



Public Health
England

The prevention and self care workshop

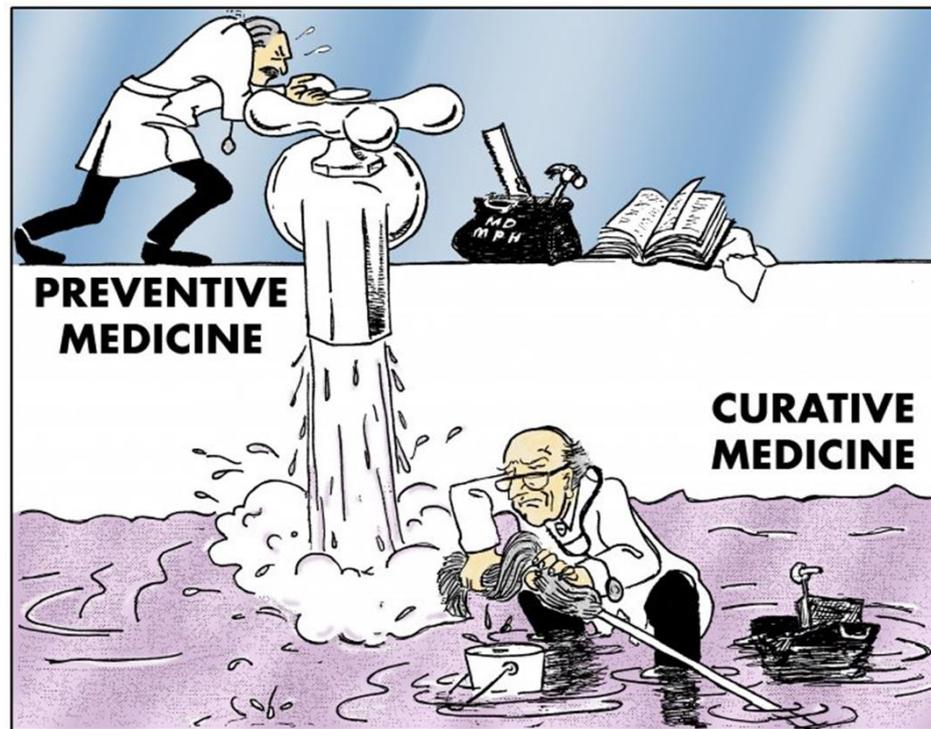
16th September 2016

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The health and wellbeing gap



If the nation **fails to get serious** about prevention then recent **progress** in healthy life expectancies will **stall**. Health **inequalities** will **widen**, and our ability to fund beneficial new treatments will be crowded-out by the need to **spend billions** of pounds on **wholly avoidable illness**.



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Overview

- Welcome and introductory remarks
- Jane Hogg, Director of Integration and Transformation, Frimley Health NHS Foundation Trust
- Sarah Scott, Director of Public Health, Gloucestershire County Council
- Discussion in smaller groups



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Sustainability and Transformation Plans: Primary delivery vehicle for **prevention** in the NHS

Health and
wellbeing gap

Healthy life
expectancies gap

Increasing burden of
preventable disease

Persistent health
inequalities

Care and quality
gap

Persistent variations in
healthcare

Integration of
prevention within care
pathways

Finance and
efficiency gap

Opportunity costs of
not having a
prevention focus

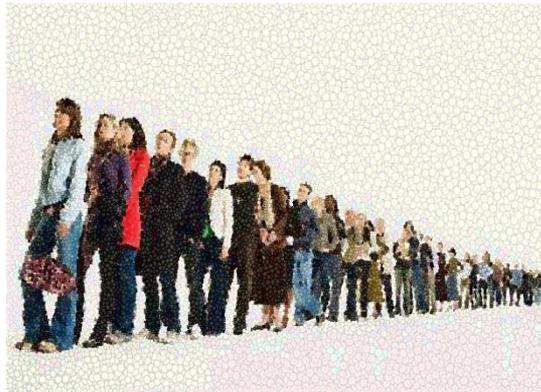
Public Health* action for addressing three gaps



Sustainability: Twin Paradigms

Managing Demand

- Increasing supply
- Waiting targets
- Service flow and efficiency
- Improving discharge
- Changing skill mix
- New models of care



Drives expectation, increases throughput, **creates demand & cost**

Extends Life Expectancy and **prolongs health and care service need**

Preventing Demand

- Improving lifestyles & tackling wider determinants of health
- Prevention services
 - Health checks
 - Screening and Immunisation
 - DPP
- Tackling variation

