Public Health England

RSPH
ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE

Everyday interactions

Measuring the public health impact of healthcare professionals

June 2017

Contents

Foreword

Shirley Cramer CBE
Chief Executive, Royal Society for Public Health

Today, the public health workforce is a broad church, with individuals from many diverse and disparate professions, linked by a desire to improve the public's health.

This has not always been the case. Historically, public health was seen as the domain of doctors and the medical profession, and the development of a multidisciplinary workforce has only emerged since the late 1980s (Knight and Evans, 2007). In fact, until 2001, the most senior public health official at the local level in England had to be a physician (Sim and Mackie, 2007).

In recent years the definition of who constitutes the public health workforce has changed, and at a time when the challenges facing us are significant – particularly with an ageing population and high numbers of individuals experiencing preventable conditions linked to lifestyle and the social determinants of health – it is clear that a more open and inclusive strategy is needed to reach the health needs of the population.

In 2014, the Royal Society for Public Health defined the wider public health workforce as "any organisation or individual, who is not a professionally qualified public health specialist, but has the ability or opportunity to positively impact public health" (RSPH, 2014). This could range from a health professional in another discipline to someone working in a role that would not traditionally see improving health as a key priority, such as the fire service or hospital porters. In a subsequent report from the RSPH and the Centre for Workforce Intelligence (CFWI and RSPH, 2015), around 20 million individuals across a range of different occupations were recognised as having a part to play in this wider workforce and much has been done to engage them. However, a gap has been highlighted: the wider workforce is increasingly being required to demonstrate their public health impact, and there is little guidance or support to help them achieve this.

This report focusses on the public health impact of four of the key healthcare professions within the wider workforce: nurses and midwives, dentists, allied health professionals and pharmacists (although we hope it will have wider appeal) and aims to support these healthcare professionals as they record and measure their public health impact.

Much progress has been made in recent decades towards a more inclusive and expansive public health workforce, and we are a long way from the hierarchical set-up of old. We are encouraged that there is now a means for healthcare professionals to clearly demonstrate the importance of their role within the public health workforce. As the wider workforce journey is charted over the coming years, this report will help provide evidence of the progress that has been made.

Shirley Cramer
Chief Executive, RSPH
June 2017

Why should healthcare professionals measure their public health impact?

It is estimated that around two thirds of premature deaths - that is deaths before the age of 75 - could be prevented by addressing key public health issues such as a poor diet, being overweight, smoking, and high blood pressure. The NHS Five Year Forward View and Public Health England's From Evidence into Action call for a much greater focus on prevention. This is because the burden of preventable disease negatively impacts on many people's lives and threatens the sustainability of England's health and social care services. It's estimated that if the public were fully involved in managing their health and engaged in prevention activities, £30 billion could be saved.

The NHS Five Year Forward View (5YFV) describes the NHS as a social movement, recognising that collectively and cumulatively, we can help shift power to patients and citizens, strengthen communities, improve health and wellbeing, and as a by-product, help moderate rising demands on the NHS.

It is time for health and care professionals to act to make a difference. They have relationships with individual people, families and communities and reach across all ages and all places. This means that there is a huge opportunity 'for health promoting practice' to make a difference to health outcomes and health inequalities. In addition, through acting collectively they can be a force for change in building a culture of health and wellbeing in our society. In 2014, there were nearly 100,000 deaths in England and Wales from causes considered potentially preventable through public health interventions. Of these, 40% were due to cancers, 23% were due to cardiovascular disease and 20% due to injuries (ONS, 2016). There has been increasing recognition that a social movement that encourages healthier lifestyles and takes pressure off the NHS is desperately needed. The wider public health workforce are already creating momentum towards such a movement and there is barely an occupation where the case for embedding public health prevention cannot be made. In fact, the wider public health workforce has been estimated to include 20.2 million people in the UK, covering 57 occupation groups and 185 working occupations (CFWI and RSPH, 2015).

In April 2015, Public Health England published 'All Our Health', an approach to maximise the impact health and care professionals in England can have on improving health outcomes and reducing health inequalities (PHE, 2015). The online content of All Our Health was subsequently updated and relaunched in 2016. All Our Health seeks to answer the concerns raised in the Five Year Forward View: "If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial treatments will be crowded out by the need to spend billions of pounds on wholly avoidable illness" (NHS England, 2014). The potential to truly make every contact count for improving the public's health is staggering. Furthermore, the evidence base demonstrating that very brief interventions, both to improve health and deliver savings to the NHS, are effective and should be invested in, continues to grow (PHE, 2016a).

The role of healthcare professionals

The research undertaken from this report focussed on four groups of healthcare professionals (HCPs) based on their high numbers in the UK and therefore their high levels of contact with the public:

- **allied health professionals – over 170,000 AHPs in the UK (The Health Foundation and Nuffield Trust, 2014);**
- **nurses and midwives – over 360,000 in England (NHS Confederation, 2016);**
- **pharmacy – over 11,600 community pharmacies in England (NHS Digital, 2016); and**
- **dentistry – over 88,600 dentists and dental professionals in England (General Dental Council, 2015).**

Our findings clearly highlight that many of these HCPs are already improving the health of individuals. However, the first survey carried out as part of this project also highlighted that four in five HCPs are not recording or measuring their public health impact with the barriers to this including time and capacity constraints as well as lack of training.

Why measure public health impact?

Measuring public health impact is vital on many levels. For healthcare professionals themselves, it highlights the worth of the work they are doing and provides encouragement to continue to invest time and energy in public health. Recording interactions around public health priorities also enables follow-up and helps to deepen the relationship between individual and HCP.

The Chief Medical Officer (CMO) has set out the need to 'build a culture of health' in our society and the 5YFV promotes a social movement for health. Measuring impact empowers healthcare professional leadership and raises awareness among the public of healthcare professional roles in prevention.

Measuring impact is also a clear way to demonstrate to commissioners the public health value of services (LGA., 2015). Commissioners surveyed as part of the development of this toolkit all considered public health to be a priority when awarding tenders.

When data is collated across services, it helps to benchmark and compare services, highlighting what works and what doesn't, helping to improve practice. Evidence supporting the positive impact that can be made by public health interventions by healthcare professionals makes the case for continued investment and ensures that government policy recommendations continue to support this vital work.

Measuring public health impact ultimately helps to improve the public's health.

How was this toolkit developed?

Prior to the commissioning of this project, Public Health England observed a need for a tool to support healthcare professionals (HCPs) to better measure their public health impact in line with the aims of All Our Health. It was observed that HCPs were developing 'health promoting practice' by applying evidence that protects health and promotes wellbeing. However this was not being uniformly measured and therefore not recognised at the local level as an outcome of their work.

A full description of the methodology is available in Appendix A. In brief, HCPs were initially surveyed to ascertain which areas of public health they were engaging with in their role and whether they were measuring their public health impact. It was found that although many HCPs were engaging in public health interventions across a range of priority public health areas, many were not recording or measuring their public health impact and there were few resources available to support them in doing so. Desk-based research and twitter discussions supported this finding.

A logic model approach was supported by HCPs in a second survey. Therefore 10 logic models were developed, reviewed by the PHE topic experts and tested in practice by HCPs across a range of disciplines.

How will this toolkit help?

This toolkit seeks to provide a quick, straightforward and easy way for HCPs to record and measure their public health impact in a uniform and comparable way. It is to support healthcare professionals in the prevention and health improvement interventions that they do as part of routine clinical practice. There is an emphasis on making every contact count (MECC) interventions within this toolkit because this is what HCPs identified as an unmet need. Clearly the move to health promoting practice by healthcare professionals is broader than MECC, however there are already evaluation tools available for some of the broader public health interventions undertaken by HCPs, for example, standard evaluation frameworks for obesity and physical activity interventions (PHE, 2017) and the arts and wellbeing (PHE, 2016b).

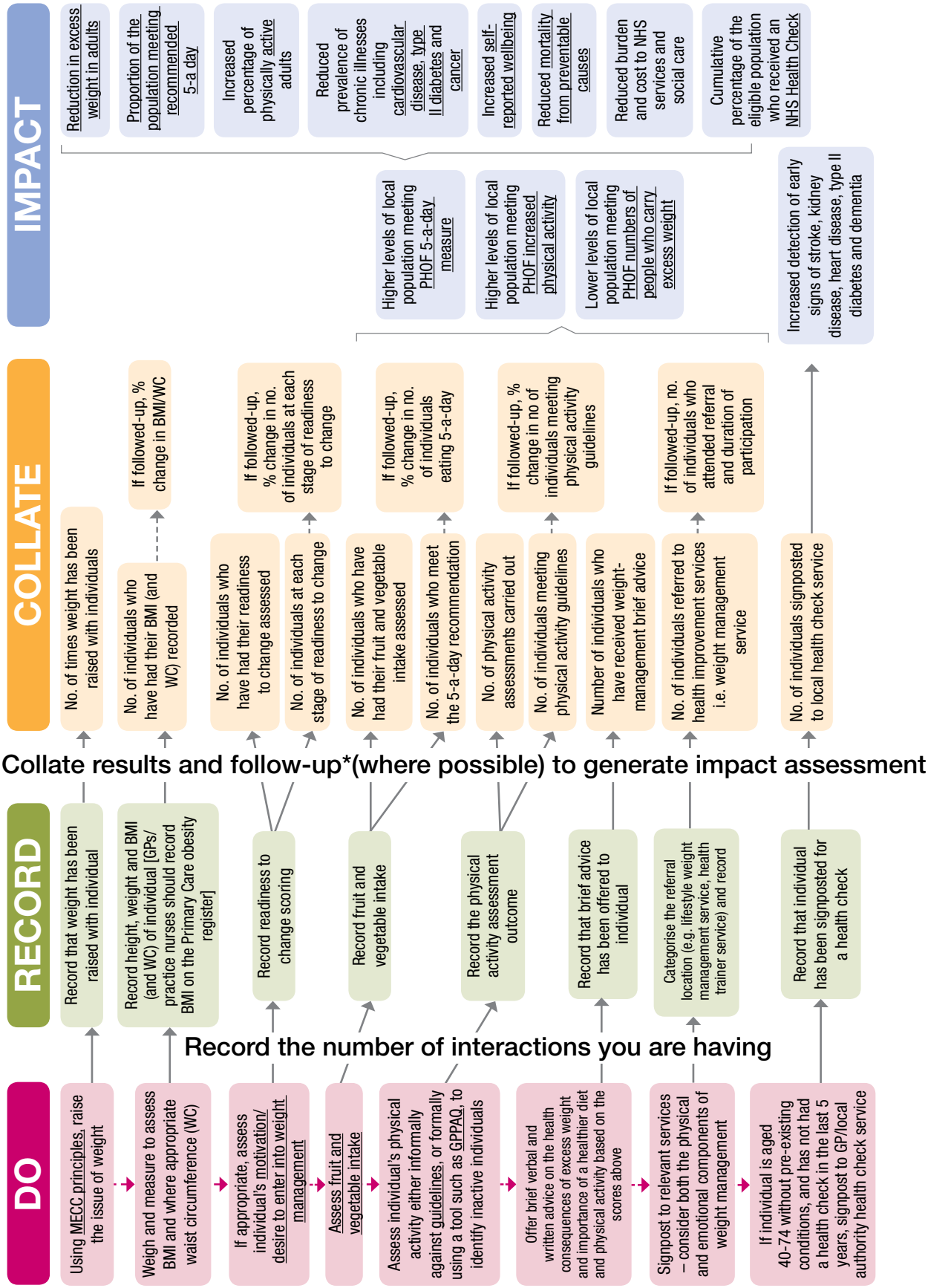
Based on the priorities identified by All Our Health as key to closing the gap in health and wellbeing and reducing NHS costs, ten impact pathways based on logic modelling have been developed. A logic model is a visual pathway that links inputs to desired outcomes. In the impact pathways produced in this report, HCPs will be supported to record what they 'do' in their interactions with individuals, what data can be collated and also the possible impacts from these interactions. For example, when using the physical activity pathway, a HCP will record that an individual has received brief advice about physical activity. Over time, these records can be collated, to demonstrate the number of individuals who have received brief advice on physical activity over the previous 12 months. The impacts in the models link to national indicators, and for physical activity include reduction in national prevalence of obesity and reduction in falls.

