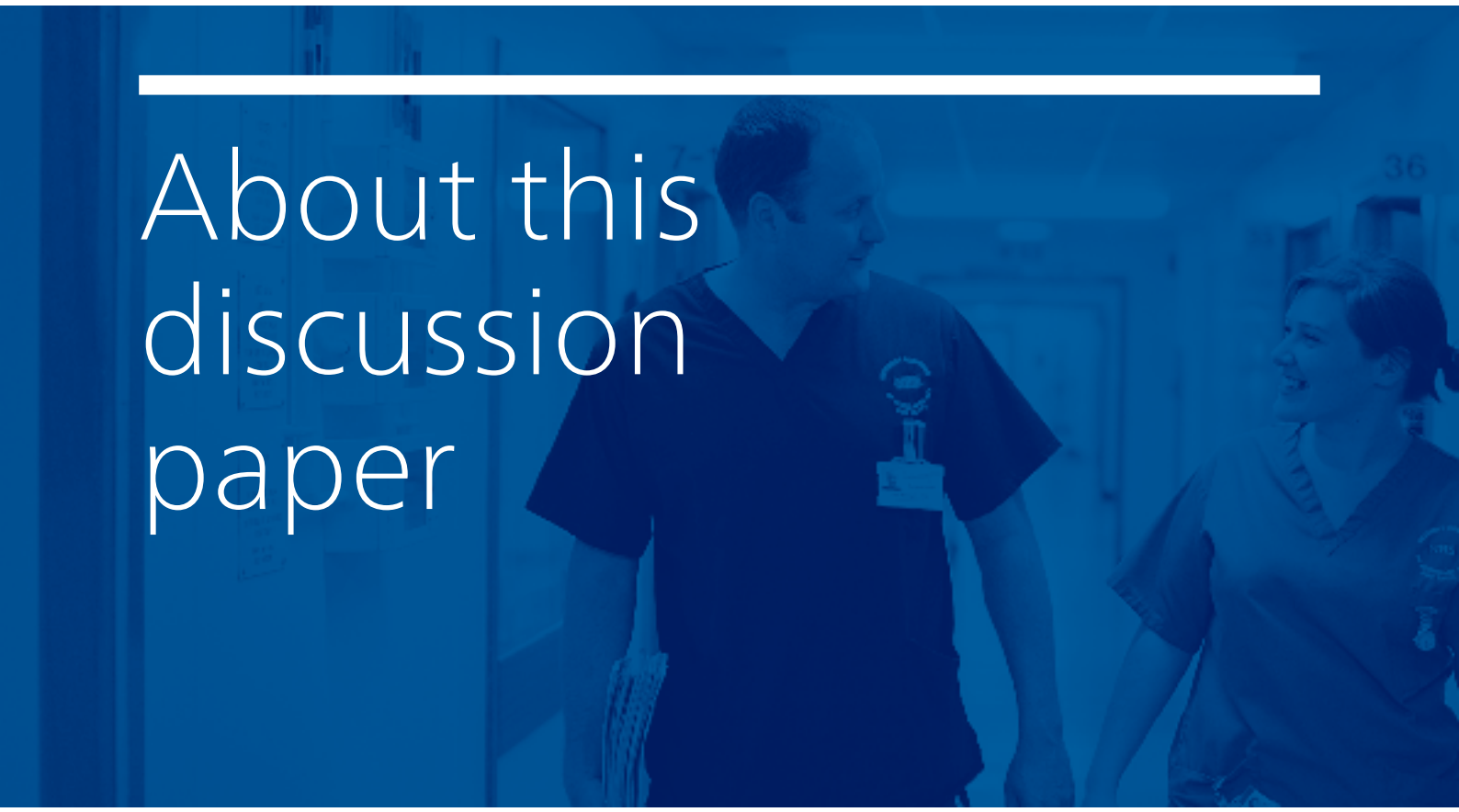
The Role of the NHS in Prevention

What public health and NHS leaders are telling us

Discussion paper

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 ill-health prevention. Our project began in August 2018 and will end in mid-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 NHS organisations currently deliver prevention
- Understand what 'good' prevention in different NHS organisations looks like
- Explore the enablers and barriers for NHS organisations seeking to take a more preventive approach
- Determine initial priorities for increased investment and focus
- Support the case internally for FPH to prioritise healthcare public health in our training, education, policy, and standard setting role

This discussion paper draws together the key themes that have emerged 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. It builds on many of the themes outlined in this project's first discussion paper, which you can read here.

Audience

This paper is aimed at:

- FPH members and other public health professionals working within or in partnership with NHS organisations
- NHS staff with an interest in prevention, even if it's not formally part of their role
- Policy – makers at local and national level
- FPH and other health system leaders

What evidence informs this paper?

1. A 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, impact, and barriers and enablers to implementation. Sources covered all four nations. You can read the full review here.

2. Policy workshops

We convened two policy workshops in October 2018 and April 2019 to help us assess our evidence base, challenge our thinking, and determine what this project should focus on. A diverse range of experts from Public Health England, NHS England, NHS organisations in England and Scotland, Clinical Commissioning Groups, academia, and the wider public health community attended each workshop.

