Living well? living longer?

John Middleton,

President, UK Faculty of Public Health

Open Forum Events: Population health: Prevention is better than cure. Manchester Conference Centre, April 30th 2019

FACULTY OF PUBLIC HEALTH

www.fph.org.uk

Who we are and what we do

FACULTY OF PUBLIC HEALTH

- The United Kingdom Faculty of Public Health is a faculty of the three Royal Colleges of Physicians of London, Edinburgh and Glasgow (Physicians and Surgeons)
- FPH is a membership organisation for nearly 4,000 public health professionals across the UK and around the world
- We also have a growing number of student, associate and international members in more than 80 different countries

To improve and protect the public's health: through standards, advocacy, training and knowledge

www.fph.org.uk

Living well? Living longer?

FACULTY OF PUBLIC HEALTH

Population health: some definitions

The Public's Health

Prevention is better than cure

The NHS plan

The Prevention Green Paper

Living well? Living longer?

FACULTY OF PUBLIC HEALTH

Population health: some definitions

FACULTY OF PUBLIC HEALTH

Population Health

An approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies.

Kings Fund

FACULTY OF PUBLIC HEALTH

Our definition of population health is an unpacking of Acheson's (**1998**) definition of the purpose of public health,

'the science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society'.

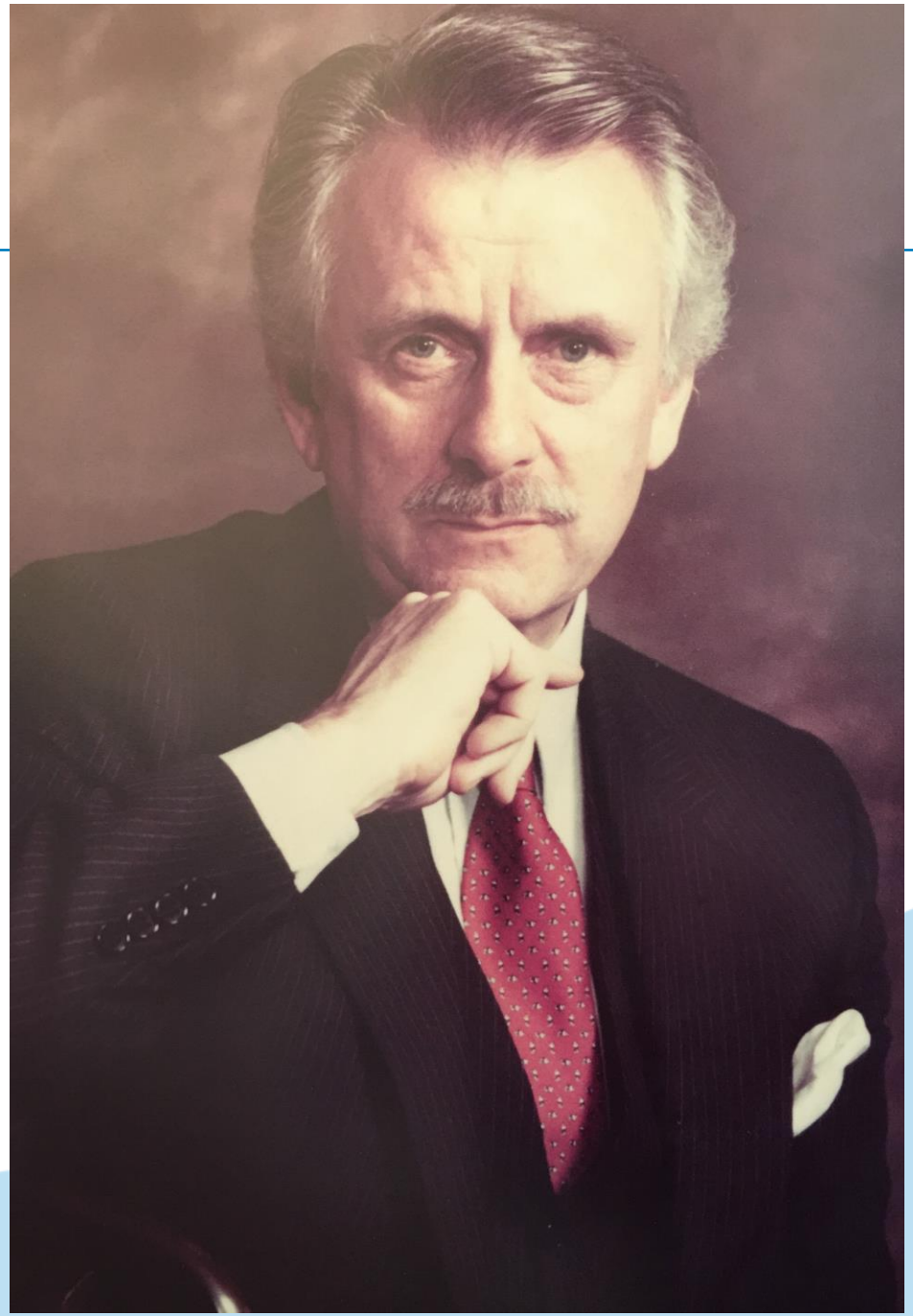
Kings Fund

FACULTY OF PUBLIC HEALTH

Population health management

one of many tools for using data to guide the planning and delivery of care to achieve maximum impact on population health.
It often includes segmentation and stratification techniques to identify groups of patients (and sometimes wider population groups) at risk of ill health and to focus on interventions which can prevent that ill health or equip them to manage it. Integrated care systems (ICSs) here and abroad often use population health management in this sense when deciding how best to allocate resources to different groups of patients (**Noble *et al* 2014**).

Alwyn Smith, President of the UK Faculty of Public Health, 1981-1987



FACULTY OF PUBLIC HEALTH

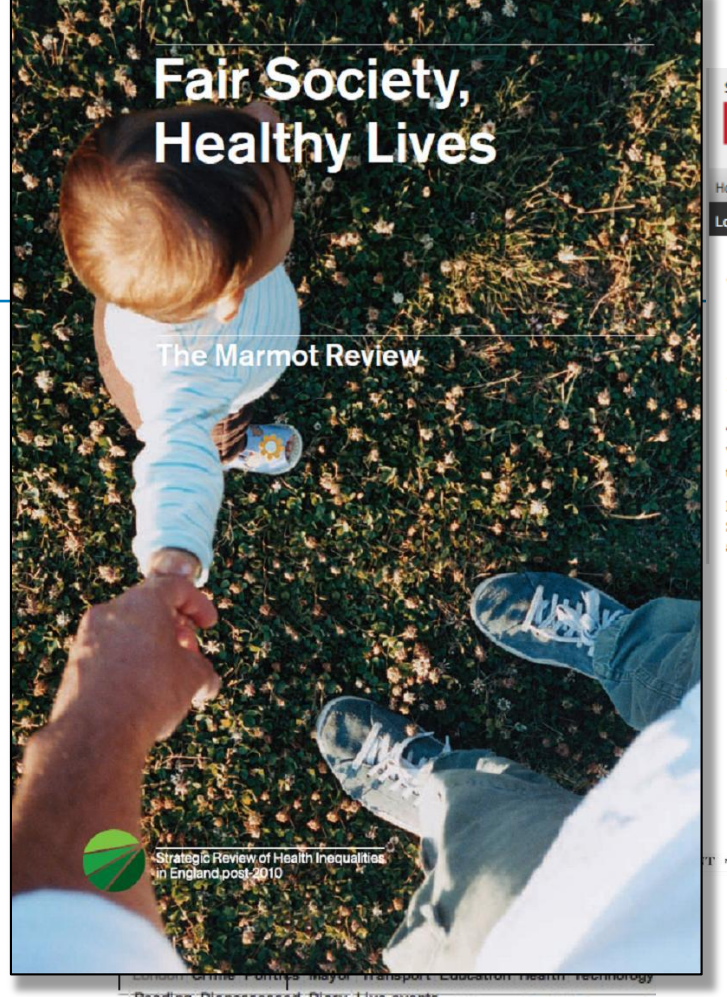
‘Don’t just fight for the profession of public health fight for the public’s health’

Public health professionals are not here to make decisions easier, it is to make things better

Living well? Living longer?

FACULTY OF PUBLIC HEALTH

The Public’s Health



Sunday, July 7, 2013

Express & Star

Jobs | Property | Motors | Local Busines

Home | News | Sport | Business | Education | Entertainment | Lifestyle | Pictures & Video | Blogs

Local News | Wolverhampton | Walsall | Dudley | Sandwell | Cannock | UK News | Crime | 999 | News Video

July 1, 2013 8:59 pm

Wednesbury council tenant killed himself on eviction day

A council tenant killed himself the day he was due to be evicted from his home after falling into arrears, an inquest heard.

Trevor Swann, aged 55, was found hanged in his Sandwell Council home on Warner Road in Wednesbury by bailiffs and police officers when they turned up to evict him on October 31 last year.

Manjit Rai, an area manager within the housing department at the council, told the inquest at Smethwick Council House on Friday Mr Swann had got into arrears after the Department for Work and Pensions stopped his disability benefit.

This site uses cookies. More info Close By continuing to browse the site you are agreeing to our use of cookies. Find out more here Close

Views And Reviews

The UK's current health problems should be treated with urgency

BMJ 2017; 359 doi: https://doi.org/10.1136/bmj.j4526 (Published 02 October 2017) Cite this as: BMJ 2017;359:j4526

- Article
- Related content
- Metrics
- Responses
- Peer review

Michael Marmot

Author affiliations

m.marmot@ucl.ac.uk

Health inequalities, the slow-down in life expectancy, and the north-south divide all need tackling

Alarm about the nation's health is a rational response to recent evidence. Current national health problems should be treated with as much urgency as a winter bed crisis in the NHS. The recent evidence has three components that are probably linked: improvement in life expectancy, going on for 100 years, has slowed since 2010; health inequalities, which probably reduced during the 2000s, have grown again since about 2012; and the persistent north-south divide in health—particularly marked among younger people.

Life expectancy

Between 1920 and 2010, life expectancy increased from 55 to 78 in men, and from 59 to 82 in women. We simply got much healthier as a society, remarkably quickly. Over this period, life expectancy increased by about one year every four years. To see how remarkable that is, think that if you rose at 6 in the morning, by noon you still have as long to live as you did when you woke—six hours every 24 hours. There was, however, a marked slowing of the rise after 2010. From 2011 to 2016 life expectancy increased by about one year for every 6.5 years in men and one year for 10 in women.

FACULTY OF PUBLIC HEALTH

Reading Dispossessed Diary Live events

Hot Topics | Christmas | Chelsea F.c. | Boris Johnson | David Cameron | T

Come Dancing

London children fainting in class because parents are too poor to feed them

Hungry: There is a growing demand for food banks and free school

News | Voices | Culture | Lifestyle | Tech | Sport

News › UK › UK Politics

The real cost-of-living-crisis: Five million British children 'sentenced to life of poverty thanks to welfare reforms'

Charity's report blames benefit cuts, increased cost of living and stagnant wages for looming crisis

Emily Dugan, Jonathan Owen | @emilydugan | Wednesday 28 May 2014 | 293 comments

0 shares

Vicky Cunningham and her son, Oliver-James, are on the cusp of poverty in West Yorkshire *Elizabeth Dalziel*

Five million children in Britain could be "sentenced to a lifetime of poverty" by 2020 because of welfare reforms, according to research from Save the Children.

GRAND CANYON 5:00 PM TICK THE BOX USA

BBC | Sign In | News | Sport | Weather | iPlayer

NEWS HEALTH

Home | World | UK | England | N. Ireland | Scotland | Wales | Business | Politics | Health

30 October 2013 Last updated at 14:18

Share

Jobless youth are 'public health time bomb', says WHO

By James Gallagher
Health and science reporter, BBC News

Youth unemployment in the UK is a "public health time bomb waiting to explode", according to a review by the World Health Organisation.

