The NHS's role in the public's health

A report from the NHS Future Forum

Workstream members

- **Vicky Bailey - Chair, NHS's role in the public's health group**
  Chief Operating Officer, Principia Rushcliffe Clinical Commissioning Group
- **Ash Soni - Chair, NHS's role in the public's health group**
  Community Pharmacist; Clinical Network Lead, NHS Lambeth
- **Dr Charles Alessi**
  Senior GP Partner, The Churchill Practice
- **Dr Frank Atherton**
  President, Association of Directors of Public Health; Director of Public Health, North Lancashire Cluster
- **Ratna Dutt**
  Chief Executive, Race Equality Foundation
- **Paul Farmer**
  Chief Executive, Mind
- **Moira Gibb**
  Chief Executive, London Borough of Camden; Chair, Social Work Task Force
- **Chris Long**
  Chief Executive, Humber Cluster
- **Claire Marshall**
  Head of Professions, Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- **Dr Tim Riley**
  Chief Executive, Wellstate Group Ltd
- **Tom Riordan**
  Chief Executive, Leeds City Council
- **Dr Robina Shah**
  Chair, Stockport NHS Foundation Trust
- **Professor Jimmy Steele**
  Head of School and Professor of Oral Health Services Research, School of Dental Sciences, Newcastle University
- **Gill Walton**
  Director of Midwifery, Portsmouth Hospitals NHS Trust

Contents

Foreword

It has been a privilege to be the co-chairs of this workstream, and to hear about people's commitment to the NHS and its essential role in improving the public's health. The rise in preventable illness and the persistence of health inequalities are amongst the greatest challenges that the health system faces, and we have been struck by the vast number of people who took the time to share their views with us.

These are truly national issues, so we wanted to hear from as many people as possible. We travelled from Cornwall to Newcastle, from Manchester to Portsmouth, and a number of places in between. We listened to patients and the public, public health and other healthcare professionals, local government, the voluntary and community sector, and many more. On behalf of our workstream, and the wider NHS Future Forum, we would like to thank everyone who came to meet us and wrote in with comments and suggestions.

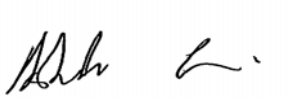
Everywhere we went, we saw excellent examples of NHS and partner organisations working in new and innovative ways to improve their communities' health and reduce health inequalities. We saw that these initiatives are typically driven by highly committed individuals and that system-wide action is needed to embed them into the structure of the NHS, so that preventing poor health becomes the "norm" for NHS business.

We also heard that it can be difficult to spread this good practice to new areas, because people say that their area is "too different" or, occasionally, because "it wasn't invented here". This told us of the importance of the NHS getting better at learning from itself and others. There isn't the time or resource to keep reinventing the wheel; the NHS must look to what is already shown to work well and tailor it to their own population's needs.

Fundamentally, it was clear early on that the places where the NHS is working most effectively to improve the public's health share a common ethos: partnership. The NHS can achieve the best for patients and the public if it works in partnership with them and with other local services, including local government and voluntary and community organisations. It was also quickly apparent that improving the public's health is about more than supporting someone's medical needs. Health and wellbeing depend on a large number of factors, and some of the most effective initiatives we heard about – especially in mental health – took a holistic and creative approach to the basic question: how to help someone to feel well and stay well.

Our report focuses on some key themes: supporting the NHS to use every contact with patients and the public to help them maintain and improve their health, including those already living with a condition; helping the NHS workforce to improve their own health and act as role models for their patients and communities;

and embedding the prevention of poor health and promotion of healthy living into the NHS's day-to-day business. We have recommended actions for the Government, NHS and others, which we believe, from what we have heard, could really make a difference. However, we know that ultimately this cannot be left to the heroic efforts of a few passionate individuals. We therefore urge leaders at all levels and in all sectors to commit to support individuals and the NHS to improve the public's health and reduce health inequalities.



Ash Soni

Chair, NHS's role in the public's health
Community Pharmacist;
Clinical Network Lead, NHS Lambeth

Vicky Bailey

Chair, NHS's role in the public's health
Chief Operating Officer,
Principia Rushcliffe Clinical Commissioning Group

Terms used in this report	
Healthcare professionals	Any healthcare professional employed by, or working as a partner in, an organisation contracted to provide NHS-funded care, who has contact with members of the public.
Professional bodies	Professional regulators, royal colleges, specialist societies and associations, and other professional representative bodies.
Providers of NHS-funded care	All organisations contracted to provide NHS-funded care, including private, voluntary and community sector organisations.
NHS commissioners	Clinical commissioning groups and the NHS Commissioning Board in its commissioning capacity.

Summary

We have heard that people expect the NHS to do more than treat them when they are ill; it must also help them to stay well. Everyone has a responsibility for their own health, but the NHS is also responsible for helping people to improve their health and wellbeing. The NHS's role in preventing poor health and promoting healthy living is essential to reduce health inequalities and sustain the NHS for future generations.

Millions of people come into contact with the NHS every day, and we believe that every contact must count as an opportunity to maintain and, where possible, improve their mental and physical health and wellbeing. Our recommendations reflect some of the changes needed at all levels to reach an NHS where every contact counts. A summary of key recommendations is below, and the full set of recommendations is set out in the rest of this report.

Healthcare professionals making every contact count

1. Every healthcare professional should "make every contact count": use every contact with an individual to maintain or improve their mental and physical health and wellbeing where possible, whatever their specialty or the purpose of the contact. To emphasise the importance of this responsibility, the Secretary of State should seek to include it in the NHS Constitution.

2. Health Education England, Public Health England and the NHS Commissioning Board should build a coalition with professional bodies to agree a programme of action for making every contact count. Key features should include:

   a. Professional bodies promoting this broader role to their members and the public, and issuing guidance about the responsibilities it entails;

   b. Managers identifying where healthcare professionals' skills and knowledge for making every contact count need development and working with public health and education and training partners to support this;

   c. The NHS Leadership Academy demonstrating to leaders that supporting staff to make every contact count is a key part of their role.

Improving the health and wellbeing of the NHS workforce

3. In partnership with their staff, NHS organisations and their delivery partners should design and implement a strategy for improving staff mental and physical health and wellbeing. They should report annually on their progress against this strategy and hold their chief executive, or other senior responsible officer or partner, to account against it. Key features of this strategy should include:

   a. Implementing the recommendations of the Boorman review of NHS health and wellbeing and using NICE public health guidance and the Public Health

Responsibility Deal pledges to guide how they support their staff;

b. Developing managers and leaders to support staff mental and physical health and wellbeing, and holding managers and leaders to account for doing so in their performance appraisals.