The impact pathways produced cover ten public health priorities that healthcare professionals can help to support: adult obesity; alcohol; child oral health; dementia; healthy beginnings; falls; mental wellbeing, physical activity, sexual and reproductive health and HIV; and smoking and tobacco.

Demonstrating impact on these public health priorities is important to improving the public's health, reducing health inequalities, and ultimately, preventing premature deaths from causes that public health interventions can, and should, prevent.



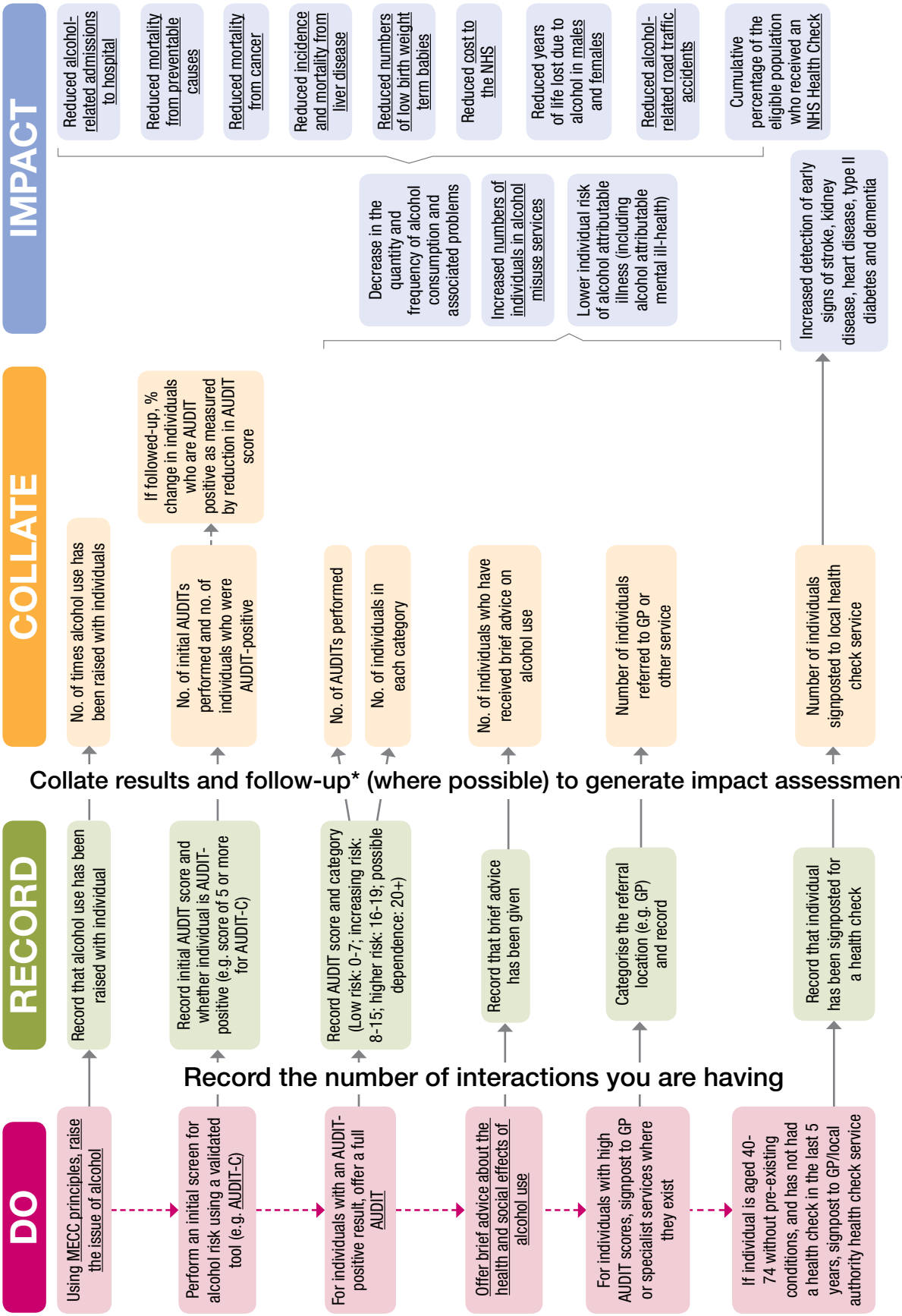
IMPACT PATHWAYS – Adult obesity



Supportive resources: There is training available on the health implications of obesity. The Public Health England (PHE) framework 'All our health' has a section dedicated to adult obesity, containing extensive literature on the different forms intervention can take. Public Health England has a list of accredited and validated tools to use in the management of weight management interventions. All have their applications and limitations and should be used on a service-by-service basis.

*Follow-up is optional and in many cases will not be possible. However, should the opportunity arise, the impact pathway highlights the data that could be collected to further demonstrate impact.

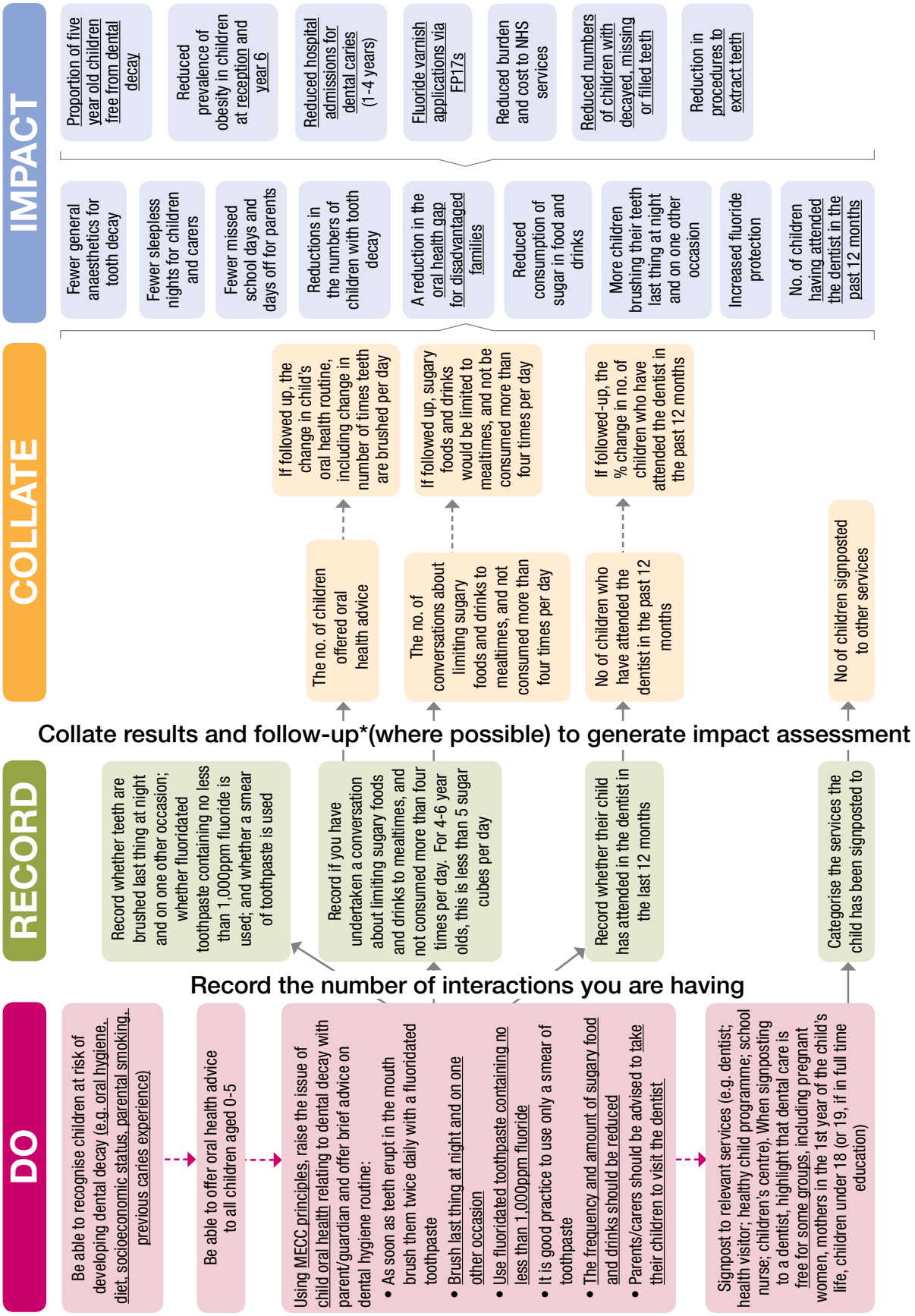
IMPACT PATHWAYS – Alcohol



Supportive resources: There are e-learning training packages available on Alcohol Identification and Brief Advice (IBA) in primary care, community pharmacy, hospital settings and dental settings on the e-Learning for Health Care website: **http://www.e-lfh.org.uk/programmes/alcohol/**
The Public Health England (PHE) framework 'All our health' has a section dedicated to alcohol, containing extensive literature on the different forms intervention can take.

*Follow-up is optional and in many cases will not be possible. However, should the opportunity arise, the impact pathway highlights the data that could be collected to further demonstrate impact (reduction in AUDIT-C or AUDIT score).

