Welcome to the October 2019 edition of the Public Health England (PHE) national Healthcare Public Health (HCPH) team’s quarterly newsletter. Throughout this edition, we intend to provide you with key updates on core elements of our work, as well as helping to make links across the system by showcasing practice based articles, key opportunities and information.

The HCPH team would very much welcome ongoing feedback and article contributions including your workplace updates, news, and opportunities that you would like to share with a wider network in future editions. Please email to discuss via healthcarepublichealth@phe.gov.uk.

Sue Dewhirst, Population Health Services Manager, Healthcare Public Health (HCPH) team

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Foreword

Yvonne Doyle Medical Director & Director of Health Protection for Public Health England (PHE)

Welcome to a great newsletter. It has been over five months since I took on the role of Medical Director & Director of Health Protection for Public Health England (PHE). One of the key areas I have focused on in my new role is the opportunity to improve population health outcomes by focusing on the contribution of health care to population health, and by working more closely with colleagues in the NHS. In addition, I have four other priorities areas that are driving my work:

1. Keeping the country safe
2. Addressing the global burden of disease in England
3. Building our knowledge base
4. Nurturing relationships with all our stakeholders

Critical to delivering all these priorities is the relationship the public health system has with all parts of the NHS. The importance and impact that the NHS has on the prevention and wider determinants agenda cannot be underestimated. The NHS Long Term Plan (LTP) implementation provides new opportunities for public health. Most welcome is the new role that Regional Directors of Public Health will have with the NHS. This offers us a new front to improve population health outcomes through a placed based lens and will play an important part in delivering the prevention ambitions set out in the LTP.

In support of these opportunities, our newly established NHS Facing Board provides strategic oversight of the work PHE will be undertaking with the NHS. The Board is taking a true ONE PHE approach through close collaboration between colleagues at national, regional and local levels.

We have several examples now of how the opportunities with the NHS could play out to the benefit of the population. Last month PHE held its annual conference at University of Warwick where our Infectious Disease Strategy was launched. That Strategy defines the possibilities for reducing infections and microbial resistance over the next 5 years, with the NHS as a key location for delivery. The priorities have been chosen for their potential to achieve tangible benefits.

At the Warwick conference, a successful Primary Care Network (PCN) session was led by Deborah Millward from PHE’s Strategy team, with over 100 cards submitted by delegates outlining what they see as the opportunities for prevention in the NHS at a local level.

There is also information in this issue about the development of Primary Care Network specifications and how these can help to embed changes such as improving oral health in care homes following a recent CQC report.
One of the key underlying issues in all our work is the importance of reducing health inequalities, raised by Lina Toleikyte from PHE Health Inequalities team in her article which highlights a new resource to support local action.

Earlier this month I was fortunate to attend a meeting of the Provider Public Health Network. This group of over 90 public health professionals who work in or closely with provider trusts, is supported by and works closely with PHE. The network recently in conjunction with NHS Providers launched a Framework for Population Health in Healthcare Providers, available here, to aid trusts when considering their approach to population health as part of day-to-day business. It’s pleasing to see that there are several articles contributed by members of the network and others working in healthcare settings in this month’s edition including:

- ‘Managing patient flow in maternity and neonatal care’
- ‘Think kidney, future proofing kidney care: predicting demand for renal replacement therapy’
- ‘Public health systems leadership in cardiac services- a route in from specialised services’
- ‘Taking on the challenge of AMR: how local areas are working together’

Another important network hosted by PHE is the National Falls Prevention Coordination Group (NFPCG) which is made up of over thirty national organisations involved in the prevention of falls, care for falls-related injuries and the promotion of healthy ageing. It was formed to co-ordinate and support falls-prevention activity in England. In this issue members raise awareness of the importance of home adaptations in preventing falls and maintaining independence. They also highlight the importance of finance available through the Disabled Facilities Grant and the importance of reducing delays.

Thank-you again for your interest in this newsletter from the Healthcare Public Health community, we strongly encourage you to share your work and updates with us. This will be seen by many colleagues with an interest in public health, so it is an opportunity to provide updates from across the system.