Refocusing the NHS towards prevention and promotion

3. All providers of NHS-funded care should build the prevention of poor health and promotion of healthy living into their day-to-day business, and be recognised for achieving excellence.

4. NHS commissioners should ensure that providers of NHS-funded care redesign their business in this way, using contracts and incentives to encourage providers to improve health and wellbeing and reduce health inequalities, and working with public health commissioners and providers to design interventions into NHS care pathways that achieve these outcomes. To support clinical commissioning groups to do this:

   a. The NHS Commissioning Board, with support from Public Health England and the Department of Health, should provide them with guidance;

   b. The NHS Commissioning Board, Public Health England and the Local Government Association should jointly publish arrangements showing how, from April 2013, the Board will access national and local public health advice; emerging clinical commissioning groups and local authorities should put in place transparent arrangements showing how, from April 2013, clinical commissioning groups will access local public health advice.

   c. The national and local outcomes and priorities for NHS commissioners should encourage them to work in partnership with the public health system to improve health and wellbeing and reduce health inequalities, underpinned by NICE quality standards or other accredited evidence. In particular, the outcomes frameworks should be aligned, with further shared outcomes across the NHS and public health system.

Building partnerships outside the NHS

5. NHS commissioners and providers of NHS-funded care should use partnerships with other local services to improve the health and wellbeing of communities that the NHS locally finds difficult to reach, providing training where appropriate.

Sharing learning and best practice

6. Healthcare professionals, NHS commissioners and providers of NHS-funded care should share learning about improving the public's health and wellbeing and reducing health inequalities, and seek to learn from others. Public Health England should ensure that evidence and best practice are spread across the NHS, and we recommend that a top priority should be evidence about improving the health and wellbeing of children and young people.

Introduction

The NHS Future Forum was asked how to keep the public's health at the heart of the NHS, following the Government's reforms. A key question was what the NHS can do to improve the health of individuals and communities and reduce health inequalities.

We have seen how this topic motivates and concerns many. We have listened to thousands of people involved in designing, planning, delivering and receiving healthcare and other local services. We have seen examples of NHS, local government and voluntary and community sector organisations working innovatively to improve health and wellbeing. We have heard support for the Government's public health reforms as well as strong agreement from all quarters that improving people's health and wellbeing must remain at the heart of the NHS – and that this is the only way that we can address the unacceptable health inequalities that persist in our country.

On average, people living in the poorest neighbourhoods in England die seven years earlier than people living in the richest neighbourhoods, and spend 17 more years living with a disability. We know that the causes of health inequalities are complex and cannot be fixed by the NHS alone. As Sir Michael Marmot has described, they go far beyond medical issues:

> "The Commission on Social Determinants of Health concluded that social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources. These social and economic inequalities underpin the determinants of health: the range of interacting factors that shape health and well-being. These include: material circumstances, the social environment, psychosocial factors, behaviours, and biological factors. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, gender, ethnicity and race. All these influences are affected by the socio-political and cultural and social context in which they sit… [A]ction is required across all these social determinants of health and needs to involve all central and local government departments as well as the third and private sectors. Action taken by the Department of Health and the NHS alone will not reduce health inequalities."[1]

Further, there is a lot that everyone could do to make a difference, starting with our own and our families' health. The NHS Constitution recognises that the decisions we make every day can have a significant impact on our health and wellbeing, and that we should take personal responsibility. This is not always easy, and the range of factors that determine how healthy we are mean that some changes can be difficult to make. When faced with conflicting messages from multiple sources, some may need support from professionals to help them take the best care of themselves and

[1] *Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010* (Feb 2010); http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

their families. People trust the NHS and those who work in it. They expect it to not only treat them when they are ill, but also help them stay well and give them messages about healthy living. The NHS has a responsibility to support individuals, their carers and family to think and act more healthily wherever possible, and guide them to any further help they might need – especially those who can find it difficult to access NHS services, such as the homeless, Gypsies and Travellers, and Roma communities.

In particular, the evidence suggests that the NHS can make considerable progress towards reducing health inequalities if it focuses energy on the health and wellbeing of children and young people, regardless of their background and geographical location – especially in the early years, when behaviours and patterns of mental and physical health can be set for future life.

By supporting people to live more healthily, the NHS not only helps the people it was created to serve; it also helps to preserve itself for future generations. Diabetes provides an example of the difference this could make. Around 10% of the NHS budget is spent on diabetes and the complications that arise from it, yet the risk of developing type two diabetes could be reduced by up to 80% by adopting a healthier lifestyle. Over its lifetime, the NHS has become an effective service for the treatment of illness. If it is to remain successful for another 60 years, it will need a cultural change towards the prevention of poor health.

This change does not need to take years. There are many small steps that everyone involved in the NHS can take to make a big difference to the health and wellbeing of the people with whom they meet and work.

This report begins by reflecting a compelling vision shared with us of an NHS that makes every contact with the public count towards improving the public's health and reducing health inequalities. It then considers some of the key steps that we have heard are needed, and makes recommendations for the NHS and others.

A shared vision: “Make every contact count”

Millions of people talk with a member of NHS staff every day, spanning a diverse range of professions: from doctors and nurses to pharmacists and midwives, from optometrists and dentists to physiotherapists and health visitors – and far beyond. Each day, GPs and practice nurses see over 800,000 people and dentists see over 250,000 NHS patients. There are 31,000 NHS sight tests, while approximately 1.6 million people visit a pharmacy. We can encounter healthcare professionals in our schools, at home and in practices, surgeries and hospitals. Outreach activities by many also means we can meet the NHS in less traditional locations: on high streets, at sports grounds and at supermarkets.

There are millions of opportunities every day for the NHS to help to improve people’s health and wellbeing and reduce health inequalities, but to take this opportunity it needs a different view of how to use its contacts with the public. A routine dental check-up or eye test, for example, is a chance to offer advice to help someone stop smoking. A visit from a midwife or health visitor is an opportunity to talk about a new parent’s anxieties and consider options for accessing mental health support. Collecting medication from a pharmacy is a chance to offer someone help with cutting down on alcohol. A pre-surgery check-up is an opportunity to talk over concerns about smoking, diet and physical activity.

We heard of some excellent examples where this is already happening, but also that it is not routine and does not happen everywhere. We therefore considered what needs to change for every contact to count:-

- At an individual level, healthcare professionals must change how they use their time. They must understand that this is a part of their job, and be supported to have the skills and knowledge they need to make every contact count. They should also be able to look to clinical leadership for strong direction about how to make every contact count.