3. Opinion polling of NHS leaders

We commissioned polling experts ComRes to survey 310 NHS leaders working across a diverse range of clinical disciplines about prevention. By 'NHS leader' we mean directors, deputy directors, and clinical leads at provider, commissioner, and primary care level. Two-thirds of those polled were employed at NHS trusts and only 3% were part of the specialist public health workforce. You can see the demographics of our sample along with summary results of the opinion-polling findings here.

4. Survey of FPH members

We surveyed our members working primarily in local government in March 2019 for this project and wider FPH work on public health funding. The survey asked our members to consider which 'low or no cost' taxes and regulations would most benefit the health of their local population. This survey was intended to allow us to compare the views of the specialist public heath workforce with those of NHS leaders.

5. Feedback from this project's first discussion paper

We published our first discussion paper on the role of the NHS in prevention in December 2018. We have received over 50 pieces of written feedback on the questions posed in the paper from a wide range of stakeholders, including from FPH's Specialty Registrar Committee, six medical royal colleges, and the Department of Health and Social Care. We have assessed and used this feedback to distill which areas of this work programme seem to be the most compelling or valuable to our key audiences.

6. A focus group with FPH's Primary Care & Public Health Special Interest Group (SIG)

Our Primary Care & Public Health SIG is a forum where public health clinicians, general practitioners, academics, and commissioners within public health come together to collaborate on projects and share experiences. We convened a focus group with some of its members in March 2019 to explore the questions posed in the first discussion paper and learn what matters most from a primary care perspective.

7. FPH Health Services Committee

We have relied particularly on the combined expertise of the members of our Health Services Committee (HSC). The HSC represents the views and opinions of FPH members working mostly in healthcare public health roles and ensures that health services public health remains a critical priority area for FPH and other public health bodies.

Introduction

What would an NHS that prioritised prevention look like? This question has emerged time and again over the course of our project exploring the different roles the NHS plays in prevention.

We routinely hear from those working in or in partnership with NHS organisations that while the NHS is currently playing an important role in delivering prevention, the NHS at a national level and organisations locally are grappling with a vision for a future NHS that is even more health promoting and balanced far more in favour of prevention than it currently is.

This is a timely moment to be considering NHS prevention activity. The recently published NHS Long Term Plan has explicitly placed prevention and reducing health inequalities at the core of NHS business and committed the NHS to taking a population health approach to service design and delivery. Additionally, FPH members and others working in Scotland are looking towards the establishment of a new national body for public health – Public Health Scotland – and debating now what these reforms will mean in practice for the whole health system for years to come.

This is also a timely moment for FPH in particular to be considering this agenda in our role as the training and standard setting body for public health. With a curriculum review on the horizon and a new organisational strategy in development, we're now asking our members working in public health roles across the country what more we as an organisation can do to ensure the workforce of the future has the analytical and influencing skills it needs to deliver national prevention aspirations.

Looking more broadly, the forthcoming Prevention Green Paper also provides a once in a generation opportunity for the public health community to make our case for what prevention-led public services look like, reaching far beyond the NHS and into our communities. This includes coming together to create a consensus view on several fundamental issues, including: what proportion of spending on public health services, including the NHS, should be on prevention; what outcomes we would expect to see from that level of investment; and the targeted areas that need to be addressed first in order to unlock some of the barriers to prevention delivery across the system.

In this paper we begin to explore some of those issues in greater detail, drawing on a wide range of sources and building on the themes that emerged from this project's first discussion paper. First, we consider prevention priorities within the context of the NHS Long Term Plan, comparing what NHS leaders think are current priorities with what they think the NHS's priorities should be for the future. Then we discuss commonly occurring barriers to effective NHS prevention activity and specifically take a closer look at what the majority of NHS leaders who we polled agree is the main barrier to prevention - a lack of funding.

Then we reflect on the various different roles we think the NHS is currently playing in prevention and dig more deeply into how the NHS is – or could be- acting as an advocate for prevention. Lastly, we consider the FPH role in NHS prevention and outline some initial thoughts as to what we as an organisation should prioritise for workforce training over the next five years to support this agenda.

Throughout this paper we pose some questions that we very much hope you will help us answer. It is our hope that this discussion paper will lead to lots of additional conversations with our members, partner organisations, and those interested in helping the NHS become more prevention-led and in supporting our organisation in making sure the specialist public health workforce of the future can lead that effort.

Please do offer your thoughts via email to policy@fph.org.uk. Thank you so much in advance for reading and we look forward to hearing from you soon.

June 2019

1. Prevention priorities

What does the NHS Long Term Plan say are priorities for prevention and reducing health inequalities?

The NHS Long Term Plan for England explicitly situates prevention at the heart of NHS business and recognises for the first time in recent years that the NHS has a responsibility for reducing health inequalities. The plan lays out a renewed NHS prevention programme focused on maximising the role of the NHS in tackling the top risk factors identified by the global burden of disease study. These risks are smoking, poor diet, high blood pressure, obesity, and alcohol and drug use, with air pollution and lack of exercise also seen as important. There is also a large focus on improving the health and wellbeing of the NHS workforce and mental health, alongside commitments for NHS organisations to take a population health approach to service delivery.