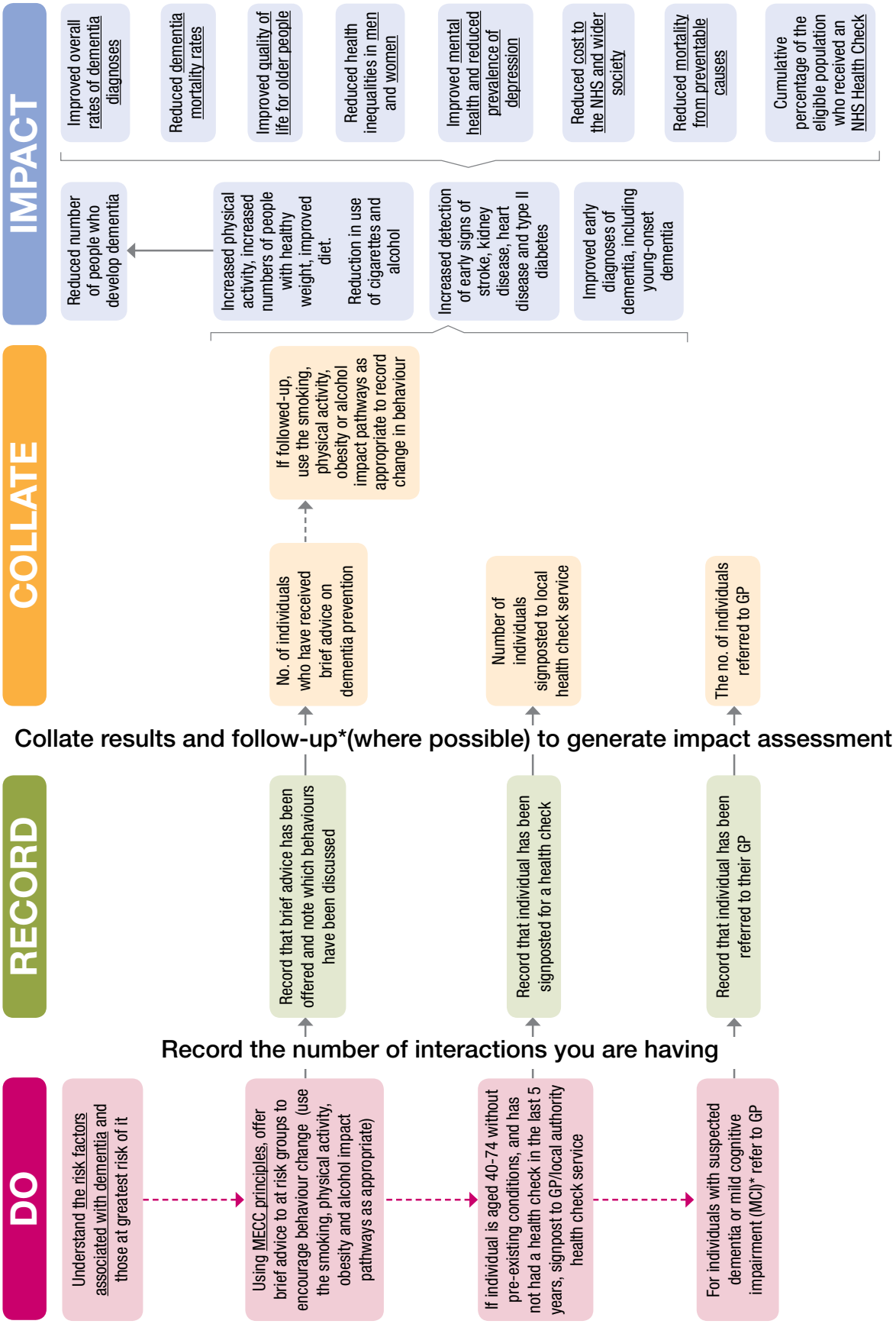
IMPACT PATHWAYS – Child oral health (0-5 yrs)



Supportive resources: There is training available on child oral health (e.g. the Healthy Child Programme e-learning module 10). The Public Health England (PHE) framework *'All our health'* has a section dedicated to child oral health, containing extensive literature on the different forms intervention can take.

*Follow-up is optional and in many cases will not be possible. However, should the opportunity arise, the impact pathway highlights the data that could be collected to further demonstrate impact.

IMPACT PATHWAYS – Dementia



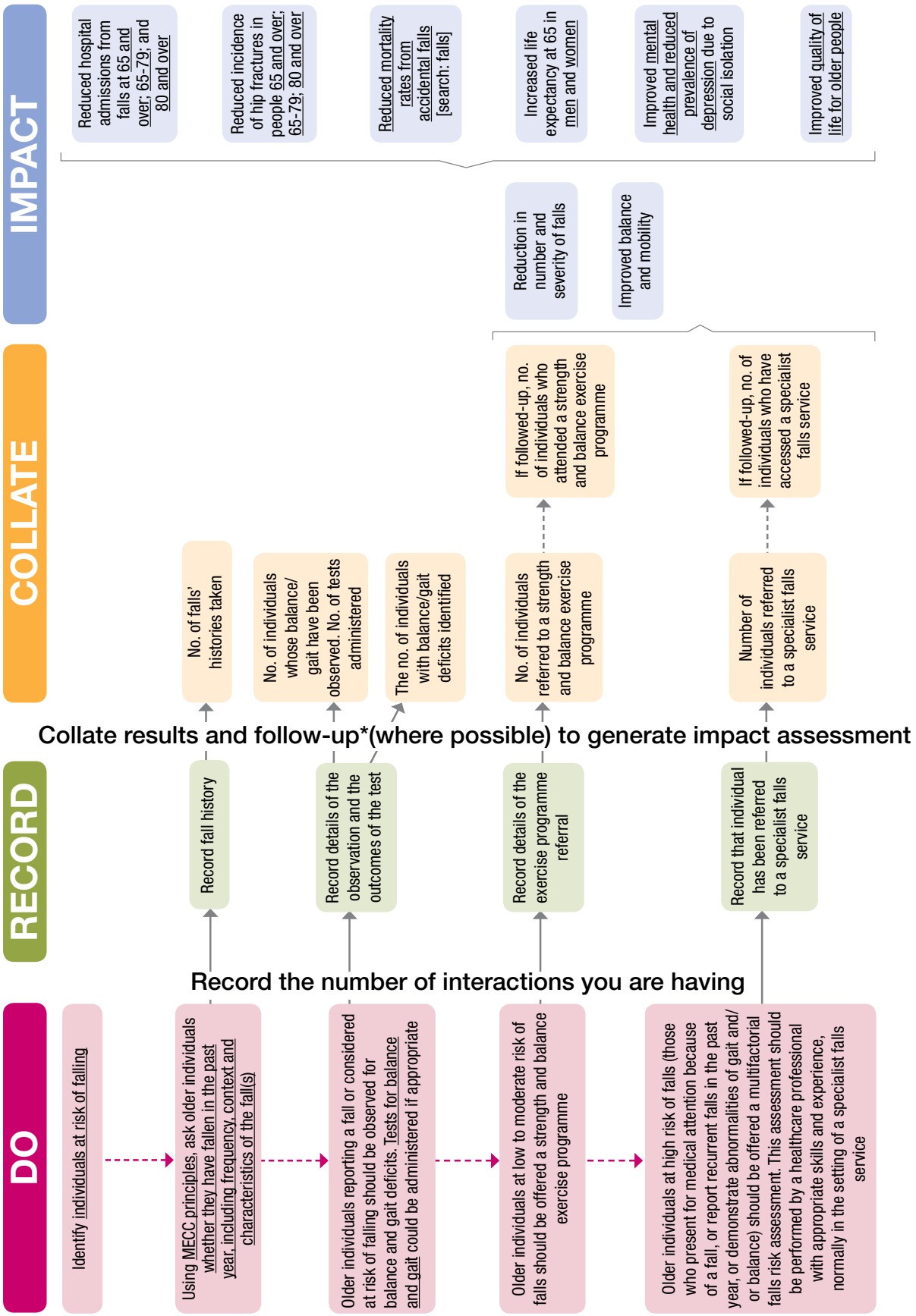
Supportive resources: There is training available on dementia awareness, the issues around young-onset dementia and the increased risk of dementia for people with learning disabilities.

The Public Health England (PHE) framework 'All our health' has a section dedicated to dementia, containing extensive literature on the different forms intervention can take.

*Mild cognitive impairment is a syndrome defined as cognitive decline greater than expected for an individual's age and education level, which does not interfere notably with activities of daily living. It is not a diagnosis of dementia of any type, although it may lead to dementia in some cases.

**Follow-up is optional and in many cases will not be possible. However, should the opportunity arise, the impact pathway highlights the data that could be collected to further demonstrate impact.

