Public Health England

Protecting and improving the nation's health

The Prevention Challenge – One Year On

A self-assessment review of progress by Clinical Commissioning Groups in the East Midlands

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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Published May 2018

PHE publications
gateway number 2018013

PHE supports the UN
Sustainable Development goals

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Abbreviations

ACS	Accountable Care System
CCG	Clinical Commissioning Group
CAMHS	Child and Adolescent Mental Health Services
CQUIN	Commissioning for Quality and Innovation
FPH	Faculty of Public Health
JSpNA	Joint Specific Needs Assessment
JSNA	Joint Strategic Needs Assessment
MECC	Making Every Contact Count
MSK	Musculoskeletal
NDPP	National Diabetes Prevention Programme
NHS FYFV	NHS Five Year Forward View
NICE	National Institute for health and care excellence
ONS	Office for National Statistics
PHE	Public Health England
QIPP	Quality, Innovation, Productivity and Prevention Programme
QOF	Quality and Outcomes Framework
STP	Sustainability Transformation Plan

Foreword – Public Health England

Public Health England (PHE) fulfils the Secretary of State for Health's duties to protect health and address health inequalities, and executes the Secretary of State's power to promote the health and wellbeing of the nation. PHE undertakes a range of evidence-based activities that span the full breadth of public health, working locally, nationally and internationally.

A core function of PHE is to improve population health through sustainable health and care services.

We aim to secure improvements to the public's health, including supporting the system to reduce health inequalities and to deliver the priorities set out in *'From Evidence into Action'* and the NHS Five Year Forward View commitments for a radical upgrade in prevention. We do this through our own actions and by supporting Government, local government, the NHS and the public to secure the greatest gains in physical and mental health, and help achieve a financially sustainable health and care system.

As demand for health and care services continues to rise, our work on prevention and demand management is critically important. Working with the NHS and local government, PHE supports local implementation of the NHS Five Year Forward View prevention agenda - particularly on closing the health, financial and quality gaps - to help reduce avoidable increases in demand on the NHS.

The Prevention Challenge

As set out in *'From Evidence into Action'*, PHE has an ambition: for people of this country to live as well as possible, for as long as possible. This report recognises the challenge we face as a society in tackling the current epidemic of largely preventable long-term diseases. We may be living longer, but we – and future generations – risk spending many of these extra years in poor health. The need to tackle major risks such as obesity, poor diet, physical inactivity, smoking, and excessive alcohol consumption has never been more pressing.

It is simply not feasible to think that the health challenge we face can be solved by spending ever more on hospitals, clinicians and care services treating people who are ill. Resources are scarce and the health and care sectors are under huge pressure from constrained budgets and rising demand. Something else has to change.

In *'Meeting the Prevention Challenge in the East Midlands: A Call to Action'* we set out to provide practical recommendations to commissioning organisations about the part they need to play in delivering a radical up-grade in prevention.

In taking forward our Prevention Challenge, we have established a supported self-assessment programme and have demonstrated through this that there are criteria against which the prevention effort of commissioning organisations can be assessed. Furthermore, self-assessment can support the identification of progress and next steps within this agenda.

Our findings show positive action is being taken and that commissioning organisations are ideally placed to support the delivery of prevention activities but there is still much more to be done if the NHS Five Year Forward View vision is to be achieved.

The work set out in this report aims to support commissioning organisations to assess their own progress on prevention activities and to encourage them to adopt systematic prevention policies, plans and programmes. It shines a light on an important area of work and I recommend it to both NHS Provider and NHS Commissioning organisations.

Dr Fu-Meng Khaw

Director, Public Health England East Midlands

Foreword – East Midland Clinical Senate

Clinical Senates have been established to be a source of independent, strategic advice and guidance to local health and care systems, to assist them to make the best decisions about healthcare for the populations they represent.

The Clinical Senate is pleased to endorse this report which has been led by Public Health England. Preventing ill health is the first job of any strategy or plan on healthcare and has been a key East Midlands Clinical Senate line.

This report builds on work previously undertaken to develop a clear understanding of what it would mean for provider and commissioner organisations to deliver the Five Year Forward View's prevention challenge.

It is widely recognised that there needs to be a significant improvement in helping people to live healthier lives as avoidable illness is widespread. We have already begun to see national action on obesity, smoking, alcohol, and other major health risks.

Self-assessment tools developed as part of this work create a robust and consistent methodology for provider and commissioner organisations to evaluate their current position against the original recommendations, and to identify strengths, gaps, and their own next steps.

Work in this important area can only be commended, particularly as we know that the NHS faces a level of unprecedented challenge as demand for services increases.

Dr Neill Hepburn Professor Ashley Dennison

East Midlands Clinical Senate Co-chairs

1. Executive summary

Public Health England (PHE) in the East Midlands and East Midlands Clinical Senate jointly published *'Meeting the Prevention Challenge in the East Midlands: A Call to Action'* in December 2015. Drawing on the NHS Five Year Forward View, this report sets out the case for prevention across NHS organisations in the East Midlands, including 10 practical recommendations for NHS Provider Trusts and 10 recommendations for Clinical Commissioning Groups (CCG).

To support delivery of prevention action and as part of the PHE's system leadership role, a self-assessment toolkit was developed for CCGs and PHE sought approval for its use from stakeholders including the CCG Congress and CCG Chief Officers. Directors were nominated to lead the self-assessment for their organisation's practice and to plan next steps. The self-assessment tool is based on *The Prevention Challenge* report's recommendations and structured on the NHS Commissioning Cycle:

1. Strategic planning
    1.1. Assessing needs
    1.2. Reviewing service provision
    1.3. Deciding priorities
2. Procuring Services
    2.1. Designing services
    2.2. Shaping structure and supply
    2.3. Planning capacity and managing demand
3. Monitoring and evaluation
    3.1. Supporting patient choice
    3.2. Managing performance
    3.3. Seeking patient and public views

The tool consists of 40 statements asking organisations to self-assess using a 4 point scale to discern the level of systematised approach within the CCG. Following their self-assessment, CCGs were asked to highlight any areas of good practice or opportunities for development that they felt they had.

Between July and November 2017 supported self-assessments were completed in 6 out of the 19 CCGs belonging to East Midlands STPs (32%). Some CCGs preferred to wait whilst Sustainability Transformation Plan (STP) refreshes were occurring or while local system reconfigurations and moves towards Accountable Care Systems (ACS) took place, whilst others just lacked the capacity to prioritise engaging. The low take up

rate illustrates the pressures on East Midlands CCGs during this period, but also where prevention sits within their priorities.

Due to the supported self-assessment methodology the detailed information from each CCG is owned by the CCG and therefore not included in this report, strengths and next steps are, however, included (Section 5).

The interpretation or knowledge provided of or about each statement often depended on the people in the room and their particular job roles. For example Human Resources (HR) staff often had more information about workforce health strategies, meaning that self-assessments where HR staff were not present were less detailed regarding workforce health than those where they were present. Given this difference in self-assessment participants, it is not possible, and was never intended, to compare CCGs against each other. Nevertheless common themes have emerged and an overview of these is provided in Section 6. In summary:

1. All CCGs had a strong commitment to prevention recognising its importance both in terms of cost effectiveness and health impact. All had examples of different prevention activities but none demonstrated a holistic approach to prevention perhaps reflecting the differing interpretations of prevention. There was little evidence of a clear strategic approach to embedding prevention within all aspects of commissioning and as a result all CCGs felt that their approach to prevention could be more systematic.

2. All CCGs reported a lack of capacity to consider or truly harness their organisational prevention potential. All regretted this but felt they had neither the time nor the luxury of fully embracing prevention given other competing priorities which came with both financial and time pressures.

3. None of the CCGs linked their prevention agenda to NHS England governance or leadership structures nor felt accountable for any prevention activities they did or did not do.

4. Despite most CCGs having local authority Public Health Consultant representation on their governing bodies these are non-voting representatives and none of the CCGs had a formally appointed director level board champion for prevention. Equally none had an overarching strategy for prevention though some linked to their STP strategy or had prevention incorporated in other corporate strategies.

5. CCGs worked most closely with public health colleagues regarding the Joint Strategic Needs Assessment (JSNA) and identification/prioritisation of need.

6. Not all CCGs were fully aware of the potential expertise that public health colleagues can provide and although all CCGs worked with public health to a varying degree, all

felt that there were opportunities for greater joint working. This was mirrored by those local authority public health colleagues involved in the self-assessments (4 out of 6 assessments).

7. There were some examples of good practice around prevention but few opportunities for promoting this or learning from others.

8. Two CCGs reported ongoing work around Making Every Contact Count (MECC) and most had examples of projects or initiatives, for example a smoking cessation intervention for pregnant women. However most of those involved in the assessments were unaware of or reported a lack of systematic monitoring or evaluating of MECC outcomes; MECC did not appear to be on the radar of those involved possibly because this was not their area of work.