What does the public health community think?

In a workshop we held in October 2018 with public health leaders, we asked participants to prioritise their own 'wish list' of NHS prevention areas or activity. The biggest message we heard from them was that a collection of individual interventions alone will not achieve change at a population level. This, they argued, required a systems approach where different partners are working together more effectively towards a shared vision for the public's health. They told us that achieving a systems approach required making progress on several different areas, including: implementing better governance of prevention, realising the potential of the community, increasing investment in public health expertise in healthcare and population health, and focussing relentlessly on effective cross-sector partnerships.

But they also told us that this isn't an 'either or.' We do need to prioritise – and then implement well – prevention interventions that we already know are impactful, cost-effective, and deliverable. They listed mental health, smoking, alcohol, early years, reducing inequalities, addressing multi-morbidity, and NHS staff health and wellbeing as key priority areas. You can read the full list of priorities from the first workshop here.

We've been testing this list with FPH members and the wider public health and health communities. Although there are some differences in opinion about priority risk factor areas and criteria for prioritisation, there is a general consensus that the list – with its dual focus on system level change and targeted risk factors and population groups– 'feels' right.

What do NHS leaders think?

To further test our emerging findings, we wanted to see what NHS leaders working across clinical disciplines think about their local NHS's prevention priorities.

In order to do this, we used the findings from our evidence review regarding 'types' or 'kinds' of NHS prevention activity to first group activity into nine different categories. This was not an exact science and we fully recognise that these categories are imperfect descriptors for what can be complex and extremely varied activity and they are in no way mutually exclusive. In most instances the categories describe a particular approach or mind-set to 'doing' prevention, rather than discrete activity. We believe, however, that in the round most NHS primary and secondary prevention activity or programmes are accounted for in some way within these nine categories.

Our survey then asked NHS leaders to select the top three that the NHS in their local area is currently prioritising and then to select the top three that they thought the NHS in their local area should be prioritising.

This is what they told us:

Q: In your local area, what do you see as the NHS's current prevention priorities?
(choose top 3)

Shows % selecting each in top 3

1. Addressing common risk factors, e.g. smoking or alcohol **(48%)**
2. Delivering universal prevention programmes, e.g. screening and vaccinations **(45%)**
3. Embedding prevention into clinical and/or patient pathways **(44%)**
4. Delivering a systems approach to prevention **(41%)**
5. Embedding prevention into routine practice, e.g. MECC **(31%)**
6. Targeting specific populations, e.g. healthy ageing or maternity **(30%)**
7. Reducing health inequalities **(25%)**
8. Ensuring the NHS is a good employer, e.g. promoting NHS staff health and wellbeing **(21%)**
9. Addressing the wider determinants of health, e.g. air pollution **(6%)**

Q: In your local area, what do you think the NHS's prevention priorities should be?
(choose top 3)

Shows % selecting each in top 3

1. Delivering a systems approach to prevention **(64%)**
2. Embedding prevention into routine practice, e.g. MECC **(45%)**
3. Embedding prevention into clinical and/or patient pathways **(43%)**
4. Reducing health inequalities **(39%)**
5. Addressing common risk factors, e.g. smoking or alcohol **(29%)**
6. Delivering universal prevention programmes, e.g. screening and vaccinations **(24%)**
7. Addressing the wider determinants of health, e.g. air pollution **(20%)**
8. Ensuring the NHS is a good employer, e.g. promoting NHS staff health and wellbeing **(16%)**
9. Targeting specific populations, e.g. healthy ageing or maternity **(15%)**

You can read a summary of all of the opinion polling findings here or view the publicly published ComRes results tables here.

Our initial thoughts on what this is telling us

We think this is a very rich finding, which provides a glimpse into how diverse NHS prevention activity is being delivered and where the direction of travel is headed. Below we begin to explore two issues that seemed most interesting to us (the top priority now and for the future, and health inequalities), but we'll be actively looking for feedback from stakeholders and FPH members about what else these two lists tell us.

The top priorities: risk factors and the systems approach

- Current NHS priorities are predominantly risk factor and single-issue based, e.g. screening programmes or addressing smoking or harmful alcohol use. However, like the public health leaders we've spoken to, NHS leaders overwhelmingly think that the NHS should be prioritising a systems approach to prevention over other approaches. This alignment in priorities is encouraging and is a potential sign that external drivers, such as the move towards Integrated Care Systems (ICSs) in England and Integration Authorities (IAs) in Scotland, are shaping the aspirations of health system leaders.
- Twenty-nine per cent of NHS leaders say that addressing common risk factors should be a top priority for the NHS in the future, a considerable drop from the nearly half (48%) who think it is currently the top priority. This doesn't necessarily mean that NHS leaders don't think that the NHS should be addressing common risk factors, only that they don't believe this approach to prevention should be prioritised as strongly as it currently is. This could be for a variety of reasons, including the view put forward by the Chair of FPH's Health Services Committee Chris Packham that over the past five years the NHS has 'visibly swung away' too far from pathway development for services built around prevention and instead focuses its efforts on dealing with immediate, acute demand.
- We think this means that there is some tension between what the NHS Long Term Plan identifies as prevention priorities over the next ten year period (predominantly addressing common risk factors) and what both public health and NHS leaders think should be priorities for the future (delivering a systems approach and embedding prevention into routine practice and clinical care pathways). However, to reiterate what we've heard from the public health community, this is not an 'either or' proposition; the NHS needs to be doing both simultaneously. We think the order and composition of the 'future' priorities list from NHS leaders is broadly reflective of that sentiment. The challenge will be for both public health and NHS leaders to advocate for this dual approach.

