial partners, schools, and other voluntary groups to deliver prevention. Examples of what this kind of work looks like include:

- **Working with commercial weight loss programmes, such as Weight Watchers or Slimming World**
- **Partnerships with the Fire and Rescue Service to identify adults at high risk of fires**
- **Partnerships with local authorities to offer free leisure centre access**
- **Partnership with Premier League football clubs to support weight loss for overweight and obese male football fans**

What role is this activity fulfilling?

Based on our evidence-gathering, we've come up with five descriptors that we think do a good job of categorising distinct NHS prevention activity. It's important to stress that this doesn't mean the NHS as whole, everywhere and all of the time, fulfils these functions. It's also important to stress that these labels are imperfect descriptors, often overlap, and are a work in progress that we will be looking to refine as the project continues.

5 Roles that the NHS currently plays in the prevention of ill-health

1. **Leader** – e.g. commissioning services, providing governance and management, setting the national agenda, role modelling
2. **Partner** – e.g. providing services, hosting services, working in collaboration to deliver services with local authority, statutory, or other voluntary sector groups
3. **Employer** – e.g. initiatives aimed at improving NHS staff health and wellbeing; NHS as a community employer and 'anchor institution'
4. **Advocate** – e.g. lobbying governments on public health agenda, lobbying for prevention within individual institutions
5. **Researcher** – e.g. funder and driver of research

Key questions for further exploration:

1. **Do the above outlined roles that the NHS is playing in prevention chime with your experience? Have we missed anything?**
2. **Do you think that these roles are legitimate roles for the NHS to be fulfilling?**

3. Action and focus for the next 3-5 years

We heard that a collection of individual interventions alone will not achieve the change we're looking for at a population level. This requires a systems approach. But there is also a need to prioritise the delivery of prevention interventions that we already know are impactful, cost-effective, and deliverable within current structures if implemented well.

This requires clarity and alignment on priority areas for action and approaches that should be agreed via consultation. Alongside that, we need a simplicity and clarity of approach and communication that can enable big change to happen. While this is clearly very complicated, presenting a case that requires a generation of political effort and many billions more in funding may simply lead to the challenge remaining on the 'too difficult' pile.

Background

In early October, we convened a workshop that brought together over 40 experts in NHS prevention. A wide range of organisations – including Public Health England, the Association of Directors of Public Health (ADPH), and the Provider Public Health Network – were present, as were academics, FPH leaders, Health Foundation partners, and front-line staff.

As part of the workshop we asked attendees to assess our compiled evidence and then help us determine a short list of prevention priority areas. We asked attendees to do this for two specific reasons. The first reason was to support FPH's consultation response to the NHS Long Term Plan. The second reason was to determine a broad, but still manageable set of areas for this project to use as a starting point for assessing where and how NHS organisations were adding the most value – or could add the most value – to the prevention agenda. By examining these areas, we hope to get a better sense of the roles and functions different NHS organisations perform when 'doing' prevention.

We started from a long-list of 26 different areas, which were grouped into five different categories for the purpose of discussion. The categories were selected based on evidence of how prevention programmes were delivered. The categories were: common risk factors, clinical and/or patient pathways, population group or life stage, NHS as an employer, enablers, and universal prevention programmes. Through structured discussion and then voting, the long list was narrowed down to a short-list of 11.

Following the workshop, members of the project team interviewed several workshop attendees and key stakeholders who could not attend on the day, such as colleagues from Public Health Wales and FPH's Health Services Committee, to get a better sense of what the short list was telling us.

What did we do at our stakeholder workshop?

A guide to the staged process we took to arrive at a short-list of areas

Step 1

In advance of the workshop, the project team compiled a draft long list of 26 different areas for stakeholder consideration.

The list includes five categories: common risk factors, clinical and/or patient pathways, population group or lifestage, NHS as an employer, enablers for prevention activity, and universal prevention programmes.

Step 2

Participants add to and amend the long list

Through structured discussion, the workshop participants challenged our draft long list. Many participants added to the list and others reframed the draft categories. Conversations started to centre around the need for a systems approach versus what was practical to achieve now.

Step 3

In small groups, participant tables at the workshop chose their top eight from the revised long list, yielding a collective group short list of 11 priorities. Their selection is listed below in no particular order:

1. A systems approach to prevention
2. Better governance for prevention
3. Realising the potential of the community
4. Tackling inequalities
5. Tackling multi-morbidities
6. NHS staff health and wellbeing
7. Mental health and wellbeing
8. Smoking
9. Alcohol
10. Early years
11. Health promotion

What does our prioritised list of prevention areas tell us?

1. We need a systems approach to achieve change at population level.

Attendees were near-unanimous that achieving change at a population level requires a systems approach to prevention. But what does this mean in practice?

There is no one single definition of a system or systems change. This means that people may often mean different things when talking about it. We see this in the current published evidence base about system change within public health, which sometimes discusses the boundaries of a 'system' in a narrow way (e.g. a clinical care pathway), in a condition specific way, or in a wider community sense.

The World Health Organization (WHO) states that 'systems thinking is an approach to problem solving that views "problems" as part of a wider dynamic system…It demands a deeper understanding of the linkages, relationships, interactions, and behaviours among the elements that characterize the entire system." Viewed within this framework, it becomes apparent that there are two different types of health interventions: interventions with system-wide effects, which tend to focus on a health or care issue, and system-level interventions that tend to focus on the 'building blocks' of the system, such as the workforce or financing.