- If we expect healthcare professionals to make every contact count, we have a responsibility to support the 1.4 million members of the NHS workforce to become healthier too.

- The whole system must align itself towards the prevention of poor health. Providers of NHS-funded care must build the prevention of poor health and promotion of healthy living into their day-to-day business. NHS commissioners must encourage providers to do this through contracts, payment, incentives and pathway design, and the priorities set for commissioners must reflect this responsibility. Commissioners and providers must build partnerships with non-NHS services to reach people who do not often come into the NHS.

- Professionals, providers and commissioners are already doing much of this, but it is not spreading across boundaries. The NHS also needs a way to share learning and reproduce good practice.

The rest of this report considers these changes in more detail.

Healthcare professionals

We have heard clearly that the starting point for making every contact count must be for healthcare professionals to reassess how they use their time with the public. A number of factors and priorities influence the content of an NHS appointment or consultation, but it is ultimately the responsibility of each healthcare professional to decide how they use their time. Simply put, they should aim with every contact to offer advice and support to maintain or improve a person's mental and physical health and wellbeing, which might mean looking outside their initial symptom or concern. This was a clear message in our engagement, and the public expects it.

We have heard about some excellent examples where this is already happening across many different types of professions – for instance, in dental practices.

Case study: Windsor Dental Practice, Salford

The Windsor Dental Practice in Salford serves quite a young population, with many students as well as a large proportion of younger people from low income backgrounds. Their dental needs are relatively high, so they have regular contact with the dental team but often little contact with the rest of the NHS.

Working with local commissioners, the practice started taking on smoking cessation services some years ago. The programme's success, combined with the patient demographic, led the practice to take on other important health roles.

Sexual health screening services may not seem the obvious thing to do in a dental practice, but by building up trust through BMI and blood pressure checks, the practice has been able to provide a very successful chlamydia screening service to under 25 year olds with little contact with the NHS: the population where the need is greatest. Screening samples are collected in the practice under the supervision of dental nurses and are then forwarded to the test lab, with GP services following up.

Recommendations:

Every healthcare professional should "make every contact count": use every contact with an individual to maintain or improve their mental and physical health and wellbeing where possible, in particular targeting the four main lifestyle risk factors: diet, physical activity, alcohol and tobacco – whatever their specialty or the purpose of the contact. To support this:

- **The Secretary of State for Health should seek to include this responsibility in the NHS Constitution; and**

- **Managers of healthcare professionals should use the appraisal process to incentivise them to do this.**

Education and training for healthcare professionals

Shared identity

We have heard concerns that rigid professional boundaries could mean healthcare professionals feel unable to identify or address a health need that falls outside their specialty. These boundaries could also deter the public from raising a health concern with a professional, fearing it might be the wrong place for it. We heard from groups such as dentists, optometrists and pharmacists that their own understanding of their roles, and how they are perceived by the public, must broaden so that contacts are used for more than eye care, dental and medication needs.

We therefore believe that healthcare professionals should recognise themselves as responsible for improving people's mental and physical health and wellbeing, whatever their specialty. This broad identity must be owned and shared by professionals and promoted by them to the public. It must encompass the broad range of professions, to take advantage of the NHS's diverse workforce. We heard, for instance, that surgeons, health visitors, dental nurses, practice nurses, pharmacy staff and many others are enthusiastic about broader health and wellbeing responsibilities.

Case study: Healthy Living Pharmacies

NHS Portsmouth has taken an innovative approach to the role of pharmacies in the health and wellbeing of their communities. The PCT has developed and implemented the Healthy Living Pharmacy framework, which aims to reduce health inequalities and prevent poor health by using pharmacy staff to promote healthy living, provide wellbeing advice and services, and support people to self-care and manage long-term conditions.

Pharmacies awarded the Healthy Living Pharmacy quality mark are places where their local community's health and wellbeing is at the heart of everything the team does. They promote a healthy living ethos and deliver high quality public health services, including smoking, weight loss, contraception and sexual health, and advice on alcohol. The whole pharmacy team is involved: each pharmacy has a Healthy Living Champion (with a Royal Society of Public Health qualification), who keeps up to date with community health services and spreads this knowledge throughout the team.

The programme has seen significant improvements in local health outcomes – for instance, more then doubling the number of local people who quit smoking between April and September 2010 compared with that period in 2009. The programme is

now being adopted by 20 pathfinder pharmacies across the country.

The education and training that healthcare professionals receive both before they qualify and throughout their careers needs to embed and reinforce this broad identity, whilst the professional bodies should lead the way in promoting this new understanding to their members and the public – for example, through their communications and promotional activities.

Skills and knowledge

We have heard clearly that making every contact count will require a range of skills and knowledge, and whilst some healthcare professionals have considerable expertise, others may need more support.

Many told us that healthcare professionals are experts in their fields, but may need further education and training so that they feel confident in other health areas, such as nutrition and obesity, or the signs of unhealthy stress or anxiety. We heard how universal training in child safeguarding or patient safety could provide good models for NHS public health training.

We also heard that some healthcare professionals may need support to strengthen their communication skills, so they can engage with individuals and communities to understand the attitudes and behaviours that underpin their health and the influence of factors like family and culture. This will be essential if the NHS is to support people to make healthy changes and ultimately reduce health inequalities.

Finally, we have heard that some healthcare professionals may need training to spot where an individual might be better supported by a different service in health, social care or the wider public service system, and know how to help people access it. We were encouraged by examples of professionals already joining up with partners in other services to make sure that this happens – for instance, in maternity care.

Case study: Acorn Team, Newham University Hospital NHS Trust

Contact with midwives offers an ideal opportunity to influence not only a pregnant woman's health and wellbeing, but also that of her partner and family, both during pregnancy and long after their need for maternity services ends. Along the maternity pathway, midwives assess a woman and her family's health and wellbeing needs, and work with other healthcare professionals and third party providers to guide them to further support and information.

Newham University Hospital NHS Trust found a gap in their maternity service and approached commissioners to fund a new post leading on care for vulnerable women. This has led to the creation of the Acorn Team, which provides midwifery care for women with complex social needs, including those who have experienced domestic abuse or substance misuse, refugees and asylum seekers. The team works closely with other services to identify further needs, such as the perinatal mental

health team, early years intervention service, and children and young people's service. These agencies all plan care together and signpost and support women and their families to access help from other agencies, like domestic violence support teams.