9. All CCGs reported using RightCare[1] to support priority setting and tackling variation, though the degree to which this happened varied between CCGs. Even those who felt they had only just started to use RightCare reported increasingly relying on it to support their work.

10. Most of the CCGs did not have an overall workplace health and wellbeing strategy but had separate initiatives such as annual occupational health checks or access to smoking cessation.

In conclusion, there is widespread recognition regarding the role of prevention in contributing to a more sustainable health system resulting in a genuine commitment to prevention and a genuine desire to do more.

The NHS Five Year Forward View (FYFV) calls for a “radical upgrade in prevention”, for the “future health of millions of children, the sustainability of the NHS and the economic prosperity of Britain.” It calls for strong leadership and a systematic approach in order to prevent progress on healthy life expectancies stalling and health inequalities widening. However CCGs are under huge competing pressures. There are no national ‘prevention incentives’ for CCGs similar to the Commissioning for Quality and Innovation (CQUINs) for NHS Providers. Consequently, despite clear evidence that investment in prevention will save money, for many CCGs, prevention comes at the bottom of a long list of competing priorities; it is not seen as saving money in the current NHS planning time frame. As a result there is significant variation in approach and practice to prevention, a lack of clear systematic approach and leadership and no evidence of a “radical upgrade in prevention”. For many CCGs the prevention agenda feels like a luxury they simply cannot afford.

[1] An NHS England supported programme which aims to identify and tackle over and under use of resources, identify priority programmes and identify and reduce unwarranted variation, see: www.england.nhs.uk/rightcare

2. The East Midlands population: making the case for prevention

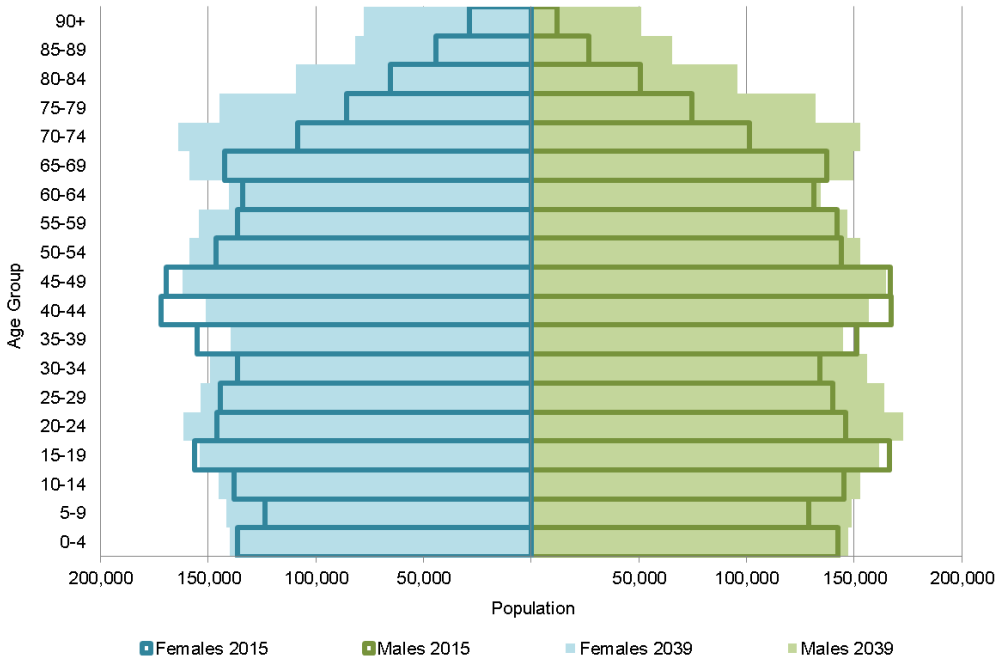
2.1 Summary

In the East Midlands, the population is both growing and ageing. People are living longer in ill health and this is particularly true for those in the more deprived groups who are likely to have more complex needs. The most common causes of ill health are due to lifestyle factors such as diet, smoking and alcohol or obesity, and this means that ill health is largely preventable, ie by adopting healthier lifestyle habits many people could avoid or delay the onset of illnesses later in life. Although preventable deaths in the East Midlands have decreased in recent years, indicators for unhealthy lifestyle factors are stabilising across the region and in general show little improvement over time. This means that, without significant action to change this trajectory, we can expect to see the most common causes of ill health continuing to result in more people living longer but in poor health.

2.2 An ageing population

In 2015 the population of the East Midlands was estimated to be 4,677,038 people. Of these, 877,557 were over 65 years of age, corresponding to 18.7% of the population (Figure 1). By 2039 the population is projected to rise to 5,338,800 people, of whom 1,382,600 will be aged 65 or over (ie 25% of the population).

Figure 1: Mid-2015 population estimates and 2039 population projections by age group and sex for the East Midlands. Source: ONS



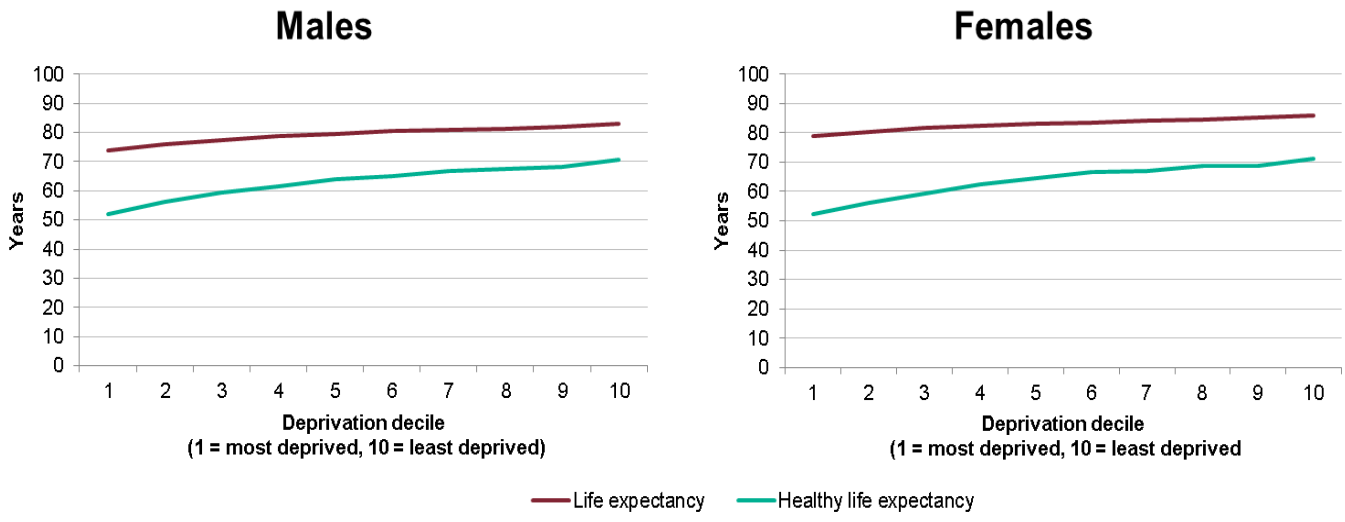
2.3 Life expectancy and the 'window of need'

Life expectancy at birth has gradually increased since 2001 to 2003 in the East Midlands. In the period 2013 to 2015, the highest life expectancy at birth was in Rutland for both males and females at 81.8 years and 85.2 years respectively, while the lowest were in Nottingham at 76.8 and 81.4 years respectively. The average life expectancy at birth across the East Midlands is 79.3 years for males and 82.9 years for females, both significantly lower than the national average.

Healthy life expectancy, the number of years lived in good health, has remained stable since 2009 to 2011, with the highest in Rutland and lowest in Nottingham for both males and females. In the East Midlands in 2013 to 2015 the healthy life expectancy for males was 62.5 years (significantly worse than the national average) and 63.5 years for females (similar to the national average).

There is a correlation between life expectancy and deprivation and between healthy life expectancy and deprivation. As shown in Figure 2, people in the least deprived deciles of the population have a higher life expectancy and live a greater number of years in good health than people in the most deprived deciles.

