Centre for Population Health Organisational Response for the Change NHS Consultation (2nd December 2024)

Centre for Population Health is a not-for-profit think tank working to drive improvements in population health and equity through the focus on mobilising staff and communities across health, social care and community sectors across England and further afield. Despite only being two years old, we have already supported many organisations across England to develop knowledge, skills, confidence and approaches for population health and equity. This response has been compiled following an engagement exercise with over 140 people representing over 60 organisations across UK who attended our first Centre for Population Health conference on 27th November 2024. In this document we have highlighted headlines that we hope will help to inform your work. If you would like further information or support please do contact us on info@centreforpopulationhealth.co.uk and we will gladly support your efforts further.

1. What would you like to see featured in the NHS 10-year plan and why?

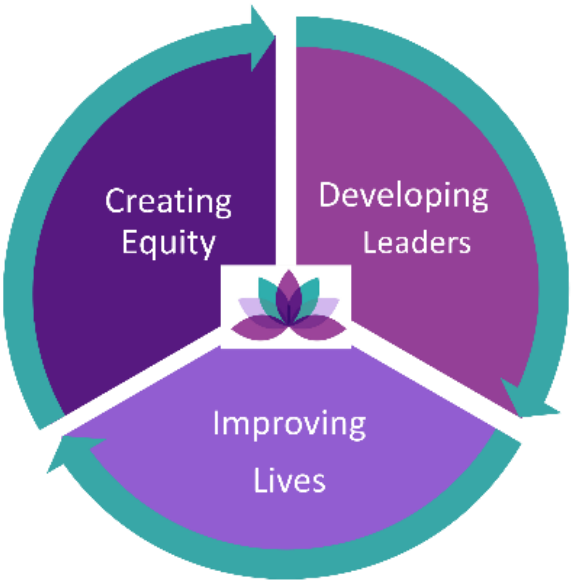
We welcome the three shifts outlined by the government as underpinning the NHS 10-year plan. However, we believe that several things will be essential to focus on for delivering this to ensure maximum benefit for improving population health and tackling health inequalities:

[A] Clear Focus on Equity: Whilst the three shifts are welcome, we believe a fourth shift is missing: a shift from inequality to equity. It is well recognised that those in society who are most in need for timely help and support are also those most at risk of not being able to access this as easily[i]. Historic efforts to design the NHS, whilst broadly right[ii], we now realise did not factor in sufficient focus on tackling health inequalities in the way we now understand is needed and still missing, despite commendable works to address this[iii]. For example, work by NHS Race and Health Observatory shows how the assumption of one size fits all, like in medical devices[iv] causes harm, being suboptimally designed for the diverse population in England. As such neonatal jaundice may be diagnosed at a later stage in babies with darker skin tone and hence they are at risk of suffering poorer outcomes[v]. Similarly, fixed GP consultation times risks widening inequalities[vi]. For some people who have simple issues or contexts or have no problem with the English language or additional needs, the set time may be sufficient. However, for others who have complex clinical, social, psychological or other contexts (often a combination of these[vii]) or for whom English is a second language or have lower levels of understanding or confidence in the NHS due to traumatic experiences, more time is needed. The current design needs re-thinking and scheduling according to needs with more time and resources for those who need it more (or 'proportionate universalism' as described by Professor Sir Michael Marmot from the Institute of Health Equity[viii]). This must be built into the design of the NHS going forward at every step, including prevention, digital and community efforts, and across the whole NHS. Hence it is needed as a fourth shift to ensure due and dedicated focus throughout.