However, we also heard that many teams lack these links across services, so healthcare professionals are unaware of some important services lying outside their specialty. There was particularly strong agreement amongst those involved in non-health services that the NHS is often too medically-focussed, and does not look as a matter of course to services outside the NHS – for instance, a Citizens Advice Bureau offering debt advice as a way to improve someone's depression or anxiety.

Therefore, managers should work with their staff and public health experts to identify where skills and knowledge need development to ensure that healthcare professionals can make every contact count, and work with others to address these gaps. Education and training providers can deliver much of the skills and understanding that professionals need, whilst the local voluntary and community sector's deep understanding of local communities should be harnessed. Further, health and wellbeing boards offer a forum where knowledge of all relevant local services can be brought together in one place.

Recommendations:

The system of education and training should ensure that all healthcare professionals understand their broader role in making every contact count and are equipped with the skills and understanding needed to do so. To support the system to do this:

- **Health Education England, Public Health England and the NHS Commissioning Board should build a coalition with professional bodies to promote this broader role to healthcare professionals and the wider public, and professional bodies should issue guidance to their members about the responsibilities this role entails for improving population health and wellbeing;**

- **Managers of healthcare professionals should:**
  - **put in place a way to identify gaps in, and opportunities to enhance, the skills and knowledge healthcare professionals need to carry out this broader role; and**
  - **work in partnership with public health experts, education and training providers, health and wellbeing boards and other local services to fill these gaps with education, training and information sharing.**

NHS leadership

We heard from many that clear and consistent messages from clinical leaders about the role of every healthcare professional in improving the public's health and wellbeing and reducing health inequalities will help motivate healthcare professionals to make every contact count.

We therefore feel that NHS clinical leadership should take responsibility for driving forward the move to a culture where every contact counts. Clinical leaders should send clear messages to healthcare professionals about their responsibility for improving the health of the wider public, including through the care they provide and how they look after their own health and wellbeing. A shared starting point for NHS leaders will give professionals a focus to rally around – smoking, for instance, as the single biggest cause of premature death.

Recommendations:

NHS clinical leadership should provide national momentum and focus for healthcare professionals to make every contact count. To support this:

- **The coalition referred to above should agree a programme of action for making every contact count. We recommend focusing initially on making every contact count to contribute to the national ambitions in the tobacco control plan for England;[2]**

- **The NHS Leadership Academy should demonstrate to leaders at all levels that, if they are to improve service quality, as set out in the NHS leadership framework, they should support their staff to make every contact count.**

The health and wellbeing of NHS staff

A very strong message from our engagement is that, if we expect healthcare professionals to improve the health and wellbeing of the people they meet in the course of their work, the NHS must first "put its own house in order".

Many emphasised that the NHS has the opportunity to improve the mental and physical health and wellbeing of a workforce of 1.4 million people, who could in turn support their families and friends to make changes for better health and wellbeing. We further heard from patients and the public that it is harder to accept messages from the NHS if it is clear they do not follow these messages for their own health. By supporting the health and wellbeing of its staff, the NHS should see that they in turn will act as advocates both for their patients and in their own communities. Given the

[2] *Healthy lives, healthy people: a tobacco control plan for England* (March 2011); http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917

diversity of the NHS workforce across a range of cultural and social backgrounds, this could make a big impact on health inequalities.

Many told us that supporting staff to improve their health and wellbeing should be a core principle of every NHS organisation – including commissioners and providers of NHS-funded care (not only acute trusts, but also private and voluntary and community sector organisations, primary care practices, mental health services, pharmacies and others). Where appropriate, this should also extend to the organisations that they contract with to supply goods and services.

In the NHS Constitution, the NHS commits to providing support and opportunities for staff to maintain their health, wellbeing and safety, including their mental health. We were encouraged to hear of NHS organisations already supporting the health and wellbeing of their staff – for instance, at The Walton Centre NHS Foundation Trust in Merseyside:

Case study: Work Well the Walton Way

The Walton Centre NHS Foundation Trust, a specialist neuroscience trust, employs roughly 950 staff. The trust developed a local strategy for improving staff health and wellbeing, "Work Well the Walton Way". They asked staff how they wanted support with issues like obesity, smoking, physical exercise and staff engagement, and fed their views into an action plan. This led to initiatives on the ground including virtual health and wellbeing champions in every ward and department, onsite zumba, table tennis and pilates, an in-house weight management course, a cycle scheme, a running club, and staff counselling.

The trust has maintained communications and engagement with staff throughout, holding regular staff summits with the executive team so that the staff have an opportunity to feed back and ask questions.

Since introducing the strategy, the trust has seen staff sickness fall from over 7% in January 2010 to less than 4% now. Staff feedback has been positive, and staff survey results have shown more positive attitudes to health and wellbeing and job satisfaction.

However, we also heard that the NHS has a long way to go before this is standard across the system. In particular, we heard that some organisations do not work with their staff to ensure that initiatives are designed around their needs. We also heard that the quality of occupational health services for NHS staff is variable, and that all occupational health services for the NHS should seek accreditation.

National recommendations and programmes can help organisations to know where to start with improving staff health and wellbeing. For instance, there is strong support for the recommendations in the Boorman review of NHS health and

wellbeing[3], yet many organisations have not fully implemented them. NICE public health guidance and the Public Health Responsibility Deal pledges also show how organisations can improve health around diet, alcohol, physical activity and health at work, which could be used to support improved staff health; we therefore feel that more NHS organisations signing up to the Responsibility Deal could be helpful.

We have heard that progress will only be made if NHS leaders are accountable for helping to improve the health and wellbeing of their staff. Rates of staff sickness absence, the number of staff successfully using wellness services (such as the number of staff who have joined a smoking cessation service and their quit rate), and the number of eligible staff immunised against flu could all provide a good indication of progress. However, we were also told that the impact NHS leaders can have is dependent on the input and commitment of their staff, and we would encourage the workforce to acknowledge their own responsibility and take advantage of opportunities to improve their health.

We therefore feel that all employers of NHS staff should act to improve their staff's health and wellbeing, led by accountable leadership in partnership with staff.