Figure 2: Life expectancy and healthy life expectancy at birth for males and females, East Midlands, England, 2013-15. Source: PHOF

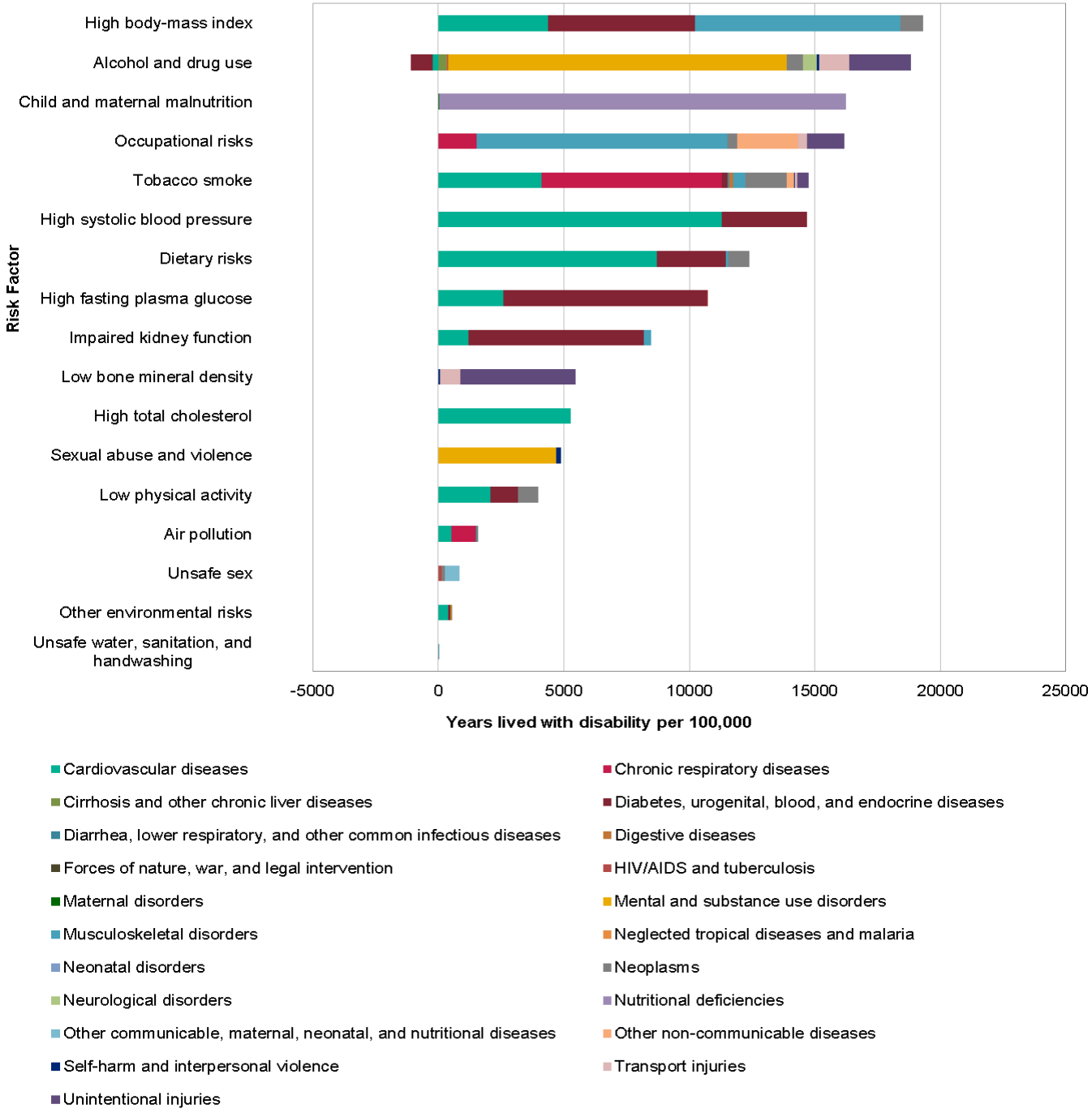


The gap between life expectancy and healthy life expectancy is referred to as the 'window of need' and is the number of years that an individual can expect to live in ill health, almost certainly with the support of health and care services. In England, a male living in the most deprived areas will live for 22.1 years in ill health, while a male in the least deprived areas will live for 12.5 years in ill health. Females in the most deprived areas will live for 26.7 years in ill health, compared with females in the last deprived areas who will live in ill health for 14.7 years.

2.4 Risks to health and the causes of disability

The World Health Organisation (WHO) Global Burden of Disease Study highlights the most common risk factors that lead to years lived in disability. In the East Midlands, the top 5 risk factors leading to years lived in disability are obesity, alcohol and drug use, poor diet, occupational risks and smoking (Figure 3). Many of the risk factors identified in the region lead to disability through cardiovascular diseases and diabetes, urogenital, blood and endocrine diseases.

Figure 3: Years lived with disability per 100,000 population by risk factor and cause of injury, East Midlands. Source: WHO Global Burden of Disease Study 2015



3. Background

3.1 Foundations: The NHS Five Year Forward View

In December 2015, Public Health England (PHE) in the East Midlands and the East Midlands Clinical Senate published a joint report called *'Meeting the Prevention Challenge in the East Midlands: A Call to Action'.* The report followed the national publication in October 2014 of the NHS Five Year Forward View (FYFV) which called for a ***"radical upgrade in prevention and public health"*** in the face of the sharply rising burden of avoidable illness threatening the sustainability of the NHS. The FYFV argued that previous warnings about the rising tide of avoidable illness had not been heeded and that the NHS is now on the hook for the consequences. It suggested that the economic after-effects of recent global recessions make it implausible to think that NHS budget growth could continue to keep pace with the rising demand for health care for a growing population which is becoming older and sicker. Something else must change.

The FYFV required NHS organisations to play a more active part in prevention by backing hard-hitting national action to tackle obesity, smoking, alcohol and other major health risks for both patients and the NHS' 1.3 million staff. NHS organisations were therefore required to set a national example as employers, to use NHS influence to advocate for public health measures, to commit NHS organisations to policies with prevention at their heart and to use the combined purchasing power of the NHS to improve health. Many of these themes and issues are re-asserted in the 'Next Steps on the NHS Five Year Forward View' document published in March 2017. Examples include reducing unwarranted variation in care, tackling obesity, increasing access to primary care services, prevention of cardiovascular disease and using the RightCare programme to identify prevention priorities and reduce variation. Actions for NHS Providers included the need for all NHS estates to become completely smoke free and NHS Provider Trusts being required to screen, deliver brief advice and refer patients who smoke and/or have high alcohol consumption.

3.2 Prevention matters

In common with much of the rest of the UK, the East Midlands population is both growing and aging with more people living to very old age (ie over 85). However, although more people are living longer, many people are becoming ill younger as a result of smoking, drinking too much alcohol, eating a poor diet and being physically inactive. Whilst ever more effective treatments are helping people to live longer and to survive acute episodes of illness, it is often not possible to undo the underlying damage to health and this means that more people are living for many years with poor health towards the end of their lives.

As well as the human cost to individuals having to endure the limiting and/or unpleasant experience of long-term illness, the societal costs of this are enormous. In terms of the pressure on health and social care services, the King's Fund estimated in 2014 that rising demand for NHS services will lead to a £30 billion funding gap in the NHS by 2020/2021.

The government committed to providing an additional £8bn for the NHS over 5 years leaving £22 billion required through the delivery of efficiency savings as set out in the FYFV. In Social Care, the Local Government Association estimated a £15 billion funding gap over the same period as a result of rising demand for social care services against a back drop of reduced local government funding.

3.3 What can be done?

Improving the health of the population and increasing the number of years people can expect to live in good health (healthy life expectancy) is clearly not something that the NHS can deliver on its own. It requires support and action across government, from employers, businesses and many agencies as well as from all of us as individuals taking action in our own lives. However, the NHS is well placed to make a difference. Indeed, sometimes the NHS is uniquely well placed to offer advice and support or to influence the lifestyle decisions that will shape the habits and health of a lifetime for individual patients and staff members.

The report *'Meeting the Prevention Challenge in the East Midlands: A Call to Action'* set out to stimulate and support action on prevention by NHS provider and commissioning organisations in the East Midlands. It highlighted the projected rises in demand for health and care services and described an expanding 'window of need' for health and care services as the populations' healthy life expectancy falls further behind total life expectancy. The report provided a framework for prevention action by identifying areas for intervention and highlighting case studies of local good practice. Implicitly targeted towards the NHS, the requirements of the FYFV were incorporated into sets of **'Prevention Top Ten'** recommendations for both NHS commissioning organisations and NHS provider organisations respectively. These recommendations aimed to provide practical support to enable organisations to deliver their part of the required radical shift towards prevention.

3.4 Prevention top 10 recommendations for NHS commissioners

The full report of *'Meeting the Prevention Challenge in the East Midlands: A Call to Action'* is available via the East Midlands Clinical Senate and can be accessed via: http://www.emcouncils.gov.uk/write/east-midlands-prevention-challenge-report-2015-final.pdf

The report's recommendations for NHS commissioning organisations are relevant as broad recommendations of good practice and are detailed below (italics and bold as in original report):

1. To embed Prevention within corporate governance structures, appoint a board level champion for Prevention and Public Health and develop Prevention Impact Assessment for all policies, plans and programmes.