Please contact the team on healthcarepublichealth@phe.gov.uk if you have any articles, opportunities or events that you would like us to share.
### Healthcare Public Health Regional/ Centre Director leads in Public Health England

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<tr>
<td>Andrew Furber</td>
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<td>Yorkshire &amp; Humber</td>
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<tr>
<td>Debra Lapthorne</td>
<td>Centre Director</td>
<td>South West</td>
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<tr>
<td>Ben Anderson</td>
<td>Deputy Director for Healthcare Public Health</td>
<td>East Midlands</td>
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<tr>
<td>Michael Baker</td>
<td>Deputy Director for Healthcare Public Health</td>
<td>South East</td>
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<tr>
<td>Jo Broadbent</td>
<td>Deputy Director for Healthcare Public Health and Workforce</td>
<td>East of England</td>
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<tr>
<td>Helen Carter</td>
<td>Deputy Director for Healthcare Public Health &amp; Workforce</td>
<td>West Midlands</td>
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<tr>
<td>Sue Gordon</td>
<td>Deputy Director Healthcare</td>
<td>North East</td>
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| Marilena Korkodilos | Deputy Director, Healthcare and Clinical Lead for Revalidation  
                       | Interim Deputy Director, Health Improvement and Workforce Development | London |
| Sue Longden       | Programme Director                        | North West                       |
| Kevin Smith       | Deputy Director, Healthcare               | Yorkshire & Humber               |
| Debbie Stark      | Deputy Centre Director, Deputy Director for Healthcare Public Health | South West |

You can find contacts for PHE Centres [here](#)
The Healthcare public health team are supporting topic and cross cutting leads in PHE and regional Directors of Public health to deliver the NHS Long term plan.

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<tr>
<td>Dr Raymond Jankowski</td>
<td>National Lead for Population Healthcare</td>
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<td>Business Support Officer (from 28/10/19)</td>
<td>Team business support</td>
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Primary Care Network specifications - Embedding prevention

Sue Dewhirst, Population Health Services Manager, Healthcare Public Health

Dr Rachel Coyle, Public Health Registrar, Health Improvement Directorate, Public Health England.

We would like to update you on the development of proposals for the Primary Care Networks (PCNs) service specifications that will be delivered from April 2020.

A primary care network (PCN) consists of groups of general practices working together with a range of local stakeholders, including across primary care, community services, social care, public health and the voluntary sector, offering more personalised, coordinated health and social care to their local populations.

Networks are normally based around natural local communities typically serving populations of at least 30,000 and not tending to exceed 50,000. They are small enough to maintain the traditional strengths of general practice but at the same time large enough to provide resilience and support the development of integrated teams.

PCNs are now in place across almost all of England. In forming PCNs, practices have signed up to the Network Contract Directed Enhanced Service (DES), which also requires that they deliver seven national service specifications. Implementation of five of these services (described in detail below) will begin from April 2020, and the remaining two (Cardiovascular Disease Prevention & Diagnosis and Tackling Neighbourhood Inequalities) from April 2021.

Proposals for the specifications to be introduced in April 2020 have been produced through a national process of co-design with relevant commissioners, providers, representative bodies and patient groups, and are now being considered as part of the annual GP contract negotiations process. NHSE/I will continue to work closely with these groups, and the wider system as the proposals develop, and will engage on the proposals before they are finalised. Public Health England is providing advice and evidence to NHSE/I to support the development of the specifications.

A high-level description of each service that will be delivered from April 2020 is provided below:

- Enhanced Health in Care Homes (EHCH)
  This will support implementation of the EHCH Framework, which was tested in the six care home vanguards between 2014/15 and 2017/18, and which is currently being refreshed. It will support PCNs and community services providers to provide consistent healthcare support to all care homes, across the clinical elements of the EHCH framework; enhanced primary care support; multi-disciplinary team (MDT) support (including coordinated health and social care); reablement & rehabilitation and high-quality end-of-life care & dementia care.

- Anticipatory Care
This will help people to live well and independently for longer through delivery of proactive care for those at high risk of unwarranted health outcomes. The service is intrinsically linked to population health management approaches being developed across the country, builds on work already happening in primary care to identify and treat people living with frailty and will include evidence-based prevention.

- **Personalised Care**
  This will help people have choice and control over the way their care is planned and delivered, based on ‘what matters’ to them and their individual diverse strengths, needs and preferences. It includes personalised care and support planning, promotion of personal health budgets and support for the continued development of social prescribing.