Recommendations:

NHS organisations and their delivery partners should take action to improve their staff's health and wellbeing. To support this:

- **We would encourage them to design and implement, in partnership with their staff, a strategy for improving staff mental and physical health and wellbeing. Their board, or other governing body, should hold their chief executive, or other senior responsible officer or partner, to account against this strategy and report annually on their progress;**

- **They should implement the recommendations of the Boorman review of NHS health and wellbeing and use NICE public health guidance and the Public Health Responsibility Deal pledges to guide how they support their staff;**

- **They should train managers and leaders to support the mental and physical health and wellbeing of their staff and use the appraisal process to incentivise them to do so.**

Providers of NHS-funded care

As well as looking after their staff, we have heard that providers of NHS-funded care can encourage healthcare professionals to make every contact count by incorporating the prevention of poor health and promotion of healthy living into

[3] *NHS Health and Well-being* (November 2009); http://www.nhshealthandwellbeing.org/FinalReport.html

their every day business. It should be at the heart of the services they deliver, the environment they work in and the culture they share.

We have heard how providers of NHS-funded care can integrate prevention and promotion into the care they provide on their premises, as well as the way they work with their communities. When a person attends hospital, for instance, they should be in a safe environment, and not at risk of additional illness or injury. The organisation's information systems should ensure that any healthcare professional who views a person's records can identify health risks to follow up on, such as a missed screening appointment. Further, providers should seek to co-produce health initiatives in partnership with local communities and minimise their premises' impact on their local environment. We have seen how these principles underlie health promoting hospitals, which are currently being piloted at sites across the country and provide a model that other providers could follow.

Case study: Health Promoting Hospitals Network

'Health Promoting Hospitals' is a concept for hospital development that builds on the WHO Ottawa Charter for Health Promotion[4], which sees the reorientation of healthcare services as a major action area for health improvement. It is an international movement, which focuses on the hospital as a health promoting setting and workplace, provider of health-related service, training, education and research, and advocate and change agent for health promotion in the community and local environment.

Members of the Health Promoting Hospitals network aim to integrate health promotion within all relevant decision-making processes. They use tools including organisational structures and strategies, objectives and action plans, indicators and metrics, and staff education and training to embed health promotion into their everyday business, including the services they deliver, the support they give staff, and their impact on communities and the environment.

There are over 50 members of the pilot Health Promoting Hospitals network in England, already undertaking activities to help improve the wellbeing of their communities and reduce health inequalities. The Royal Free Hampstead NHS Trust is one of the members that has implemented a raft of programmes and policies aimed at improving and protecting the health of its local community. For instance, alcohol-linked violence is a common cause of admission to the trust's accident and emergency department. To help reduce injuries caused by violent assault, the trust collects information from people presenting with these injuries and shares anonymised data with the police. This has improved links between the trust and domestic violence services and informed licensing decisions, police investigations and police resourcing.

We therefore believe that every provider of NHS-funded care should take steps to integrate prevention and promotion into their relationships with those receiving

[4] http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

their services, visitors to their premises, and the community and environment around them. We believe that this would be helped if providers of NHS-funded care implement a strategy for achieving it and hold their chief executive, or other senior responsible officer or partner, to account for its impact. We also feel that recognising achievement in prevention and promotion would be important to drive innovation, and the NHS Institute for Innovation and Improvement (and any body taking on its relevant functions from April 2013) could have a key role in this.

Recommendations:

Providers of NHS-funded care should build the prevention of poor health and promotion of healthy living into their day-to-day business, to help healthcare professionals make every contact count. To support this:

- **We would invite the NHS Institute for Innovation and Improvement to explore how to use a national award scheme to recognise excellence and innovation in the prevention of poor health and promotion of healthy living by providers of NHS-funded care, including small and voluntary and community sector providers.**

NHS commissioners

Incentives for providers of NHS-funded care

Many told us that, if providers of NHS-funded care are to focus more on the prevention of poor health and promotion of healthy living, this should be regarded as an essential component of high quality and reflected in the payments, rewards, contracts and frameworks NHS commissioners use to support improvements.

We have been encouraged, for instance, by the proposed new dental contract. Many have suggested similarly redesigning other standard contracts, such as the pharmacy contract, to focus more on providers' roles in preventing poor health as well as treating it.

Case study: Proposed new NHS dental contract

Even when it is necessary, dental treatment is irreversibly damaging to the teeth and is an expensive way to manage diseases that are, after all, preventable. The risks for decay and gum disease are the same as those for other abundant chronic conditions, such as obesity, diabetes and cardiovascular disease: diet, smoking and lifestyle. Dentists and their teams are also well trained in health and medicine in its broadest sense, and have regular contact with millions of patients who may have little other contact with health services.

Steps are now being taken to move to an integrated system, where the dental practice can make a positive contribution to the public's health. A new contractual approach to the commissioning of, and payment for, NHS oral health services is currently being piloted. It is based on:

- measuring risks and ensuring that they are addressed as a first step;
- rewarding professionals on outcomes, such as cleaner mouths, less disease and better oral health, with spin-off benefits for general health;
- incentivising clinical teams to drill and fill teeth only when disease cannot be managed in other ways;
- encouraging dentists to become involved in helping patients make other lifestyle choices not usually associated with dentistry, such as smoking cessation and reducing alcohol intake.

Harnessing the skills of the dental team as health professionals is starting to deliver positive health and lifestyle messages in practices where this approach is employed, making contacts count for many who would not often interface with the NHS in any other way.

We have also heard about some financial rewards that commissioners already use effectively as incentives for providers to prevent poor health and promote healthy living – for instance, the Commissioning for Quality and Innovation (CQUIN) payment framework.

Case study: Medway Stop Smoking Service

Medway Stop Smoking Service (MSSS) began working with Medway Maritime Hospital in 2006, aiming to support patients and hospital staff to make informed decisions about smoking and support them to quit. MSSS trained hospital staff so they could raise the subject of smoking with every patient as a standard part of their care, but saw that there was still a large gap between the number of potential referrals to MSSS and the actual referral rates.

MSSS therefore approached the local commissioner to set a CQUIN indictor for smoking cessation referrals, to give the hospital a greater incentive to carry out smoking cessation work. The indicator was introduced for 2010/11, and helped MSSS to train more staff and publicise the specific staff and patient support services.

MSSS saw referrals from the hospital rise by over a quarter between 2009/10 and 2010/11, partly due to the CQUIN indicator. Building on this success, a more ambitious indicator has been set for 2011/12.

However, we have also heard concerns that the NHS is not sufficiently exploiting some rewards.

Many have said that some incentives are not designed in a way that encourages providers to do things differently. We referred above to the complex network of factors affecting our health. We have heard that, where it is difficult to isolate a provider's impact on a health outcome from other factors, incentives linked to outcomes may not encourage providers to take action.