Related St

Living well? living longer? John Middleton, Open Forum events 30/0419

FACULTY OF PUBLIC HEALTH

BMJ 2019;364:l1123 doi: 10.1136/bmj.l1123 (Published 11 March 2019)

NEWS

Life expectancy in England and Wales has fallen by six months

Harriet Pike

Cambridge

Life expectancy of adults in England and Wales has fallen by around six months, show new figures from the Institute and Faculty of Actuaries.[1]

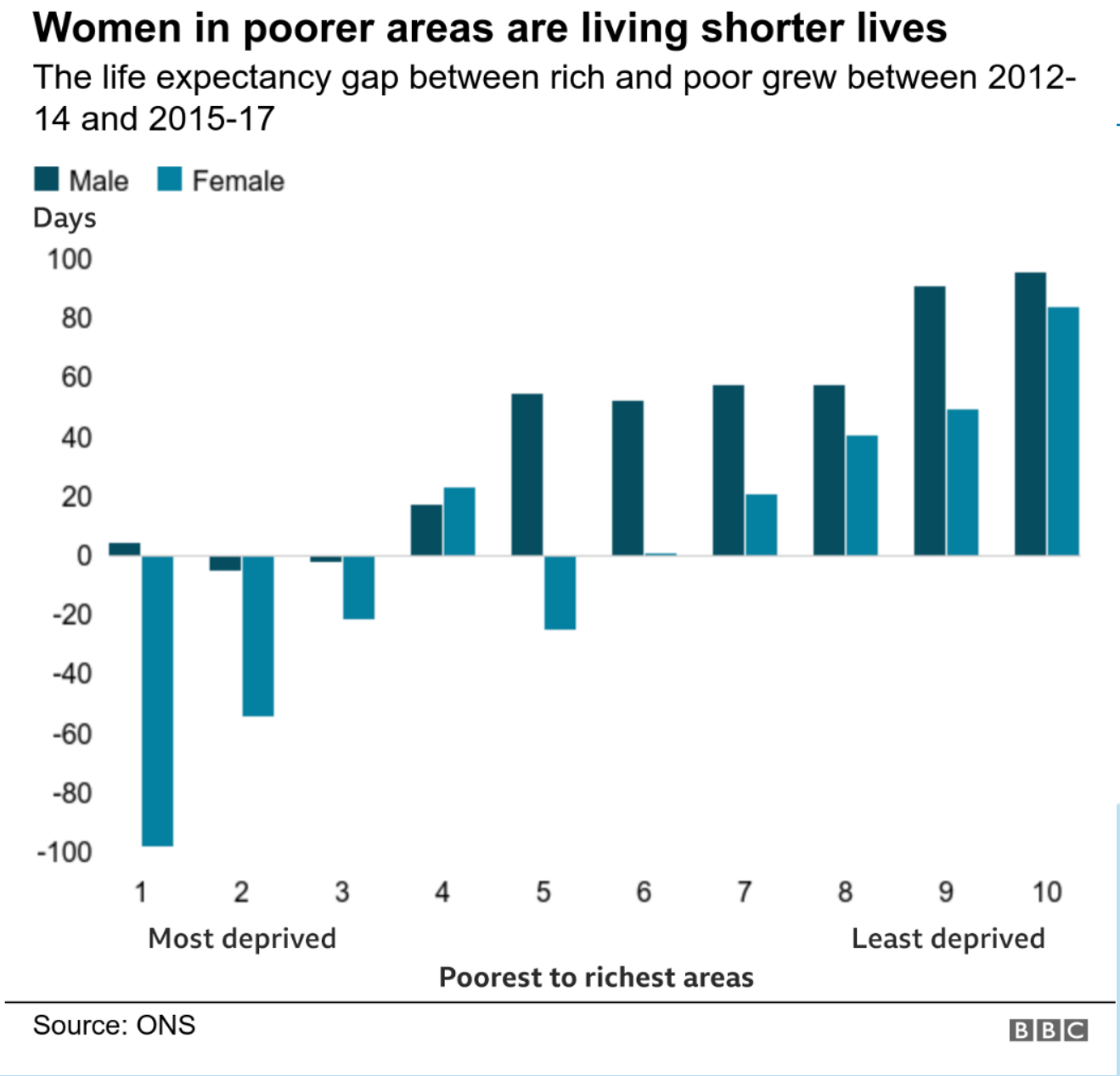
The institute, which calculates life expectancy on behalf of the UK pensions and insurance industries, expects men who are now aged 65 to die at 86.9 years on average. This is down from last year's estimate of 87.4 years. The average age of death of women who are now 65 is 89.2 years, down from 89.7 years.

that smoking and drinking rates have fallen and that the generation that have become more obese are not the generation that have died in greater numbers," he said. "It is time we were clear about what is happening, if only for the sake of future generations who could learn from what we have failed to prevent. It is now too late for all those who have died."

In December 2018 Public Health England looked at the possible reasons for higher mortality and the slowdown in life

Living well? living longer? John Middleton, Open Forum events 30/0419

FACULTY OF PUBLIC HEALTH



Living well? living longer? John Middleton, Open Forum events 30/0419

FACULTY OF PUBLIC HEALTH

BMJ 2019;364:l963 doi: 10.1136/bmj.l963 (Published 5 March 2019)

EDITORIALS

Child health unravelling in UK

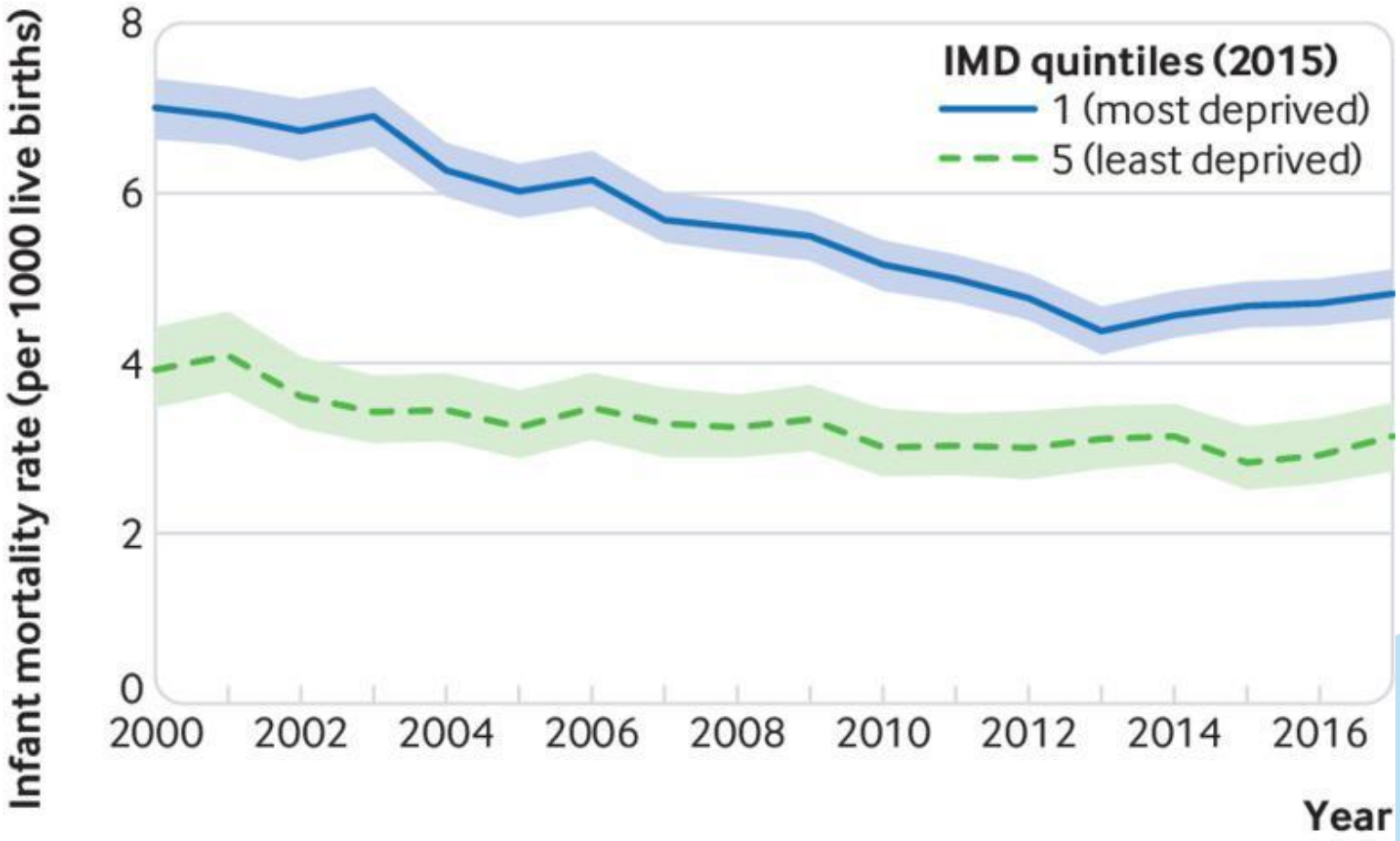
Poverty is a key driver of the UK's dismal performance on child health

David C Taylor-Robinson *professor of public health and policy*, Eric T Lai *postdoctoral research fellow*, Margaret Whitehead *W H Duncan professor of public health*, Ben Barr *senior clinical lecturer in applied public health research*

Department of Public Health and Policy, Farr Institute@HeRC, Liverpool, UK

Living well? living longer? John Middleton, Open Forum events 30/0419

FACULTY OF PUBLIC HEALTH



FACULTY OF PUBLIC HEALTH

- https://rightsinfo.org/schools-are-the-unofficial-emergency-service-for-the-victims-of-britains-poverty-head-teachers-warn/

Rights Info

Human Rights News, Views & Info

DON

NEWS FEATURES OPINION

CHILDREN DISABILITY EQUALITY FAMILY HEALTH JUSTICE PRIVACY

Schools Are The 'Unofficial Emergency Service' For The Victims Of Britain's Poverty, Head Teachers Warn

A public health approach to violence prevention

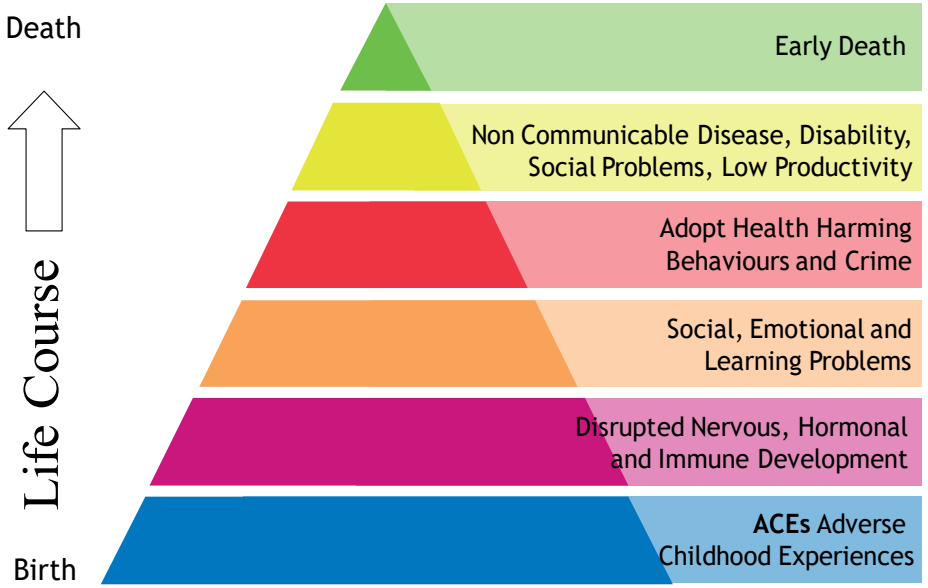
FACULTY OF PUBLIC HEALTH

Crucial importance of early years, the first 1001 days and adverse childhood experiences

An evidence based approach – Good systematic reviews re early years interventions, parenting training, youth mentoring; good modelling of alcohol pricing, control of access and enforcement.

A life course approach- new concerns about adverse childhood experiences (ACES) impacts on violent behaviours, poor communication and poor mental health in later life

A public mental health approach- linked to ACEs, the neurobiological hardwiring of young brains in the first 1001 days; Reinforcing positive mental attributes: self-confidence, self-esteem, self-expression and positive communication



Adverse Childhood Experiences (ACEs): impacts across the life course. *adapted from Felitti et al, 1998*

Met police chief to visit Scotland for ideas to reduce knife crime

Cressida Dick will travel to Glasgow to hear how stabbings were dramatically reduced

▲ Police and a forensics tent at the scene of a stabbing in Camden, north London, which took place on Tuesday night. Photograph: Yui Mok/PA

The Metropolitan police commissioner is travelling to Scotland to seek a solution to London's knife crime epidemic, after two men were stabbed to

FACULTY OF PUBLIC HEALTH

thebmj

BMJ 2018;361:k1967 doi: 10.1136/bmj.k1967 (Published 8 May 2018)

Check for updates

EDITORIALS

Preventing violent crime

Partnerships between health, education, social, and police services are essential

John Middleton *president*, Jonathan Shepherd *professor of faciomaxillary surgery*

UK Faculty of Public Health,

The recent surge in killings in north London has created public outcry. The Metropolitan police are investigating 55 murders in London so far this year. There have been welcome calls for a "public health approach" to tackling violent crime.[1] But what does that entail?