- **Structured Medications Reviews and Optimisation**
  This will help people who have complex or problematic polypharmacy. Timely and proactive application of structured medications reviews to individuals most at risk from problematic polypharmacy will support a reduction in hospital admissions caused by medicines-related harm in primary care.

- **Early Cancer Diagnosis**
  This supports the ambition in the Long-Term Plan that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters (75%) of cancer patients. Achieving this will mean that, from 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis. To deliver this aim, PCNs will need to work closely with wider system partners to understand their diagnosis rates and patterns, to improve referral practices, and to ensure high screening uptake in their localities.
Oral health: Supporting good oral health for vulnerable older people - essential for healthy ageing and people in care homes

Semina Makhani, Consultant in Dental Public Health, Public Health England

Maintaining good oral health throughout life and into older age not only improves a person’s general health and wellbeing, by enabling them to eat, sleep and communicate without pain or embarrassment, but can also play a part in helping people stay independent for as long as possible.

Although it is encouraging that the oral health of older people has improved in England since the late 1960s, with more adults keeping their teeth into old age, many of these teeth will have fillings and other restorations requiring long term review and complex care from dental teams.

Evidence suggests that in older people, prioritising action to assess oral status, maintain oral hygiene and arrange appropriate dental treatment is essential because as people age they are likely to live with a range of complex co-existing medical conditions, dependent on multiple factors, which may predispose them to loss of independence, disability and frailty. The reciprocal relationship between oral health and independence shows that people are able to stay independent for longer, or recover from episodes of crisis or frailty, if they are able to eat and drink properly and take part fully in life.

There is a growing body of evidence to support a reciprocal relationship between poor general health and poor oral health. For example:

- patients with diabetes and gum disease (periodontitis) would benefit from regular oral care
- there is a positive association between pneumonias and poor oral health
- there is a greater risk of developing tooth decay one year after being diagnosed with cognitive impairment
- there are associations between coronary heart disease, stroke, peripheral vascular disease and oral health

The NHS Long Term Plan (LTP) recognises the importance of all care home residents being supported to have good oral health.

The Care Quality Commission (CQC) report, Smiling matters. Oral health care in care homes shows that too many people living in care homes are not being supported to maintain and improve their oral health. The report includes a number of recommendations to improve the oral health of care home residents, including the implementation of the NICE guideline Oral health for adults in care homes.

Public Health England (PHE) has established the Adult Oral Health Oversight Group bringing together system leaders with an ambition that ‘all adults have a healthy
mouth as part of living well’. The group aims to improve oral health in all adults and will also target specific vulnerable adult groups to reduce inequalities. (If you have any questions please contact: semina.makhani@phe.gov.uk)

One of the work streams for this group is the oral health of people in care homes. Following a workshop with stakeholders on 14th October 2019, a task and finish group is being set up to look at best practice across the country and produce a toolkit for commissioners and providers to take forward the CQC recommendations and NHS England and Improvements responsibilities in the LTP.

To support commissioners in improving the oral health of vulnerable older people in all settings, including residential and nursing home residents, PHE has published resources including Commissioning better oral health for vulnerable older people. An evidence-informed toolkit for local authorities.

There are dental public health consultants at all PHE Centres to help support work on improving oral health in care homes.

If you have any questions please contact: semina.makhani@phe.gov.uk

Enabling local action on health inequalities through place-based approaches

Lina Toleikyte, Public Health Manager, Health Inequalities team, Public Health England

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.

PHE, LGA and ADPH have worked together to publish ‘Place-Based Approaches for Reducing Health Inequalities’ which aims to:

• reinforce a common understanding of the complex causes and costs of health inequalities
• provide a practical framework and tools for places to reduce health inequalities

The development of ‘Place-Based Approaches for Reducing Health Inequalities’ has been informed by the views of a wide range of professionals across the country. This collaboration will continue as the resource is designed to be a live and iterative tool, reflecting new developments as they arise as well as emerging good-practice. The resource complements the NHS’s new ‘Menu’ of Evidence Based Interventions for Addressing Health Inequalities and in tandem they support local NHS bodies to create plans for reducing health inequalities as part of the Long-Term Plan.