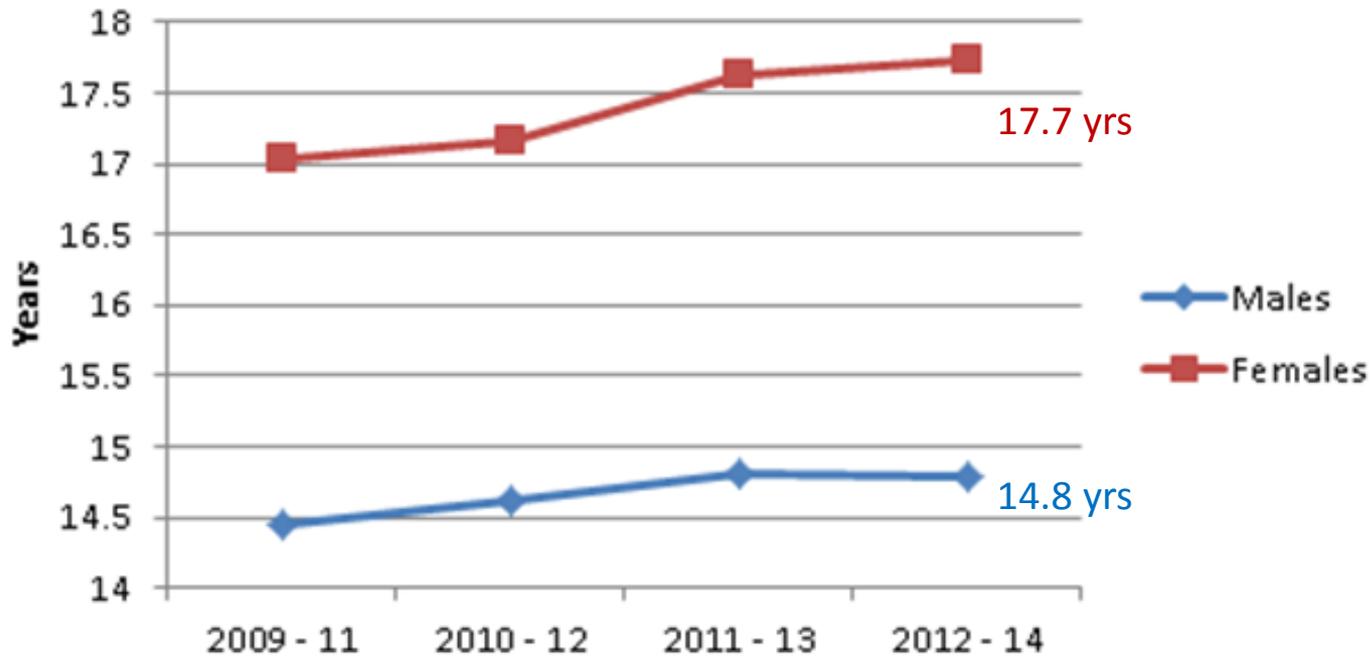
Supports empowerment, reduces throughput, **stems demand & cost**

Extends **Healthy** Life Expectancy, reduces inequalities, **delays health and care service need**



Health and wellbeing gap

Gap between Healthy Life Expectancy and Life Expectancy at birth in the South of England



How ambitious should we be for the South of England?



Effective “prevention at scale” interventions, that if implemented at scale will reduce activity - commissioned by CCGs & LAs and delivered by primary and secondary care providers

	Intervention	Description	Commissioned by
Pushing Boundaries	Alcohol Identification Brief Advice	Screen patients, c27m, at next consultation spread over five years, and GPs/nurse provide brief advice on alcohol (to 30% of c27m patients screened) who reduce consumption by c12%	CCGs
	Domestic violence	Expand 'identification & referral to improvement safety' programme in primary care to increase detection of those suffering from DV by 2%	CCGs: CCG Domestic Violence advisor (PHE contribute and co-fund)
	Sick smokers	Screen 95% patients who smoke in secondary care, refer c800k people to stop smoking services, 80% of whom take up the referral, and of these 15% (100k) patients quit long-term	CCGs: training services; NHS: electronic referral system; LAs: Local Stop Smoking Services
Reducing Variation	Alcohol Care Teams	Introduce alcohol care teams (nurses) to manage alcohol-related repeat admissions (for 27% of hospitals without one at the moment)	Joint commission: CCGs & LAs
	Hypertension	Improve management of hypertensives for 1m of c2.5m currently 'uncontrolled', reducing likelihood of stroke, heart attack and kidney failure	CCGs
	Sexual/ Reproductive health	Increase take up of more effective contraception (LARC) through GPs and maternity and abortion services, having 7.7% of women switching from pill to LARC	Joint CCGs and LAs
	Falls and fractures	Increase coverage to 100% of Fracture Liaison Service from currently 39% national coverage	Joint commission: CCGs & LAs;
	Diabetes and obesity	Improved management and care of diabetes; and primary prevention of obesity	CCGs and LAs