Public health has a role in identifying risk and protective factors, monitoring and understanding the changing threat of violence, and supporting the development of a robust evidence base around what works for prevention and control.[2-4]

rise in the supply, use, and purity of crack cocaine.[8-13] Suppliers are increasingly reaching out beyond their urban bases to hubs in other towns and rural areas, recruiting young or vulnerable people to help store and supply drugs or move cash (the "county lines" distribution).[14] A pernicious use of social media is facilitating this,[15] bringing new drugs, new violence, new human trafficking, and new drug related deaths and harms to places not previously in the headlines.

Many supportive public services have been lost or reduced;

Areas of action for the public health community in preventing violence

- ✓ **The epidemiology of violence**
- ✓ **Evidence-based violence prevention:** a life course approach
- ✓ **Asset based community development**
- ✓ **Primary, secondary &tertiary prevention** role of the public health community as primary preventers of violent conflict, through healthy public policies and tackling major social inequalities in health; and as early reactors, mitigaters and responders to violence.
- ✓ **New public mental health approaches**
- ✓ **A role for public health in conflict resolution** with aid agencies, political scientists, theologians and international lawyers
- ✓ **A role for public health educational bodies**
- ✓ **A leadership and partnership role for public health**

www.fph.org.uk/uploads/Violence%20report.pdf

FACULTY OF PUBLIC HEALTH

The role of public health in the prevention of violence

A statement from the UK Faculty of Public Health

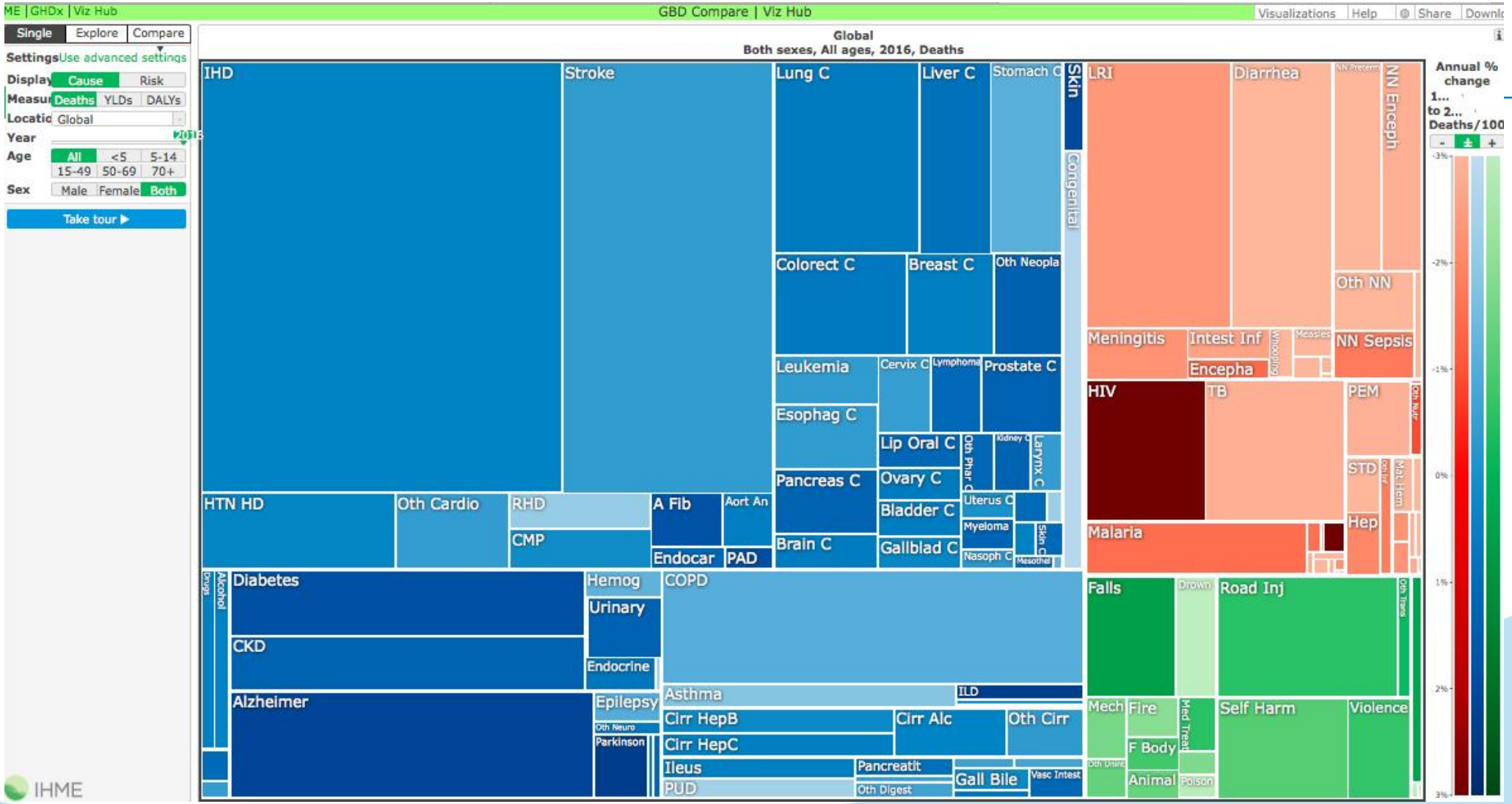
Global burden of disease study, 2017

FACULTY OF PUBLIC HEALTH

Globally, mortality rates have decreased across all age groups over the past five decades, with the largest improvements occurring among children younger than 5 years. However, at the national level, considerable heterogeneity remains in terms of both level and rate of changes in age-specific mortality; increases in mortality for certain age groups occurred in some locations.

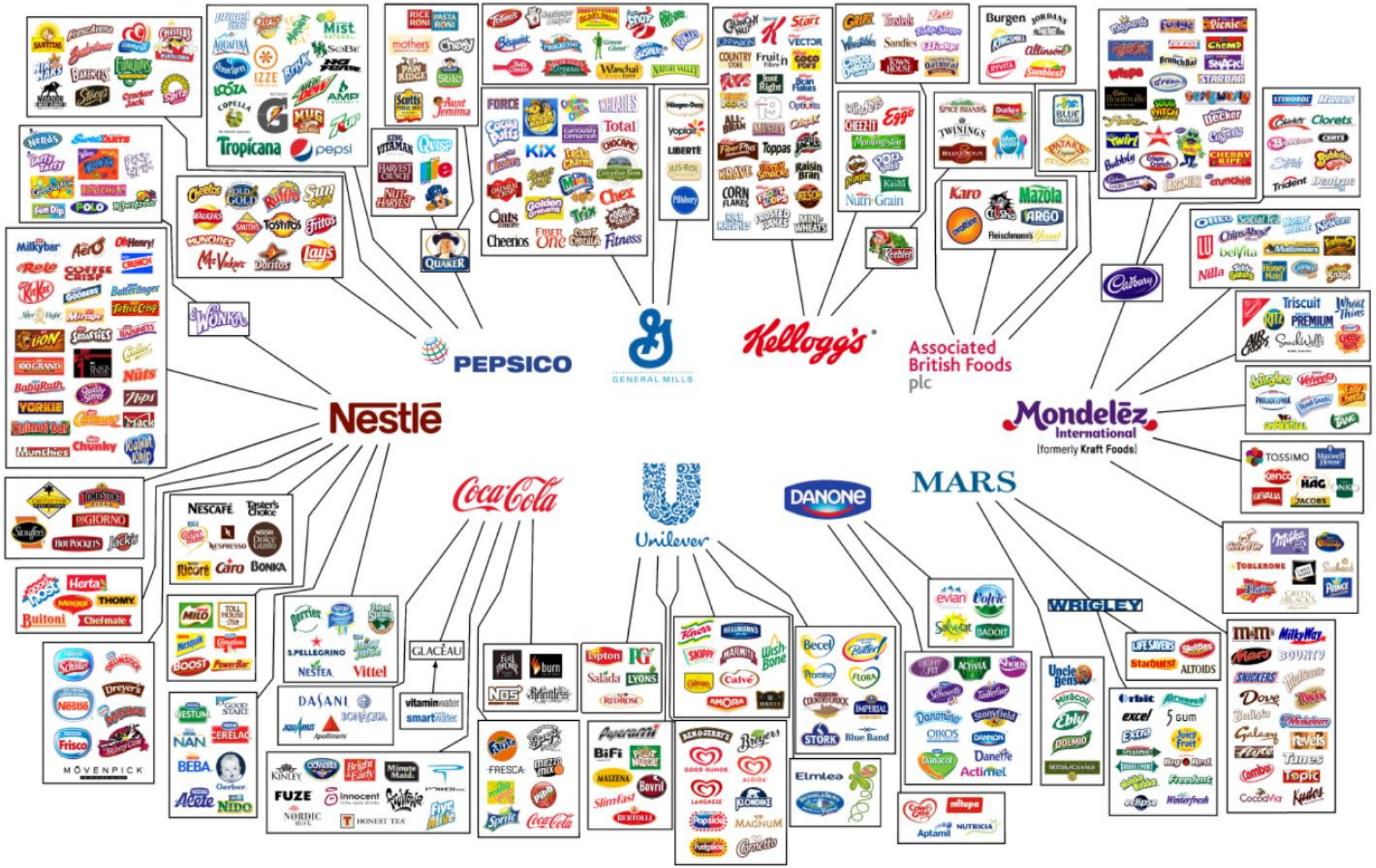
Countries have saved more lives over the past decade, especially among children under age 5, but persistent health problems, such as obesity, conflict, and mental illness, comprise a “triad of troubles,” and prevent people from living long, healthy lives.

Total deaths in children younger than 5 years decreased from 1970 to 2016, and slower decreases occurred at ages 5–24 years. By contrast, numbers of adult deaths increased in each 5-year age bracket above the age of 25 years.



FACULTY OF PUBLIC HEALTH

These 10 Corporations Control Almost Everything We Eat



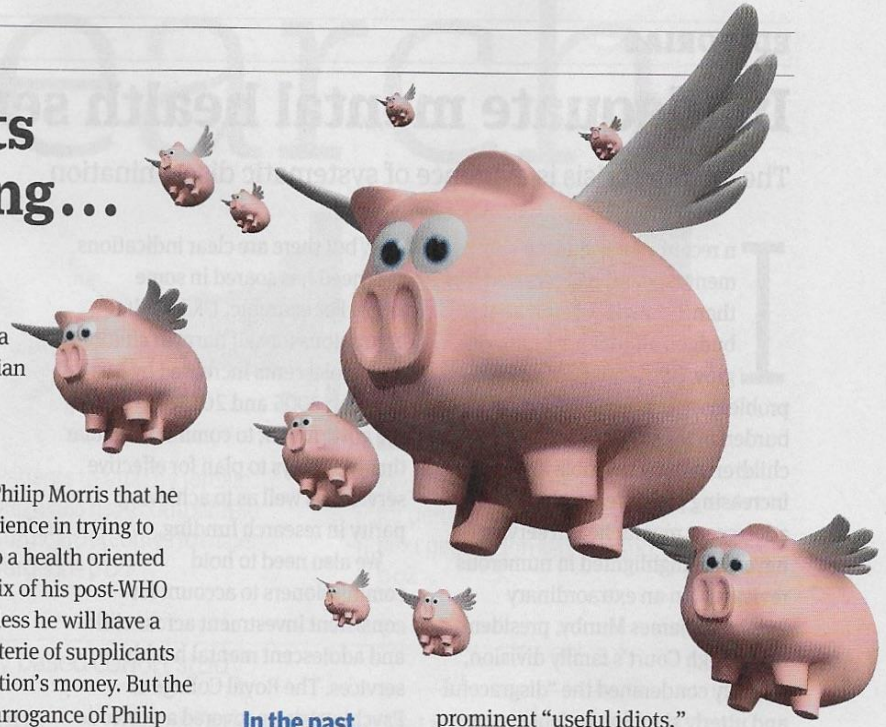
FACULTY OF PUBLIC HEALTH

FACULTY OF PUBLIC HEALTH

EDITORIAL

Tobacco giant wants to eliminate smoking…

…and pigs might fly



The Foundation for a Smoke-Free World, an "independent" research funding body fully funded by tobacco company Philip Morris, launched on 13 September.[1] It will provide $960m (£711m) over 12 years to help "eliminate smoking worldwide." No benchmarks for this modest task have apparently yet been announced. This largesse is a mere $80m a year from a company with global revenue in 2016 of $26.7bn[2] and a marketing budget (in 2012) of $7bn intended overwhelmingly to promote smoking.[3]

The long, deceptive, and failed history of tobacco harm reduction has seen filters (including crocidolite asbestos); misleading "reduced carcinogen" brands; and a wide range of breathlessly announced innovations.[4] Each had their academic touts. None reduced harms from

Will this be a modern Faustian tale, as many expect, or will Yach have the success with Philip Morris that he failed to experience in trying to turn Pepsi into a health oriented company for six of his post-WHO years?[8] Doubtless he will have a predictable coterie of supplicants for the foundation's money. But the breathtaking arrogance of Philip Morris and Yach shunning WHO's article 5.3 on industry interference in the Framework Convention on Tobacco Control[9] will surely steel the resolve of thousands of researchers to continue to shun money obtained from tobacco sales.