2. To mainstream commissioning for Prevention, ensuring a whole pathway approach to maximise primary, secondary and tertiary prevention within all pathways. For example, to aim for 100% take up of Cardiac Rehabilitation.

3. To embed Making Every Contact Count (MECC) within all contracts and commissioning, ensuring data collection and contract management reflects MECC outcomes.

4. To work in partnership through Health and Wellbeing Boards to develop clear prevention and lifestyle service pathways with a single point of access.

5. To tackle variation across clinical services, and reduce exception reporting within QOF.

6. To adopt Proportionate Universalism and target prevention activity where it is most needed.

7. To develop the role of the organisation as an advocate for prevention and health improvement within local and national policy debates.

8. To work with Health and Wellbeing Boards and other partners to commission collaboratively, incorporating prevention into pathways and removing barriers to access.

9. To develop a Corporate Social Responsibility strategy with prevention at its heart to maximise the organisation's impact for prevention across its staff, estates and corporate activity.

10. To consider system, scale and consistency in the organisation's approach to prevention to ensure delivery of an equitable population level impact.

The report was shared widely across the health and social care system during 2016 and its influence was evident within each of the 5 Sustainability and Transformation Plans (STPs) in the East Midlands. As part of the dissemination strategy, the report was shared with NHS Provider Chief Executives, Directors of Public Health and Clinical Commissioning Groups (CCGs). Clinicians from across the East Midlands attended Clinical Senate 'Prevention' events in April 2016 and the report was additionally presented to the Acute Trust Chief Executives forum.

3.5 One year on

3.5.1 NHS Provider organisations

In October 2016 the Clinical Senate Council agreed to support a piece of follow-up work to assess the impact of the report and its recommendations and to encourage further progress. This follow on work became known as *'The Prevention Challenge - One Year On'* and was originally aimed at NHS Provider Trusts to:

1. Develop a self-assessment tool to facilitate supported self-assessments of progress against the Prevention Top Ten recommendations

2. Identify areas of good practice and any opportunities or barriers to further prevention work as part of the supported self-assessment process.

3. Analyse and disseminate common themes and key findings.

Supported self-assessments in 12 out of 15 NHS Provider Trusts in the East Midlands were carried out between December 2016 and June 2017.

The subsequent report – *'The Prevention Challenge – one year on: A self-assessment review of progress by NHS Provider Trusts in the East Midlands'* revealed some gaps but equally notable progress and a genuine commitment to prevention. However prevention activity did not appear to be prioritised or driven consistently across all organisations with many reporting a lack of capacity for prevention. The use of CQUINs provided good incentives in certain areas (such as staff wellbeing) but areas without such incentives or input from commissioning bodies meant that many providers felt there was a lack of "meaningful dialogue about their prevention work through the wider governance 'machinery' of the NHS".

3.5.2 Clinical Commissioning Groups (CCGs)

This generally perceived lack of "meaningful dialogue" alongside increasing appreciation of the usefulness of the supported self-assessments with Provider Trusts facilitated a momentum to offer a similar opportunity to NHS commissioning organisations or CCGs. As a result, with the support of the Clinical Senate and the East Midlands CCG Congress, it was agreed that PHE would:

1. Develop a CCG appropriate self-assessment tool to facilitate supported self-assessments of progress against the commissioning Prevention Top Ten recommendations.

2. Offer and carry out (where accepted) supported self-assessments of all CCGs within the East Midlands to review progress against the Prevention Top Ten recommendations for commissioning organisations.

3. As part of the process, identify areas of good practice, opportunities or barriers to further prevention activity and work.

4. Identify any common themes or key findings from across all commissioning organisations, including individual CCG and East Midlands wide potential next steps and further actions.

5. Disseminate findings and next steps/further actions.

4. Methodology

4.1 Development of self-assessment tool

The main objective in developing the toolkit for CCGs was to make it as relevant and simple as possible in order for any commissioning organisation to be able to use regardless of PHE input or support. The tool used the top ten recommendations from "*Meeting the Prevention Challenge in the East Midlands: A Call To Action"* as a base and structured these and other supporting documents around the 3 domains of the NHS commissioning cycle:

1. Strategic planning
    1.1. Assessing needs
    1.2. Reviewing service provision
    1.3. Deciding priorities
2. Procuring Services
    2.1. Designing services
    2.2. Shaping structure and supply
    2.3. Planning capacity and managing demand
3. Monitoring and evaluation
    3.1. Supporting patient choice
    3.2. Managing performance
    3.3. Seeking patient and public views

Other documents used in the development of the toolkit included:

- The NHS Five Year Forward View
- Meeting the Prevention Challenge in the East Midlands: A Call To Action
- NHS England. Commissioning for Prevention

- NICE guidelines on workplace health
- NHS Statement of support for tobacco control
- RightCare Commissioning for Value packs

Links to all documents and guidance were included as part of the toolkit as well as definitions of the 3 tiers of prevention – primary, secondary and tertiary. The final tool had 40 statements on an excel spreadsheet asking organisations to self-assess themselves on a 4 point scale:

We **CAN NOT** demonstrate this practice/haven't made any progress in our organisation	0
We can demonstrate **some relevant practice** within our organisation but can identify room for improvement	1
We can demonstrate that this practice is **systematic in some departments or teams** within our organisation and have evidence to support this	2
We can demonstrate that this practice is **systematic across the whole organisation** and have evidence to support this	3

Please see Appendix 1 for a complete list of questions included in the toolkit.

4.2 Approach

4.2.1 Securing system-wide support

An East Midlands Clinical Senate Council meeting on 4 October 2016 provided strong support for undertaking a collaborative review of progress for NHS Provider Trusts with similar support and agreement given by the East Midlands Directors of Public Health and the East Midlands Acute Trust Chief Executives fora. Additional support and commitment to be involved was given by the CCG Congress on 18 November 2016 and 12 May 2017 on behalf of CCGs within the East Midlands. Such contacts and discussions with organisational and system leaders ensured a high level support and mandate to take the work forward for both NHS provider and commissioning organisations.

4.2.2 Timescale, capacity and context

An original timescale was set for supported self-assessments to be offered and completed by the summer of 2017. However, this piece of work came during a period of considerable change for CCGs. Several CCGs were undergoing management level mergers with neighbouring CCGs, some were heavily involved in their respective STP refresher process and others in the initial stages of discussing a move towards an

Accountable Care System (ACS). Consequently, despite all CCGs being invited to take part, some felt that carrying out a single CCG self-assessment was not the right approach preferring to wait until their ACS or refreshed STP was in place. Others were unable to source the capacity they felt was needed to do the self-assessment justice and asked to revisit the process at a quieter time.

Finding the right time to carry out this piece of work was always going to be difficult and while it is a shame that it was not possible to carry out more assessments those that were involved reported the process as useful and at least one CCG intended to incorporate discussions and conclusions into their CCG planning cycle.

Supported self-assessments were carried out between July and November 2017. Those involved had generally been nominated by their CCG Chief Officer and had in turn nominated other appropriate colleagues to be involved. Meetings involved from 2 to 4 representatives and in 2 instances included public health input from the local authority. Job roles of those involved varied meaning that responses to different sections of the assessment varied (re: detail and/or awareness) depending on knowledge or job role.

- Head of Planning, Partnerships and Improvement
- Transformation Delivery Manager
- Director of Strategy & Implementation
- Director of Operations and Corporate Affairs
- Programme Director Primary Care & Neighbourhood Teams
- Director of Nursing & Quality
- Director Primary Care
- Head of Planning
- Service Improvement Manager
- Public Health Consultant
- Chief Commissioning and Performance Manager
- Head of Planned Commissioning & Strategy
- Locality Lead

4.2.3 The supported self-assessment process

The intention of this work was for it to be a collaborative, supportive process recognising that many CCGs are already strongly committed to leading, delivering or supporting prevention activities in their local area or beyond.

The completed toolkit was presented to the CCG Congress in May 2017 where it was agreed that the best approach would be to contact all CCG Chief Officers of the 19 CCGs belonging to East Midlands STPs asking them to nominate a Director/s to lead the self-assessment process (see Appendix 2 for all invited CCGs). Following identification of a lead Director, an introductory email/phone call was made outlining the

process, a copy of the self-assessment tool sent and arrangements made to meet the lead Director and other CCG nominated Directors as relevant. It had been anticipated that CCGs would prefer to at least partially complete the tool before the supported self-assessment meeting but in reality most preferred to complete the tool as part of the supported self-assessment.

Lead Directors were all asked to invite relevant colleagues to participate in the self-assessment discussions though it was often difficult to get everyone together at the same time due to time and diary constraints. In those instances where there was insufficient time or knowledge to complete any part of the self-assessment, details were completed after the meeting by relevant staff.