Reducing health inequalities

- NHS leaders want their local NHS to do more to reduce health inequalities. Only 25% of NHS leaders polled say that reducing health inequalities is a current priority for their local NHS service, but 39% think it should be a top priority. Commissioners were much more likely to think that the NHS should prioritise tackling health inequalities (58%), compared with providers (37%).
- While many within the NHS want to do more to reduce health inequalities, the free-text comments from the poll do reveal some degree of scepticism or uncertainty about how the NHS can meaningfully contribute to this agenda. Their comments stress that the NHS itself has relatively few levers over the public's health and health inequalities, e.g. 'the NHS cannot treat people out of inequality.'
- But as the Provider Public Health Network and the Health Foundation have demonstrated, NHS providers can impact on health inequalities in a number of ways, including by ensuring equitable access to services, focusing on areas where healthcare interventions can make the biggest difference (such as cancer, stroke, and heart disease – representing 50% of health inequality gap) and acting as an 'anchor institution' in its local community.
- While some questions might remain around how funding models within the NHS will change in practice to tackle health inequalities or how local areas will be incentivised or held accountable for them, we think that the commitments to reduce health inequalities that run throughout the Long Term Plan provide some helpful clarity and vision on this issue.

Key questions for further consideration:

1. **What is most interesting or surprising to you about the two lists of current and future prevention priorities?**
2. **Do you think the future priorities identified set out the 'right' direction of travel?**

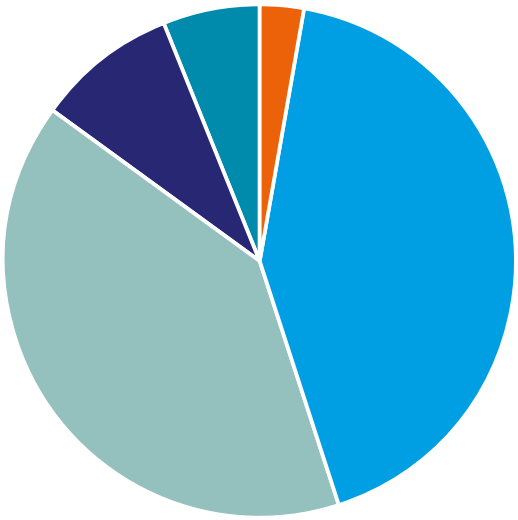
2. Barriers to NHS prevention

Our evidence review into NHS prevention activity identified 31 commonly occurring barriers to implementing impactful NHS prevention programmes, regardless of the organisational setting or exact type of initiative. These barriers can be broken down into three categories:

1. **Uptake** – often at the level of the individual or programme, e.g. fear amongst individuals about attending services or receiving a diagnosis or difficulty targeting interventions appropriately
2. **Implementation** – often at the programme level, e.g. programmes not drawing on evidence or guidelines about what works or insufficient staff training, confidence, or knowledge to deliver the programme effectively
3. **System** – often at the organisational level, e.g. lack of national policy or guidelines to support prevention on some topics, inappropriate remuneration models, or lack of infrastructure, such as wifi access

The review found that there is a tendency for researchers and decision-makers to address individual or programme level barriers when trying to improve the effectiveness of prevention interventions. This can be short-sighted, as wider organisational or system level factors are often the most significant barriers that need to be overcome to prioritise prevention effectively within the NHS.

This distinction is especially important for this work, as our survey of 310 NHS leaders revealed that around half of NHS leaders surveyed think that the NHS is currently **ineffective** at delivering its current prevention priorities.



Q: How effective or ineffective do you think the NHS in your local area is at delivering its current prevention priorities?

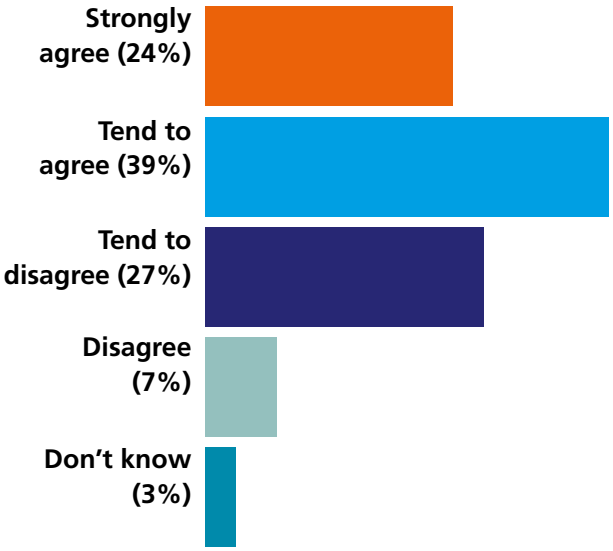
- Very effective: **3%**
- Fairly effective: **42%**
- Fairly ineffective: **40%**
- Very ineffective: **9%**
- Don't know: **6%**

What do NHS leaders think are the main barriers to prevention?