Nearly 120 health organisations have called on the company instead to simply stop selling cigarettes.[10]

In the past, Philip Morris has publicised seductive research funding and courted prominent scientists

prominent "useful idiots," as Lenin might have called them,[14] formerly working in tobacco control, who now attend global tobacco industry meetings to cheer on their tobacco host's "game changing" while doing nothing about this industrial vector's daily efforts to promote smoking?

Disturbingly, the main task for

http://www.bmj.com/content/358/bmj.j4443?sso=

thebmj

BMJ 2017;357:j2676 doi: 10.1136/bmj.j2676 (Published 2017 June 02)

http://www.bmj.com/content/357/bmj.j2676

FACULTY OF PUBLIC HEALTH

EDITORIALS

Check for updates

ELECTION 2017

Time to put health at the heart of all policy making

National government must become a public health government

John Middleton *president*

Faculty of Public Health, London, UK

Improving the health of people in the UK will improve the productivity of our nation, and enhancing our health and care industries will provide a platform for creating health related jobs: the "health dividend."[1] The next UK government therefore needs to make health central to all its policies.[2] And it must not surrender our rights to health in the post-Brexit era.[3]

Local authorities have recognised the opportunity of getting health into all policies, including education, environment, economy, licensing, leisure, and town planning, as they seek to become "public health councils."[4] National government must now become a public health government. The new government must think beyond its term of office and implement policies through which the UK grows the wellbeing of future generations.

Unequal and divided

We live in a divided UK, where gross inequalities in health and life chances persist or have increased.[5 6] Decades of science on inequalities in health require policies to reduce inequalities in income, improve early childhood development, and reduce other social, educational, and environmental disadvantages.[5 7] Inequalities in health cost £65bn (€74bn; $83bn) in lost productivity and taxes and increased benefits payments plus £5.5bn for direct NHS treatment in 2010.[5] The next government must deliver real improvements in incomes, opportunity, and health for the poorest sections of our society.

Economic and industrial policy

We need health, environment, education, and social usefulness to be the main drivers of a new industrial strategy.[1-9] Higher education is a major economic generator, and international students must be regarded as a resource for knowledge and international cooperation, not as a negative figure in net migration.[8] The NHS provides a platform for innovation, and the UK needs to retain and develop its global pre-eminence in biomedical science, health, and care technology. It is vital for jobs and trade,[8] but it also benefits international health, as we

The next government must be a world leader for green technology, green energy systems, energy conservation, and a green economy.[11] Even if climate chaos wasn't happening, a fossil-free fuel policy would make sense now because of air pollution, escalating costs of fossil fuels, and fuel insecurity.[12]

New approach to housing

The next government also needs to ensure that the supply of affordable living spaces meets the level of need, and that the existing housing stock is restored, developed, and retrofitted to improve health. There are around 25 million housing units in the UK, and 27.1 million households (including 18.9 million family units). The price of housing greatly outstrips any rise in incomes. More needs to be done to reduce the ill health caused by cold homes and to improve home safety.[12] A carrot and stick approach is needed to make land and properties available for people at affordable prices, including encouraging holders of underused living space to relocate to more manageable homes.

New food act

In 2015, UK consumers spent £201bn on food, and the agri-food chain contributed £108bn gross to the national economy. Of this, only 9% went to farmers, while manufacturing took 25%, catering 27%, and retailing 30%. Even wholesalers made more (11%) than the people who grow the food.[13 14] UK horticulture is parlous and dependent on migrant labour. The UK balance of food payments is £28bn in deficit. Payments under the EU common agricultural policy support sugar beet growing in East Anglia, and now we have the sugar tax to control sugar consumption. Multinational sugar companies benefit most from the EU policy.[14] We waste 20% of our overpriced food and grow food banks for the hungry. We could pay our farmers more, build more jobs in food production and processing, and have slimmer children and a less poisoned environment. In the EU, or outside it, we need a new food act to secure these objectives.[15]

Inequalities in health cost £65bn (€74bn; $83bn) in lost

productivity and taxes and increased benefits payments plus

£5.5bn for direct NHS treatment in 2010.5

Living well? Living longer?

FACULTY OF PUBLIC HEALTH

Prevention is better than cure

FACULTY OF PUBLIC HEALTH

Prevention is better than cure, November 2018

Vision to protect and promote the health of the nation.

Healthy ageing grand challenge as part of industrial strategy, to ensure that people can enjoy at least five extra healthy independent years of life by 2035 while narrowing the gap between richest and poorest

1) Why prevention matters
2) Vision for preventing problems from arising in the first place
3) Prevention for people living with a health or social care need

'Health a precious asset'

Which we must 'Protect and nourish'

Prevention is better than cure, November 2018

FACULTY OF PUBLIC HEALTH

Good physical and mental health central to our happiness

A healthy nation is vital for a strong economy Ill health costs the economy £100 billion a year

Better health reduces pressures on NHS, social care, and other public services, including crime, justice and welfare

FACULTY OF PUBLIC HEALTH

- https://jech.bmj.com/content/71/8/827

Review

OPEN ACCESS

Return on investment of public health interventions: a systematic review

Rebecca Masters,[1,2] Elspeth Anwar,[2,3,4] Brendan Collins,[2,4] Richard Cookson,[5] Simon Capewell[2]

► Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/jech-2016-208141).

[1]North Wales Local Public Health Team, Public Health Wales, Mold, Flintshire, UK
[2]Department of Public Health and Policy, University of Liverpool, UK
[3]Department of Public Health, Halton Borough Council, Cheshire, UK
[4]Department of Public Health, Wirral Metropolitan Borough Council, Merseyside, UK
[5]Centre for Health Economics, University of York, UK

Correspondence to
Rebecca Masters, North Wales Local Public Health Team, Public Health Wales, Mold, Flintshire CH7 1PZ, UK;

ABSTRACT

Background Public sector austerity measures in many high-income countries mean that public health budgets are reducing year on year. To help inform the potential impact of these proposed disinvestments in public health, we set out to determine the return on investment (ROI) from a range of existing public health interventions.

Methods We conducted systematic searches on all relevant databases (including MEDLINE; EMBASE; CINAHL; AMED; PubMed, Cochrane and Scopus) to identify studies that calculated a ROI or cost-benefit ratio (CBR) for public health interventions in high-income countries.

Results We identified 2957 titles, and included 52 studies. The median ROI for public health interventions was 14.3 to 1, and median CBR was 8.3. The median ROI for all 29 local public health interventions was 4.1 to 1, and median CBR was 10.3. Even larger benefits were reported in 28 studies analysing nationwide public health interventions; the median ROI was 27.2, and median CBR was 17.5.

intervention against the total costs of its delivery. The CBR is the benefit divided by the cost, and the ROI is the benefit minus the cost expressed as a proportion of the cost, that is, the CBR−1. To help inform the discussion of proposed cuts to public health budgets, we set out to determine the ROI and opportunity cost for a range of public health interventions at the local and national levels. The theory underpinning this review is that, because political backing for public health intervention is often lacking, many interventions with a high ROI are not funded. This is because public health interventions are often opposed by powerful commercial interests, and the health gains for individuals are often perceived as too small to sway their voting intentions, despite adding up to large gains at the population level.[4]

METHODS

We conducted a systematic review to examine the ROI of public health interventions delivered in

FACULTY OF PUBLIC HEALTH

Living well starts with individuals and families. Prevention is for everyone - at every stage of life

Decisions we take every day can help us improve our health. These could be small choices, such as choosing a low sugar drink or minimising screen time before bed, to the broader decisions we take: where we live or where we work.

There are also the larger healthy lifestyle choices that reduce our chances of becoming unwell. These include: not smoking, eating a good diet, being physically active, reducing our alcohol intake, not taking illegal drugs, and taking care of our mental health.[47]

FACULTY OF PUBLIC HEALTH

Some features that weren't individual focused

Health and social care reorientation towards prevention
Key leadership role for DsPH
Anchor economic role of NHS
Predictive prevention (population health management)
Action from national and local government - eg Regulation and taxation Soft Drinks Levy
Health in all policies and cross government
Best start in life
Healthier food and drinking choices
Physical activity
Active travel
Loneliness and isolation
Air pollution
Workplace health

Living well? Living longer?

FACULTY OF PUBLIC HEALTH

The NHS plan

FACULTY OF PUBLIC HEALTH

NHS Long term plan, January 2019

1)NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting.

2) New, funded, action the NHS will take to strengthen its contribution to prevention and health inequalities.

3)NHS's priorities for care quality and outcomes improvement for the decade ahead.

4) Current workforce pressures will be tackled, and staff supported.

5) Wide-ranging and funded programme to upgrade technology and digitally enabled care across the NHS.

6) 3.4% five year NHS funding settlement will help put the NHS back onto a sustainable financial path

FACULTY OF PUBLIC HEALTH

Some features

National priorities based on Global burden of disease

Expectation on prevention, and reducing inequalities: inequalities as in vulnerable groups and protected characteristics

Case study of Pathway Homelessness services in primary care

Hospital tobacco and smoking cessation efforts RCP ‘Hiding in plain sight’ tobacco control recommendations

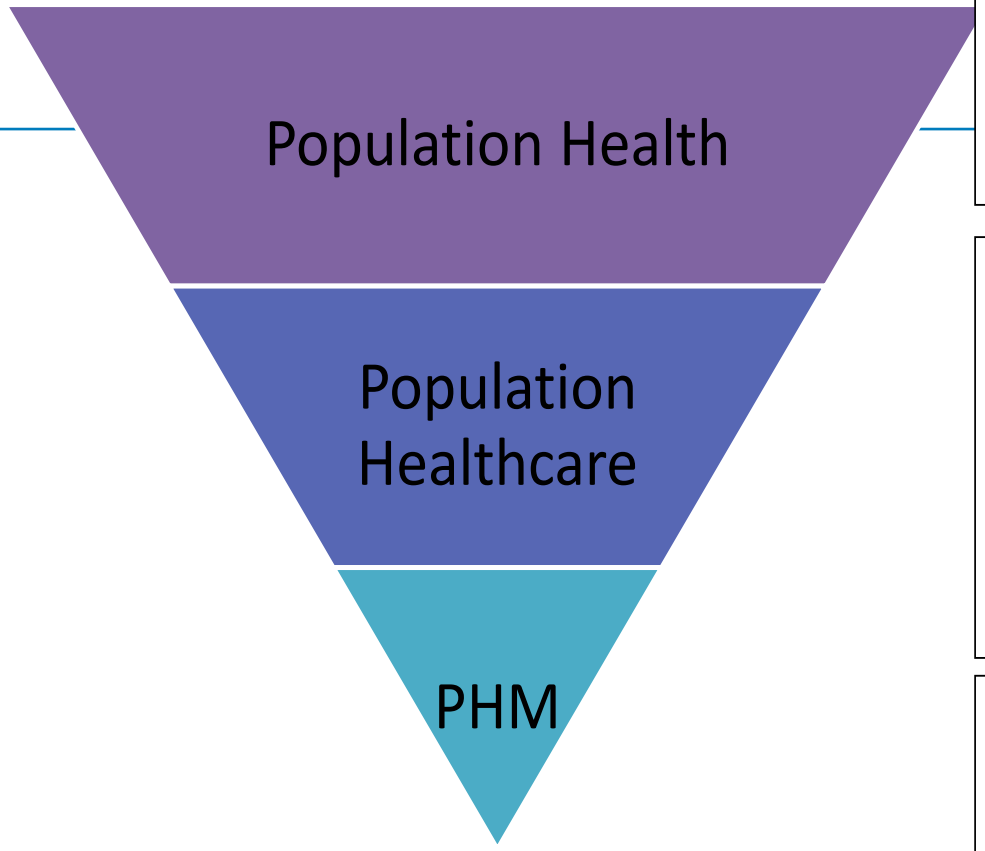
Strong centrally driven prevention programmes in Diabetes, Cancer, Social prescribing

‘Personalised care’- dream of prevention linking genomics and behaviours

Lot of expectation on technology, digital, artificial intelligence, genomics

Strong references to staff needs and workforce development

Lots of aspiration, and why not?