Not a prescriptive list for local use. PHE continues to work with NHS England to identify further areas of potential savings through preventative interventions e.g. mental health and musculoskeletal disease



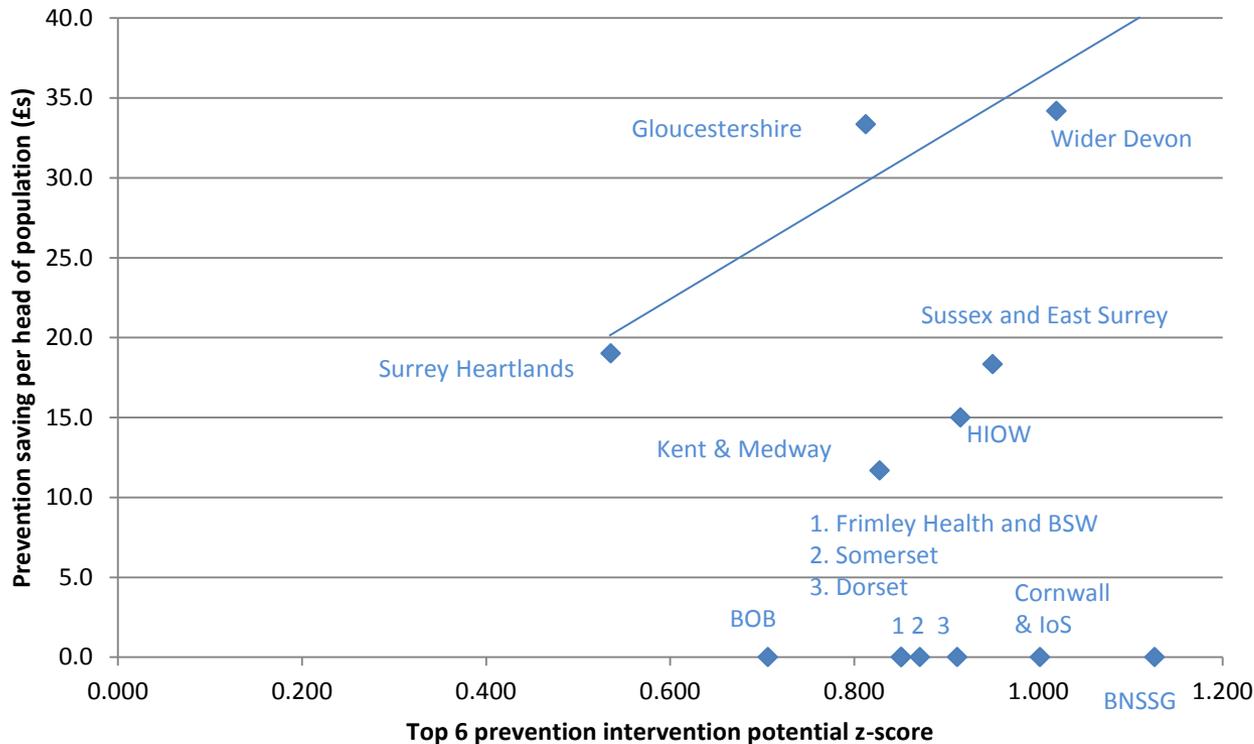
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What could we be aiming for?

Association between prevention saving per head of population and MOI prevention scores



- South of England Benchmarking suggests £20-40 per head is a reasonable aim.
- For Surrey this equates to 13.7% of their do nothing cost pressure. For Gloucestershire it is 8.4% and Wider Devon 7.2%



Benchmarking

A good **range** of prevention services **across the system**, designed to attract **populations in need**

Prevention in all pathways supported by **digital platforms**

Clear plans for **supporting the health of their workforce**

These are not limited to but should include costed, **at scale**, MOI services to

- Identify heavy drinking and give brief advice
- Control BP in those uncontrolled
- Help sick smokers quit

AND

- Universal fracture liaison services

Phrases of concern



We can't afford prevention



We don't know what to do



We are waiting for someone else to pay



We are waiting for the Council to do prevention



We can't do anything until we get the investment money



We are waiting.