Out of all of those barriers, we wanted to understand which ones NHS leaders saw as the main barriers getting in the way of their department delivering more or more effective prevention. We found that two-thirds (63%) of NHS leaders surveyed strongly agree or tend to agree that a lack of funding is the main barrier to delivering prevention locally.

Q: To what extent do you agree or disagree with the following statement about NHS spending on prevention

Lack of funding is the main barrier to delivering prevention at a local level (n=310)



Prevention funding in the NHS

Over the course of this project, we've found that funding for prevention is a challenging topic to pin down, not least because there is no agreed definition of what actually constitutes 'preventive spend.' We do know that the Office for National Statistics attributes around 5% of total UK Government healthcare expenditure to 'preventive healthcare' – the definition of which is expanded upon here.

In England this is mainly distributed via Public Health England through the ring-fenced public health grant to local authorities. NHS England also commissions some public health functions (mainly screening and immunisations) under Section 7A of the NHS Act 2006.

But we know that this 5% figure probably doesn't include a wide range of broader activity across the system, including much secondary prevention within NHS settings and prevention work NHS organisations are engaged in with community partners. The truth is that we don't actually know how much the whole health and care system spends on prevention.

NHS leaders and the public health community both agree that the health system should be spending more on prevention, but there is no consensus over how much 'more' is or what we would achieve with 'more.' We think this ambiguity is a problem; we need to know where we are now before we're able to move forward with a vision for the future that matches resources adequately to rhetoric.

It's perhaps not surprising then that when our survey asked NHS leaders to estimate the percentage of their budget that is on average spent on prevention, nearly three-quarters (73%, n= 227) said they 'didn't know'. This is particularly interesting when we consider that of the 21% per cent of respondents (n=66) who say that prevention is core to their department's work, over two-thirds of them were still unable to estimate the amount they spend on it.

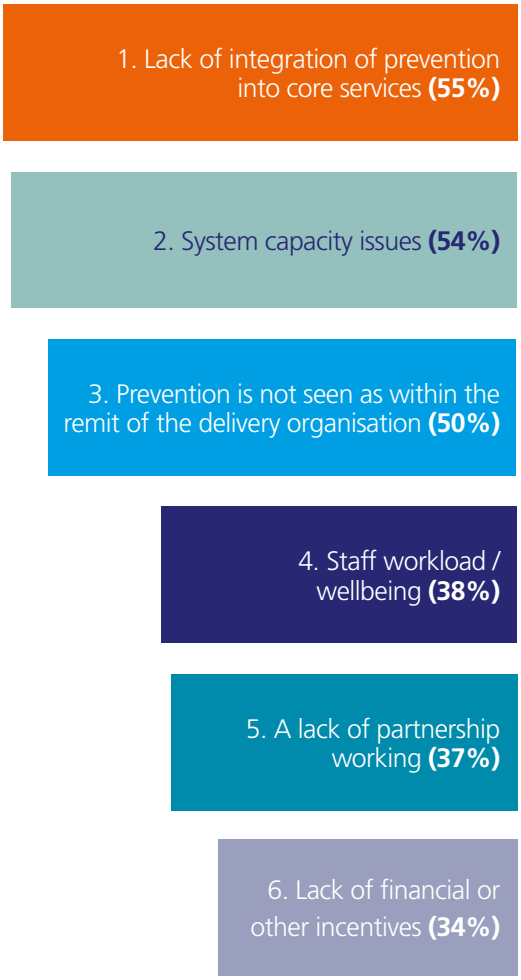
The respondents who were able to answer this question (n=83) said that on average 11% of their total budget is spent on prevention, but the proportion should rise to 27%. This suggests that NHS leaders who responded to this question think their prevention budgets should be more than doubled – a significant increase on whatever amount their baseline spend currently is now.

With 67% of NHS leaders surveyed also agreeing that the NHS should reallocate its current resource to spend more on prevention, we hope this finding – despite the small sample size - can be used to help inform initial views about what a rebalancing of budgets towards prevention would look like in real terms.