IMPACT PATHWAYS – Falls

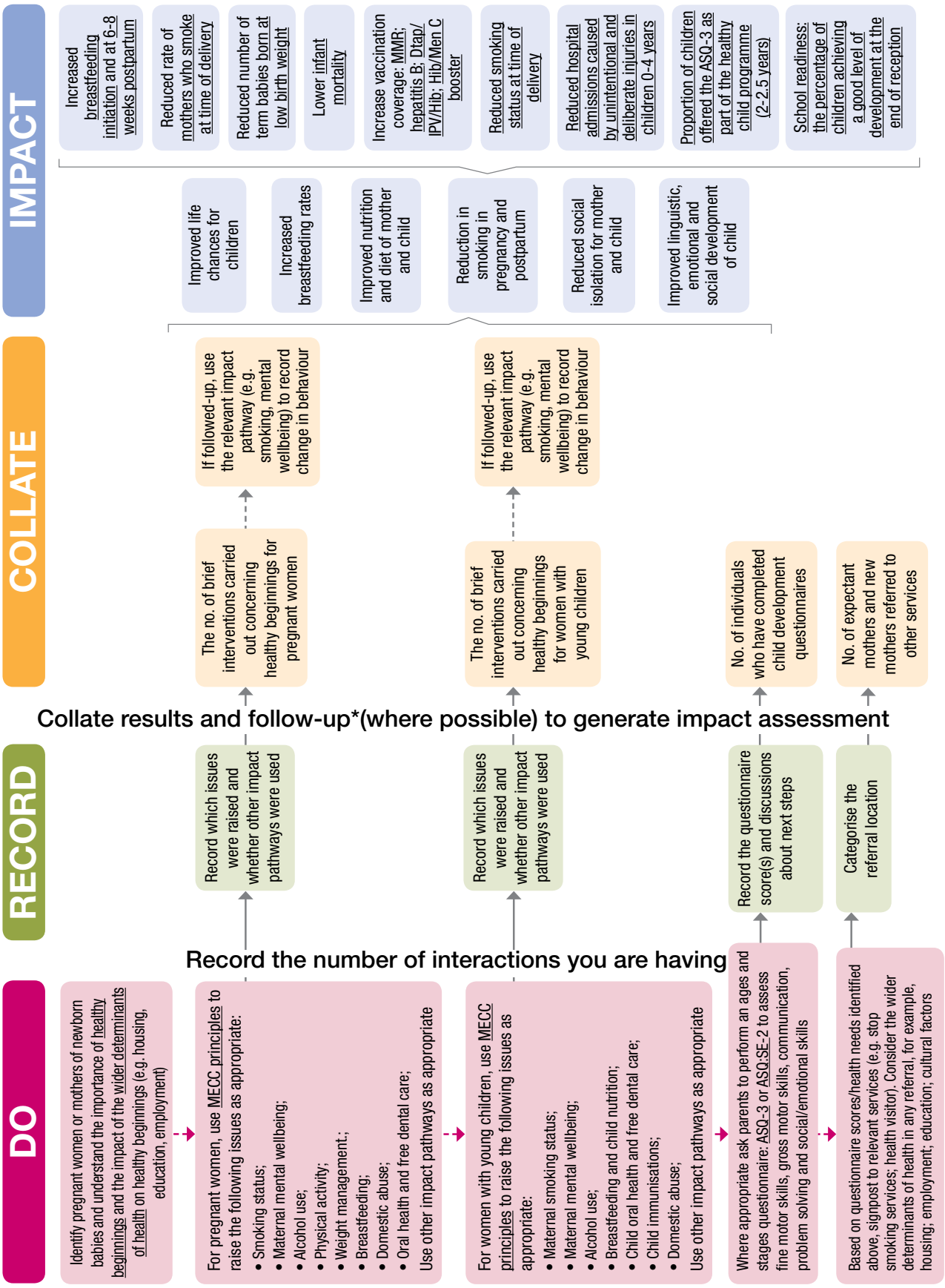


Supportive resources: Training in falls awareness is available. Southwark and Lambeth Integrated Care Pathway for Older People with Falls (Slips) has a series of assessment forms which are appropriate to use with the timed up and go test: it is advised that you use the General Assessment Form alongside the GUP test, but each service should assess the appropriateness and utility of each.

The Public Health England (PHE) framework 'All our health' has a section dedicated to falls, containing extensive literature on the different forms intervention can take.

*Follow-up is optional and in many cases will not be possible. However, should the opportunity arise, the impact pathway highlights the data that could be collected to further demonstrate impact.

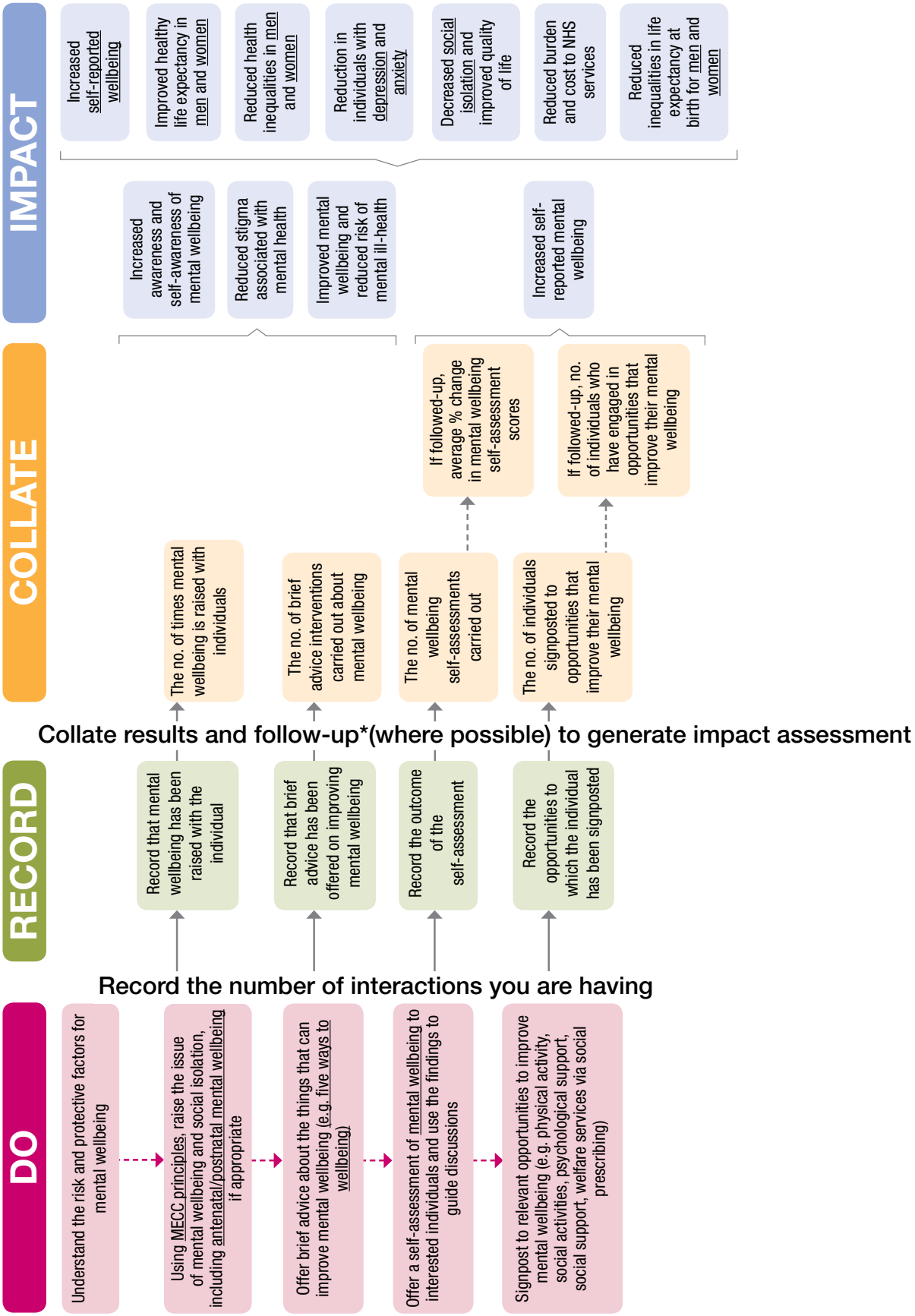
IMPACT PATHWAYS – Healthy beginnings



Supportive resources: There is training available in healthy beginnings. The Public Health England (PHE) framework *'All our health'* has a section dedicated to healthy beginnings, containing extensive literature on the different forms intervention can take.

*Follow-up is optional and in many cases will not be possible. However, should the opportunity arise, the impact pathway highlights the data that could be collected to further demonstrate impact.

IMPACT PATHWAYS – Mental wellbeing

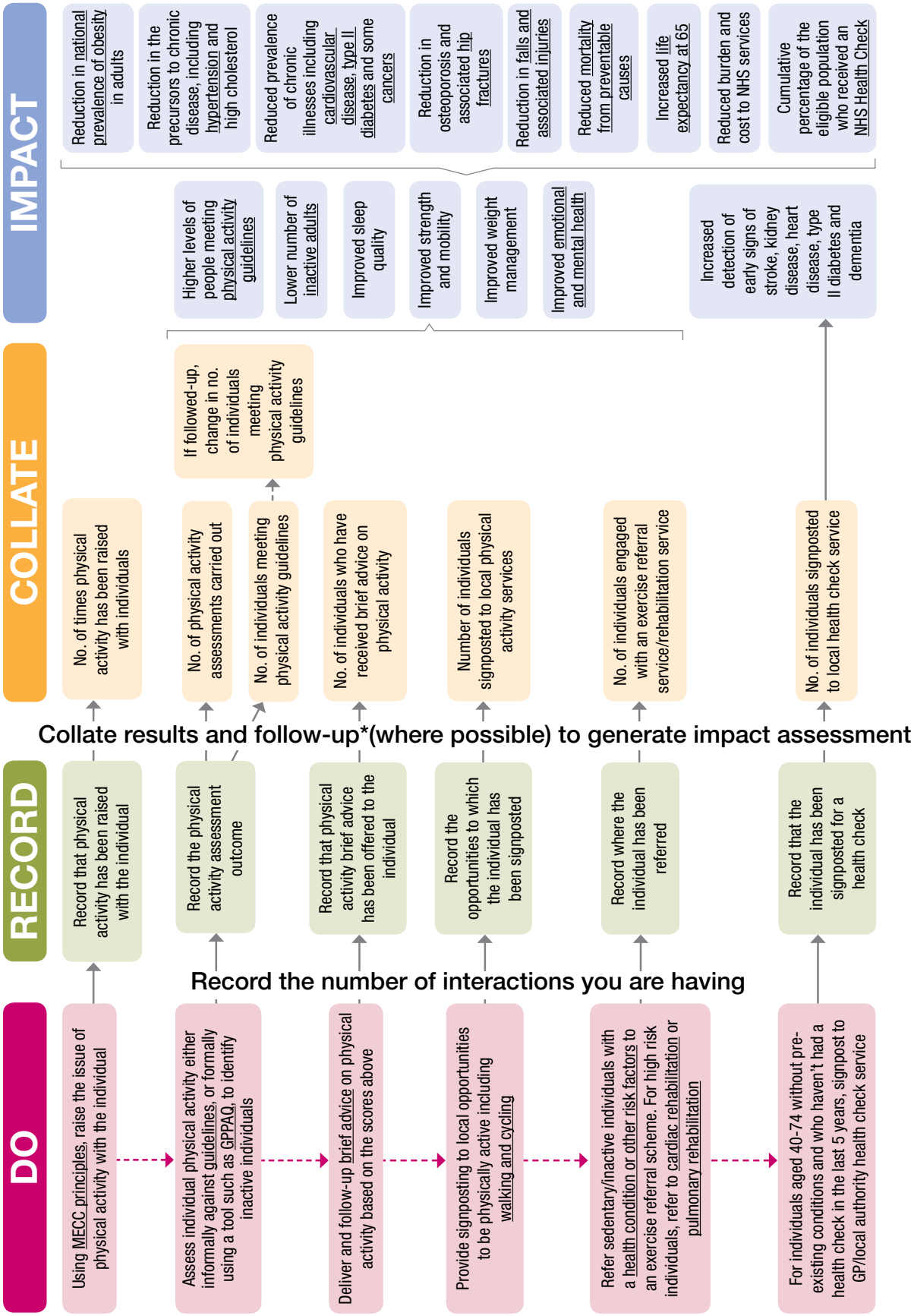


Supportive resources: There is training available on understanding mental wellbeing. The Public Health England (PHE) framework 'All our health' has a section dedicated to mental wellbeing, containing extensive literature on the different forms intervention can take.

There are a number of validated tools to assess mental wellbeing across all subpopulations: these include WHO-5 and WEMWBS/SWEMWBS. These and tools should be used appropriately across interventions and in relation to HCPs ability to deliver them.

*Follow-up is optional and in many cases will not be possible. However, should the opportunity arise, the impact pathway highlights the data that could be collected to further demonstrate impact.