‘Place-Based Approaches for Reducing Health Inequalities’ is modular resource with a range of annexes and tools which include:

• practical self-assessment tools to implement the place-based approach
• case studies of existing good practice
• guides to local health inequalities data to support decision making

PHE are working to identify areas across the country to pilot the Place-based Approaches for Reducing Health Inequalities and develop a robust evaluation methodology. We recognise the importance of effective communication. Therefore, we are working with a number of PHE Centres/ Regions and stakeholders to increase the awareness of this resource locally and nationally.

For more information please see blog: https://publichealthmatters.blog.gov.uk/2019/07/29/enabling-joint-action-to-reduce-health-inequalities/ or contact health.equity@phe.gov.uk
The PHE Infectious Diseases Strategy was launched in September 2019. This article describes one local approach to the growing risk of Anti-Microbial Resistance (AMR):

Taking on the challenge of AMR: how local areas are working together

Victoria Wells, Healthcare Public Health Support Officer, PHE East of England

Healthcare Public Health and Health Protection in the East of England have teamed up to develop a new, Centre-wide approach to tackling Healthcare Associated Infections (HCAI) and antimicrobial resistance (AMR) in the region. AMR is an issue which affects us all and which is driven by a broad range of factors, from infection control and hygiene to education/training, the environment, research and academia, and even public perception and behaviour. As such, it requires concerted effort from a broad range of functions and disciplines to ensure that we tackle these drivers together.

In PHE, the Health Protection function undoubtedly has a big role to play with regards to infection prevention and control, outbreak management, and working directly with providers and prescribers to ensure that antibiotics are used responsibly. However, the rest of us also have an important role to play. We are well placed to start to tackle some of those other drivers of AMR – education and training, workforce, healthy places, and public perception and behaviour – by raising awareness and working with the NHS, local authorities, and other stakeholders to ensure that AMR is considered in public health and policy strategies. While strategic leadership of the programme sits with Health Protection, the Healthcare Public Team has been heavily involved in shaping and delivering the action plan.

The Centre-wide programme in the East of England has now been up and running for just over one year, and in that time frame we have made a lot of progress! Together with Health Protection, we have broadened the focus of our AMR work and engaged with a range of wider health and care staff. We have:

- secured engagement in the programme from all Centre teams
- piloted an antimicrobial stewardship training session for out-of-hours primary care staff
- raised awareness among Centre staff by co-presenting a Lunch & Learn session on AMR
- worked with PHE’s national Primary Care Unit to deliver a webinar for all community pharmacy staff in England to coincide with the national AMR campaign
• secured funding from Health Education England to design and deliver bespoke train-the-trainer sessions for care homes in the region, focusing on antimicrobial stewardship and infection management
• begun completing the Health Equity Assessment Tool (HEAT) to identify inequalities associated with AMR in our region and
• produced a briefing for wider health and care staff on relevant AMR resources and a briefing for the Centre on how STP/ICS Long Term Plans have included AMR

While we’re proud of what we have managed to accomplish so far, there is always more to do, and we look forward to moving ahead with our plans to deliver training to care homes in the coming months. As we start to move into 2020/21, we also hope to strengthen our collaboration with other Centre colleagues, with other stakeholders and existing and new AMR networks to explore new ways in which we can innovatively tackle the AMR challenge. It’s not a question of if we do it, it’s a question of how we do it!

Any questions or suggestions please contact: Victoria.wells@phe.gov.uk
Public health systems leadership in cardiac services: a route in from specialised services

Dr Mark Lambert, Consultant in Public Health, PHE North East Centre

Context

The North East and North Cumbria is a population of over 3 million people from the Tees Valley to the Scottish border; from east to west coast. It is served by many world-class cardiac services and has achieved notable improvements in cardiovascular health. The oversight of the tertiary cardiac services is supported by Public Health England, principally through a consultant in public health embedded in NHS England’s commissioning team. Public health led investigations identified access to these services such as diagnostic imaging and device implantation is uneven, depending on location and route into services. In 2018 NHS England commissioners recognised that the cumulative evidence demonstrated these prescribed Specialised Services do not serve local people well enough; that access is uneven, and experience is largely unknown. This despite spending more than £50 million a year on specialised cardiovascular care. Further, Specialised Commissioners recognised that their historical approach - serial negotiation with individual providers (supported by a professional network) could not resolve these problems. An alternative approach was difficult to identify, not least because the commissioning and delivery responsibilities for preventive, treatment and supportive cardiac services are widely distributed.