Self-assessment discussions lasted between 45 minutes and one and a half hours and were led by PHE. During each a brief introduction provided an overview on the background of the work, the commitment of the Clinical Senate and CCG Congress and an emphasis that the completed self-assessment was for the use of the CCG and the CCG alone. It had been agreed from the start that the self-assessment was meant to support CCGs with their prevention agenda, that it shouldn't be seen as monitoring or inspection but as a way of allowing CCGs to genuinely review where they were regarding their prevention activity providing a supported opportunity to discuss next steps and potential developments through a process of continual improvement. As a result it was agreed that self-assessments or overall scores would not be published but that PHE would publish agreed individual CCG strengths, next steps and common themes from all self-assessments.

Supported self-assessment meetings discussed each statement in turn with examples provided or further details sought where necessary. CCGs self-scored each statement on the 4 point scale and at the end of all statements were asked to identify any key strengths and next steps. Notes taken during the meeting were completed on the excel spreadsheet following the meeting and these were sent back to the CCG with a copy of strengths and next steps for final agreement. In a few instances CCGs updated the spreadsheet following the meeting after further discussions with colleagues.

4.3 Completed self-assessments

Of the 19 CCGs belonging to East Midlands STPs, 6 completed a supported self-assessment between July and November 2017 (32%). One assessment was carried out jointly on 2 CCGs:

East Leicestershire & Rutland CCG	31 October 2017
Erewash CCG	4 October 2017
Leicester City CCG	12 July 2017

South Lincolnshire CCG & South West Lincolnshire CCG	28 September 2017
West Leicestershire CCG	22 November 2017

5. Self-assessed strengths and next steps

5.1 East Leicestershire & Rutland CCG, 31 October 2017

5.1.1 Strengths

- There is a positive belief in prevention within the CCG with recognition that it is both cost and health effective
- The CCG has good knowledge and evidence around chronic disease particularly around diabetes and is a national lead within the National Diabetes Prevention Programme (NDPP). It is good at case finding and sets stretch targets to reduce exception reporting.
- The CCG is committed to using the evidence base in delivering its prevention activities with recent examples being its involvement with the new Musculoskeletal (MSK) triage service and low back pain re-developed pathway following recent NICE guidelines.
- There is good engagement with partners and stakeholders including genuine clinical engagement, engagement with district councils and the local population.

5.1.2 Next steps

- To consider formalising its prevention strategy: making the implicit explicit. This could include having a CCG board level prevention champion to work alongside the public health consultant representative, developing a corporate prevention strategy allowing for a more formal and systematic way of assessing its prevention impact and for monitoring/identifying potential gaps.
- Continue to develop/use links with public health and identify more opportunities of working together; increase understanding of the input public health could provide and the best way to make use of its expertise. This may help the CCG to increase its understanding of key priorities, needs, or national messages and provide an identified opportunity for evidence reviews to feed into commissioning plans.
- Developing ways to more formally target those communities most in need. This could be an example of something that public health could provide support for.
- Explore opportunities for greater early primary prevention. This could be an example of something that public health could provide support for.

5.2 Erewash CCG, 5 October 2017

5.2.1 Strengths

- The CCG has a clear picture of the health needs of its population and how it wants to address these; it actively explores ways to address these needs in collaboration with partners and stakeholders.
- There are good operational links with public health colleagues that allow for strong joint working arrangements at an operational level.
- There are some good examples of innovative joined up practice such as work around smoking in pregnancy and alcohol licence applications in schools, which show that large amounts of money are not always necessary to improve public health.
- The CCG actively uses RightCare and other similar resources to identify priorities, with regular reviews to ensure plans are in line with current identified need. There is a good system of incorporating priorities and/or changes in the CCG planning processes and good consultation and priority development with partners and stakeholders.

5.2.2 Next steps

- To consider identifying a formal Board level champion for prevention.
- To explore opportunities to develop a more systematic approach to prevention by developing an associated corporate vision/strategy which would enable prevention to be considered in all CCG policies, procedures and contracts in addition to providing a method of monitoring and reviewing prevention activities.
- To discuss the potential for introducing a prevention impact assessment process for all reports, plans and programmes similar to the current equality and quality impact assessment process.
- To build on the good operational links with public health colleagues to develop greater strategic links.
- To look at opportunities to showcase areas of good practice such as the smoking in pregnancy work and alcohol licence applications. This is something that PHE could provide support with if useful.
- To look at ways to develop the CCG's approach to Make Every Contact Count (MECC).

5.3 Leicester City CCG, 12 July 2017

5.3.1 Strengths

- The CCG is an active member of the Health and Wellbeing Board and has strong links with public health to the extent that strategies and priorities are based on up to date identification of need via Joint Strategic Needs Assessments (JSNA) and Joint Specific Needs Assessments (JpSNA) and other public health data sources.
- The CCG is a national lead on diabetes prevention, dementia prevalence and NHS Health checks.
- The CCG has a clear process for and good examples of community engagement and responding to identified need such as its refugee and homeless programme.
- The CCG has good examples of jointly funded programmes such as its joint recovery and resilience hub for mental health.

5.3.2 Next steps

- To consider the need for a board level champion for prevention. This would allow for a more systematic overview and for increased reporting/monitoring of all prevention activity.
- To consider a more systematic process of identifying and reviewing those prevention activities that are already taking place.
- To build on the CCGs strength of identifying communities of greatest need by considering a more systematic approach to monitoring how such communities access services. This is something that public health may be able to provide support with.
- To continue developing its use of RightCare resources and data.
- There is recognition that, due to financial constraints, at times it is difficult to consider or prioritise prevention when allocating resources. This may be worth revisiting in the future.

5.4 South & South West Lincolnshire CCGs, 28 September 2017

5.4.1 Strengths

- Prevention runs strongly through many of the CCGs' programmes and activities with good examples of specific areas of prevention work such as the support for carers and the commitment to improving diabetes, obesity and Child and Adolescent Mental Health Service (CAMHS) provision.
- There are good links with Public Health colleagues whose involvement includes Board level representations, active contribution towards identification of need and priorities and support around highlighting and monitoring prevention progress and development.
- The use of RightCare is a priority within the CCGs. A RightCare prioritisation and decision tool is currently being developed and Right Care resources are used to understand variation, develop plans and opportunities for the future.

5.4.2 Next steps

- To identify director level CCG prevention champions that will work closely with PH to explore opportunities to develop a more systematic approach to prevention across the 2 CCGs including:
    1. The further systematic use of the Lincolnshire JSNA across the planning and commissioning cycle
    2. The continued development of a standard health/prevention impact assessment tool that can be applied across all CCG policies, pathways and service developments
    3. Working together with other Lincolnshire CCGs and health and social care partners, to explore the introduction of prevention indicators across the health and social care services commissioned for the Lincolnshire population
- To continue to develop a greater understanding, with the support of PH, of the health inequalities and areas of need within the CCGs and the CCGs' neighbourhood teams.
- To continue using/developing RightCare resources to identify priorities to tackle variation and inequalities in access of care and opportunities for early prevention interventions.
- To consider ways in which the CCGs can highlight areas of good practice as prevention advocates such as the development of the RightCare prioritisation and decision tool.
- To explore ways of bringing together all staff health and wellbeing policies perhaps using PHE's staff health and wellbeing charter template.
- To continue working closely with the Health and Wellbeing Board to develop and implement the Health and Wellbeing Strategy in Lincolnshire

- To work with partners across Lincolnshire to implement the Lincolnshire STP prevention plan.

5.5 West Leicestershire CCG, 22 November 2017

5.5.1 Strengths

- The CCG has a strong ethos of prevention, having an implicit recognition of the need to prioritise prevention in order to relieve pressure on the health care system.
- The culture of the CCG is one of an open, supportive, collaborative organisation with a collective sense of responsibility that is led from the top.
- There are key advocates for prevention within the CCG who are happy to challenge and take a proactive lead, for example around inequalities, including prevention of illness in the most disadvantaged and socially excluded groups.
- The need for a good evidence base is well recognised and embedded within the CCG with good examples of evidence based interventions being developed or in place such as the Future in Minds programme and the commitment to social prescribing.
- The CCG recognises its responsibility to the population it serves to get the best population health gain for available resources, including where this involves preventative approaches
- The CCG has recognised processes for reducing variation in healthcare delivery eg via its QOF analysis and annual appraisals of GP practices; these are well received.
- The CCG works well in partnership with other local provider and commissioning organisations with examples such as Better Care Together/Sustainability Transformation Partnership workstreams, the integrated locality teams (ILT), the work around mental health and the work with GP practices.

5.5.2 Next steps

1. To consider ways in which the prevention agenda could be made more systematic and strategic across all areas of the CCG's approach to commissioning services. This could involve nominating a Board level champion and developing an explicit corporate vision/strategy for prevention. This would consider all tiers of prevention (primary, secondary and tertiary) at all levels through the organisation. Such a strategy would support a more strategic identification of potential prevention gaps and impacts, helping to make the implicit more explicit.
2. To have further discussion and consideration on whether having a process for prevention impact assessment would be beneficial.
3. To have greater oversight of and commitment to MECC and its potential.
4. To increase public health engagement into the CCG regarding public health commissioned lifestyle services.