IMPACT PATHWAYS – Physical activity

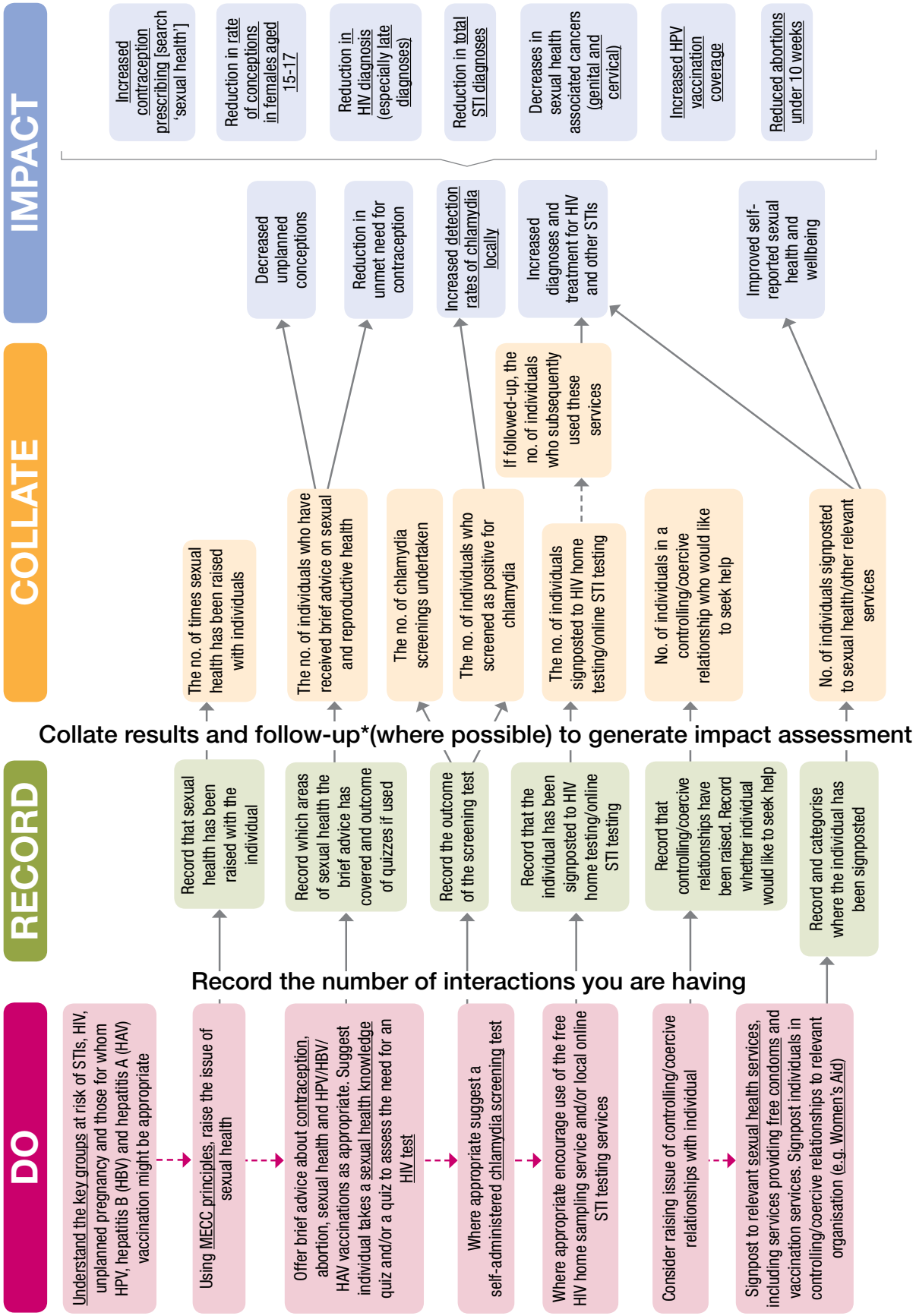


Supportive resources: There is training available on the health benefits of physical activity.

The Public Health England (PHE) framework 'All our health' has a section dedicated to physical activity, including extensive literature on the different forms intervention can take.

*Follow-up is optional and in many cases will not be possible. However, should the opportunity arise, impact pathway highlights the data that could be collected to further demonstrate impact.

IMPACT PATHWAYS – Sexual and reproductive health and HIV

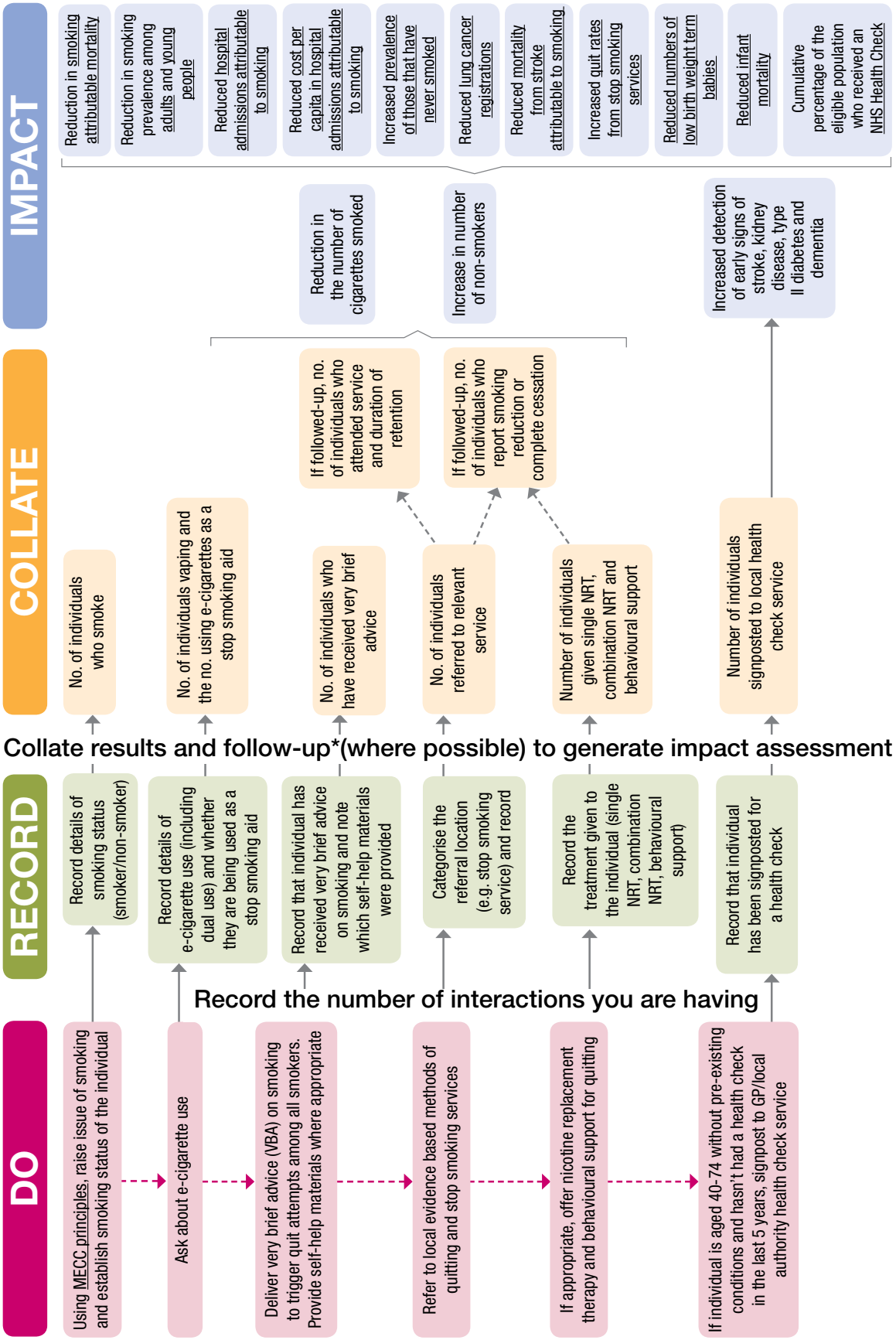


The actions taken will depend on the setting. In some settings tests, treatment and partner notification may be undertaken in situ. In other settings, signposting to other services will be sufficient. Antibiotic stewardship in sexual health is also a factor in treatment choice (especially in gonorrhoea) – see NHS England's Antibiotic Awareness Campaign

Supportive resources: There is training available in sexual health and HIV. The Public Health England (PHE) framework 'All our health' has a section dedicated to sexual health and HIV, containing extensive literature on the different forms intervention can take.

*Follow-up is optional and in many cases will not be possible. However, should the opportunity arise, the impact pathway highlights the data that could be collected to further demonstrate impact.

IMPACT PATHWAYS – Smoking and tobacco



Supportive resources: There is MECC training available for smoking cessation. The Public Health England (PHE) framework 'All our health' has a section dedicated to smoking and tobacco, containing extensive literature on the different forms intervention can take.

*Follow up is optional and in many cases will not be possible. However, should the opportunity arise, the impact pathway highlights the data that could be collected to further demonstrate impact.

Using the toolkit

This toolkit consists of ten impact pathways. These cover the public health priorities of adult obesity; alcohol; child oral health; dementia; healthy beginnings; falls; mental wellbeing, physical activity, sexual and reproductive health and HIV; and smoking and tobacco.

For each individual, the healthcare professional treating them will be required to use their own judgement about which, if any, of these areas would be worth pursuing.

Each impact pathway is divided into sections: 'Do', 'Record', 'Collate', 'Impact'. This is explained in more detail below based on the adult obesity impact pathway.

Do

The first column refers to what the HCP might do as part of a brief intervention. For example, if an individual presents who the HCP would like to talk to about obesity, there are eight inputs listed (although not all of them may be undertaken by all healthcare professionals). The top input is 'Using MECC principles, raise the issue of weight'. Following this, if appropriate, BMI and waist circumference could be measured, motivation to change could be assessed as well as fruit and vegetable intake and physical activity levels. Brief advice and signposting to other services that will support behaviour change may then be appropriate.

Signposting to health checks has been included in all of the relevant prevention models because they are a central component of All Our Health: they aim to promote and improve the early identification and management of individual behavioural and physiological risk factors for vascular disease and other associated conditions.

Record

At each of the 'do' stages, information will be gathered. The second column refers to what a HCP would ideally record. For example, when carrying out a BMI test, it will be necessary to record both the height and weight of the individual alongside their BMI. If an individual is signposted to other obesity-related services, where they have been signposted should be recorded and if individuals are seen again, follow up data for all of these areas should be documented and any change noted.

Data should be recorded in a way that meets data protection and confidentiality requirements.



Collate

This leads to the third column, which refers to data collated over a time for multiple individuals. It suggests the HCP calculates how many interventions and follow-ups have been carried out; e.g. for adult obesity, this includes recording the number of individuals who have had their BMI and waist circumference measured, the number of individuals who have had their readiness to change assessed; the number of weight-management brief interventions conducted and the number referred or signposted for further support.