Population Health
System-level approach, for optimising outcomes and their distribution, reducing inequity and addressing wider determinants of health (including environmental) across a population

Population Healthcare
Maximising population health outcomes via healthcare; considering health of the wider population (not just those who present for treatment) through activity such as cross-sector optimal value pathways of care, healthy workplace and sustainability initiatives, action to address inequalities in a health problem of local importance.

Population Health Management
A delivery approach for how healthcare systems may better organise pathways of care. Includes stratification and modelling to identify defined local 'at risk' population to support delivery of prevention and chronic disease management.

FACULTY OF PUBLIC HEALTH

Diagram taken from NHS Prevention Board paper on 22nd January 2018

Table 2 a Preventable causes of hospital admission, Sandwell and Western Birmingham Clinical commissioning group, 2012-13

Admission Subgroup	Events 2012/13	Spend 2012/13
Ambulatory Care Sensitive - Chronic conditions	4,732	7,996,049
Ambulatory Care Sensitive - Acute conditions	5,465	8,760,922
Medicines related	810	1,769,949
Self Harm	1,028	592,857
Falls related	2,565	7,326,049
Vaccine preventable	1,379	3,546,201
Alcohol Wholly Attributable	961	1,258,349
Alcohol Somewhat Attributable	1,554	2,560,359
Alcohol Marginally Attributable	7,969	19,378,897
Smoking Wholly Attributable	701	1,508,148
Smoking Somewhat Attributable	8,402	13,612,605
Obesity Wholly Attributable	83	255,235
Obesity Somewhat Attributable	3,346	7,896,152
Obesity Marginally Attributable	657	1,338,593

FACULTY OF PUBLIC HEALTH

Layering population health intelligence

FACULTY OF PUBLIC HEALTH

Indicator	Period	All clusters			
		Avg	Worst/ lowest	Range	Best/ highest
1 Recorded dementia prevalence (%) as recorded on practice disease registers (all ages)	2016/17	0.58	0.33		1.02
2 Exception rate recorded by GPs for Dementia as recorded as QOF indicators	2016/17	8.80	4.20		16.28
3 Long-term mental health problems (GP Patient Survey): % of respondents to GP Patient Survey reporting a long-term mental health problem	2016/17	4.43	2.85		9.09
4 % reporting Alzheimer's disease or dementia	2016/17	0.55	0.00		1.17
5 % GP registered population aged under 5 years	2017	6.55	4.80		8.14
6 % GP registered population aged 5-14 years	2017	13.15	10.76		17.38
7 % GP registered population aged 75+ years	2017	6.34	3.79		10.92
8 % GP registered population aged 85+ years	2017	1.80	0.83		3.12
9 % GP registered population aged under 18 years	2017	23.03	18.95		29.78
10 Depression recorded prevalence (QOF): % of patients on GP practice registers recorded as having depression (aged 18+)	2016/17	8.62	5.92		12.14
11 GP patient survey: smoking prevalence	2016/17	14.89	23.78		10.49
12 GP patient survey: ex-smoking prevalence	2016/17	26.11	32.28		14.73
13 Severe mental illness recorded prevalence (QOF): % of people with severe mental illness on GP practice registers (all ages)	2016/17	0.81	0.52		1.35
14 People on primary care mental health register with a comprehensive care plan: % of people on mental health register	2016/17	75.09	9.64		90.59

Key:

- Significantly better than all clusters average
- Not significantly different from all clusters average
- Significantly worse than all cluster average
- Significantly lower than all clusters average
- Significantly higher than all clusters average
- Not compared

CCG value — Benchmark Value — England value

Worst/Lowest — 25th Percentile — 75th Percentile — Best/Highest

BLMK GP Cluster Spine Charts produced by PHE LKIS East

Population health care

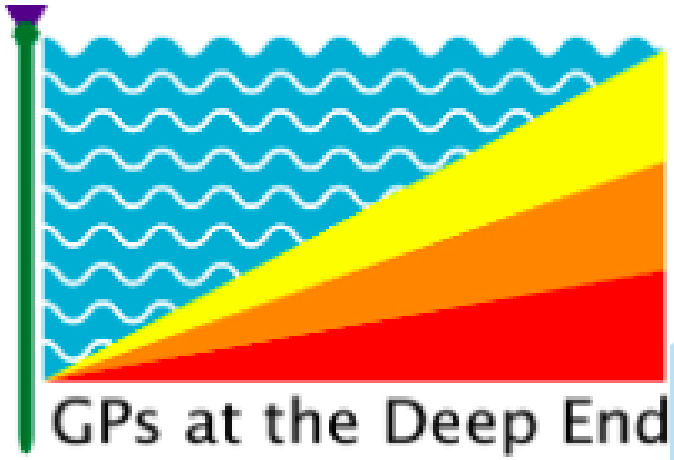
FACULTY OF PUBLIC HEALTH

General Practitioners at the Deep End

General Practitioners at the Deep End work in 100 general practices serving the most socio-economically deprived populations in Scotland.

The activities of the group are supported by: the Royal College of General Practitioners (Scotland); the Scottish Government Health Department; and General Practice and Primary Care at the University of Glasgow.

NEW Deep End Pioneer Scheme



MSD Clinical Manager

Clinical audit | GMS contract tracking | MSD informatics web page

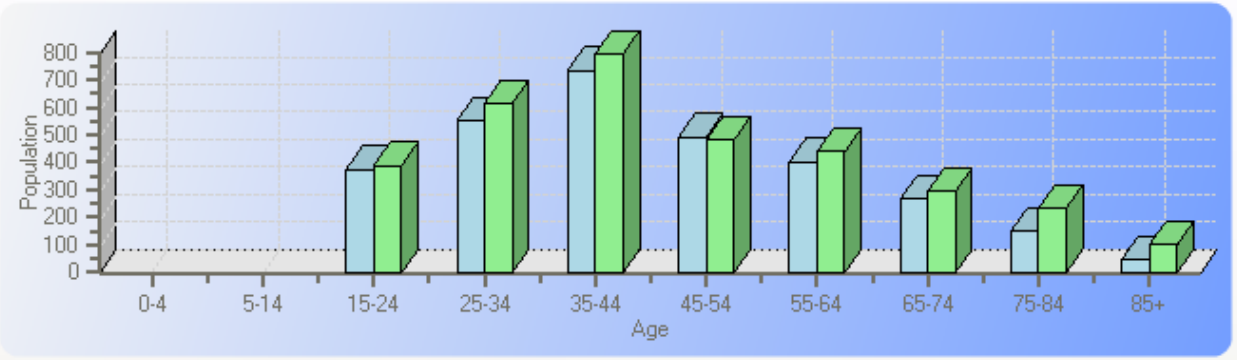
13/06/2007

Patient list | Demographics | Patient Changes | Historic trends

8710 patients analysed:

- Cardiovascular
  - CHD Audit
    - Patients over 18 with PVD ever (108 patients)
    - Patients over 18 with TIA ever (79 patients)
    - Patients with a 10yr Framingham Risk Score >30%
    - Patients with 10yr Framingham Risk score >30%
    - Patients with CHD (G3 Code) (233 patients)
    - Patients over 18 with Diagnosis of Heart Failure (3
    - Patients over 18 with Diagnosis of Angina (166 pa
    - Patients over 18 with Diagnosis of MI ever (103 p
    - Patients with 10yr Framingham Risk score >15.01
    - Patients over 18 with Stroke ever (137 patients)
    - Patients with a 10yr Framingham Risk Score and
    - Number of patients aged 65 years and over immu
    - Patients with 10yr Framingham Risk score not cal
    - Patients with 10yr Framingham Risk score 0-15%
    - Patients over 18 with Atrial Fibrilation (48 patients)
    - Patients over 18 with CHD (233 patients)
  - Familial Hypercholesterolaemia
    - Patients with Cholesterol ever >8.0mmol/L with n
    - Patients with FH not referred for Specialist advice
    - Patients with family history of FH or Premature CH
    - Patients with Familial Hypercholesterolaemia
    - Patients with LDL cholesterol ever over 4.9 mmol/
    - Patients with FH referred for Specialist advice
- Diabetes
- Enhanced Services
- Ethnicity
- Ethnicity (WAG Reports)
- GMS Prevalence
- Gms Contract
  - Asthma Tidy-up Searches
  - Atrial Fibrillation Tidy-up Searches
  - Cancer Tidy-up Searches
  - CHD Tidy-up Searches
    - CHD recorded but No Beta Blockers, ACEi or Sta
    - CHD not recorded: Aspirin/Clopidogrel prescribed

Patients with 10yr Framingham Risk score not calculated (6378 patients)



Gender	0 - 4	5 - 14	15 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85 - 94
Male			375	551	734	492	402	266	150	47
Female			389	615	794	481	438	295	234	101

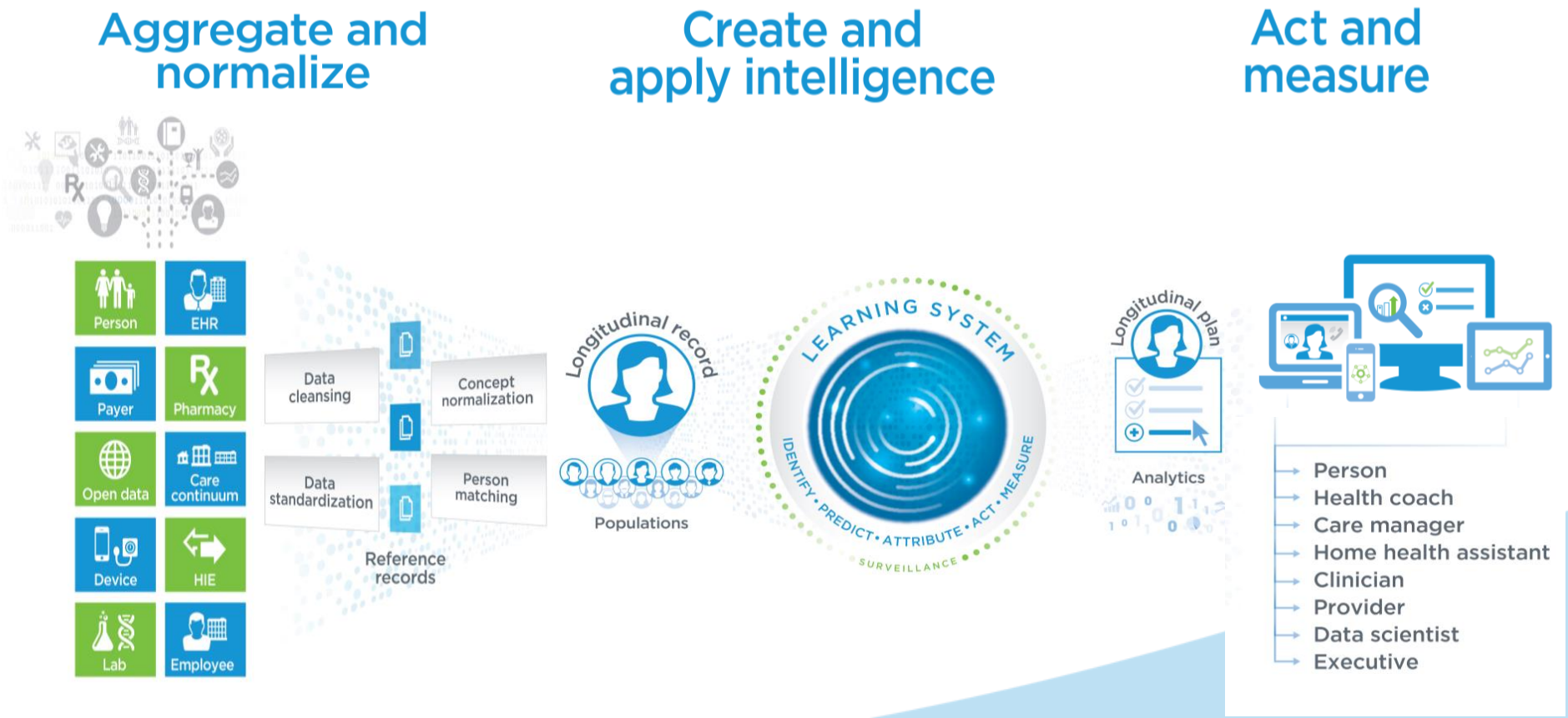
Name	Gender	Age	DOB	GP
Patient1016, ---	M	48	22/09/1958	---
Patient1037, ---	M	45	03/09/1961	---
Patient1050, ---	M	46	21/06/1961	---
Patient1055, ---	M	48	31/05/1959	---
Patient1057, ---	M	49	08/01/1958	---
Patient107, ---	M	46	22/04/1961	---
Patient1077, ---	M	47	02/08/1959	---
Patient1088, ---	M	46	06/08/1960	---
Patient1104, ---	M	50	30/08/1956	---
Patient1119, ---	M	46	20/12/1960	---
Patient1132, ---	M	45	03/03/1962	---
Patient1163, ---	M	50	13/07/1956	---
Patient1206, ---	M	47	12/08/1959	---
Patient1223, ---	M	54	18/05/1953	---
Patient1253, ---	M	46	13/05/1961	---
Patient1258, ---	M	45	28/12/1961	---
Patient1261, ---	M	46	04/04/1961	---
Patient1324, ---	M	47	18/05/1960	---