At the workshop, attendees began the process of figuring out what system-level interventions we should look to prioritise as part of a systems approach to prevention in the NHS. This thinking will be developed as the project progresses, but opinion coalesced around:

- **Implementing better governance for prevention** – with the possible exception of CQUIN, we heard that prevention is not being systematically driven across NHS organisations by current governance practices. Challenges with service specifications, data collection and monitoring processes, performance management, and contract management were raised.
- **Realising the potential of the community** – community services are a hugely significant part of NHS activity, but sit awkwardly in current frameworks that tend to situate community services with primary care only.
- **Increased investment in public health expertise in healthcare and population health** – there is concern over the perceived lack of public health specialist input into healthcare planning and commissioning. This support is needed to ensure CCGs are able to deliver competent local commissioning of effective and efficient healthcare services based on need.
- **Cross-sector partnerships with local authorities, community and voluntary sector organisations, commercial partners, and other statutory bodies** – partnership working is a system enabler for prevention delivery and is only going to become more important as the integration agenda gathers pace. There is a need to examine what makes a partnership work well and how different NHS organisations behave in different partnership arrangements. Investment to support partnerships was also an area highlighted for consideration.

2. But there is also a need to prioritise the delivery of prevention interventions that we already know are impactful, cost-effective, and deliverable within current structures if implemented well.

Striving for a systems approach to prevention doesn't preclude continuing to implement prevention interventions at scale that we already know can work if done well. In addition to the system level interventions discussed on the previous page, attendees at the workshop listed the following areas of NHS prevention activity that they thought this project should explore. They are:

- NHS staff health and wellbeing
- Tackling inequalities
- Mental health and wellbeing
- Smoking
- Multi-morbidities
- Alcohol
- Early years
- Health promotion

In particular, we heard that we need to use the above issues to further tease out some of the main questions this project is interested in exploring. For example, when NHS organisations are delivering early years prevention interventions, which roles are they performing? What does 'good' mental health and wellbeing prevention look like when the NHS is performing its different prevention roles? This will require looking not just at which interventions go 'underneath' those above listed areas, but examining how those interventions are implemented well.

We also heard that we need to decide criteria for assessing these areas and/or their interventions.

Are we looking for areas with the biggest impact? Are we looking for the greatest cost-effectiveness? Or are we looking for what is most deliverable?

At the time of writing, the NHS Long Term plan has not yet been published. However, the process which led to our short list raises some interesting comparisons with the approach and priority areas identified during the Long Term plan consultation process. Public Health England has publicly prioritised the prevention of smoking, cardiovascular disease, and obesity as three issues that the NHS must do more to address and has flagged priority interventions that they would like to see funded in the plan. Our prioritised list is much wider than that and reflects a significant difference in priorities and approach.

Questions for further consideration:

1. **What does a system wide approach to prevention across the NHS look like?**
2. **Do you agree with the prioritised short list of 11 prevention areas agreed at the workshop? If so, why? If not, why not and what would you change?**

In terms of individual prevention areas:

3. **Are we aiming for the areas with the biggest impact (short, medium, or long-term)?**
4. **Are we looking for greatest cost-effectiveness? And if so, do health benefits count as well as direct financial benefits?**
5. **Are we looking for the most deliverable? And do we mean deliverability in terms of how the NHS functions, political deliverability, or workforce deliverability?**

Next steps

This project is seeking to examine the different ways in which prevention is the NHS's business and the roles that different NHS organisations play when they are doing prevention.

This paper is the first iteration of some of our thinking and learning so far. It covers issues with the evidence, with defining roles and responsibilities, and with priority areas for action and investigation. It doesn't attempt to provide all of the answers. Instead this paper deliberately exposes some of the tensions and complexities that make this area of policy so challenging and poses a series of questions that we will need to address to advance this conversation in a way that is helpful to NHS leaders and staff, policy-makers, and researchers.

We will be using this paper to continue to engage with FPH members and the wider health and care community over what they think the NHS role in ill-health prevention is now and should be in the future. To help the discussion even further we will also be publishing a series of blogs on the FPH blogsite over the coming weeks. You can read them by visiting https://betterhealthforall.org/.

We plan to host two more policy workshops in the spring in order to continue to refine our thinking and represent the voice of our membership on this issue. At those workshops we intend to examine the barriers and enablers to good prevention activity in the NHS, explore what good prevention activity looks like, and further refine, clarify, and expand on the different roles that will enable the NHS to deliver a step-change in prevention activity.

After each workshop we will publish another discussion paper similar to this one. And at the end of the project we will publish a final report setting out a summary of everything we have learned.

We hope you will take the time to continue to engage with us during this project and please do send us any feedback about the questions we pose and the issues we've raised.

To feedback, please email policy@fph.org.uk

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Summary of the questions asked in this paper:

Theme 1

- Do you agree with our analysis of the current state of the public health evidence base? Are there overarching points that you think we've missed?
- How do local decision-makers leading prevention in the NHS bridge the research-to-action gap effectively? What tools, methodologies, or approaches do they use that allows them to 'go beyond' the evidence they have?

Theme 2

- Do the above outlined roles that the NHS is playing in prevention chime with your experiences? Have we missed anything?
- Do you think that these roles are legitimate roles for the NHS to be fulfilling?

Theme 3

- 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 agreed at the workshop? If so why? If not, why not and what would you change?

In terms of individual prevention areas:

- Are we aiming for the areas with the biggest impact (short, medium, or long-term)?
- Are we looking for greatest cost-effectiveness? And if so, do health benefits count as well as direct financial benefits?
- Are we looking for the most deliverable? And do we mean deliverability in terms of how the NHS functions, political deliverability, or workforce deliverability?

FACULTY OF PUBLIC HEALTH

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About the UK Faculty of Public Health

The UK Faculty of Public Health (FPH) is a membership organisation for approximately 4,000 public health professionals across the UK and around the world. We are also a registered charity. Our role is to improve the health and wellbeing of local communities and national populations. We do this by supporting the training and development of the public health workforce and improving public health policy and practice in partnership with local and national governments in the UK and globally.