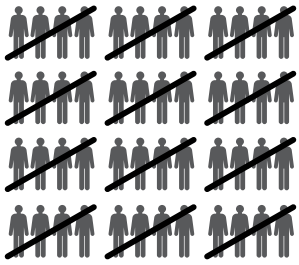
Follow-up is optional and in many cases will not be possible. However if the opportunity arises, the impact pathways highlight the outputs that may come from this. For adult obesity, this includes a % change in BMI (the average % change to be calculated when data is collated) and the % change in number of individuals meeting the 5-a-day recommendations.

Impact

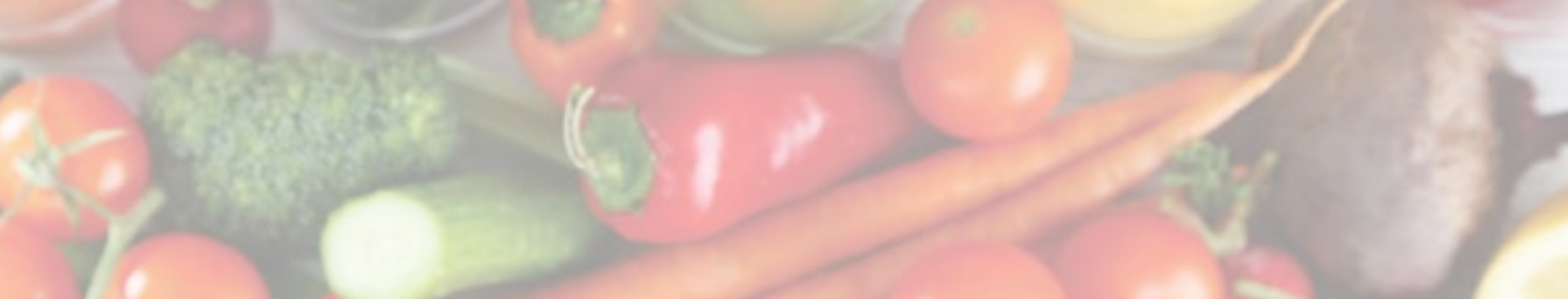
Finally, the last section is impact which consists of two columns. In the first column is the evidence that a particular service can use to demonstrate the impact their service is having on the local population where the service is operating, for example, a reduction in average BMI for those seen by the service will mean lower levels of the local population with excess weight.

In the final column of the impact section is a list of the national public health priorities that these interventions will impact upon. This information is important for promoting the service and developing business cases, and places the service within its national context. Not all outcomes have been included due to space, however, each All Our Health topic section contains a list of relevant national outcomes, including those from the Public Health Outcomes Framework and Health and Social Care Centre.

The RSPH has developed a short e-learning resource to support the use of the impact pathways, available at **www.rsph.org.uk/interactions**

	Example	
Do	**Signpost to relevant services** – consider both the physical and emotional components of weight management	
Record	Categorise the referral location (e.g. lifestyle weight management service, health trainer service) and record	
Collate	Number of individuals referred to health improvement services i.e. weight management service	
Impact	Mean weight loss or change in BMI	

The impact pathways bring together, under each of the ten headings, a broad structure for how HCPs can maximise the impact of their interactions with individuals. Completing them will enable healthcare professionals to measure their impact in a consistent, replicable manner. While many healthcare professionals will be familiar with some of the public health priorities covered by the impact pathways, there will be priorities that are less familiar and the impact pathways provide guidance and support to ensure that HCPs feel comfortable raising these issues. It is hoped that, in time, there will be a way for this data to be held centrally to ensure that collation and analysis can happen on a national level. In the meantime, it will be necessary for different services to find the best way to make data collection work for them. This may mean adding fields to current databases or producing a spreadsheet that can be shared internally to enable internal reporting and analysis.



It is acknowledged that the impact pathways assume some understanding of making every contact count (MECC) and brief interventions in primary care. Background information on each topic is available in All Our Health. Each impact pathway links to training that might be pertinent to the topic matter, but general training is also available. The MECC website contains links to e-learning, and there are also brief intervention resources available online. One of the calls to action in this report is that training for HCPs in these areas would become more accessible and available.

The impact pathways can appear to be very process driven, but it is important to keep the need to improve outcomes for people living with a range of health issues as the central aim when using the pathways. They are not intended as a step approach but as guidelines to be used sensitively based on the needs of the individual in front of you. The boxes in the inputs column are connected by dotted lines to indicate that you should use your discretion about which to raise. Furthermore, it is acknowledged that the models are simplified depictions of the relationships between variables, and in reality, there are many more interconnections.

Tackling health inequality is central to the aims of All Our Health, and the impact pathways, by focussing on prevention and the lifestyle factors associated with poor health also have the reduction of health inequalities at their core. The impact pathways take a life course approach, tackling poor health from birth (the healthy beginnings pathway) through childhood (child oral health), adulthood (smoking and tobacco, alcohol, adult obesity) and into older age (dementia and falls). They seek to tackle some of the root causes of health inequality at each stage of life. HCPs may also find that tackling health inequalities in specialist populations requires further development of the impact pathways – and this is something we would encourage. This may include individuals with learning difficulties, who are specifically referred to within All Our Health due to their increased risk of experiencing health inequality across a range of outcomes. Other specialist groups that may require HCPs to develop specific knowledge or skills include individuals in prisons, individuals with mental health problems, Lesbian, Gay, Bisexual and Transgender communities, certain black and minority ethnic groups, individuals with physical disabilities, pregnant women or homeless populations.

It should also be noted that there may be outcomes that are not included in the models that will be improved. In some cases, these have been deliberately excluded because of the difficulties inherent in their measurement, for example, increases in health literacy or improvements in service partnerships. These outcomes could however be recorded if baselines were obtained and followed up.



Conclusion

The public health impact of healthcare professionals can only be fully appreciated and supported where there is evidence of impact. This toolkit aims to provide HCPs with simple, quick and effective guidelines for recording and measuring the impact of the public health activities they are already undertaking – and also to encourage new areas of public health prevention to be considered. It is hoped that HCPs will find the toolkit useful and usable, and that the impact data produced will help convince commissioners of the value of HCPs as part of the wider public health workforce, as well as their increasingly vital role in tackling the public health priorities facing every UK community.

References

CFWI and RSPH., 2015. Rethinking the public health workforce. London: Centre for Workforce Intelligence and Royal Society for Public Health. Available at: https://www.rsph.org.uk/our-work/policy/wider-workforce/rethinking-the-public-health-workforce.html (accessed 15 Nov 2016).

General Dental Council., 2015. Registrant reports: October 2015. Available at: https://www.gdc-uk.org/search?querytext=registrant+reports (accessed 16 June 2017).

Knight, T., Evans, E., 2007. History of multidisciplinary public health mini-symposium. *Public Health,* 121(6):401-403.

LGA, 2015. Commissioning for better outcomes: a route map. London: Local Government Association. https://www.local.gov.uk/commissioning-better-outcomes-route-map-updated-edition (accessed 16 June 2017)

NHS Confederation., 2016. Key statistics on the NHS.
Available at: http://www.nhsconfed.org/resources/key-statistics-on-the-nhs (accessed 18 Jan 2017).

NHS Digital, 2016. Find data. Available at: http://content.digital.nhs.uk//searchcatalogue?q=title%3A%22General+Pharmaceutical+Services+in+England%22&area=&size=10&sort=Relevance&topics=1%2FPrimary+care+services%2FCommunity+pharmacy+services#top (accessed 18 Jan 2017).

NHS England., 2014. London: NHS England. The Five Year Forward View.
Available at: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf (accessed 27 Dec 2016).

ONS., 2016. Death rates and years of life lost for causes considered avoidable, amenable and preventable, England and Wales, and English regions. London: Office for National Statistics.
Available at: http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathratesandyearsoflifelostforcausesconsideredavoidableamenableandpreventableenglandandwalesandenglishregions (accessed 15 Nov 2016).

PHE., 2015. All Our Health. London: Public Health England. Available at: https://www.gov.uk/government/collections/all-our-health-personalised-care-and-population-health (accessed 27 Dec 2016).

PHE., 2016a. Local Health and Care Planning: Menu of preventative interventions. London: Public Health England. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565944/Local_health_and_care_planning_menu_of_preventative_interventions.pdf (accessed 9 Jan 2017).

PHE, 2016b. Arts for health and wellbeing: An evaluation framework. London: Public Health England.
Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/496230/PHE_Arts_and_Health_Evaluation_FINAL.pdf (accessed 18 Jan 2017).

PHE, 2017. Standard Evaluation Frameworks. London: Public Health England Obesity.
Available at: http://webarchive.nationalarchives.gov.uk/20170210161227/http://www.noo.org.uk/core/Frameworks (accessed 16 June 2017).

RSPH., 2014. Tackling health inequalities: the case for investment in the wider public health workforce.
Available at: https://www.rsph.org.uk/resourceLibrary/tackling-health-inequalities-the-case-for-investment-in-the-wider-public-health-workforce.html (accessed 7th March 2017).

Sim, F., Mackie, P., 2007. Sharing the business of public health. *Public Health*, 121(6):399-400.

The Health Foundation and Nuffield Trust., 2014. Quality Watch. Focus on: Allied Health Professionals.
London. Available at: http://www.qualitywatch.org.uk/sites/files/qualitywatch/field/field_document/Focus%20On%20Allied%20Health%20Professionals.pdf (accessed 18 Jan 2017).

Appendix A: How the toolkit was developed

Healthcare professionals (HCPs) represent an incredibly broad and diverse workforce. In order to capture their diverse, and sometimes disparate, experiences, a steering group was established. The constituent members were experts drawn from the wide range of professions and the group had 14 members in total:

- Linda Hindle (Public Health England) – Lead Allied Health Professional
- Anna Lowe (Sheffield Hallam University) – Senior Lecturer in Physiotherapy
- Ginny Edwards (Public Health England) – Chief Nurses Directorate
- Gul Root (Public Health England) – Lead Pharmacist
- Kiran Kenth (Royal Society for Public Health) – Head of Development
- Jude Stansfield (Public Health England) – Mental Health Consultant
- Julia Csikar (Public Health England) – Senior Dental Public Health Manager
- Helen Donovan (Royal College of Nursing) – Professional Lead for Public Health Nursing
- Kelly Clifford (Chartered Society of Physiotherapy)
- Viv Speller (Health Knowledge) – Director and MECC academic
- Jamie Waterall (Public Health England) - National Lead for Cardiovascular Disease Prevention & Associate Deputy Chief Nurse
- Duncan Stephenson (Royal Society for Public Health) – Director of External Affairs
- Caitlyn Donaldson (Royal Society for Public Health) – Project Lead
- Daniel Honeybun (Royal Society for Public Health) – Researcher

The steering group met three times during the project (February 2016, April 2016 and January 2017) and also fed into the research at critical points.