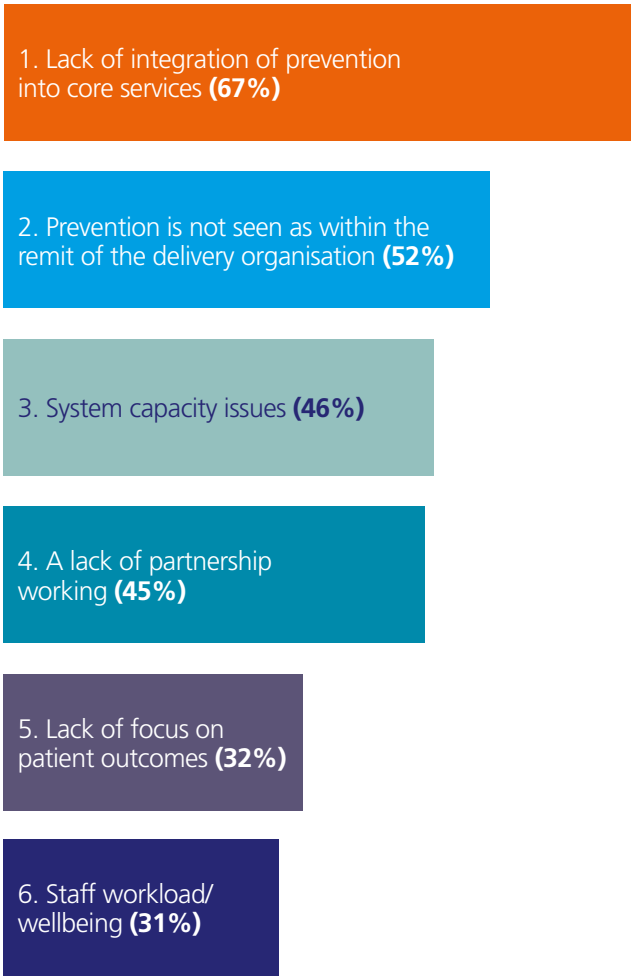
We asked NHS leaders a number of other questions about NHS prevention budgets – which you can view here.

The other main barriers respondents identified included:

Of those who considered lack of funding as the main barrier to prevention at a local level, the other main barriers considered were: (n= 197)



Of those who considered lack of funding not to be the main barrier to prevention at a local level, the main barriers considered were: (n= 113)



These are an interesting grouping of barriers, mostly speaking to wider system level issues (with the exception of staff workload and wellbeing – which can also be a programme implementation issue). A lack of integration of prevention into core services is clearly a top issue for all respondents, mirroring feedback from the public health community that the overall context for integration remains very challenging, with organisations striving to achieve major change in partnership with others while simultaneously managing rising demand for services and delivering high quality care.

We think that the barrier 'prevention not seen as being within the remit of the delivery organisation' is particularly ripe for further exploration. We argue in this project that NHS organisations have an important role to play in prevention, but in different ways and at different times. We continue to hear in workshops and via written feedback that this is something that 'everyone seems to agree on' and the issue is really around implementation, not intention. But the findings from NHS leaders surveyed question the premise of that narrative somewhat and suggest that there is still a perception within some NHS organisations that prevention is not part of what the NHS does.

Better governance of prevention

There are many potential solutions for overcoming those kinds of integration and perception barriers and it's very likely that different organisations in different places will need to address these challenges in locally specific ways. However, we've also heard from participants at our first workshop and during subsequent interviews with stakeholders that getting the governance of prevention right is something that NHS organisations everywhere and the wider health and care system in local areas needs to urgently address in their own way if they are sustainably pivot towards prevention. If the 'governance machinery' of the NHS does not systematically drive prevention across the organisation, we heard that it is much less likely to happen.

Governance can mean different things to different people because it typically describes a process rather than an end product. In this context, we understand governance to mean the process for how the NHS makes its important decisions, who it involves, who is held accountable for those decisions, and how success is measured and rewarded. We've heard that although the NHS is full of people who are passionate about improving the public's health, this passion isn't reflected in the governance arrangements.

We heard that there is often no common thread from national to system/organisational level prevention strategies, although there is considerable optimism that this will start to change following the steer in the NHS Long Term Plan. Many organisations also lack consistency of role or remit when it comes to prevention and there is no measurement of progress as part of assurance and regulation. We heard that although some aspects of prevention are embedded within core contracting, they are often not performance managed.

This is compounded by a lack of coding and measurement tools to enable tracking of essential prevention activity, meaning that staff directly involved in doing prevention are both unable to measure the full impact or effectiveness of their work and also unable to communicate that impact to others across the organisation to further encourage or improve prevention delivery. This matters because, as our survey of NHS leaders highlighted, when staff are not directly involved in prevention activity they are more likely to consider prevention interventions to be ineffective or to be unaware of their impact.

Participants at our April workshop reflected on some of these governance gaps, raised further areas that would need to be explored, and put forward some potential solutions:

- We (public health specialists) need to clearly articulate high level principles for good governance for different NHS organisational levels, which can then be locally adapted. A good start is to encourage prevention boards at the right geographical level, with the appropriate clout
- Establish and empower new regional directors of public health
- Service models are driven by governance and performance mechanisms. At both whole community level (such as ICS) and locally, it is vital that evidence-based prevention work is mandated (and modelled) in all pathway management work the NHS does
- Leaders at a local level need to focus on public health workforce building capacity and explore undertaking joint appointments across local authorities and the NHS
- Develop or agree a shared vision for prevention across the NHS and local authorities at a local level

Questions for further consideration:

1. What is needed to enable NHS organisations and its leaders to understand better what they currently do and spend on prevention and the extent of the shift in activity and spending that may be required to make a meaningful step-change towards prevention?
2. Do these top barriers resonate with your experience of delivering prevention within or in partnership with NHS organisations? Do you have any experience of overcoming them? If so, please email policy@fph.org.uk to share your story- we'd love to hear from you!
3. What do you think are some high level principles for governance of prevention within NHS organisations?