QOF v9.0

FACULTY OF PUBLIC HEALTH

HealtheIntent platform

FACULTY OF PUBLIC HEALTH



With thanks to Cerner UK

Bedfordshire Population health matrix

FACULTY OF PUBLIC HEALTH

	Generally well		Long term conditions / Long term needs		Complexity of LTC(s) and/or disability	
	Low risk	High risk	Low risk	High risk	Low risk	High risk
Children and Young People (0- 25)		**Risk factors e.g:**	**Single LTC e.g:** • COPD • Cancer • CHD	**2 + LTC**		**1+ LTC with e.g:** • Mental Health Need • Palliative Care need • Social Care need • Dementia • Nursing Home • Residential Home • Disability
Working Age Adults (26- 65)		• Smoker (14yrs +) • Sedentary • High BMI • High BP • Pre-Diabetes • Drug use • High alcohol intake	• Asthma • Mental Health Condition - managed • Diabetes • TIA	**Or**		
Older People (66 and over)			• Hypertension • CHD • RA • MS	**1 LTC plus risk factors**		

Adapted from Dr Steve Laitner (@SteveLaitner) and the NAPC

Living well? living longer? John Middleton, Open Forum events 30/0419

FACULTY OF PUBLIC HEALTH

thebmj

BMJ 2019;364:l218 doi: 10.1136/bmj.l218 (Published 16 January 2019)

EDITORIALS

Check for updates

BMJ 2019;364:l218
doi: 10.1136/bmj.l218

The NHS long term plan and public health

An opportunity to create a unifying “national service for health”

Rachel Chapman *specialty registrar in public health*, John Middleton *president*

UK Faculty of Public Health, London, UK

Living well? Living longer?

FACULTY OF PUBLIC HEALTH

The Prevention Green paper?

FACULTY OF PUBLIC HEALTH

Challenges in delivery

Workforce biggest issue

Needs genuine partnership with local government and communities

Unease over ‘para 2.4 role’ for NHS in sexual health and community nursing– seen as a ‘land grab’

Need for more public health skills

Need for specialist public health in all levels of NHs management and planning Regional DsPH seconded from PHE a good start

Properly funded community involvement and community services

Integrated care systems vs Health and wellbeing boards?

Good data needed and a national information governance framework that allows data linkage and sharing

National plan for reducing health inequalities needed as with the national plan in the 2000s

FACULTY OF PUBLIC HEALTH

Post plan, we need to see:

More investment in public health, local government and social care through the CSR?

FPH proposal for a Prevention Transformation Fund spent through local government

Health in all policies approach - housing, food and agriculture, transport welfare rights and personal taxation policies

A chance for a **"National Service for Health"**

FACULTY OF PUBLIC HEALTH

FPH strategy 2019-2025

Improve and protect health through sustainable development principles.

Pursue the Sustainable Development Goals for human health, ecosystems, climate and planetary health upon which we rely.

Steer, local, national and global health systems towards greater reliance on prevention and early intervention.

Promote health as a fundamental economic benefit that enables communities to thrive.

Apply an asset-based approach to improve and protect health, recognise our communities as a resource for health and maximise public engagement.

FACULTY OF PUBLIC HEALTH

FPH Strategy 2019-2025

Health in all policies.

Reduce inequalities in health by reducing inequalities in economic opportunity, educational attainment and environmental conditions.

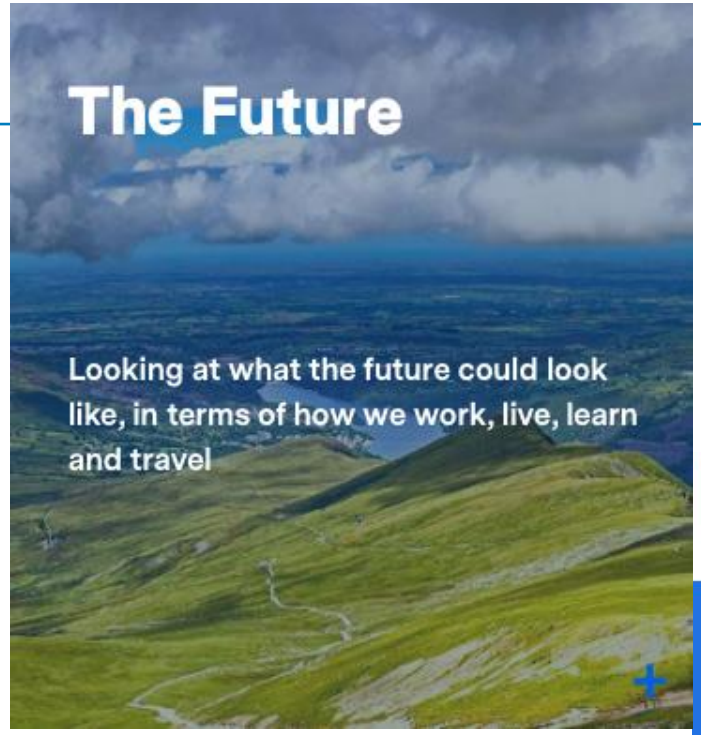
Harness the Right to Health in our campaigning and through the rule of law.

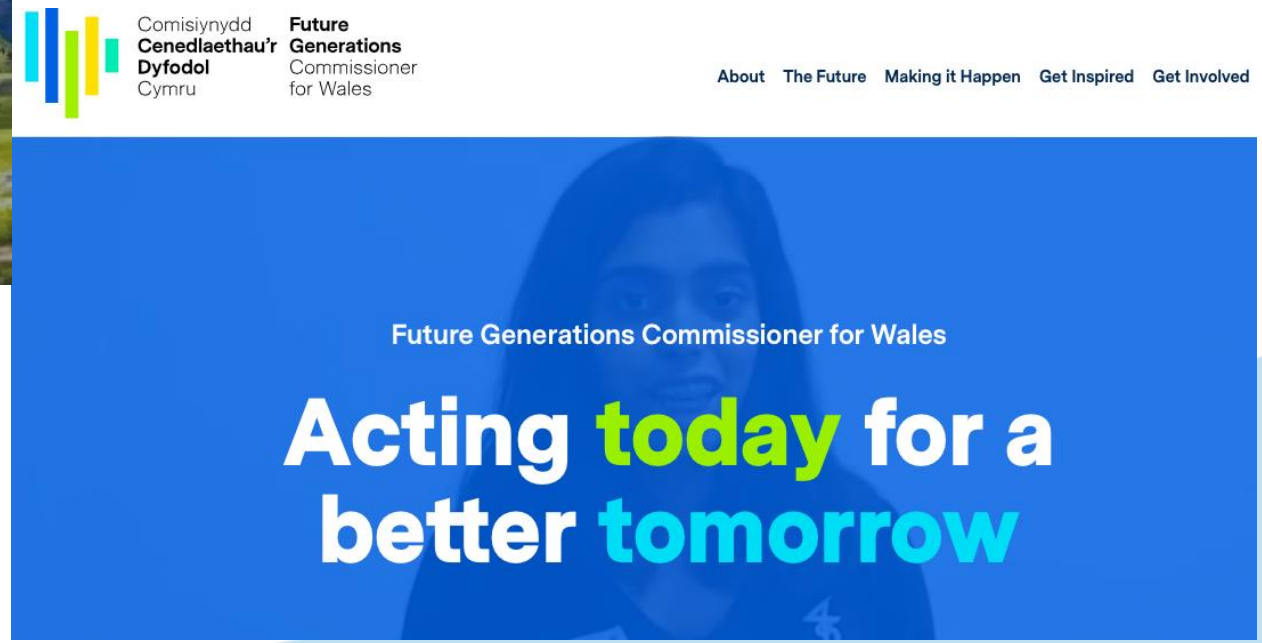
Policies and services to improve the health of future generations.

Champion equality of opportunity and the rights of all minorities.

FACULTY OF PUBLIC HEALTH

‘Protecting resources from one generation to the next’





The Welsh Wellbeing of Future Generations Act, 2015

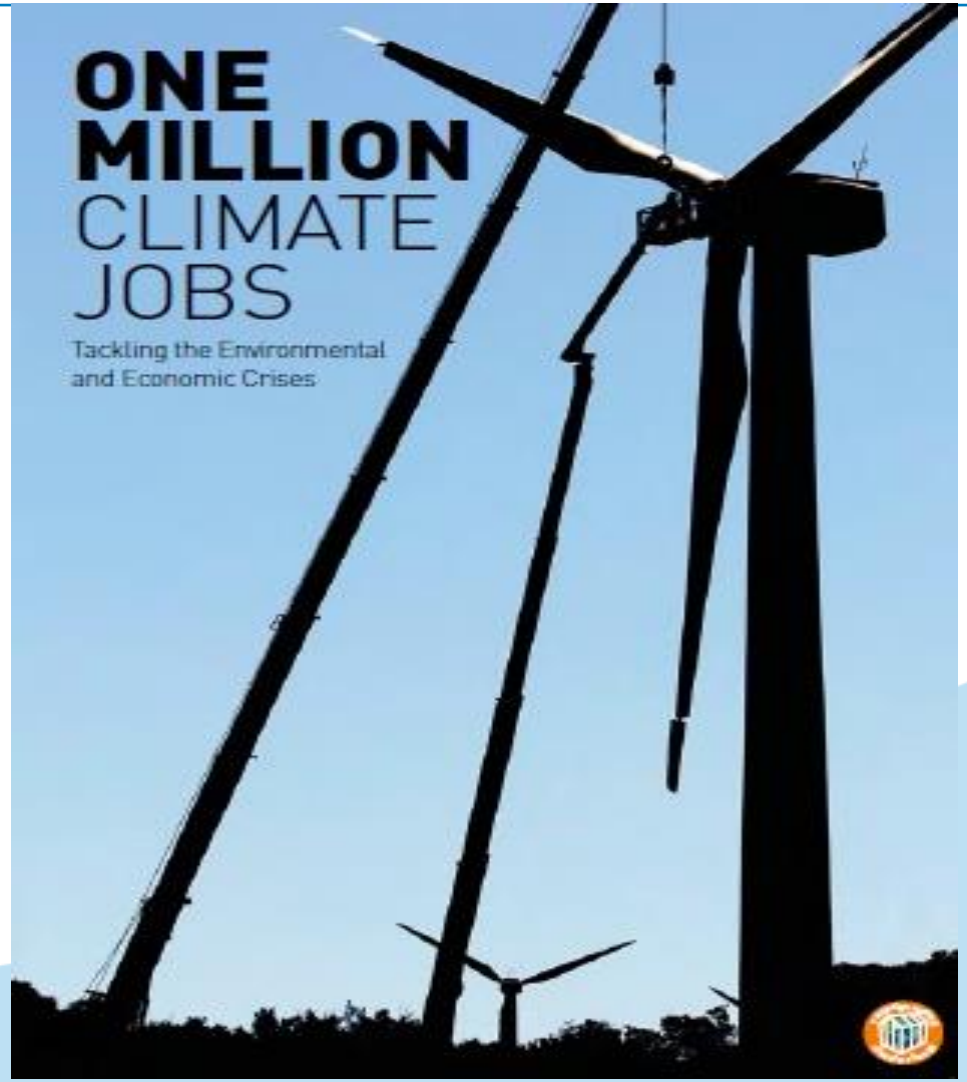
FACULTY OF PUBLIC HEALTH

Public health and the EU post Brexit

- A country fit to live in… where

- Britain can power itself ? and
- House itself ? and
- Employ itself ?

http://www.campaigncc.org/sites/data/files/Docs/one_million_climate_jobs_2014.pdf



MiddletonJ The public's health and the public health system 180530

Figure 31 The ultimate technological fix?