Approach and Outcomes
As the embedded public health consultant in a specialised commissioning team, I identified the potential for system-wide working and led the development of a proposal for this. Specialised service commissioners subsequently adopted a Large-Scale Change programme for addressing this problem, in partnership with the local cardiovascular network. This meant securing the commitment of statutory and non-statutory stakeholders with responsibilities across preventive and treatment services, with the embedded public health consultant taking the lead. This culminated in a stakeholder event held in December 2018, where patients and their experiences took centre stage. The result was very different conversation between patients, clinicians and policy makers than was possible before.

The development of this work programme is led by a project team, where I spend much of my time facilitating the conditions required to undertake the system-wide work; making connections between individuals, groups and organisations. As a result, there is now a set of agreed design principles for a new approach to cardiac services, a set of outline plans for priority cardiac prevention and treatment topics, now approved in principle by the Integrated Care System.

The Large-Scale Change continues, with a series of leadership events, developing detailed system-wide plans for tackling big service dilemmas. The first of these in October 2019 developed initiatives to improve cardiac emergency pathways, with more planned for later this year, focusing on cardiac pacemakers and diagnostic imaging and a strategy for CVD prevention among others. This has been a fabulous and well-supported opportunity to change a system view of health services. It has gone well beyond describing the problem. I have helped to shape partnerships, form views about what change is needed and possible and shape timely, sustainable service improvements in cardiac services for local populations.

For further information please contact: Mark.lambert2@nhs.net

**NHS Long term plan and CVD Prevention**

Further information can be found [here](#)
Think kidney-future proofing kidney care: predicting demand for renal replacement therapy

Catherine Croucher, Consultant in Public Health, Specialised Commissioning, NHS England and NHS Improvement, PHE London.

The public health burden of chronic kidney disease (CKD) is high. It affects around 6% of adults and around one third of people are unaware they have the condition. It causes illness, premature mortality and can severely impact on quality of life. It also imposes a large economic burden on individual patients as well as the healthcare system.

The renal care pathway is truly multi-organisational, beginning with prevention and early identification, then management of early stage kidney disease through to renal replacement therapy for end stage kidney disease (dialysis and transplantation). The pathway includes commissioners from local authorities, clinical commissioning groups and NHS England (NHSE) with services provided across primary, secondary and tertiary care, in hospitals and in patient’s homes. The multi-organisational care pathway for renal services makes it a likely candidate to pilot the NHS Long Term Plan ambition of “place-based, integrated primary, secondary and specialist services being delivered through Integrated Care Systems by April 2021”.

In London, two renal clinical advisory groups have developed in the North and South of the capital, aiming to share best practice, develop effective care pathways and improve outcomes across the system. Both groups are working together to assess the opportunity for a whole pathway approach to renal commissioning. This requires a solid understanding of population need, opportunities for prevention, current demand and how this may change in the future.

Using UK Renal Registry and Secondary User Service data, an analysis of recent trends by provider and Integrated Care System (ICS) area was undertaken. Different scenarios for future demand were then developed, based on population projections and trend data. It was established that even when using moderate estimates of future demand, growth in the dialysis population will overwhelm current capacity. In this “no change” scenario, the predicted increases in North and South London over the next decade would result in the requirement for a whole new renal unit in each network the size of the Royal Free and Guys & St Thomas’ renal units respectively. This is

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not a realistic solution and so renal networks need to plan how to mitigate this growth, developing a system-wide approach to standardising integrated renal care pathways including;

- increasing kidney transplantation rates
- diversifying the mix of dialysis modalities available, especially home therapies
- improving shared decision making and the offer of supportive care

Prevention and early identification:

One of the most important aspects of managing future demand is the prevention and early identification of kidney disease in primary care, especially amongst those diagnosed with diabetes and hypertension. The albumin to creatinine ratio (ACR) test provides an early indication of such problems and testing rates across London vary widely, as does the “diagnosis gap” between the estimated true prevalence of CKD and recording as part of primary care registers. Reducing this variation represents an opportunity to support patients to delay or even prevent progression of their kidney disease.

The Specialised Commissioning public health team (embedded within NHSEI) is well placed to support the renal networks in this effort, providing a population health view and helping to build relationships between renal services and ICS long term condition prevention programmes, especially for diabetes and cardiovascular disease. We can advocate for prevention and provide the evidence to justify raising awareness of this condition within communities, public health teams, NHS commissioners and healthcare professionals, encouraging all to “think kidney”.