Frimley STP Prevention

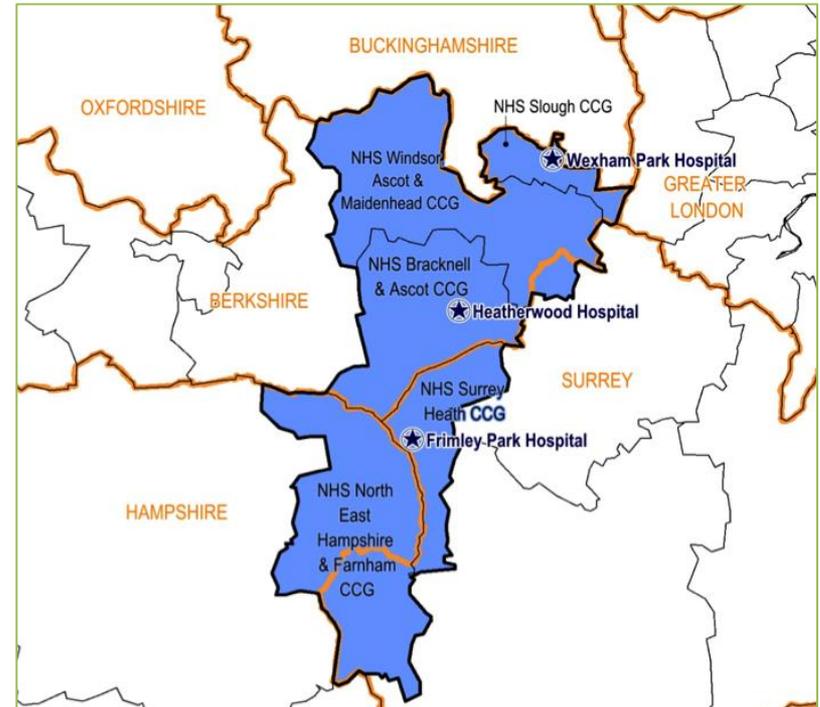
Jane Hogg – Integration and Transformation
Director

Context for Frimley Health and Care System

- 750,000 population

Organisations

- 5 CCGs
- 3 unitary authorities
- 2 district councils
- 2 county councils
- 1 acute trust (recent acquisition)
- 3 community/mental health trusts
- 2 NHSE areas (senates) and 2 HEE areas



- Life expectancy - generally good, affluent
- PH outcomes - good
- PH Budget - low and below fair shares

The Frimley STP priorities for the next 5 years

Our priorities for the next 5 years

P1

Priority 1: Making a substantial step change to improve wellbeing, increase prevention, self-care and early detection.

P2

Priority 2: Action to improve long term condition outcomes including greater self management & proactive management across all providers for people with single long term conditions

P3

Priority 3: Frailty Management: Proactive management of frail patients with multiple complex physical & mental health long term conditions, reducing crises and prolonged hospital stays.

P4

Priority 4: Redesigning urgent and emergency care, including integrated working and primary care models providing timely care in the most appropriate place

P5

Priority 5: Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence.

An underpinning programme of transformational enablers includes:

A. Becoming a system with a **collective focus on the whole population**. **B.** **Developing communities and social networks** so that people have the skills and confidence to take responsibility for their own health and care in their communities. **C.** **Developing the workforce** across our system so that it is able to delivery our new models of care. **D.** Using **technology** to enable patients and our workforce to improve wellbeing, care, outcomes and efficiency.