We have also heard that some rewards do not encourage providers to reach people who do not often come into the NHS – for instance, because they do not address the needs of unregistered patients or because they allow providers to earn maximum rewards for providing the relevant care to only a proportion of their patients. Some suggested that there should be better incentives to reach out to unregistered patients, and that there should be higher thresholds in the Quality and Outcomes Framework (QOF) so that there are stronger incentives for GP practices to ensure that all patients receive the best care.

Further, we have been told that some incentives do not sufficiently target improved population health and wellbeing. The QOF, for example, rewards GP practices for their achievements against indicators, such as keeping a register of obese patients. It does not go further and reward practices for supporting patients to eat more healthily, exercise more or access weight loss support.

We therefore feel that work is needed nationally to determine how to design payment incentives to more effectively encourage providers of NHS-funded care to improve population health outcomes linked to mental health and health risks like smoking, alcohol, diet and exercise, and reduce health inequalities. Further, NHS commissioners should reconsider how they use contracts, tariff flexibilities and other incentives locally to reflect that prevention and promotion are integral to high quality services and encourage this from all providers. This should go beyond the existing CQUIN and QOF frameworks to equally incentivise providers in other settings, such as dentists, optometrists, pharmacists and those delivering community care.

The design of NHS care pathways

We have heard that when someone is receiving NHS care, they may be particularly receptive to public health messages aimed at improving their health and wellbeing. We have learned that there is a good deal of evidence about the positive impact of incorporating appropriate public health interventions into NHS care pathways, in terms of improved health and wellbeing and reduced demand on NHS services.

Case study: Paddington Alcohol Test, St Mary's Hospital[5]

When assessing people attending the Emergency Department (ED) at St Mary's Hospital in Paddington, London, after attending to their immediate needs, medical and nursing staff apply the one-minute Paddington Alcohol Test (PAT) to those presenting with one of ten conditions often associated with alcohol misuse, such as a fall or collapse. If the PAT identifies the presenting condition was alcohol-related, feedback is given, including an information leaflet and the offer of an appointment with an Alcohol Health Worker (AHW) within 24 hours (or straight away if the patient is sober and an AHW is available).

Between 2004/5 and 2008/9, St Mary's saw an increase of over 75% in referrals to an AHW; for every two accepted referrals to an AHW there was one fewer

[5] http://alcalc.oxfordjournals.org/cgi/reprint/agp016?ijkey=HImeNEO7f6izT0F&keytype=ref

reattandance to the ED over the following year. 65% of those counselled by an AHW reduced their alcohol intake within the following six months.

We have also heard that some pathways do not start early enough or stop too soon, failing to cover the support that might help to prevent an illness developing or to enable someone living with a diagnosis to continue in optimum health and wellbeing, for instance by helping them to understand and minimise the risks of developing other illnesses as a result of their diagnosis.

We therefore believe that NHS commissioners, the public health system and providers of NHS-funded care should work together to design NHS care pathways that make the most of appropriate opportunities in the course of an individual's care for healthcare professionals to provide advice and support to help that individual maintain and, where possible, improve their mental and physical health and wellbeing.

Public health expertise

From April 2013, local authorities will be responsible for commissioning most public health programmes, supported nationally by Public Health England. The NHS Commissioning Board will also be responsible for commissioning some public health services, such as screening, on behalf of Public Health England and will need national and local public health advice to support this. But, as we said in our interim letter,[6] we have heard very strongly that public health expertise must be embedded in NHS commissioning as well. If we expect NHS pathways to improve public health and reduce health inequalities, clinical commissioning groups will need high quality local public health advice, whilst the NHS Commissioning Board will need both national and local public health advice to support its commissioning decisions and broader system-leadership role. A helpful analogy we heard was that public health expertise should be the "yeast" in the commissioning process, and not the "icing" added as an afterthought.

We have heard a range of different suggestions and opinions about ensuring that population health advice is integral to NHS commissioning. Many have reflected that locating public health experts within local authorities offers an excellent opportunity to imbue their advice with insight into the range of other services delivered by local government. They suggested that the new arrangements must provide a clear route for clinical commissioning groups to access this expertise, underpinned by obligations on local authorities. Some have told us that public health experts should have a fixed position within the NHS Commissioning Board and clinical commissioning groups, as well as in Public Health England and local authorities.

We therefore welcome the Department of Health's commitment that public health experts in local authorities will provide NHS commissioners with public health advice, but we have heard that specificity is needed about what this will look like. We are

[6] http://healthandcare.dh.gov.uk/ff-letter/

clear from what we heard that the exact arrangements for sharing population health expertise should be determined locally – but that this must happen.

Recommendations:

NHS commissioners should ensure that providers of NHS-funded care build the prevention of poor health and promotion of healthy living into their day-to-day business – in particular, relating to the four main lifestyle risk factors. To support this:

- **NHS commissioners should use contracts, payments and incentives to encourage providers to do so.**
    - **CQUIN awards and QOF indicators, for example, should reward acute providers and GP practices for improving the local population's mental and physical health and wellbeing and reducing health inequalities;**
    - **The NHS Commissioning Board and Public Health England should work together to improve the effectiveness of payment incentives in this respect, based on evidence provided by NICE or other accredited sources;**
    - **Clinical commissioning groups and providers of NHS-funded care should explore together how to use local tariff flexibilities to support providers to deliver innovative NHS care that prevents poor health and promotes healthy living;**

- **NHS commissioners, local authorities and providers of NHS-funded care should work together to design into NHS care pathways specific interventions that will prevent poor health and promote healthy living. The NHS Commissioning Board, with support from Public Health England and the Department of Health, should produce commissioning guidance to help clinical commissioning groups to do this;**

- **The chief executive of the NHS Commissioning Board Authority, chief executive designate of Public Health England and the Local Government Association should jointly publish arrangements showing how, from April 2013, they will work together to improve population health outcomes, including through the Board accessing high quality national and local public health advice;**

- **Emerging clinical commissioning groups and local authorities should put in place transparent arrangements showing how, from April 2013, they will support each other to improve local health outcomes, including through clinical commissioning groups accessing high quality local public health advice.**

NHS and public health commissioners working in partnership

Commissioning for outcomes

We have heard very strongly that, to encourage NHS commissioners to work in partnership with public health commissioners and support providers of NHS-funded care to do more for prevention and promotion, they should be held to account for the outcomes this should achieve.

The prevention of poor health and promotion of healthy living should therefore feature strongly in the NHS Commissioning Board's commissioning levers, such as the expectations that the Board sets for clinical commissioning groups in the Commissioning Outcomes Framework – based on NICE quality standards or other reliable evidence – and the guidance it issues to support high quality commissioning.