For more information please contact Catherine.croucher1@nhs.net
Housing Adaptations and the Disabled Facilities Grant

Martin Hodges, Health and Housing Research Associate, Care & Repair England and member of the National Falls Prevention Coordination Group

You might be thinking “is this article worth reading as I do not work in housing” and asking yourself the following questions:

- why is the grant relevant to my work? – the grant is intended to assist individuals who you might be helping either in community or health settings
- how might it help my patients/service users? – you may have experienced people living in unsuitable homes but not known what advice to give.

Background

The Disabled Facilities Grant (DFG) has existed for 30 years but is still relatively unknown to many health, care and public health practitioners, commissioners and academics. All local authorities (including unitary and district councils) receive an annual allocation from government through the Better Care Fund to administer the grant programme in their area. That budget has doubled in the last 4 - 5 years (£0.5 billion). It is available to assist people of all ages with a relevant need, sometimes assessed by an occupational therapist, irrespective of whether they live in a property they own or rent from a housing association or private landlord. Similar assistance is available for council tenants. However, the grant is not available in specialist settings such as nursing or residential care homes. Over 65% of grant recipients are older people often with other health needs in addition to disability.

What the DFG provides

The DFG ensures properties are accessible and facilities are capable of being effectively used. The most common modifications are: bathroom adaptations, stairlifts, ramps, rails and kitchen redesigns. Whilst the grant is means tested for adults many people qualify for the full cost of works. Local authorities are encouraged to exercise discretion in how funding is used to reflect community needs. Increased budgets have enabled opportunities for integration and the development of a wide range of approaches across England. A report by the Centre for Ageing Better showcased 24 examples of innovation and good practice across England. eg. Care and Repair Manchester Agency is commissioned by three hospitals to contact every older person discharged from hospital and check that their home is safe, including a falls risk assessment. They put in place the necessary interventions straight away.
Context

All this sounds very positive and indeed it is as people receiving DFG assistance report very high levels of satisfaction and improvements in their health and wellbeing in a variety of ways including greater dignity and independence with less social isolation. In addition, Public Health England published a Return on Investment tool for common falls prevention measures. Home modifications demonstrated the greatest return on investment of the listed interventions. However, in a systematic evidence review of adaptations there was reasonably good evidence on the efficacy of minor adaptations but many gaps in good quality studies related to major adaptations.

Commissioners are increasingly demanding evidence on what adaptations deliver. Service providers have an appetite for participation in research that can robustly evidence outcomes from major adaptations but lack the expertise to undertake it themselves.

How can you get involved?

Health, care and public health managers and practitioners – if you consider that there may be some synergy between your services and the DFG identify and speak to your local service provider through Foundations here.

You can read more about how delays in providing adaptations can be reduced in the next article by Karin Orman from the Royal College of Occupational Therapists.

Academics – if you consider you could help fill some of the evidence gaps through research please contact me martinhodges@careandrepair-england.org.uk
Adaptations Without Delay

Karin Orman, Assistant Director - Professional Practice, Royal College of Occupational Therapists (RCOT)

It has long been acknowledged that adaptations play a crucial role in prevention and improving health and wellbeing for older adults, disabled adults and children. In consequence the sooner they are installed the greater the benefit.

Occupational therapists provide a key role in the adaptations process alongside other interventions in support of people’s health, wellbeing and engagement in meaningful activity. Increasing demand on occupational therapists and services in general often results in delays in the provision of adaptions. In order to support services to address these issues, the Royal College of Occupational Therapists published Adaptations without delay in June this year. This innovative guide explores how the planning and delivering of adaptations could be carried out differently across the UK.

The Housing Learning and Improvement Network (LIN) was commissioned to produce this guide that was developed with a steering group of experts. The guide has been endorsed by expert bodies from across the UK, including the Chartered Institute of Housing, Foundations, Care and Repair in England and Wales, the Scottish Federation of Housing Associations, and the Northern Ireland Federation of Housing Associations.

The guide proposes that adaptations should be based on the complexity of the situation as opposed to type and cost. It also provides a structured framework illustrated by real service case studies. Adaptations without delay can be used by practitioners and organisations to reflect on current service provision and consider redesigning services to incorporate a universal, targeted and specialist approach.