Understanding current behaviour and needs

The first stage of the research involved surveying healthcare professionals across a range of disciplines to understand how they viewed public health within the context of their role. The survey, which was designed using surveymonkey.com, included both open and closed answer questions (Appendix B), and was shared by the steering group with members of their respective disciplines and also disseminated through communications channels of Royal Colleges and professional bodies. It asked which public health priorities healthcare professionals were currently engaging with, and which priorities they felt they could contribute to, given the right support. It also sought to understand how (and whether) public health impact was being measured, the barriers to measuring and recording impact, and what public health measures were being requested of services by commissioners.

The online survey generated 805 responses between 1st April – 20th April 2016 and the data was collected and analysed utilising the tools available on the surveymonkey website. The responses were from a broad spectrum of healthcare professionals (Figure 1). The survey found that the majority of healthcare professionals saw protecting and promoting the public's health as largely important (70% and 71% respectively).

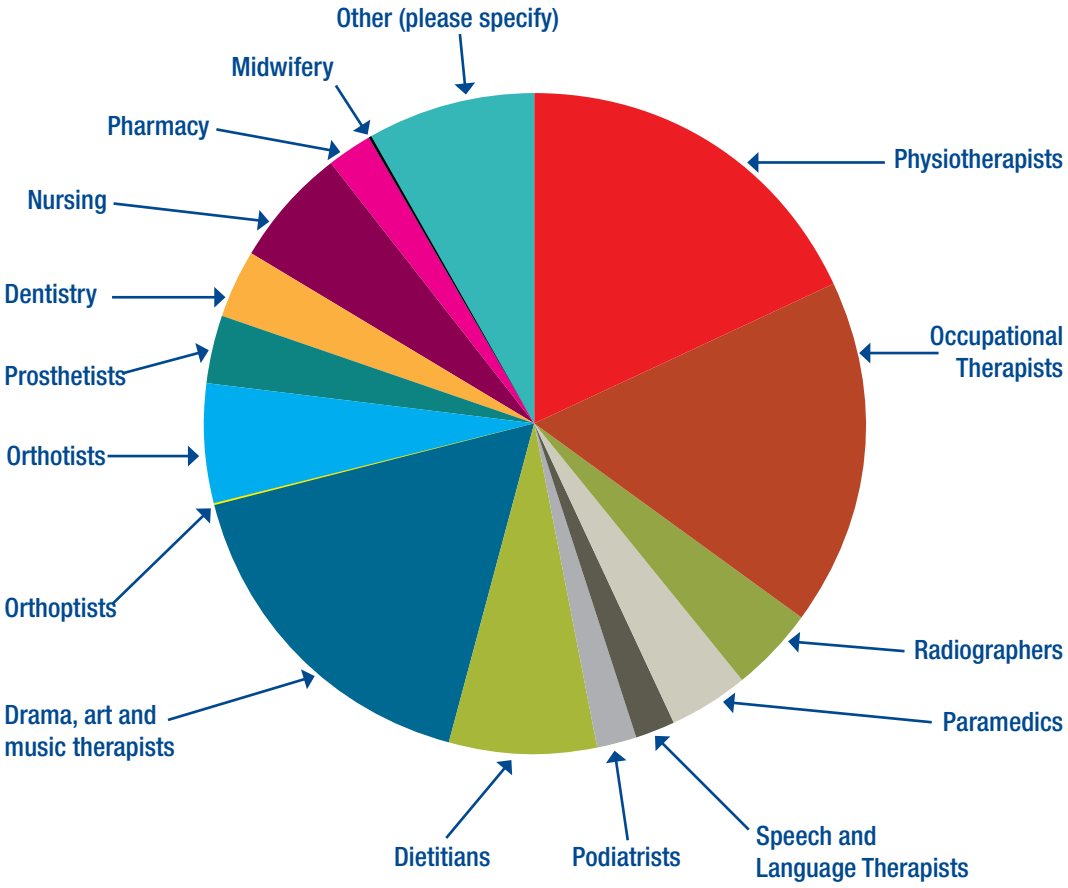


Figure 1: The breakdown, by discipline, of healthcare professionals who responded to the survey.

Many healthcare professionals felt they contributed to a significant number of public health issues including:

- **mental wellbeing (62% of HCPs);**
- **physical activity (57%); and**
- **obesity (48%).**

Furthermore, many healthcare professionals stated that they could contribute to public health priorities beyond those they were currently investing in (Figure 2).
This was particularly evidence for:

- obesity (29% of respondents not currently contributing to this priority felt that they could);
- NHS Health Checks (27%);,
- increasing independence (24%); and
- dementia (22%).

Despite these positive findings, only 19% of respondents stated that they currently measure their public health impact. This highlighted that there is a discernible gap and certainly a missed opportunity to further demonstrate the impact healthcare professionals can have on the public's health. Those who said that they record and measure their public health impact highlighted a number of tools used. These were generally highly specialised and intervention specific. It was assessed that many of the tools were therefore unlikely to be acceptable in all practice.

The survey also sought to understand the opportunities and barriers in providing, collecting and recording data from public health interventions. Nearly half (47%) of respondents felt that time and capacity were barriers to them recording and measuring their public health impact, and 17% stated that they did not feel sufficiently well trained.

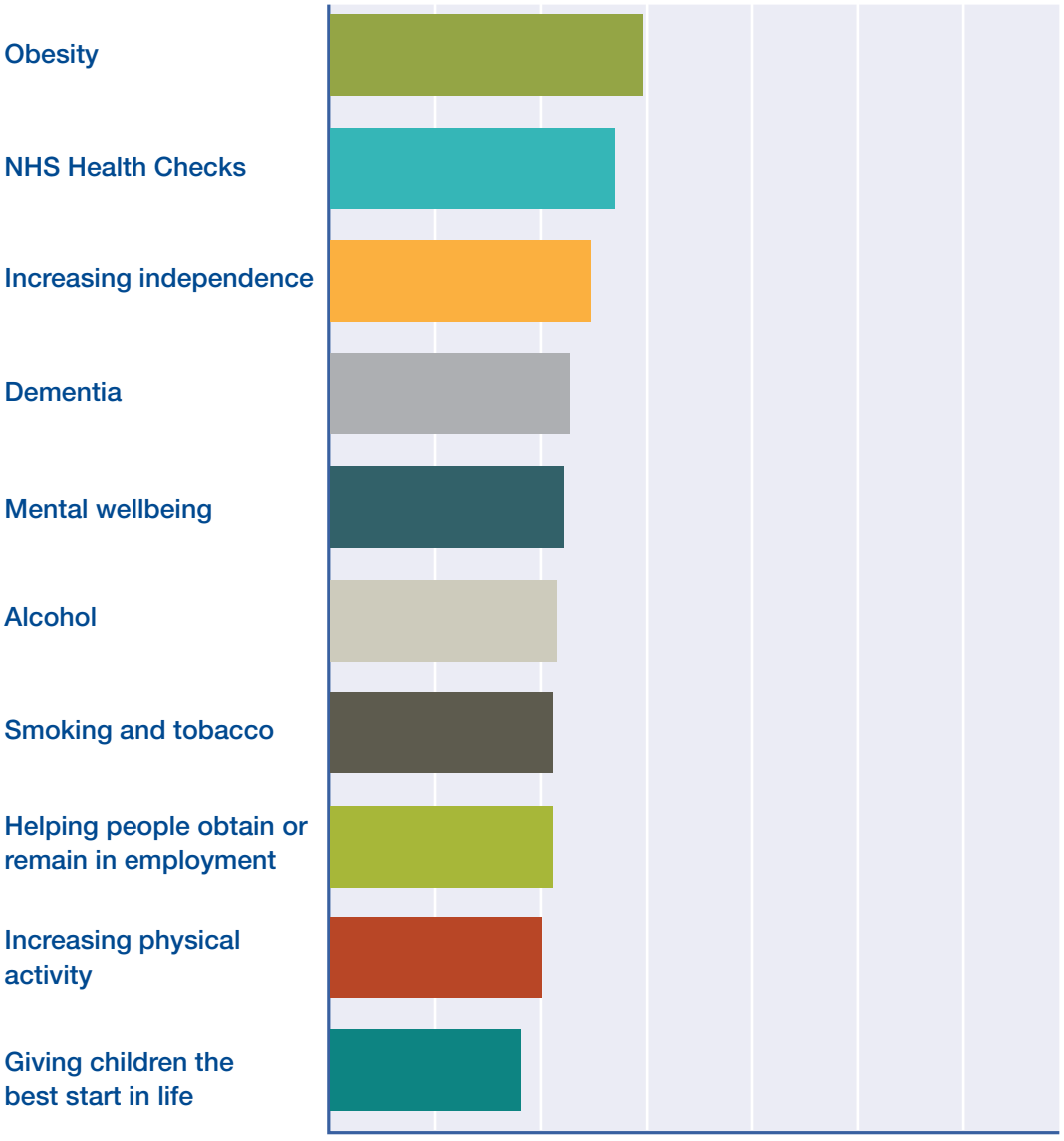


Figure 2: The public health priorities that respondents said they do not currently address, but feel they could contribute to.

The project aimed to develop a toolkit relevant to all health care professionals and the message received from front time practitioners was that interventions – and the measurement of them – needed to be brief and easy to use and that specialist training to deliver them should not be needed.

To further expand on the findings of the survey and desk-based research, online twitter discussions with healthcare professionals were hosted, questioning how public health impact could best be measured and recorded, what the main barriers to measuring public health impact were perceived to be and how impact data could be best conveyed from clinical services to commissioners and other interested parties. The participants were drawn from professionals already subscribed to or following one of the relevant 'We Communities' groups. These groups host twitter chats with healthcare professionals across many fields to share experience, expertise and ideas as well as providing a platform to share best practice.

The twitter chat engaged 125 participants and generated 887 tweets about the subject matter (Figure 3). The key outcomes reconfirmed the findings of the survey. Healthcare professionals want to, and do, contribute to the public's health, but don't measure it as often as they should due to time and capacity constraints. Participants suggested that any toolkit or guide developed would need to be easy and quick to use, as well as being appropriate for use within the context of primary intervention.

Figure 3: The key themes that emerged from the WeCommunities twitter discussions.

Analysis of currently available tools

The survey was accompanied by desk-based research exploring the validated tools that were already available to measure public health impact, and assessing their validity and acceptability in practice. Echoing the findings of the survey, this research found that of the tools validated for public health impact analysis, few were appropriate for use by healthcare professionals within the time and capacity constraints of their role. Many of the tools also required training to use.

Development of a logic model approach

Taking the findings from the survey, twitter discussions and, the desk based research and interviews with commissioners and public health leaders to triangulate priority areas, it was agreed that the production of a toolkit to support healthcare professionals to measure and record public health impact within the context of their busy work place setting would be appropriate and timely.