5. To incorporate findings from the self-assessment toolkit into the CCG planning rounds, using them as an opportunity to broaden the debate and knowledge around prevention.
6. To gain assurance of how the prevention agenda currently operates within the STP processes, its scope, scale and leadership.
7. To look at linking up with other Leicester City, Leicestershire County and Rutland STP organisations and other regional or national bodies who have also undertaken the self-assessment to identify common themes and potential developments for the future. This could be something that PHE could offer support with.

6. Common themes

This report is based on a review of 6 CCG self-assessments. Each assessment was attended by different representatives of the CCG and as a result questions were answered differently with different degrees of knowledge or information depending on those present. This means that it is not possible (nor was it intended) to compare CCGs against each other. Nevertheless, common themes emerged as more assessments were carried out and these give a sense of prevention activity amongst those CCGs involved in the process.

6.1 Leadership and governance

6.1.1 Corporate vision/strategy for prevention

None of the CCGs had a specific corporate strategy for prevention but all felt that despite this, prevention ran through much of their respective CCG's priorities, plans and other strategies. As a result there was a general feeling that prevention was an implicit part of CCG activity and ethos but was not always badged and so recognised as such. Discussions on how to make the implicit more explicit and so more widely recognised throughout the CCG and its partners were a common theme in all self-assessments.

All participating CCGs were aware of their local Health and Wellbeing Board and strategies mainly for their ability to identify needs and priorities and less for their potential to drive prevention activity, contribute to a prevention strategy or to support the development of the CCG's own corporate vision.

Most CCGs referred to Sustainability and Transformation Plans (STP) as these were seen to play a key role in leading the prevention agenda. However it was not always clear how STP prevention plans translated into local CCG actions and what procedures were in place to be assured this had happened.

None of the CCGs had a process for assessing the impact of prevention and at least 2 CCGs queried whether this would be useful or just an extra tick box list that needed completing. One CCG felt this would be useful and planned to explore this further while others felt that other impact assessments or contract monitoring fulfilled at least part of this role. As a result there was no formal method of monitoring or reviewing prevention challenges with most CCGs using their Joint Strategic Need Assessment (JSNA) process, RightCare or their STP processes to do this.

6.1.2 Board level champion for prevention

Several of the CCGs had a Public Health Consultant representative on their Board and/or within other governing bodies including clinical executive boards. However, despite their championing of prevention and many CCGs believing they fulfilled a 'prevention champion' role, all such representatives were non-voting members of the Board. None of the CCGs had a director level, formally appointed and voting Board member champion for prevention.

6.2 System, scale and consistency

System, scale and consistency were measured using the CCG's self-assessment of each statement; statements scoring a '3' were considered to illustrate systematic practice across the whole organisation.

While most CCGs scored themselves optimistically and had a number of '3's in their self-assessments none of them felt they were systematic enough in their approach to prevention. Areas that CCGs felt they approached most systematically were those around identification of need and working with partners to understand need and develop priorities. Otherwise each CCG had its own specific areas that it felt were systematic ranging from tackling variation across clinical services and reducing exception reporting within QOF to ensuring MECC is included in all internal contracts. Some specific examples were provided though these tended to be specific initiatives such as support to homeless people or refugees or where activity was part of a national programme such as the National Diabetes Prevention Programme.

All CCGs felt that their approach could be more systematic despite the perceived focus on prevention running throughout their work. In addition, not all work that could be considered prevention was labelled as such, and as a result some CCGs felt that there was lost opportunity to consider all tiers of prevention (primary, secondary and tertiary) in all aspects of the CCG's work.

6.3 Targeting activity at greatest need

6.3.1 Identification of need

CCGs had a range of methods to identify their priority areas and communities of greatest need including the JSNA, RightCare, public health intelligence, integrated locality teams, risk stratification and partnership boards. Although one CCG felt they didn't do this in a systematic enough way, all CCGs were increasingly working with partners to support this process. Partners included those at a strategic and local level and most CCGs felt there was a shared understanding of need and priorities as a result.

RightCare intelligence was used by most CCGs to help identify priority areas. There were isolated examples of work targeted at specific communities of need including supporting homeless people, smoking in pregnancy and refugees/asylum seekers. One CCG had a QIPP (Quality, Innovation, Productivity and Prevention programme) scheme targeted at reducing admissions in high intensity users of acute services.

6.3.2 Access to services

There was less awareness of how or whether communities of greatest need access services, what could be done to increase access or understand if or where there may be barriers to access. No CCGs highlighted the potential support that public health could provide around understanding access, for instance. Awareness of the link between access to services and health inequalities or targeting prevention activity where it is most needed (proportionate universalism) was not always apparent.

Some CCGs used the quality and outcomes framework (QOF) to monitor uptake of services but the majority of CCGs involved in the self-assessment process were unaware of any specific work regarding understanding access to services for those communities of greatest need.

6.3.3 Commissioning for prevention and opportunities for joint commissioning

Consideration of prevention when allocating resources varied. All CCGs highlighted their need to maximise resources and saw prevention as a “good thing” that was cost effective and provided value for money. CCGs reported that the long term nature of prevention, difficulty in establishing a causal relationship between prevention activity and outcomes and lack of available resources pose considerable barriers to greater investment in prevention. Most felt that they had neither the luxury of time or resources to truly consider doing this. Erewash CCG felt they had done this in a small way with their ‘Love Bump’ social marketing campaign aimed at reducing smoking in pregnant women. They saw this as a good example of what could be achieved, anticipating building on this work in the future.

A number of CCGs provided examples of joint commissioning to address need but there was recognition that these were generally ad hoc or isolated examples and dependent on available resource or the need to re-procure a service rather than as a specific result of newly identified need or a re-allocation of resources into prevention rather than other activity. There were some examples of a whole pathway approach to commissioning such as around the National Diabetes Prevention Programme (NDPP) or a musculoskeletal (MSK) pathway but again examples were isolated rather than systematic.

The development of STPs and Accountable Care Systems (ACS) were seen as important opportunities to explore the whole concept of greater investment in prevention on a more systematic scale.

6.4 Evidence based approach

All CCGs felt that they used an evidence based approach to their work to some extent, whether designing services or planning interventions. Methods used to source the evidence varied from use of clinical NICE guidelines, via public health input or through their own efforts and google. There did not seem to be any one clear and preferred method to identify evidence nor systematic recognition of the differing quality of evidence that different sources may provide.

One CCG highlighted the value of board level scrutiny regarding specific investment proposals if there was felt to be a potential lack of a good evidence base.

6.5 Advocacy for prevention

Acting as advocates for prevention was a further example of an implicit rather than explicit commitment to prevention. All CCGs had examples of good practice where they had been advocates either locally, regionally or nationally. This included: leading roles within the National Diabetes Prevention Programme (NDPP), developing new approaches to smoking in pregnancy, using QIPP incentives to target high intensity users of acute services, early identification of dementia, having a board level champion for equalities and incorporating Making Every Contact Count (MECC) as part of the STP prevention programme. Nevertheless there did not appear to be a proactive recognised format to consider what the CCG's public stance may be on key prevention issues, rather an implicit belief that issues would be responded to appropriately as and when they arose.

The ability to advocate for prevention depends on the recognition and widespread promotion of examples when advocacy has happened. At the moment, CCGs reported that there was little opportunity or mechanisms to do this so, for example, a CCG who had supported the development of a new licencing application process, had no recognised mechanism to share their good practice beyond their own boundaries.

6.6 Tackling variation across clinical services

Whilst all CCGs understood that different communities had different health needs there was little evidence to suggest that commissioning practice addressed these differing needs.

Most CCGs used RightCare and public health data to support their efforts to tackle variation, but it was not clear that an aim to reduce health inequalities and burden of disease was systematic across all clinical services or carried out systematically; 2 CCGs highlighted a lack of systematic or formal approach to tackling variation.

All but one CCG monitor their QOF exception reporting, but there is variation in how systematically this is carried out. Some have annual monitoring and/or appraisals of

their GP practices, some monitor irregularly whilst one incorporates a reduction in exception reporting as part of its strategic priorities[2].

6.7 Making Every Contact Count (MECC)

Most of those representing their CCGs were unaware of any work around MECC, possibly because this was not their area of work or because MECC is simply not on the radar anymore. Two CCGs felt they had a more systematic approach to MECC with one reporting all of their internal policies included MECC and another highlighting MECC as being a key local authority programme that was being rolled out across the county including CCGs as part of their STP prevention programme.

All other CCGs had examples of small pieces of work around MECC such as smoking cessation initiatives but no systematic approach to building on MECC CQUINS and no systematic method of monitoring or evaluating MECC outcomes.