What is a universal, targeted and specialist approach?

Universal level – the situation and the solutions are simple and can be met by retail options or basic help to install simple adaptations.

Targeted level – the situation is still simple and straightforward but some basic guidance and support is needed to select the best option from a range of standard solutions (e.g. showers, stairlifts) and can be provided by support staff with the right level of training and where advice can be obtained from an occupational therapist if needed.
Specialist level – the person’s situation is complex and requires personalised solutions from an occupational therapist.

Using the approaches in the guide will support services to better utilise occupational therapy expertise when and where needed. This will reduce unnecessary delays and ensure adaptations support people’s independence and quality of life.
From the Provider Public Health Network:

Every baby born in the right place: applying a whole systems view to capacity and patient flow management in maternity and neonatal care

Dr Inna Walker, Specialty Registrar in Public Health, University Hospital Southampton NHS Foundation Trust and Clinical Research Fellow, University of Southampton

Complex issues, such as patient flow management, are, by definition, challenging to investigate and address. Public Health registrars, with their unique position and expertise, can help providers tackle complex issues in healthcare public health. Whilst on an acute trust placement, I had an opportunity to carry out an empirical investigation of factors influencing capacity and patient flow at Princess Anne Hospital in Southampton, a provider of both standard and specialist maternity and neonatal care. My position outside of any particular team meant that my enquiries were largely seen as impartial, which promoted staff engagement, but also meant that I needed to learn about the organisation, its culture and sensitivities, from an outside perspective.

Background

Appropriate maternity and neonatal care in the right facility can make a lifelong difference to the mother and the newborn, in particular when babies are born prematurely or complications arise. Efficient management of hospital capacity is vital in order for the right type of bed or cot to be available for each patient, including when clinical scenarios evolve and patients need higher levels of care than initially
anticipated. Healthcare providers use operational pressure escalation alerts and procedures, in order to indicate changing capacity and guide remedial steps, which are often reactive and short-termist.

Why a whole systems approach?

Systems thinking can help counteract this firefighting tendency. A systems approach, whereby various components of a system are considered within the context of their interrelationships, is well-known in public health. It has been successfully applied to emergency care provision, yet overall is underutilised in healthcare trusts.

What this meant in practice

A total of 56 members of staff, including clinicians, midwives, neonatal nurses, operational coordinators, service and data managers, and leads of the regional Neonatal Operational Delivery Network and Local Maternity System, provided their views on the factors affecting capacity and alert escalations, in interviews and focus groups. In addition, related data trends were examined, such as capacity alerts, cot occupancy, refusals to patient transfers from other providers, nursing staffing deficit, high cost staffing agency use and skill mix on shifts.

When the underlying complexity started to emerge, I decided to apply a whole systems lens to aid interpretation of the findings. The components of the system were grouped under the following categories: communication; midwifery and nursing staffing; patient-related; organisational; financial; miscellaneous. The relationships of multiple individual factors were summarised in a systems map. Successes and areas for improvement were identified and discussed with the teams, and a range of initiatives were agreed on, aimed to foster proactive capacity management. For example, one of the priorities became improving communication within and between teams, locally and regionally, including setting up weekly joint Neonatal and Child Health meetings to plan transfers, providing the duty neonatal coordinator with a mobile phone and introducing tabulated summaries of facilities at each provider in the region, to better inform transfer discussions and decisions.

In summary

To attain the goal of the right care being available for every mother and every baby, proactive management of maternity and neonatal capacity should complement reactive escalation plans aimed at restoring patient flow. A whole systems approach can be useful in interpreting complex issues in healthcare public health. Public health registrars, with their relevant skills base and also a unique position in the trusts, can assist healthcare providers in tackling complex issues.
News and Events:

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<th>Respiratory atlas launched 27/9/19</th>
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<tr>
<td>Please find below some key summary information about the respiratory atlas that can be shared widely.</td>
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The 2nd Atlas contains over 60 indicators of respiratory disease risk factors, healthcare measures and health outcomes. This expanded Atlas bring together analysis and guidance for COPD, asthma, pneumonia, bronchiolitis, TB, lung cancer, risk factors and end of life care.