3. The roles of the NHS in prevention

We think the NHS is currently playing five roles in prevention: leader, partner, employer, advocate, and researcher.

Our first discussion paper started to sketch out what those roles look like and asked for stakeholder feedback to challenge and refine our thinking. On the whole, stakeholders who fed back on our paper agreed that all of those roles are legitimate for the NHS to be fulfilling, but there was some disagreement over what type of activity belonged in the different 'buckets' and considerable uncertainty regarding the optimal balance of roles and responsibilities per organisation as they seek to address the prevention challenge.

We are exploring all of these roles in more detail for this project, but here we wanted to specifically draw out some of the feedback we've received about the NHS role as an advocate for prevention. This is because out of all of those five roles, the 'advocacy' one elicited not only the most feedback, but also the most diversity of opinion about what this role actually means in practice for organisations, front line staff and FPH in our role ensuring the public health workforce has the appropriate skill set.

We also think it's particularly valuable to explore this role in more depth here because when our survey asked NHS leaders to name the one thing they would like the NHS to do more of to encourage a greater focus on prevention, those surveyed were most likely to say that the NHS needed to do more national prevention advocacy.

Q: What should be the main area of focus for the NHS going forward at a local or national level to encourage a greater focus on prevention?

- National advocacy to improve the health of their local population **(28%)**
- Focus on exercise **(16%)**
- Partnership working to deliver prevention **(15%)**
- Tackle obesity **(15%)**
- Improve people's diet **(15%)**

The NHS as an advocate

We found there is widespread support for the principle that the NHS – and especially its senior leaders – should be prepared to act as an advocate for prevention at a national level and to shape national thinking towards prevention. We heard that this could take many different forms and that advocacy for prevention within an organisation or department can be just as critical as national level advocacy for policy change to improve the public's health.

But we also heard that there is considerable uncertainty over where the NHS advocacy 'boundary' extended to with regards to the wider determinants

of health and how to best reward NHS organisations when they act as prevention advocates within an individual organisation or at a national level. We also heard that the advocacy role can be very challenging for different system partners when, for example, trust priorities conflict with actions by commissioners or in the wider health and social care system. We heard from a number of people that fear of upsetting partners or having a negative impact on the organisation's reputation is a barrier to advocacy for prevention.

FPH's Specialty Registrar Committee – representing the future specialist public health workforce – highlighted this as a particular issue, writing to us that 'we need to be more able and confident to campaign for prevention at all levels.' This echoes the concerns of public health registrars Josie Murray and Nicolas Leigh-Hunt who stress that 'public health advocacy is a core skill of public health, yet it scarcely features in the [FPH] curriculum and is rarely taught directly.' With an FPH curriculum review due for later this year, this is clearly an issue that we need to explore further.

Priority areas for NHS advocacy

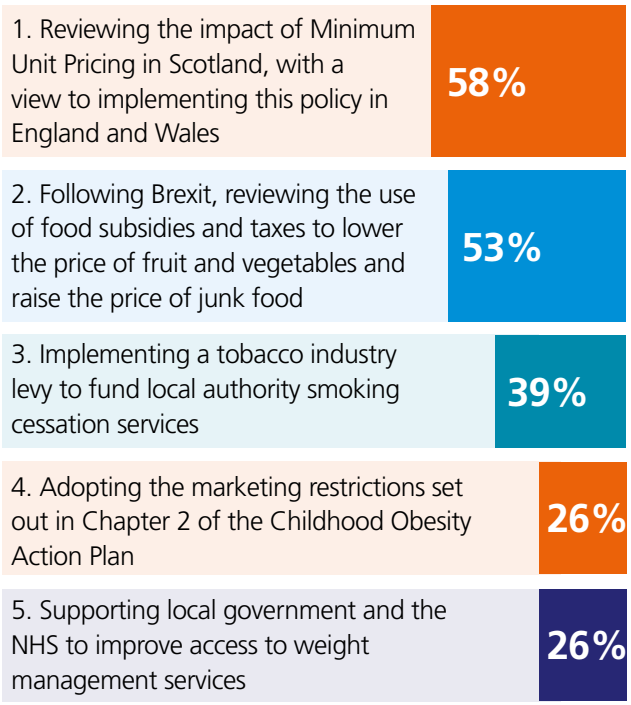
We also heard that advocacy for prevention requires clarity on priority areas of action and wider public health objectives or outcomes as well as being able to place and maintain issues on the current political agenda.

We wanted to explore with both the public health and health care communities what those priority advocacy areas might be in terms of national policy change. In our survey of NHS leaders and a separate survey of FPH members working in local government, we asked respondents to indicate which policy changes from national or local government would most benefit the health of their local population. They were all asked to choose their top five from a long-list of different 'no or low cost' tax, regulatory, or policy change measures, which covered alcohol, tobacco, drugs, and obesity and food.

