Health Services Committee comments on the NHS plan

For FPH use

1. Introduction

We warmly welcome the identification of prevention and early intervention initiatives, inequalities reduction and the role that the healthcare sector plays in that work across populations, complementing the role of public health functions of Local Authorities in England. We think this also represents a major challenge to the system as much of this work requires population and public health skills at every level. Local NHS organisations will increasingly focus on population health and local partnerships with local authority funded services through new Integrated Care Systems (ICSs). People are living much longer but extra years of life are not always spent in good health. With people more likely to live with multiple long-term conditions, pressure on services continues to grow faster than demographic changes predict, advances in medical interventions also create demand and more sophisticated care planning and analysis is also required to adapt to this change.

Life Expectancy. We have a growing and aging population and it is essential to improve upstream prevention given that demand for health and care service continues and services need to be able to focus on those who need them the most. Through providing services which support people to improve their outcomes such as stop smoking, overcoming drinking problems and preventing Type 2 diabetes (through obesity reduction), recognising the impact of wider determinates of health such as housing and employment, through enhanced supported self-management and working with partner agencies and the voluntary sector. Throughout the plan there is a strong focus on prevention to encourage people to live healthy and independent lives for longer and to tackle and reduce health inequalities

2. What is excellent in the plan: a role for all NHS organisations to support the following:

We welcome the explicit re- introduction of prevention into core NHS business and also a recognition that the NHS can play an important part in health inequality reduction - fundamental to improving population health. We particularly welcome the plans focus on the role that digital technology could play in preventative work across health and care systems.

Smoking - Smoking remains the primary cause of preventable illness and premature deaths in the UK and is significantly associated with diseases such as chronic obstructive pulmonary disease (COPD), various forms of cancer, coronary heart disease and stroke. Exposure to second-hand smoke is also known to increase the risk of these conditions and contributes to serious illnesses among children, such as asthma. Smoking is the biggest single cause of inequalities in death rates between the rich and poor.

Obesity - Obesity is the cause of a wide range of long term conditions including type 2 diabetes and high blood pressure and has a major impact on health and social care services. Stronger evidence on

effective interventions continues to grow and it is essential the NHS adopts what works and is cost effective in a timely way.

Alcohol - Alcohol misuse contributes significantly to 48 health conditions, wholly or partially, due either to acute alcohol intoxication or to the toxic effect of alcohol misuse over time. Conditions include cardiovascular conditions, cancers, depression and accidental injuries. Risk of ill health increases exponentially as regular consumption levels increase. Most of these harms are preventable.

Air Pollution - Taking action to improve air quality is crucial in order to improve population health. Evidence suggests that air pollution is a significant contributor to preventable ill health and early death. Poor air quality affects everyone and can have long term impacts on all and immediate effects on vulnerable people (wheezing, coughing and exacerbations of asthma and chronic bronchitis) with a disproportionate impact on the young and old, the sick and the poor. Deprived communities are more likely to be situated near polluted busy roads, and are more likely to experience adverse health impacts. It is estimated the burden of particulate matter (PM) air pollution in the UK in 2008 to be equivalent to nearly 29,000 deaths and an associated loss of population life of 340,000 life years lost. These health impacts impose a cost on the UK economy that has been estimated to run into billions. Environmental sustainability is a major risk to population health. The NHS is a significant contributor to the national carbon footprint emissions. The commitment of the NHS to reduce the carbon emissions of its own fleet is welcome

3. We also strongly encourage the NHS to support further work on:

3.1. Service Models

New service models. These call for a significant step change to the way we do things now i.e. collaboration and integration to deliver whole pathways of care within service systems and the changes needed to achieve this step change should be a priority for NHSE.

Community-wide outcomes: Encouraging local healthcare networks to refresh their oversight of local population health need is welcomed but requires skilled work to adapt population level data to local situations (such as Primary Care Networks). At both whole community level (such as Integrated Care Systems) and locally, it is vital that evidence-based prevention work is mandated (and modelled) in all pathway and population health management development work the NHS does.

Supporting personalised care requires significant community engagement and community development work at a universal level and the use of population segmentation alongside nudge and social capital methodologies. Broadening the community-based support offer beyond social prescribing is welcome. This needs fully integrating with other sectors in a place-based approach.

Service models are also driven by performance and governance mechanisms and we strongly support the intent that performance targets for trusts are altered so that they encourage community well-being and health outcomes not just in-hospital performance.

NHS Providers Public Health roles: We recognise that increasingly all NHS organisations see major benefits in adopting Public Health roles organisationally and in the work staff in those organisations

undertake that consider the wider population beyond the patients that the provider currently cares for. We also strongly support the work of public health professionals within NHS organisations to support them in their work as part of the emerging ICS systems in England. We also would like to see a more systematic training programme for senior clinical leaders to include public health specialists as both participants and contributors.