A stark picture is presented of variation in the quality of care and outcomes experienced by people with respiratory disease in different parts of England. The variation extends to the detection of disease with late or inaccurate diagnosis resulting in more frequent and expensive emergency hospital admissions.

The Atlas presents advice to support local CCGs to tackle the key issues in respiratory care outlined in the NHS Long Term Plan and brings together information on actions local areas can take to improve respiratory disease risk factors such as smoking, air pollution, obesity, housing and radon exposure.

A key feature of the Atlas is that the data analysis is accompanied by text, developed with respiratory experts to provide the context, reasons for variations, options for actions and resources for healthcare providers and commissioners.

The full Atlas can be accessed here:

https://fingertips.phe.org.uk/profile/atlas-of-variation

The interactive Instant Atlas can be accessed here:

https://www.england.nhs.uk/rightcare/products/atlas/

We are finalising a user survey that will be available on the fingertips page from Friday. As well as asking about the Respiratory Atlas the survey is seeking feedback from users of any previous Atlas to provide input to the future development of the Atlas products.
Quick guide to falls prevention in care homes published 30th September 2019

The North of England Falls Prevention in Care Homes Programme has launched their website, there you will find the Falls Prevention and Management Guide, poster, pocket guide and self-assessment. Any examples of good practice and case studies that could be featured on the site, as well as any training or events would be welcomed.

Please contact: annlouise.stephens@nhs.net
You will find the website at https://reacttofallsprevention.co.uk

Healthy Ageing Consensus statement - launched 16th October 2019

You will find attached a PDF copy of the Healthy Ageing Consensus statement, slides from the webinar presentation and the user guide on how to register for the Healthy Ageing Knowledge Hub.

If you have any further queries on Consensus Statement or broader programme of Healthy Ageing, please do get in contact via ageingwell@phe.gov.uk.

Productive Healthy Ageing Profile

Updates to mortality rates in those aged 65 years and over due to cardiovascular disease, respiratory disease and cancer will be published on 5 November in the Productive Healthy Ageing Profile. These indicators will provide useful summary measures of key causes of death in older people and will be an update of existing long-term trend data

Chief Medical Officer's (CMO) Physical Activity Guidelines for Health

The UK Chief Medical Officers recently published new guidelines (September 2019). Key elements remain the same (i.e. guidance on aerobic activity, strengthening activity and sedentary time), with new foci including: ‘Some is good, more is better’ message – Emphasis on getting inactive people to increase their activity rather than purely attainment of guidance levels.
Focus on ‘forgotten’ strength guidelines – Prioritising the strengthening guidelines due to poor awareness and attainment (e.g. even for those achieving aerobic guidelines, half of these people are not doing sufficient strengthening). Inclusion of inequalities groups – For the first time the Guidelines include specific consideration on groups with inequalities in activity (disabled people, pregnant women and post-birth women).


The conference will be held in London at the Kia Oval on Thursday 6 February 2020. We hope you will hold the date in your diaries so that you can join us for the event. Please feel free to share this date with your networks.

Registration for the event will open mid-December via the conference website:

National Health Checks data launch 17th October 2019

The NHS Health Check primary care data extraction is now live. More details are below:

PHE and NHS Digital jointly publish new dashboard on NHS Health Check primary care data

On 17th October PHE and NHS Digital jointly published for the first time an interactive data dashboard on NHS Health Check primary care data. This dashboard provides the number of patients attending an NHS Health Check between April 2012 and March 2018, using data recorded by participating GP practices. Data on over 10 million patients was extracted in 2018. Data can be broken down by age, sex, ethnicity as well as local authority and CCG. This first release will provide new insight into the characteristics of people attending or not attending a check. The richness of this data is significant and will help to improve our understanding of the programme’s impact and also inform what action is needed to improve service delivery and outcomes. PHE and NHS Digital are now jointly working towards releasing a range of metrics in a number of phases on this dashboard.

The NHS Health Check Programme 2012-13 to 2017-18 publication page includes key facts and a range of resources and a direct link to the data dashboard can be
found here. A supporting guidance document is available which includes a comparison of the methodology and processes used to collect and analyse this general practice data extraction data, with the NHS Health Check data returned by local authorities each quarter.

If you have any questions regarding this data publication, please contact Catherine Lagord catherine.lagord@phe.gov.uk.

THANK YOU FOR READING!