6.8 Workforce

Although most CCGs did not have an overall workforce health and wellbeing strategy, all had various health and wellbeing initiatives in place including encouraging staff to have their flu jabs, access to staff counselling, annual occupational health checks or access to different physical activity groups. None had staff below the government defined national living wage although one noted that traditionally low paid workers such as cleaning staff were provided by an external company so not covered by their own policy.

[2] Reducing QOF exception reporting ensures those of greatest need who may have been incorrectly 'excepted' have equitable access to healthcare, thus reducing a potential widening of health inequalities

7. Conclusions

Conclusions presented are a combination of those drawn as part of individual CCG supported self-assessments and those drawn by the author in response to a wider over view of all assessments.

7.1 Governance and leadership for prevention

Although this work comes under the banner of the Five Year Forward View (FYFV), none of the CCGs linked their prevention agenda to NHS England governance or leadership structures, nor did they feel accountable for any prevention activity they did or did not do. There was little, if any, awareness of either the NHS Commissioning for Prevention document or of NHS England's role in ensuring the 'radical upgrade in prevention'. As a result there appeared to be a strong mismatch between the tone and urgency regarding prevention of the FYFV and the reality and accountability of action at a local level.

Despite this, all of the CCGs carrying out the self-assessment felt that prevention was implicit in most if not all areas of their work. All had examples of prevention good practice around specific areas of work or projects. Discussions then focussed on how to make prevention more explicit *and* systematic, ie how to be clear about prevention and having governance and leadership for prevention.

Not all CCGs felt there was a need to label or badge all potential prevention activities as prevention. Some felt that this would be labelling for the sake of labelling and create unnecessary work. However there are differences in understanding: not being clear about prevention presumes that everyone has the same understanding and concept of prevention *and* the opportunity or knowledge to ensure prevention is considered in its entirety at all tiers and at all levels. Discussions with CCGs suggest that this is not the case. Defining prevention, being clear about what it entails or could entail may allow a greater, more systematic, more inclusive approach that is explicit across the organisation.

The *Prevention Challenge* stresses the need to embed prevention within corporate governance structures and to consider the system, scale and consistency in an organisation's approach to prevention. Many CCGs reported a lack of strategic approach to prevention, providing examples of local or ad hoc pieces of work rather than the system wide approaches required. None had an overarching strategy for prevention or a formally appointed board level champion for prevention, both of which would provide opportunity for prevention to be strategically and systematically considered, monitored, promoted and embraced.

CCGs were not clear of the need for a formally appointed board level champion either feeling that this was picked up by their (non-voting) public health consultant

representative or informally by other (non-specified) representatives. Regardless of their expertise, the contribution of informal or non-voting representatives is dependent on their capacity, other roles they hold and the relationships they build.

A formally appointed prevention champion provides explicit recognition and assurance of prevention and the 'strong leadership for prevention' urged by the *Prevention Challenge*.

CCGs noted a difference in their internal and external consideration of prevention. Most felt that their prevention foci were on external processes such as identification of need, priority areas or access to services rather than internal processes such as workforce, procuring supplies or contracts. Increased governance around prevention would link the internal and external better together, again helping to make the implicit, explicit.

7.2 Commitment to and capacity for prevention

There is a strong, enthusiastic commitment to and recognition of prevention. CCGs have an aspiration to commission additional services or target prevention services more but are reliant on additional funding or having enough resources to do this. In reality all are struggling to manage with the resources they have, meaning that prevention, with its lack of either incentives or penalties, sits at the bottom of the list of competing priorities. CCGs reported a frustration that prevention should be seen as a luxury or something to look at when there is time or money and even those that felt they were able to focus in a small way on prevention, did not feel they could do this in the systematic and holistic manner they wished to.

The NHS FYFV and its Next Steps both set out a strong commitment to prevention and indeed lay an element of urgency for the need for greater focus on prevention. However this comes with few additional incentives or other assurance processes to enable NHS organisations the perceived luxury of changing their focus and doing what, for the majority, feels most cost and health effective, that of investing more in prevention activity. The lack of capacity that many CCGs had to even carry out the self-assessment highlights the immense pressure they are under and the mass of competing priorities they have. At the moment, for many, prevention feels almost like something "we'd like to do, believe is important, if only we had the time and money". The *Prevention Challenge* emphasises the urgency of switching the focus to prevention but until this urgency is accompanied by practical support, many CCGs felt there was very little they could do.

7.3 Involvement of public health

7.3.1 Local authority public health

Local authority public health input and support to CCGs varied widely. Some provided board level input on a variety of boards, others more operational or day to day input.

Most CCGs were aware of certain elements of public health support they could access particularly around understanding, identifying and prioritising need, however this was not consistent. Although there is differing capacity amongst public health departments some of the core skills of public health such as health impact assessments, health equity audits, evidence reviews or population health overview were areas that CCGs were struggling with seemingly unaware that expert advice may be available. For example one CCG used google to support identification of evidence based interventions.

Specialist public health staff are trained to identify, systematically review and critically appraise evidence in order to support the use of the best available evidence, yet not all CCGs were either aware of or able to access this expertise. If CCGs are unaware of the potential support and expertise they can access from their public health colleagues, then they are unlikely to make full use of the knowledge that is available.

Local authorities were mandated to provide a Healthcare Public Health Advice Service (Core Offer) to CCGs in 2013 when the role of public health transitioned from the NHS to local authorities. Each local authority decides, along with their respective CCGs, how best to meet these requirements within resource constraints, so that no 2 ‘Core Offers’ look the same. The public health advice service is free but does not exclude the ability for CCGs to pay for additional services. There is no preferred model and PHE, the Faculty of Public Health (FPH) and the Association of Directors of Public Health have produced a briefing paper outlining a ‘shared understanding of good practice’ supplementing the 2013 guidance. It is not expected that public health departments provide all of these services, but that it should provide support or facilitate access to support for:

- Strategic oversight and leadership of public health input to commissioning
- Identifying current, and predicting future, health needs
- Supporting priority setting, prevention activity and decision making
- Review and redesign of service pathways
- Supporting the procurement process
- Monitoring and evaluation of services
- Governance

How and to what depth these services may be provided is clearly dependent on local capacity and agreement. The self-assessment highlighted, from both public health departments and CCGs, the wish (and potential) to increase links and/or joint working between public health and CCGs. It is not clear whether this perceived gap is due to a lack of capacity or a lack of shared understanding over the role of public health but it does appear clear that, subject to capacity, there is opportunity for greater public health expertise and support to strengthen the work of CCGs.

7.3.2 Public Health England

Public Health England (PHE) exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It is an executive agency of the Department of Health, and a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

It is not the role of PHE to carry out local public health functions but it does provide system leadership and the self-assessment toolkit is a good example of how it can support NHS organisations.

Several CCGs highlighted specific examples of prevention activity that they were justifiably proud of. However, they struggled to know how to promote this work, how to get constructive feedback or how to know what other areas may have done that was similar or provided relevant examples of good practice. This may be a role that PHE could be involved in. Currently, PHE East Midlands facilitates a number of 'Communities of Interest', networks of people working in similar areas such as smoking cessation. These tend to involve staff from local authorities and CCGs are not involved. An opportunity for the future may be to explore how the public health and CCG 'systems' can better link up together so that these shared networks better incorporate all aspects of public health including those of the CCG.

7.4 STPs and Accountable Care Systems (ACS)

Several CCGs preferred not to carry out an individual self-assessment but to look to doing an STP level assessment. STPs provide an opportunity to systematise prevention and many have separate prevention strategies and Boards setting and reviewing their prevention activity. Carrying out an STP or ACS wide self-assessment makes sense and would allow system wide discussions across NHS organisations.

One of the challenges would be assuring system wide approaches are taken back to individual organisations. In one STP area, self-assessments have been completed by all NHS provider and commissioning organisations. A potential opportunity (and one raised by one of the commissioning organisations) is for these completed organisation specific self-assessments to be used to bring together all organisations to produce an STP/ACS wide assessment. This would then enable an STP/ACS wide assessment to be built from its foundations with each organisation's understanding of its own respective strengths and opportunities being used to strengthen ties, links and so vision across the STP/ACS.

8. Next steps

This self-assessment by CCGs was intended as a one-off exercise to understand, encourage and support prevention actions following the publication of *'Meeting the Prevention Challenge in the East Midlands: A Call To Action'* and following a similar process offered to all NHS Providers within the East Midlands. Having completed it, each organisation will be able to use their self-assessment as a baseline against which to review and monitor their own progress in future and we would encourage CCGs to use the tool to re-assess their progress another year on.

The small number of CCGs who took part in the process limits the potential for definitive conclusions; however, there is enough detail within each assessment to suggest a number of areas for potential further development:

1. One CCG requested that this process be used to facilitate a workshop where all of its local NHS Providers and CCGs come together to explore their mutual prevention next steps. PHE is currently exploring this opportunity further.