FACULTY OF PUBLIC HEALTH

Thankyou

John Middleton

president@fph.org.uk

FACULTY OF
PUBLIC HEALTH

www.fph.org.uk

FACULTY OF PUBLIC HEALTH

Appendix

Population Health and Population health management

Layering population health intelligence

FACULTY OF PUBLIC HEALTH

Indicator	Period	All clusters			
		Avg	Worst/ lowest	Range	Best/ highest
1 Recorded dementia prevalence (%) as recorded on practice disease registers (all ages)	2016/17	0.58	0.33		1.02
2 Exception rate recorded by GPs for Dementia as recorded as QOF indicators	2016/17	8.80	4.20		16.28
3 Long-term mental health problems (GP Patient Survey): % of respondents to GP Patient Survey reporting a long-term mental health problem	2016/17	4.43	2.85		9.09
4 % reporting Alzheimer's disease or dementia	2016/17	0.55	0.00		1.17
5 % GP registered population aged under 5 years	2017	6.55	4.80		8.14
6 % GP registered population aged 5-14 years	2017	13.15	10.76		17.38
7 % GP registered population aged 75+ years	2017	6.34	3.79		10.92
8 % GP registered population aged 85+ years	2017	1.80	0.83		3.12
9 % GP registered population aged under 18 years	2017	23.03	18.95		29.78
10 Depression recorded prevalence (QOF): % of patients on GP practice registers recorded as having depression (aged 18+)	2016/17	8.62	5.92		12.14
11 GP patient survey: smoking prevalence	2016/17	14.89	23.78		10.49
12 GP patient survey: ex-smoking prevalence	2016/17	26.11	32.28		14.73
13 Severe mental illness recorded prevalence (QOF): % of people with severe mental illness on GP practice registers (all ages)	2016/17	0.81	0.52		1.35
14 People on primary care mental health register with a comprehensive care plan: % of people on mental health register	2016/17	75.09	9.64		90.59

Key:

- Significantly better than all clusters average
- Not significantly different from all clusters average
- Significantly worse than all cluster average
- Significantly lower than all clusters average
- Significantly higher than all clusters average
- Not compared

CCG value — Benchmark Value — England value

Worst/Lowest — 25th Percentile — 75th Percentile — Best/Highest

BLMK GP Cluster Spine Charts produced by PHE LKIS East

Table 2 a Preventable causes of hospital admission, Sandwell and Western Birmingham Clinical commissioning group, 2012-13

Admission Subgroup	Events 2012/13	Spend 2012/13
Ambulatory Care Sensitive - Chronic conditions	4,732	7,996,049
Ambulatory Care Sensitive - Acute conditions	5,465	8,760,922
Medicines related	810	1,769,949
Self Harm	1,028	592,857
Falls related	2,565	7,326,049
Vaccine preventable	1,379	3,546,201
Alcohol Wholly Attributable	961	1,258,349
Alcohol Somewhat Attributable	1,554	2,560,359
Alcohol Marginally Attributable	7,969	19,378,897
Smoking Wholly Attributable	701	1,508,148
Smoking Somewhat Attributable	8,402	13,612,605
Obesity Wholly Attributable	83	255,235
Obesity Somewhat Attributable	3,346	7,896,152
Obesity Marginally Attributable	657	1,338,593

FACULTY OF PUBLIC HEALTH

Table 2b, Hospital admissions for selected causes for Sandwell and Western Birmingham Clinical Commissioning group, 2012-13

FACULTY OF PUBLIC HEALTH

Admission Subgroup	Events 2012/13	Spend 2012/13
End of Life Care < 3 days	312	467,289
End of Life Care – 3 to 14 days	370	1,229,308
Medically Unexplained Symptoms	3,990	3,483,823
Zero LoS, no procedure, discharged alive - children	4,791	3,051,121
Zero LoS, no procedure, discharged alive - adults	11,066	7,360,967
Cancelled Operations	1,939	502,287
Procedures of Limited Clinical Value - relative ineffective	898	1,059,412
Procedures of Limited Clinical Value – close benefit to harm ratio	1,206	4,338,670
Procedures of Limited Clinical Value – probably aesthetic	651	928,427
Procedures of Limited Clinical Value – lower cost alternative	1,590	3,822,306
Frail Elderly - probably non-acute alternative	2,419	8,170,697
Frail Elderly - possible non-acute alternative	1,134	2,651,518
Admissions via A&E with primary MH diagnosis	682	611,758
Readmissions	8,533	18,521,320

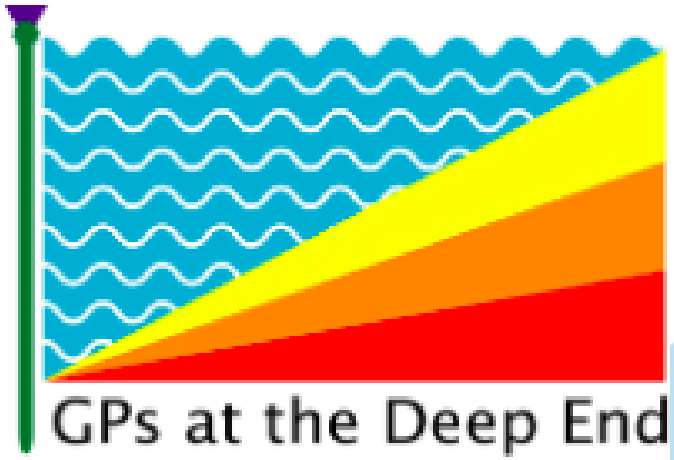
FACULTY OF PUBLIC HEALTH

General Practitioners at the Deep End

General Practitioners at the Deep End work in 100 general practices serving the most socio-economically deprived populations in Scotland.

The activities of the group are supported by: the Royal College of General Practitioners (Scotland); the Scottish Government Health Department; and General Practice and Primary Care at the University of Glasgow.

NEW Deep End Pioneer Scheme



Population health management – A pillar of Primary Care Home

FACULTY OF PUBLIC HEALTH

Developed by the National Association of Primary Care, the model brings together a range of health and social care professionals to provide enhanced personalised and preventive care for their local community.

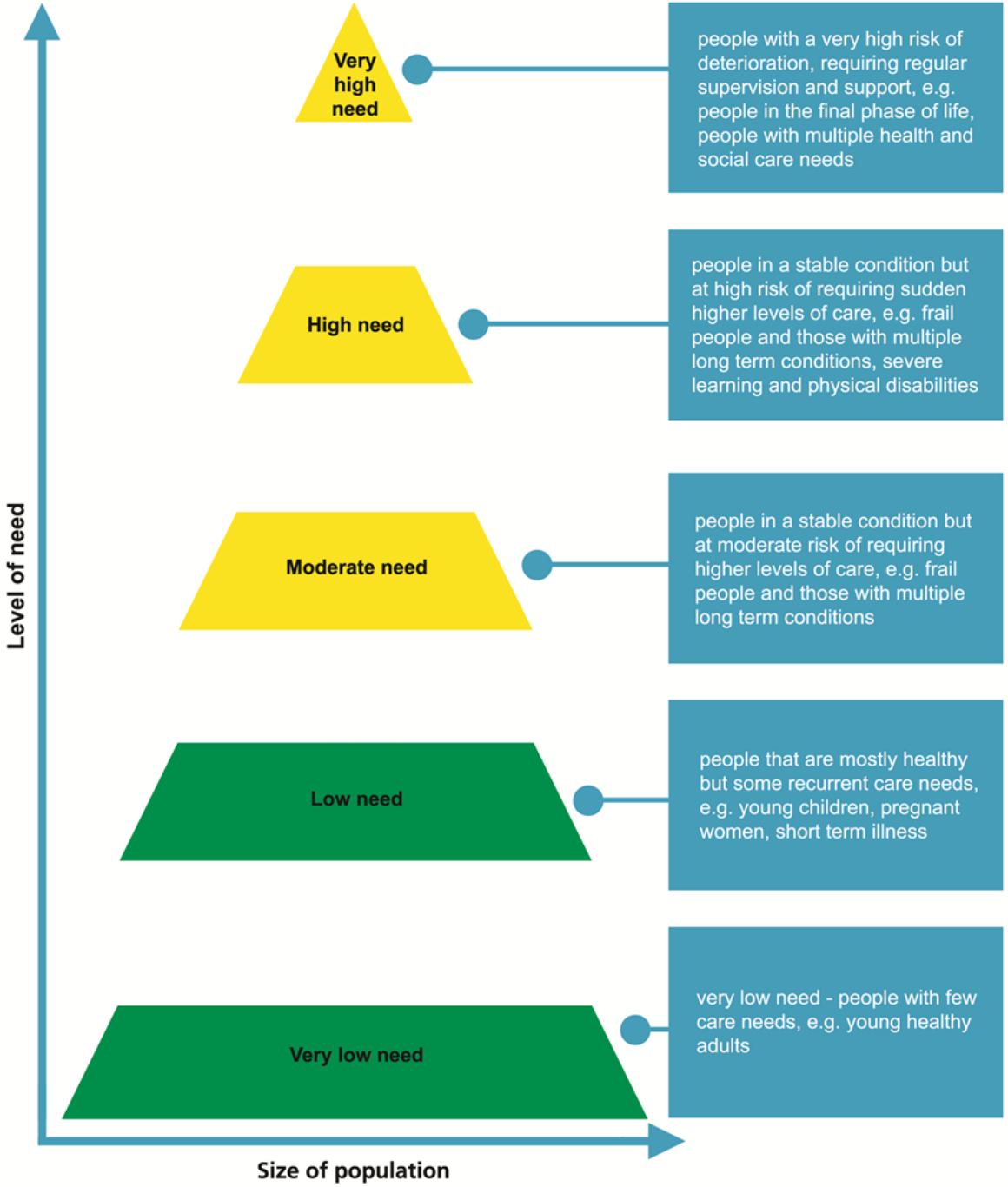
Key features of the model

- A twin focus on personalisation of care and improvements in **population health outcomes**
- An integrated workforce with a strong focus on partnership working, spanning primary, secondary and social care
- Aligned clinical and financial drivers
- Defined, registered populations of 30,000 to 50,000

NAPC | National Association of Primary Care

Adapted from Dr Steve Laitner (@SteveLaitner) and the NAPC

Typical population segmentation



FACULTY OF PUBLIC HEALTH

MSD Clinical Manager

Clinical audit | GMS contract tracking | MSD informatics web page

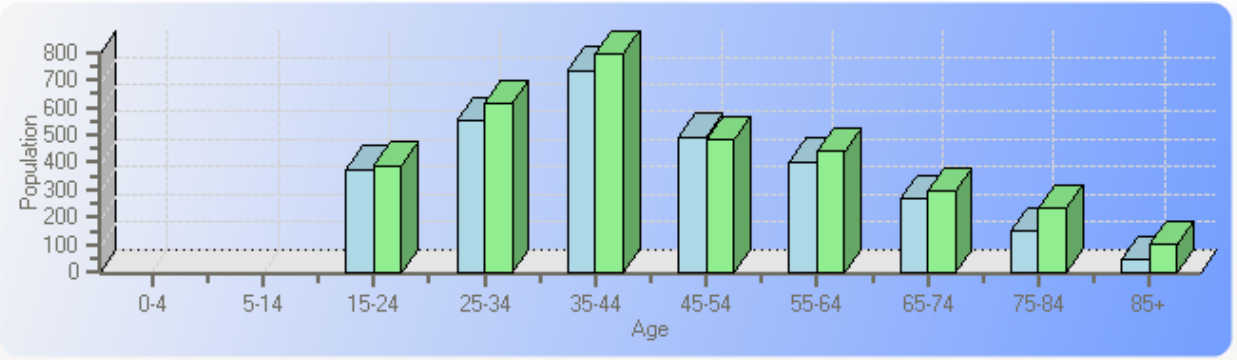
13/06/2007

Patient list | Demographics | Patient Changes | Historic trends

8710 patients analysed:

- Cardiovascular
  - CHD Audit
    - Patients over 18 with PVD ever (108 patients)
    - Patients over 18 with TIA ever (79 patients)
    - Patients with a 10yr Framingham Risk Score >30%
    - Patients with 10yr Framingham Risk score >30%
    - Patients with CHD (G3 Code) (233 patients)
    - Patients over 18 with Diagnosis of Heart Failure (3
    - Patients over 18 with Diagnosis of Angina (166 pa
    - Patients over 18 with Diagnosis of MI ever (103 p
    - Patients with 10yr Framingham Risk score >15.01
    - Patients over 18 with Stroke ever (137 patients)
    - Patients with a 10yr Framingham Risk Score and
    - Number of patients aged 65 years and over immu
    - Patients with 10yr Framingham Risk score not cal
    - Patients with 10yr Framingham Risk score 0-15%
    - Patients over 18 with Atrial Fibrilation (48 patients)
    - Patients over 18 with CHD (233 patients)
  - Familial Hypercholesterolaemia
    - Patients with Cholesterol ever >8.0mmol/L with n
    - Patients with FH not referred for Specialist advice
    - Patients with family history of FH or Premature CH
    - Patients with Familial Hypercholesterolaemia
    - Patients with LDL cholesterol ever over 4.9 mmol/
    - Patients with FH referred for Specialist advice
- Diabetes
- Enhanced Services
- Ethnicity
- Ethnicity (WAG Reports)
- GMS Prevalence
- Gms Contract
  - Asthma Tidy-up Searches
  - Atrial Fibrillation Tidy-up Searches
  - Cancer Tidy-up Searches
  - CHD Tidy-up Searches
    - CHD recorded but No Beta Blockers, ACEi or Sta
    - CHD not recorded: Aspirin/Clopidogrel prescribed

Patients with 10yr Framingham Risk score not calculated (6378 patients)



Gender	0 - 4	5 - 14	15 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85 - 94
Male			375	551	734	492	402	266	150	47
Female			389	615	794	481	438	295	234	101

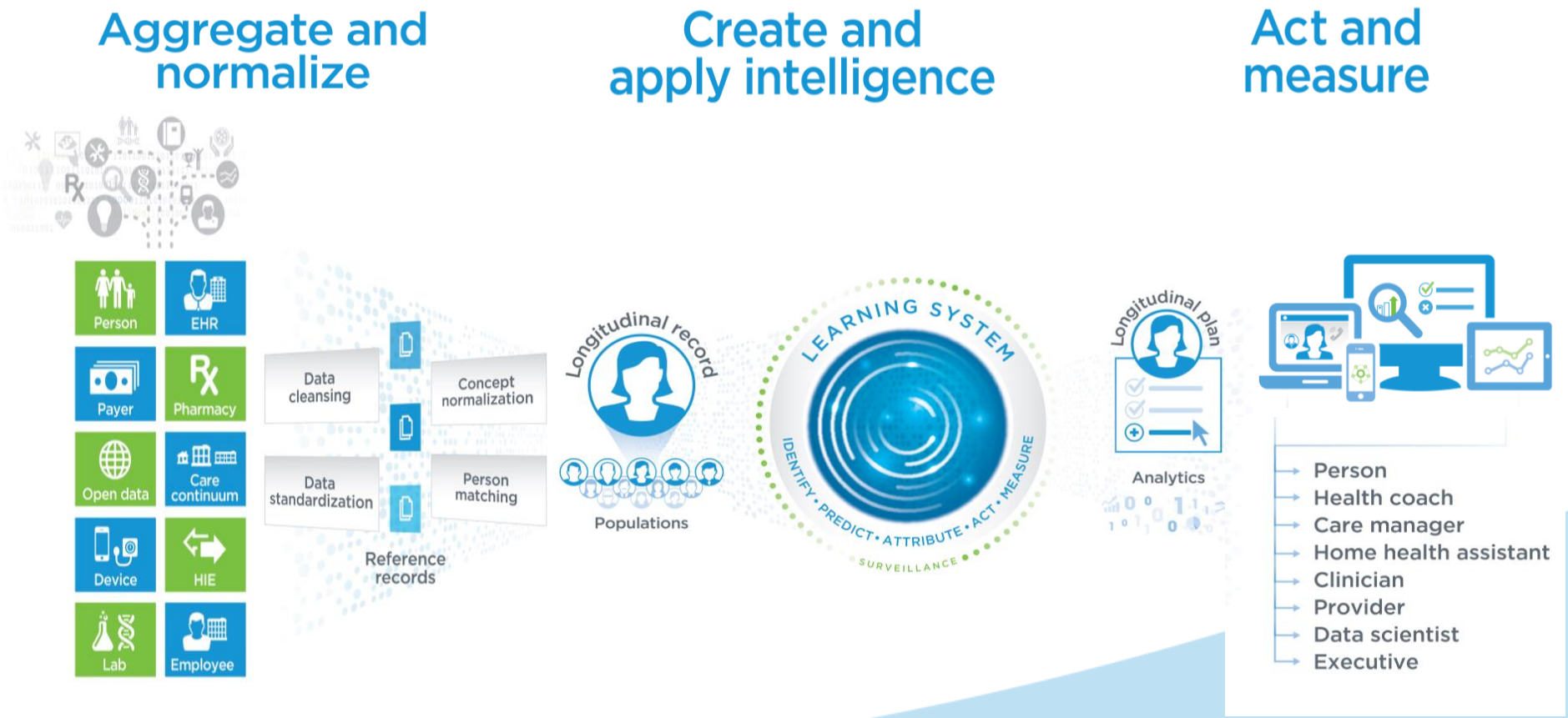
Name	Gender	Age	DOB	GP
Patient1016, ---	M	48	22/09/1958	---
Patient1037, ---	M	45	03/09/1961	---
Patient1050, ---	M	46	21/06/1961	---
Patient1055, ---	M	48	31/05/1959	---
Patient1057, ---	M	49	08/01/1958	---
Patient107, ---	M	46	22/04/1961	---
Patient1077, ---	M	47	02/08/1959	---
Patient1088, ---	M	46	06/08/1960	---
Patient1104, ---	M	50	30/08/1956	---
Patient1119, ---	M	46	20/12/1960	---
Patient1132, ---	M	45	03/03/1962	---
Patient1163, ---	M	50	13/07/1956	---
Patient1206, ---	M	47	12/08/1959	---
Patient1223, ---	M	54	18/05/1953	---
Patient1253, ---	M	46	13/05/1961	---
Patient1258, ---	M	45	28/12/1961	---
Patient1261, ---	M	46	04/04/1961	---
Patient1324, ---	M	47	18/05/1960	---

QOF v9.0

FACULTY OF PUBLIC HEALTH

HealtheIntent platform

FACULTY OF PUBLIC HEALTH



With thanks to Cerner UK

West Suffolk is implementing PHM as a global digital exemplar

FACULTY OF PUBLIC HEALTH

- West Suffolk NHS FT one of first 12 GDE sites
- Started 2016, £10m central funding, concludes March 2019
  - Digital hospital: hardware, software, infrastructure
  - Health information exchange across the system
  - Service user access: patient portal, video consultation, apps
  - Population health management platform…
  - Blueprinting and sharing learning

& everyone will have access to the analytics platform

FACULTY OF PUBLIC HEALTH

Business intelligence, quality improvement

Health needs assessment and outcomes/evaluation

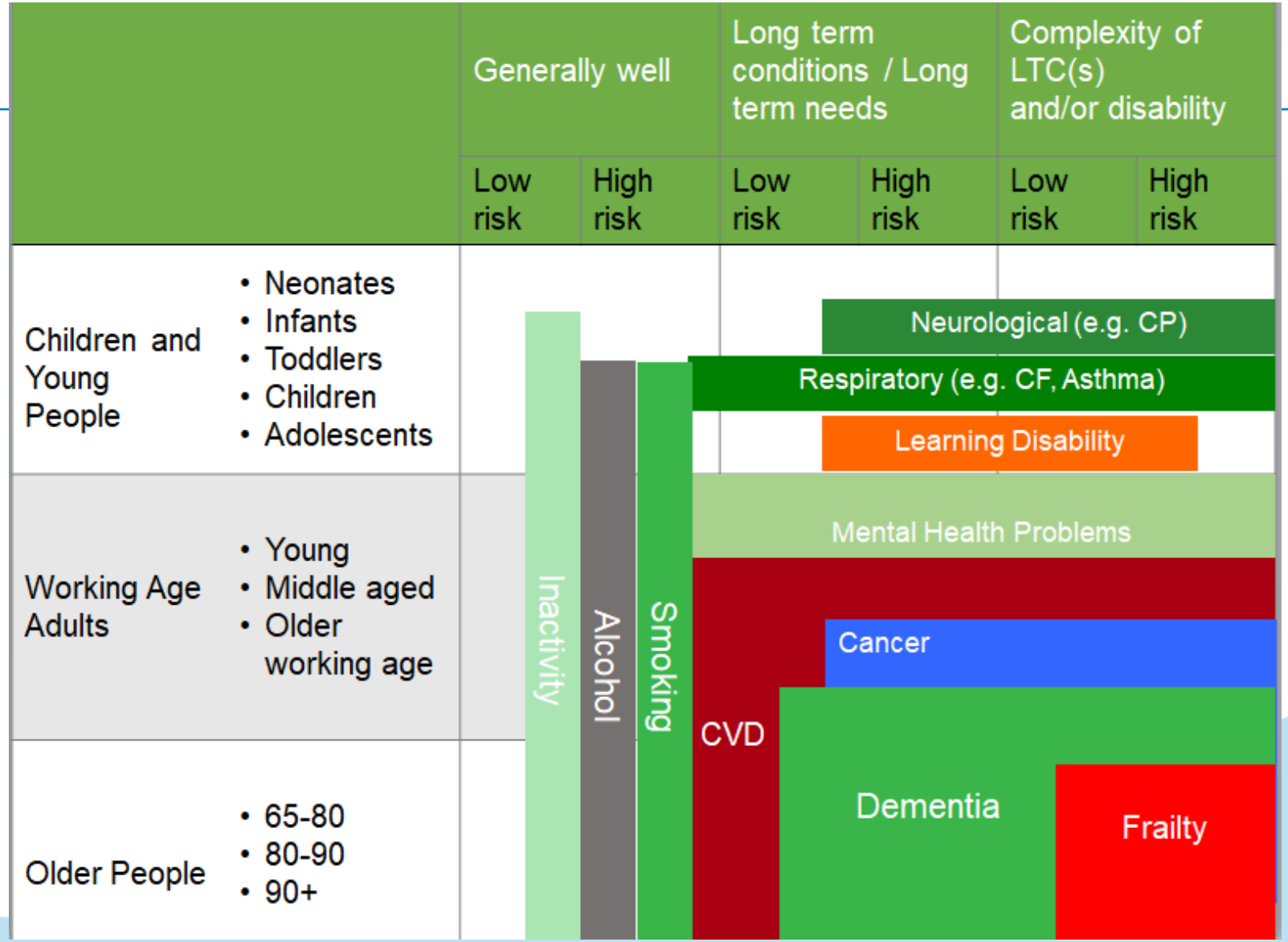
Research

Population health intelligence to drive system transformation priorities:

- Atrial fibrillation
- Risk stratification for integrated neighbourhood teams
- End of life
- A mental health topic TBC

PHE and NHS E July 2018

Mapping health behaviours and conditions



Adapted from Dr Steve Laitner (@SteveLaitner) and the NAPC

FACULTY OF PUBLIC HEALTH

Populating the matrix

FACULTY OF PUBLIC HEALTH

	Generally well		Long term conditions / Long term needs		Complexity of LTC(s) and/or disability	
	Low risk	High risk	Low risk	High risk	Low risk	High risk
Children and Young People (0- 25)		**Risk factors e.g:**	**Single LTC e.g:** • COPD • Cancer • CHD	**2 + LTC**		**1+ LTC with e.g:** • Mental Health Need • Palliative Care need • Social Care need • Dementia • Nursing Home • Residential Home • Disability
Working Age Adults (26- 65)		• Smoker (14yrs +) • Sedentary • High BMI • High BP • Pre-Diabetes • Drug use • High alcohol intake	• Asthma • Mental Health Condition - managed • Diabetes • TIA	**Or**		
Older People (66 and over)			• Hypertension • CHD • RA • MS	**1 LTC plus risk factors**		

Adapted from Dr Steve Laitner (@SteveLaitner) and the NAPC