This is what they told us:

From your perspective as an NHS leader, which of the following policy changes from national and/or local government do you think would most benefit the health of your local population? (Showing % selecting each in their top 5)

From your perspective as a public health leader, which of the following policy changes from national and/or local government do you think would most benefit the health of your local population? (Showing % selecting each in their top 5)



It is encouraging to see that public health and NHS leaders would prioritise four out of the same 'top five' measures, three of which pertain to tackling obesity and improving the local food environment. Both groups would also like to see an increase in funding for local authority smoking cessation services. The key difference appears to be around alcohol: FPH members were most likely to select reviewing the impact of Minimum Unit Pricing in Scotland with a view to implementing the policy in England and Wales, whereas NHS leaders failed to short-list any measure relating to alcohol and have instead focused almost entirely on action to reduce obesity and improve diets.

Regardless of those differences, we think this finding provides a strong steer as to which issues the public health community and our NHS partners in prevention should coalesce around when it comes to advocating for policy or regulatory changes at a national level to promote prevention. A targeted government focus on legislative changes aimed at improving the local food environment, encouraging better diet and physical activity, and reducing obesity may engender the most widespread support across the leadership of the entire health system.

However, it's paramount to stress that regulatory changes that address common risk factors are only one part of what is required to turn the dial positively towards prevention. Cross-sector action to improve the wider determinants of our health and wellbeing, such as housing, transport, or levels of community cohesion, is also needed.

This is especially relevant as we look towards the Prevention Green Paper and try to be even more effective advocates for prevention.

Question for further consideration:

1. What do you think the NHS role as an advocate for prevention is comprised of at a national and local level?

4. FPH and the NHS Long Term Plan

This project has been developing against the backdrop of the consultation around and subsequent publication of the NHS Long Term Plan in England. FPH – as the training and standard setting body for the public health workforce and the voice of the specialist public health community - has a distinct role in supporting the prevention and population health aspirations that run throughout the Plan.

Much of the internal stakeholder feedback that this project has received has been about how FPH in our role can best support the Plan's aspirations during this time of change for us as an organisation and also for the NHS and the wider prevention agenda. FPH's Health Services Committee (HSC) has been leading our developing thinking on this, drawing together what the healthcare public health workforce thinks about the prevention, service models, workforce, and data analysis aspirations outlined in the Plan. Their views were also informed by FPH's Health Improvement Committee and attendees at our April 2019 workshop.

To briefly summarise, while we warmly welcome the prevention and population health aspirations of the Plan, we also think this represents a major challenge to the system that requires expert public health skills at every level and at the front line of healthcare delivery. You can read the HSC's response in full here.

Initial thoughts on what FPH can do

We think it's vital that FPH's upcoming strategy and training curriculum review embed healthcare public health as part of the core of what specialists in public health do. A part of this is ensuring that trainees have adequate opportunities to train within diverse NHS organisations. We've heard that public health input into acute settings varies widely from locality to locality and our trainees have identified this as a critical gap in registrar training.

This isn't just about FPH trying to increase the footprint of the core public health workforce – although that would be welcome. This is also about ensuring that clinicians in other specialties, such as general practice, have the public health skills they need to help deliver the prevention agenda. To move the dial on this positively, FPH could push for a review of public health skills in clinical practice. We can also push for a more systematic training programme for senior clinical leaders to include public health specialists as both participants and contributors.

We also heard that FPH needs to play a greater role in championing public health intelligence and the role of the analyst. As part of FPH's core remit is to develop career structures for the workforce, FPH needs to consider how we can help make these kinds of intelligence roles more attractive in the short, medium, and long-term. We also heard that FPH needs to bring the expertise of our many members who are also Caldicott Guardians to bear to address

future information governance challenges that the NHS new service models will face.

We also heard that there is a wider public health workforce shortage that will need to be addressed. This confirms the findings from an FPH membership survey (2017), which revealed considerable reductions in the employed public health specialist workforce in England since the 2013 reforms. This means that FPH needs to advocate not only for increased investment for public health expertise in healthcare and population health, but for public health expertise across all the domains of public health practice. This means all 'workforce levers' within FPH – our Workforce strategy, our Education Committee, our expert external assessor role, and our oversight of the Advisory Appointment Committees – need to come together to address the workforce shortage.

Question for further consideration:

1. What are the 1-2 issues that you think FPH needs to focus on to support the implementation of the NHS Long Term Plan and support NHS prevention aspirations across the UK?

Concluding remarks and next steps

This paper explores some of the main issues and themes that have emerged from our extended consultation with the specialist public health and NHS communities about NHS prevention at what is a transformative time for the NHS, the prevention agenda, and for FPH as an organisation. It has been shaped by the concerns of FPH members and the feedback we have received from them, and from partner organisations, as this project has progressed.

The paper deliberately doesn't try to provide all of the solutions to the complex challenges that it addresses. Instead, it poses a series of questions that we think need to be answered in order to progress our understanding of NHS prevention and move the conversation forward in a way that is helpful to FPH members and others working within or in partnership with the NHS.

FPH will be using this paper to continue to engage with our members and partners about what they think a prevention-led NHS looks like and can aspire to achieve. To help the discussion along even further we will also be publishing a series of blogs on the FPH blogsite over the coming weeks and months. You can read them by visiting https://betterhealthforall.org/

We would like to thank you for taking the time to engage with our paper and larger project. Please do send us any and all feedback on the questions we pose here or the issues that we've raised by emailing policy@fph.org.uk or visiting our website.

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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.