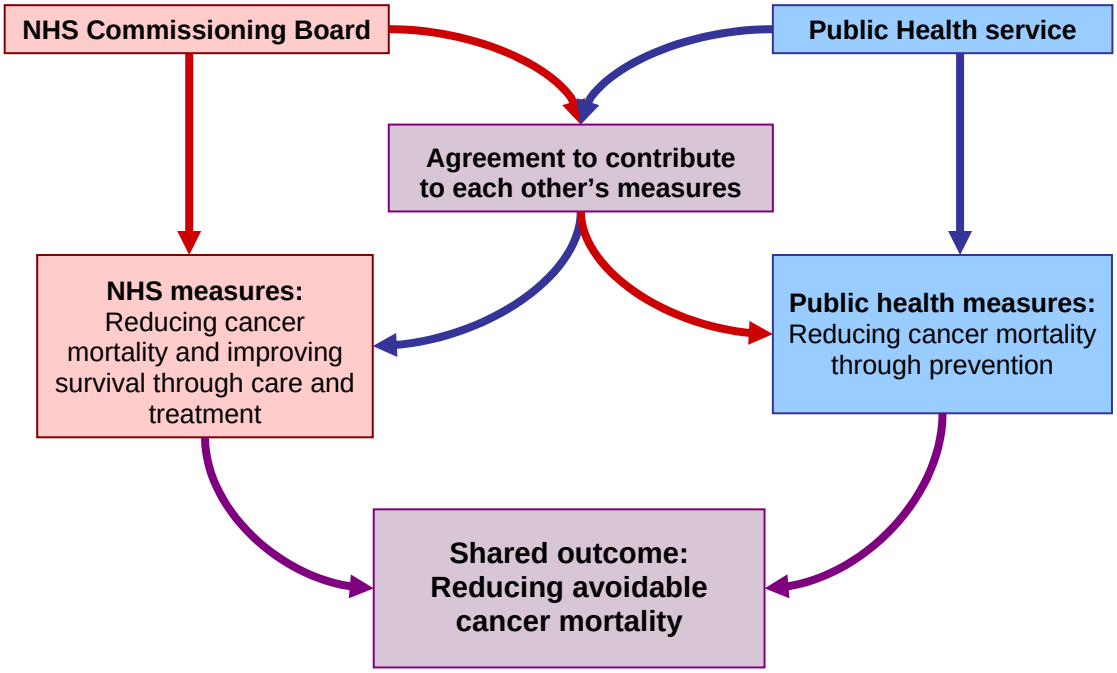
Further, as we said in our interim letter, many people told us that the outcomes frameworks issued by the Department of Health will be instrumental in encouraging the NHS and public health system to work together to design services that prevent poor health and promote healthy living. But we have heard considerable concern about the impact of separating out national expectations for the population's health and wellbeing into different frameworks for the NHS, public health and social care. The Forum's report on Integration also discusses this theme.

We are clear that a rigid distinction between the outcomes frameworks is unhelpful if it encourages the NHS to treat the prevention of poor health and promotion of healthy living as outside its legitimate business. Instead, the Secretary of State must use the frameworks to align the goals that the sectors are working towards.

We therefore feel that the increased use of shared outcomes would be particularly helpful for some health areas, where partnership working across the NHS and public health systems would lead to the biggest improvements. We welcome the Department of Health's updated NHS Outcomes Framework for 2012/13[7], which recognises the importance of sharing outcomes across the NHS, public health and social care. The update proposes a new shared indicator relating to cancer mortality, which we feel is helpful. However, we believe that the Department can do more to explore the further use of shared outcomes in other areas.

Additionally, we believe that it is important that, where shared outcomes are underpinned by separate accountability for individual measures, there is also a clear agreement about how the NHS and public health systems will contribute to each other's measures. The following diagram illustrates what this could look like in relation to cancer mortality:

[7] http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf



In this example, the NHS and public health outcomes frameworks set the same outcome for both the NHS Commissioning Board and the public health service: reducing avoidable cancer deaths. It sets separate measures that will contribute to this outcome, according to the services traditionally provided by the NHS and public health systems. But it also recognises the cross over, and requires the NHS Commissioning Board and the public health service to agree how they will work in partnership to contribute to each other's measures where relevant – for instance, how the NHS Commissioning Board will use NHS pathways and/or commissioning to help to prevent cancer developing.

Health and wellbeing boards

In addition to the commissioning outcomes set by the Secretary of State and NHS Commissioning Board, health and wellbeing boards will set out local priorities in their Joint Strategic Needs Assessment, and create a joint health and wellbeing strategy to describe how these needs will be met locally.

We have heard that this will be a key opportunity to remove artificial boundaries between what local authorities can achieve through public health programmes and what the NHS can achieve by including the prevention of poor health and promotion of healthy living in NHS care. We therefore feel that this should be taken into account when health and wellbeing boards design their joint health and wellbeing strategy.

We have also heard that health and wellbeing boards will have an important role in bringing together those who should be accountable for leading the change of culture needed across the NHS. The commissioners and experts sitting on health and wellbeing boards are equipped with the tools that can drive and help providers of NHS-funded care to change how they conduct their business. We therefore encourage them to take advantage of their health and wellbeing board as a forum

for developing joint priorities, sharing learning, discussing progress, and identifying and resolving issues about supporting the NHS to make every contact count.

Recommendations:

National and local outcomes and priorities should encourage NHS commissioners to work in partnership with the public health system to improve health and wellbeing and reduce health inequalities. In particular:

- **The NHS Commissioning Board should use its commissioning levers to ensure that clinical commissioning groups work in partnership with local authorities to prevent poor health and promote healthy living – in particular, by targeting improvements in the four main lifestyle risk factors;**

- **The Secretary of State and NHS Commissioning Board should jointly commission NICE to produce cross-cutting quality standards focused on targeting improvements in the four main lifestyle risk factors;**

- **The Secretary of State should hold the NHS Commissioning Board and the public health service to account against consistent national priorities, where appropriate. In particular, we encourage the further use of shared outcomes, underpinned by an agreement about the contribution of the NHS and the public health service to each other's outcome measures;**

- **Joint health and wellbeing strategies should reflect how NHS commissioning can contribute to meeting public health priorities through the prevention of poor health and promotion of healthy living, and the NHS Commissioning Board should use the quality reward to reward clinical commissioning groups for achieving improvements against the priorities in the strategy.**

Utilising contacts outside the NHS

When making every contact count for health improvement and the reduction of health inequalities, many told us that the NHS must also look to the interactions that take place with the public every day outside its walls.