It was decided that the toolkit should demonstrate the causal line from intervention to outcome to enable healthcare professionals to map their work to it. This would have the further advantage of aligning their outcomes with those outcomes recognised by commissioners as important for the public's health. A model that was visually like a logic model was agreed as being the most effective at achieving these aims.

An 'impact pathway' demonstrating how brief interventions could help reduce adult obesity was designed and put out for consultation to the steering group and a wider reference group of healthcare professionals (n=150). This reference group was formed from HCPs who had taken part in the first survey and had expressed an interest in participating in later stages of the project. A survey was then conducted to ascertain whether those being consulted felt that the impact pathway would be a feasible and acceptable means of measuring public health impact in practice (Appendix C).

The consultation on the impact pathway generated 73 responses and the consensus was that this approach was appropriate and useful. Fifty-eight percent of respondents said they would be able to use this tool in their service. Eighty-eight percent said that the information was useful in the way it was presented. This confirmed that using an impact pathway was the right approach.

Some healthcare professionals involved in the review felt that it did not offer enough detail. It was decided that in the context of the previous research which found that the pathway needed to be widely applicable across a range of disciplines, it was not appropriate to add in further detail which might narrow its audience.

A further nine impact pathways were then developed based on the priorities identified in All Our Health for use across different interventions: alcohol; child oral health; dementia; healthy beginnings; falls; mental wellbeing, physical activity, sexual and reproductive health and HIV; and smoking and tobacco.

The draft impact pathways were then reviewed and approved by the Public Health England leads for the relevant areas as well as the steering group and other expert groups (see Appendix D). Further road testing then took place by HCPs from a range of organisations and specialisms to confirm the models were ready for use.

Appendix B: Survey to healthcare professionals

1. Are you primarily a healthcare professional or a commissioner of healthcare services?

   ☐ Healthcare Professional (Allied Health Professional, Dentist, Nurse, Pharmacist, Midwife)
   ☐ Commissioner
   ☐ Neither

2. Which of the following healthcare professions are you/do you currently work in?

   ☐ Physiotherapist
   ☐ Occupational Therapist
   ☐ Radiographer
   ☐ Paramedic
   ☐ Speech and Language Therapist
   ☐ Podiatrist
   ☐ Dietitian
   ☐ Drama, art and music therapist
   ☐ Orthoptist
   ☐ Orthotist
   ☐ Prosthetist
   ☐ Dentistry
   ☐ Nursing
   ☐ Pharmacy
   ☐ Midwifery
   ☐ Other (please specify) _____

3. To what extent do you consider the following components of the public's health to be important in your profession?

	Largely Unimportant	Somewhat Unimportant	Neither	Somewhat Important	Largely Important
Preventing ill-health	☐	☐	☐	☐	☐
Promoting health	☐	☐	☐	☐	☐
Protecting health	☐	☐	☐	☐	☐

4. If public health is not considered important, why do you think that is?

   _____

5. Which of the following public health priorities would you say you actively engage in either preventing, promoting and/or protecting in your profession?

- ☐ Housing or Homelessness
- ☐ Obesity
- ☐ Sexual health
- ☐ Falls
- ☐ Alcohol
- ☐ Smoking and tobacco
- ☐ Dementia
- ☐ Tuberculosis
- ☐ Antimicrobial resistance
- ☐ NHS Health Checks
- ☐ Giving children the best start in life
- ☐ Increasing physical activity
- ☐ Mental wellbeing
- ☐ Helping people obtain or remain in employment
- ☐ Increasing independence
- ☐ Other (please specify)

6. Do you currently measure your public health impact?

- ☐ Yes
- ☐ No
- ☐ Don't know

7. How do you measure the public health impact of your interventions? i.e. are there any metrics or specialist tools which you use to record this information?

_____

8. How do you record this public health impact data?

- ☐ Paper records
- ☐ Data entry onto a system
- ☐ They are not recorded
- ☐ Other (please specify)

9. Of the public health priorities that you do not currently address, which do you feel that you could contribute to?

- ☐ Housing or Homelessness
- ☐ Obesity
- ☐ Sexual health
- ☐ Falls
- ☐ Alcohol
- ☐ Smoking and tobacco
- ☐ Dementia
- ☐ Tuberculosis
- ☐ Antimicrobial resistance
- ☐ NHS Health Checks
- ☐ Giving children the best start in life
- ☐ Increasing physical activity
- ☐ Mental wellbeing
- ☐ Helping people obtain or remain in employment
- ☐ Increasing independence

10. What are or could be the constraints on recording and measuring the impact of your intervention within public health priorities?

- ☐ Capacity/Time
- ☐ The use of specialist equipment
- ☐ Not currently trained
- ☐ Lack of or inflexibility of IT system
- ☐ The cost of doing so (e.g. the cost of expensive equipment)
- ☐ Other (please specify) _____

11. What are your responsibilities in regards to the commissioning of healthcare services?

12. To what extent would you say that public health impact is something which you consider a priority when commissioning healthcare services?

- ☐ Largely a priority
- ☐ Somewhat of a priority
- ☐ Neither
- ☐ Somewhat not a priority
- ☐ Largely not a priority

13. What public health information do you ask healthcare services to report?

14. In what format could this information be best communicated from clinical services to commissioners?

- ☐ Written reports
- ☐ Case studies
- ☐ Formal research
- ☐ One to one discussions
- ☐ Other (please specify) _____

15. In what format could this information be best communicated from clinical services to CCGs?

- ☐ Written reports
- ☐ Case studies
- ☐ Formal research
- ☐ One to one discussions
- ☐ Other (please specify) _____

16. Do you ask HCPs to use any specific measurement tools?

- ☐ Yes
- ☐ No
- ☐ Don't know

17. What are these measurement tools? (e.g. Clinical indicators, mental wellbeing values etc.)

18. Would you value a service more highly if it had a strong prevention focus?

- ☐ Yes
- ☐ No
- ☐ Don't Know

19. Is public health or prevention specifically mentioned in contract agreements?

- ☐ Yes
- ☐ No
- ☐ Don't Know

20. Do you envisage public health's inclusion in contractual agreements changing in the future?

- ☐ Yes
- ☐ No
- ☐ Don't Know

21. How would you rank the following public health priorities in terms of their importance to you as a commissioner when commissioning services?
(1 = not a priority to 5= a strong priority)

- ☐ Housing or Homelessness
- ☐ Obesity
- ☐ Sexual health
- ☐ Falls
- ☐ Alcohol
- ☐ Smoking and tobacco
- ☐ Dementia
- ☐ Tuberculosis
- ☐ Antimicrobial resistance
- ☐ NHS Health Checks
- ☐ Giving children the best start in life
- ☐ Increasing physical activity
- ☐ Mental wellbeing
- ☐ Helping people obtain or remain in employment
- ☐ Increasing independence

22. If you would be interested in participating in furthering the development of the toolkit, please provide your details below (all information will be kept strictly confidential).

Name: _____

Organisation: _____

Email Address: _____

Phone Number: _____

Appendix C: Survey to healthcare professionals about draft obesity impact pathway

1. Which of the following healthcare professions do you consider yourself to be?

- ☐ Physiotherapist
- ☐ Occupational Therapist
- ☐ Radiographer
- ☐ Paramedic
- ☐ Speech and Language Therapist
- ☐ Podiatrist
- ☐ Dietitian
- ☐ Drama, art and music therapist
- ☐ Orthopist
- ☐ Orthotist or Prosthetist
- ☐ Dentist
- ☐ Nurse
- ☐ Pharmacist
- ☐ Midwife
- ☐ Other (please specify) _____

2. What setting best describes where you mainly work?

- ☐ Primary care
- ☐ Secondary care
- ☐ Local Authority
- ☐ Community
- ☐ Academia
- ☐ Other (please specify) _____

3. Would you be able to apply this tool in your practice? (There will be similar models for other public health priorities)

- ☐ Yes
- ☐ No
- ☐ Don't Know

4. Is the way in which the information is presented (i.e. in the logic model structure) useful?

- ☐ Yes
- ☐ No
- ☐ Don't Know

5. How would you describe the level of detail presented in the impact pathway?

   - ☐ Not enough
   - ☐ About right
   - ☐ Too much
   - ☐ Don't know

6. Can you easily pick out the information which is relevant to your practice?

   - ☐ Yes
   - ☐ No
   - ☐ Don't Know

7. How likely are you to use the tool to measure your public health impact?

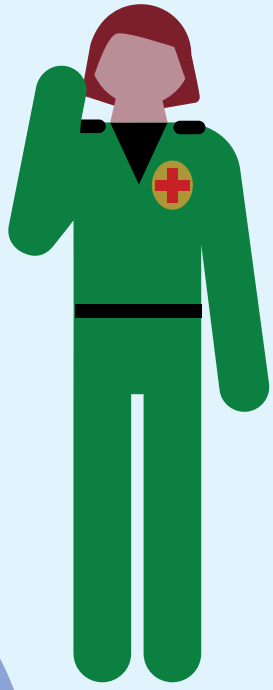
   - ☐ Not likely
   - ☐ Somewhat unlikely
   - ☐ Somewhat likely
   - ☐ Likely
   - ☐ Don't know

8. Do you have any additional comments about the impact pathway, how it can be improved; elements that work and the elements that don't etc?

Appendix D:

Thanks to the following individuals who helped review and test the impact pathways:

- **Nuzhat Ali,** Public Health England
- **Ione Ashurst,** Royal Brompton Hospital
- **Iain Armstrong,** Public Health England
- **Jamie Blackshaw,** Public Health England
- **Mike Brannan,** Public Health England
- **Amanda Cheesley,** Royal College of Nursing
- **Julia Csikar,** Public Health England
- **Helen Donovan,** Royal College of Nursing
- **Helen Duncan,** Public Health England
- **Dawne Garratt,** Royal College of Nursing
- **Jenny Godson,** Public Health England
- **Simon How,** Public Health England
- **Ian Hulatt,** Royal College of Nursing
- **Dave Jones,** Public Health England
- **Don Lavoie,** Public Health England
- **Louis Levy,** Public Health England
- **Anna Lowe,** Sheffield Hallam University
- **Daniel MacIntyre,** Public Health England
- **Sue Mann,** Public Health England
- **Tony Nardone,** Public Health England
- **Ann Norman,** Royal College of Nursing
- **Wendy Preston,** Royal College of Nursing
- **Diane Seymour,** Public Health England
- **Viv Speller,** Health Development Consulting Ltd
- **Jude Stansfield,** Public Health England
- **Jason Warriner,** Royal College of Nursing
- **Jamie Waterall,** Public Health England
- **Sarah Woodhall,** Public Health England



For more information,
please contact Caitlyn Donaldson
cdonaldson@rsph.org.uk

Royal Society for Public Health
John Snow House
59 Mansell Street, London E1 8AN
Tel: +44 (0)20 7265 7300
www.rsph.org.uk/interactions