Primary Care: The NHS Plan says:

> *"Primary care networks will from 2020/21 assess their local population by risk of unwarranted health outcomes and, working with local community services, make support available to people where it is most needed."*

In order to deliver the LTP ambition of integrated, community based care primary care needs to be strengthened. The development of primary care networks is central to this and is an opportunity to support equitable delivery of health care interventions to disadvantaged and harder to reach individuals and populations. Ensuring these population receive high quality and equitable care, (for example management of CVD risk factors, earlier detection of cancer and mental health interventions) is an important contribution to improving health and reducing inequalities. Development of primary care networks should be informed by expert public health advice and assurance processes should include the degree to which there is evidence of an implemented plan to deliver high quality care to vulnerable and disadvantaged populations.

3.2. Prevention

Prevention has been repeatedly universally accepted as the most cost effective way of improving health and reducing disease burden across healthcare systems internationally. However, not all preventative effort is effective (and occasionally can be harmful). Careful, expert public health skills are required to support systematic identification of risk, evaluation, prioritisation and training and this is needed at the front line of healthcare delivery. More work is required across populations to separate individual level interventions (well suited to appropriately trained NHS staff) and those interventions that require whole population or community of interest approaches (as well described in many of the Public Health Guidance summaries produced by NICE), which need much stronger and more systematic responses locally but also require NHS staff to help advocate at local and national level. A 'prevention mindset' needs applying to all aspects of the Long Term Plan so that all service models and systems shift towards prevention of physical and mental health problems where services can make an evidence-based difference. Achieving greater levels of physical activity amongst all our populations remains one of the most effective long term preventative actions and the NHS must do more to support patients and staff in adopting evidence-based approaches to this challenge.

3.3. Data and analysis

Where individual level data are required for population health management, it is vital to agree data sharing so all relevant health data is available to staff delivering care to patients including robust recording of risk, results and data that facilitates stratification of care where appropriate. In addition, faster efforts to share health and care data for planning and strategic use (secondary use) are needed and with appropriate anonymization, there should be no block to this use being more

consistently available to local health and care planning staff, including English Council-based Public Health specialists who have a statutory duty to support the NHS in its health care planning. Population Health Management could be a lever to make a step change in health service performance in coming years. Accompanying this, getting a shared, efficient and appropriately skilled analytical workforce to support planning, evaluation, effectiveness, equity, and impacts on health inequalities based on robust data is vital. The opportunity for health and care research could be significantly enhanced by changes in data handling and analytical alignment. Co-ordination of these data efforts requires leadership and local systems need to rapidly identify appropriately skilled leaders who can coordinate analysis to deliver Population Health Management, which should fully harness and coordinate existing analytical skills particularly those of the Local Authority Public Health Specialists.

Digital technology: There is also a need to consider how health information and intelligence could also be used to improve population health literacy and empowerment for making better choices. The NHS App (and local enhancements) should consider how such development could contribute to this.

3.4. Workforce

For patient care: Existing staff in NHS, Local Authority , Public Health and wider health and care environments already deliver many evidence-based interventions, especially around prevention. However there are challenges and it is vital substantial training and workforce development is available to ensure even simple interventions such as stop smoking and brief advice on alcohol use are made effective. Delivering community-based support requires new ways of working with communities for many practitioners and skills in effective co-production and engagement will be paramount. Achieving mental health parity of esteem requires all health staff to have knowledge and skills in promoting mental health and preventing mental health problems.

For staff health: Staff that have the skills, motivation and belief in prevention and well-being for patients also need support to achieve this for themselves in often highly challenging work environments. We also recognise the crucial role that staff who are well and motivated make to the quality of healthcare. The NHS should identify the opportunities for a focus on staff in the lowest paybands where the sickness absence is worst, years lived in disability are highest and the opportunity to impact on the local population are often unexplored. NHS organisations acting as Anchor institutions are an additional aspect of this work that deserves more attention.

There is much to be gained by applying better epidemiological techniques to NHS workforce surveys, measuring well-being consistently (such as the use of the national annual ONS well-being questions), and careful identification of interventions to improve staff well-being in higher risk groups. Wider workplace health initiatives across the NHS for all staff also support achieving better patient care. Applying the recommendations of the recent HEE report on learner and staff wellbeing is a priority.

3.5. Better Care

We strongly support the need to adopt better evaluation of changes in healthcare and social care delivery, including prevention, and suggest more epidemiological and health services research

capacity at national, regional or ICS level may be needed to achieve this especially to tackle effectiveness and equity issues.

3.6. Efficiency

The use of cost effectiveness and health economic tools to support prioritisation has faltered across many areas of the local NHS in recent years and needs to be much more strongly played into pathway development, resource allocation and decision-making frameworks as the NHS Plan develops. A strategic approach to encouraging NHS systems to support more health economic input into national and local planning is vital. Balancing a utilitarian approach with individual choice will remain a delicate and difficult task but must be addressed for the NHS to remain efficient and effective at population level.

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