We have heard that many communities do not frequently come into the NHS. Instead, they may be more likely to encounter people working in the voluntary and community sector, social care or other local services. For instance, we heard how approximately eight million people live in social housing in England, including many with complex health and care needs, and come into frequent contact with housing association staff.

We therefore feel that, if it is to reduce health inequalities, the NHS should create partnerships with these services, and use their interactions to identify health and wellbeing needs and deliver healthy living messages to people who do not regularly come into the NHS, or those who rely more on messages received from peers and community leaders.

We are encouraged by the Government's Inclusion Health programme, which focuses on improving the health outcomes of vulnerable groups in our society, including the homeless, Gypsies and Travellers, and sex workers. As part of our engagement, we visited services providing care for homeless men and women, and heard from many people from socially excluded groups. We heard about multiple innovative examples of successful partnerships between local communities, voluntary and community sector organisations, local government and the NHS, which could provide the NHS with a helpful model – for example, the White City Community Champions and Empowering Patients Empowering Communities projects.

Case study: White City Community Champions[8]

NHS Hammersmith and Fulham, in partnership with Well London, has developed a community health champion programme, training 40 local volunteers from the White City estate in public health.

The champions have reached over 2000 local residents, through services like exercise classes, stop smoking services, healthy eating workshops, and sexual health and diabetes programmes. They have had an enormous impact on local health and wellbeing. Of these 2000, 82% now make healthier eating choices, 85% take more exercise, and 79% both feel more positive about their life and have a better understanding of their mental wellbeing.

The programme has also improved the lives of the volunteers themselves, giving many their first qualification, and skills and experience to help them find employment. Analysis by researchers from the London School of Economics has found that almost half of the community health champions gained employment or moved into jobs that improved their and their families' income and quality of life.

Case study: Empowering Parents Empowering Communities, South London and Maudsley NHS Foundation Trust

Inner city areas experience twice the national rate of severe childhood mental health problems, but effective early intervention – particularly by parents – can lead to dramatic improvements and prevent problems in later life.

Empowering Parents and Empowering Communities was a community-based research programme, which aimed to improve childhood mental health in Southwark, London, by training 24 local parents to teach parenting skills to peers in vulnerable and minority communities.

Over 40 parenting groups were run, which were free for parents of children aged two to eleven, and over 350 local parents attended. The results showed significant improvements in children's behaviour, which can be linked to mental health problems, comparing favourably with outcomes achieved by professional therapists.

[8] http://youtu.be/B10wRThyYLM

Recommendation:

NHS commissioners and providers of NHS-funded care should use partnerships with other local services to improve the health and wellbeing of communities that the NHS locally finds difficult to reach, providing training where appropriate.

Building on what we already have

The overwhelming impression that we have taken from our engagement across the country is of the number of people already enthusiastically tackling the recommendations we set out above. The NHS can learn a lot from the experiences and outcomes of those already testing new approaches and initiatives for improving health and wellbeing. It should be looking to examples not only from within the NHS, but in other services as well.

However, we have also learnt about how hard it can be for good practice to spread to other areas. We were often told that the NHS is poor at learning from itself, leading to the waste of significant resource in unnecessarily reinventing the wheel. This is also an important theme of the NHS Chief Executive's Innovation Review, which notes that the NHS is not realising its full potential, because ideas and inventions are not always systematically and rapidly spread throughout the system.[9]

In particular, we heard from many that a significant obstacle is a common belief that what works in one setting would not translate well to another. Yet we have heard of examples where we feel this could been done, with appropriate modifications for local circumstances.

Case study: North East falls prevention

North East Ambulance Service NHS Trust (NEAS), in partnership with Newcastle Upon Tyne Hospitals NHS Foundation Trust (NUTH), designed an initiative to reduce falls in older people. The model, in operation since December 2006, engages frontline A&E ambulance crews to help identify people at risk of falling, or who have fallen. This information is then sent to the Falls and Syncope Service at NUTH – a single point of access referral service, which then decides how the falls pathway could support the individual.

The success of this initiative led the NHS partners to spread the model to all remaining eleven falls services across the North East SHA region, to roll out to other professionals likely to encounter those at risk of falling. This has over time included some primary care clinicians, district and community nurses, social workers, community housing wardens and voluntary organisations. All partners jointly delivered training to these services, modified according to locality and service differences to fit specific need.

[9] *Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS* (December 2011); http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131687.pdf

Between 2006 and 2011, NEAS has seen a drop in over 75% in 999 calls for falls. The partnership has shared process and tools with the wider falls community and ambulance trusts on a national basis, and continues to support and guide healthcare professionals in its deployment. The model has recently been shared with colleagues in London and is soon to be trailed in four London boroughs – Wandsworth, Chelsea, Westminster and Fulham – in advance of a wider roll-out.

The NHS should not only look inwards at its own good practice. Our engagement has shown us numerous examples of the voluntary and community sector and other local services working innovatively to improve health and wellbeing and reduce health inequalities.

Case study: Living Networks, Eden Project

Living Networks, which evolved from the Eden Project, has developed a range of programmes, including 'Growing for Life'. Growing for Life has led to the creation a market garden in south Devon, run by a partner organisation working in homeless services, and show gardens for the RHS Chelsea Flower show. The latter involved over 500 people from 48 homeless agencies and eight prisons growing and building a garden. It aims to be inclusive and move away from unhealthy labels like "addict" or "ex-offender".

Participants reported improvements in their health and wellbeing – for instance, through improved self-confidence and a new interest in healthy eating.

We therefore believe that, if we expect the NHS to collaboratively share and learn, we should ensure that they have the tools they need to be able to access and offer up evidence and best practice. Many people have called for national support to collect together evidence and best practice and help to spread it across the country. This should be more than a paper exercise. People often cited national support teams as an especially effective model, where nationally-coordinated teams with focus areas like health inequalities and infant mortality visited sites and recommended improvements based on evidence, including learning from other areas.

Since this learning is all about how to improve the public's health, we feel that Public Health England should take a national lead, encouraging further partnerships between the NHS and public health system, but should also engage local NHS partners.

Recommendation:

All healthcare professionals, NHS commissioners and providers of NHS-funded care should share their learning about improving the public's health and wellbeing and reducing health inequalities, and seek to learn from others. Public Health England should ensure that evidence is spread across the NHS, and we recommend that a top priority should be evidence about improving the health and wellbeing of children and young people.