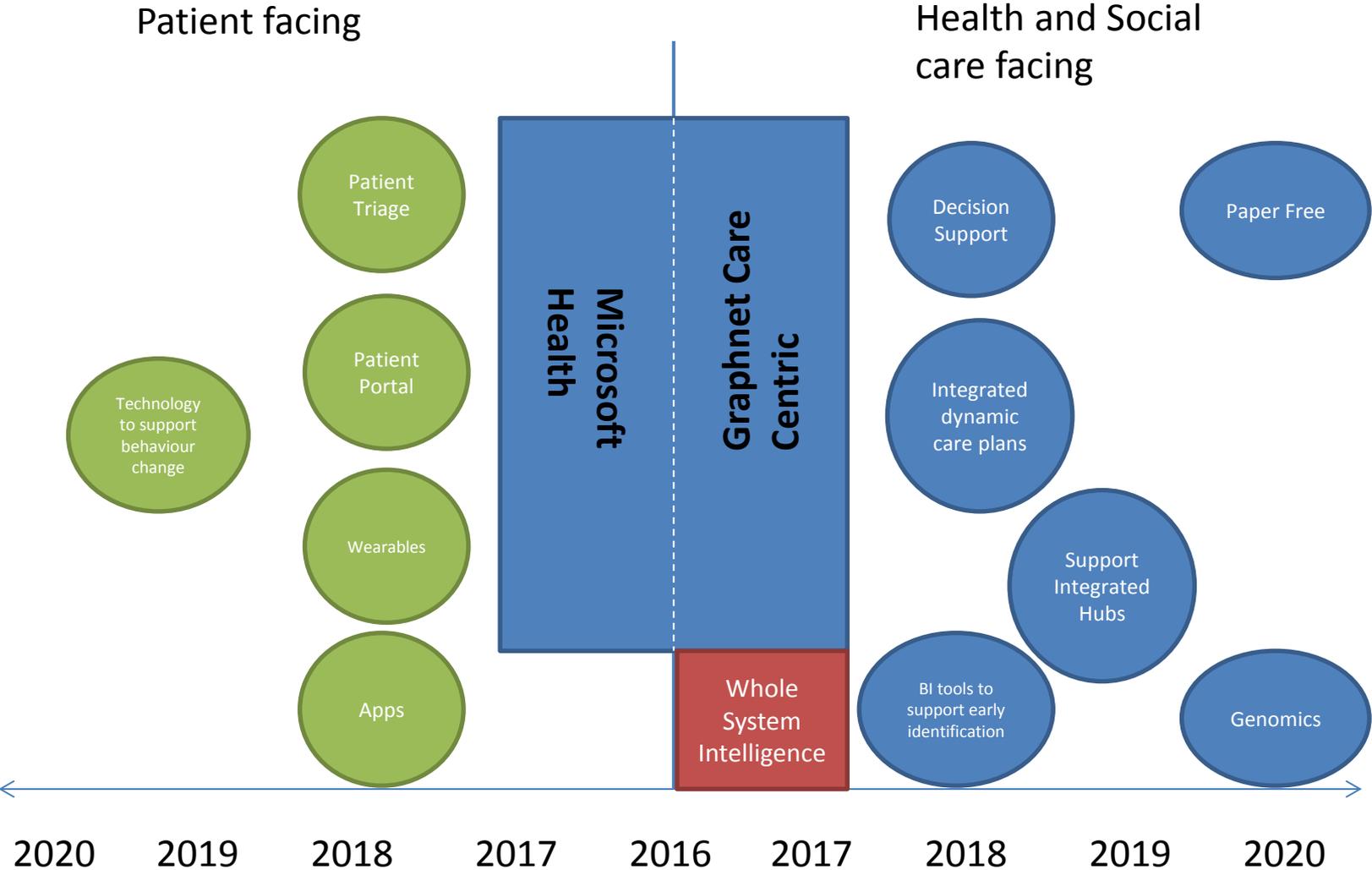
Aims and objectives

- Change of focus towards prevention, early detection and self care and management
- We want staff in every part of our system to promote healthy messages – part of how we deliver care and support
- Overall population health is good, but gaps within our communities and wards
- How we partner and support our communities and individuals is a core part of our approach
- We are working closely between health and local authority partners in a cohesive way
- We aim to be targeted in our early focus, including on the key issues, groups and communities that will derive most benefits

PH approach - Targeted

- Tackle inequalities – BP, tobacco, alcohol, overweight (physical activity), diabetes
- Geographic - Slough outlier , but wards vary , as do practices
- Communities/people - middle aged men in deprived wards are more affected by lifestyle behaviours
- Accompanying illness - residents with severe and enduring mental illness
- National evidence - local interpretation

Digital Programme: Connected Care



Summary

- This programme has a focussed range of interventions
- Whilst small still need to work with others /external support:
 - Heath Education England
training and profile of prevention as activity
 - PHE – national media / campaigns
- Future wider ambitions
- Local NHS must act as role model
- We need this now to secure future benefits

Prevention and Self-Care Plans - the art of the possible

Sarah Scott

Director of Public Health
Gloucestershire County Council



One
Gloucestershire

Transforming Care, Transforming Communities

Prevention Conundrums

- What are we seeking to prevent?
- What does a radical upgrade of prevention look like?
- Where do we go for additional return on investment models?
- We already invest in preventative services where there is evidence of ROI, so the system is already feeling the benefit
- How do we justify more investment in prevention?

Drivers and Levers

- Coterminous partners
- £20 million cashable savings target
- £1.9 million non-recurring prevention fund
- Real engagement from partners
- Pressing timescale

What did we do?

- Used return on investment as our starting point
- ROI models: alcohol, smoking, weight management and diabetes
- Developed a plan that met the STP assurance criteria but had flexibility to be adapted at a later date
 - Demand management and behaviour change
 - Children's and families agenda

What next?

- Development of stage 2 of the plan
- Engagement plan for stakeholders
- Criteria for allocating the fund
- Development of the Prevention and Self-Care Board
- Do the work!