2. The self-assessment toolkit was development for individual CCGs but does not preclude an STP or ACS wide assessment. Supported self-assessments may be available for those areas that wish to pursue this.

3. Increased dialogue between local public health teams and their CCG counterparts to increase awareness of public health expertise, knowledge and skills and opportunities for joint working.

4. Exploration of how CCGs may become more involved in Communities of Interest

9. Acknowledgements

With thanks to all those involved in the self-assessments:

- Sarah Prema, Director of Strategy & Implementation, Leicester City CCG
- Richard Morris, Director of Operations and Corporate Affairs, Leicester City CCG
- Angela Wright, Head of Planning, Partnerships and Improvement, Erewash CCG
- Caroline Duckworth, Transformation Delivery Manager, Erewash CCG
- Jacqui Bunce, Programme Director, South & South West Lincs CCG
- Elizabeth Ball, Commissioning and Governance Manager, South & South West CCG
- Dr Isabel Perez, Consultant Public Health, Lincolnshire County Council
- Paul Gibara, Chief Commissioning & Performance Officer, East Leics & Rutland CCG
- Simon Pizzey, Head of Planned Commissioning & Strategy, East Leics & Rutland CCG
- Dr Nick Glover, Locality Lead, East Leics & Rutland CCG
- Colin Thompson, Consultant Public Health, Leicestershire County Council
- Ian Potter, Director Primary Care, West Leics CCG
- Sam Kirton, Head of Planning, West Leics CCG
- Jade Atkin, Service Improvement Manager, West Leics CCG
- Dr Mike McHugh, Consultant Public Health, Leicestershire County Council

And those involved in the development of the toolkit:

- Julia Knight, Specialty Registrar, PHE East Midlands
- Bryony Lloyd, Specialty Registrar, Nottinghamshire County Council
- Deb Watson, Consultant Healthcare Public Health, PHE East Midlands
- Ben Anderson, Deputy Director, PHE East Midlands

10. References

The original report '*Meeting the Prevention Challenge in the East Midlands – A Call to Action'* provided extensive references and links to useful documents. This is available as a resource on the website of the East Midlands Clinical Senate and can be accessed by following the link below:

http://www.emcouncils.gov.uk/write/east-midlands-prevention-challenge-report-2015-final.pdf

In addition the following documents have been referenced in this report:

NHS England. Commissioning for Prevention. 2013. Available at: https://www.bl.uk/collection-items/call-to-action-commissioning-for-prevention. *Last accessed: April 2017*

NHS England. The Five Year Forward View. 2014. NHS England: London. Available at: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf. *Last accessed: November 2017*

NHS England. Next steps on the NHS five year forward view. 2017. NHS England: London. Available at: https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/ *Last accessed: December 2017*

NHS England. Commissioning for Value packs. Available at: https://www.england.nhs.uk/rightcare/intel/cfv/

NHS England. NHS CQUIN. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/03/HWB-CQUIN-Guidance.pdf. *Last Accessed: April 2017*

NHS England. NHS Statement of support for tobacco control. Available at: http://www.smokefreeaction.org.uk/declaration/NHSstatement.html. *Last accessed: April 2017*

NHS England. The NHS Commissioning Cycle. Available at: https://commissioning.libraryservices.nhs.uk. *Last accessed: January 2017*

PHE, ADPH, FPH. Core Offer: The Healthcare Public Health Advice Service to Clinical Commissioning Groups. 2017. PHE

PHE. From evidence into action: opportunities to protect and improve the nation's health. 2014. PHE. Available at: https://www.gov.uk/government/publications/from-evidence-into-action-opportunities-to-protect-and-improve-the-nations-health

11. Appendix 1: Self-Assessment questions

Each question within the toolkit had a space to enter a self-assessment score. The system used for scoring answers was a follows:

We **CAN NOT** demonstrate this practice/haven't made any progress in our organisation	0
We can demonstrate **some relevant practice** within our organisation but can identify room for improvement	1
We can demonstrate that this practice is **systematic in some departments or teams** within our organisation and have evidence to support this	2
We can demonstrate that this practice is **systematic across the whole organisation** and have evidence to support this	3

1. Leadership and Governance

1.1. Do you have a board level champion for prevention and public health? Who holds this role?

1.2. Does the CCG have a corporate vision/strategy for prevention that ensures all levels of prevention (primary, secondary and tertiary) run through your priority areas?

1.3. Does the CCG's corporate vision consider prevention regarding:

a. Internal policies and procedures

b. External contracts

c. The local economy

1.4. Has the CCG developed an approach that ensures all policies, plans and programmes are assessed for their prevention capability and potential impacts? How does it do it?

1.5. Does the CCG have a method of identifying gaps in its prevention capability? How does it do this?

1.6. Are there mechanisms in place to monitor the progress and impact of prevention?

1.7. Does the CCG act as an advocate for prevention, locally or nationally? Does it consider its public stance on key prevention issues? How does it do this?

2. Strategic planning and partnership work

2.1. Has the CCG identified the communities in greatest need within your area? How have you done it? How often does this happen?

2.2. To what extent does the CCG work with partners to develop a shared understanding of need?

2.3. To what extent does the CCG work with partners to develop common priorities and goals?

2.4. Does the CCG work with partners to commission service provision for prevention?

2.5. To what extent does the CCG commission additional services to embed prevention within identified communities of greatest need?

2.6. To what extent does the CCG ensure commissioned universal services are more focussed or have the greatest intensity of action on communities of greatest need or disadvantage?

2.7. To what extent does the CCG ensure that communities of greatest need access services? How is this monitored?

2.8. Does the CCG ensure that resources are allocated in order to maximise overall impact and outcomes?

3. Procuring services

3.1. To what extent does the CCG identify evidence based prevention programmes when designing services?

3.2. To what extent does the CCG consider prevention when allocating resources?

3.3. Has the CCG reallocated resources to fund priority prevention programmes?

3.4. Does the CCG ensure that commissioned services use appropriate evidence and best practice with regards to prevention activities?

3.5. Does the CCG have recognised processes (eg SOP), appropriate structures (eg committees), and sufficient overview of population outcomes to enhance primary, secondary and tertiary prevention when re/commissioning services?

3.6. Does the CCG take a whole pathway approach to designing services? Does it consider the different levels of prevention within the whole pathway?

3.7. Is MECC embedded within CCG contracts and commissioning?

3.8. Does the CCG have a system of identifying gaps in MECC provision or potential provision? Do you have plans to address these gaps?

3.9. How does the CCG engage with commissioning of lifestyle services and ensure a single point of access for provider services?

4. Monitoring and evaluation

4.1. Does the CCG have a process in place to review prevention challenges in collaboration with other partners on an ongoing basis? How does it do this?

4.2. Does the CCG have a systematic approach to tackling variation across clinical services?

4.3. Does the CCG have a systematic approach to case finding for those conditions where there is strong evidence that early identification leads to improved outcomes?

4.4. Does the CCG have a systematic approach to reducing exception reporting within QOF?

4.5. Does the CCG ensure data collection and contract management reflect MECC outcomes where appropriate?

4.6. Is the reporting of MECC outcomes used to inform further activity? How does it do this?

5. Promoting a healthy workplace

5.1. Do you have a staff health and wellbeing strategy? How was this developed, does it reach across the organisation and how is it monitored?

5.2. In particular do you:

a. Provide NHS health checks at work to staff members over 40 years

b. Ensure year on year improvements in staff flu vac coverage

c. Have initiatives to respond to the man cause of sickness absence

d. Have a local physical activity and mental health offer for staff?

5.3. To what extent have you implemented NICE guidelines on workplace health?

5.4. Have you signed up to/implemented the NHS statement of support for tobacco control?

5.5. Do you have specific strategies to encourage staff members to quit smoking or drink within recommended limits?

5.6. To what extent do you ensure healthy food provision within all premises?

5.7. What progress has been made to remove sugary snacks and beverages in any available vending machines?

5.8. Do you have a strategy towards implementing a living wage for all staff?

5.9. To what extent do you ensure that your commissioned providers promote a healthy workplace?

For further information or a copy of the toolkit please contact the report authors.

12. Appendix 2: Invited CCGs

Corby CCG
East Leicestershire and Rutland CCG
Erewash CCG
Hardwick CCG
Leicester City CCG
Lincolnshire East CCG
Lincolnshire West CCG
Mansfield and Ashfield CCG
Nene CCG
Newark and Sherwood CCG
North Derbyshire CCG
Nottingham City CCG
Nottingham North & East CCG
Nottingham West CCG
Rushcliffe CCG
South Lincolnshire CCG
South West Lincolnshire CCG
Southern Derbyshire CCG
West Leicestershire CCG