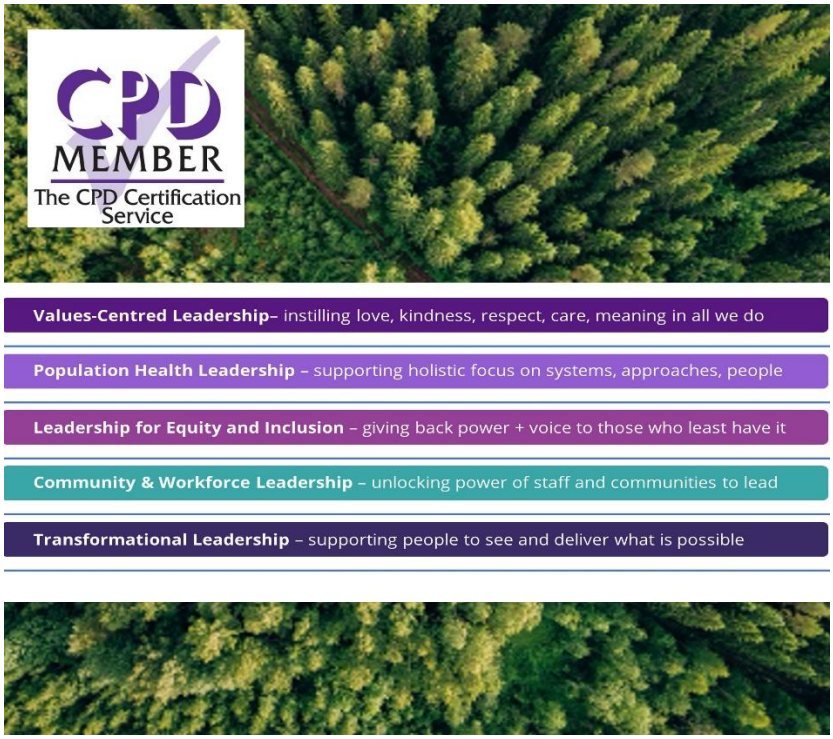
[B] Clear focus on Population Health: The NHS 10-year plan must include, or be embedded within, a wider realistic plan to improve the health of the population led by the government. At present the national shifts look at a collection of (helpful) actions, but beyond this, there must be a national plan for how this will add up to ensuring improved population health overall. There needs to be clarity as to the role of the NHS 10-year plan in this and similarly for the plans for prevention and social care. And clarity about their contribution for population health. The plan for population health should bring these together, showing how they fit together, and what else is needed to optimise population health and equity overall. Participants recommend this includes re-look at the current approaches

and ensure they are fit for purpose. For example, greater clarification about resources and their applicability for population groups, with efforts to update these for diverse populations. The Eatwell plate and dietary guidelines, as attendees give as an example, is for the "healthy". But for those with certain chronic diseases, it can be harmful (USGA). Dedicated versions should be made to fit cultures (as we did in our work with Lancashire and South Cumbria Population Health Academy) and to fit different population groups (eg those with long-term conditions such as Diabetes or cardiovascular disease, those with Learning Needs, living in poverty, or isolated). It is an opportunity to offer affordable and relevant options as well as build connections to support.

[C] Clarity about the approach and role of the NHS – there is much the NHS can do for population health and equity. It already does a lot of good work and this needs to be celebrated. In the efforts to drive focus on productivity and improved performance, we mustn't move back to top-down methods of leadership looking to name and shame, using bullying tactics, and risk collapsing the goodwill amongst people working in the health and care system that organisations have worked so hard to nurture. Effective leadership for population health requires values-based, compassionate leadership from all levels, including national bodies and senior political leaders, based on an understanding quality improvement, change management theories and the power of empowering and unlocking potentials. It requires building psychological safety, trust, motivation, and people-centred design. Examples have shown repeatedly that this is the way to drive quality, productivity and sustainability, and hence this is the approach we use at Centre for Population Health for everything we do. We champion, nurture and protect this and know it is key for improving population health and equity. As leaders from across health, social care and community organisations ourselves, we have seen how this can be done well, and the harms directly to patients, communities and families when it is not. Powerful illustrations outlining the need for this are provided in the latest book by our Associate Dr Andy Knox's and from our blogs and other work also[ix]. Our approach therefore focuses on three things as shown below:



Hence, in combination with the basic population health and tackling health inequalities understanding, technical skills, understanding the evidence, and building approaches that work in practice – we instil the following leadership practices:



We support this at every level across the health, social care and community sectors to drive improvements in population health and equity. When this is done with skill and sustained focus it can deliver powerful results. So for the NHS, early focus should be to develop this across integrated care boards. Many have begun work for population health and equity, albeit still early and varied. They should be supported to progress plans. This includes helping the NHS to identify what it can do towards this directly and as a good partner in place to support and enable the work of others – and do the same for the other sectors represented also. In addition to this, there should be clarity about the national NHS role in supporting, enabling, guiding and overseeing this. Without this there will be potential for confusion, wasted effort and lack of progress – hence this step is important also.

[D] Shifting power to communities and frontline staff – core to the NHS 10-year plan should be efforts to shift power to staff and communities. There is untapped power that sits within these groups as powerful leaders for change. It is essential that the NHS 10-year plan looks at examples of where there is good work already underway and gathers learning from this to shift the power to those for whom it matters and is currently missing. For example, the numerous examples we heard at our Centre for Population Health conference from across many sectors who can contribute. We will be sharing resources in due course and would be happy to connect you with these individuals and groups to support your development of the NHS 10-year plan if that would be useful.

This power shift to communities and frontline staffing groups needs to happen across all the NHS 10-year plan areas (including the three shifts) as an underlying ethos. There are many ways this can be done and so it will be important to bring together partners to co-create an approach forward. This cannot be done through a desktop exercise or series of roundtables with 'the usual suspects'. Instead, the next step must create ongoing dialogue and power shift in practice to those without power at present as that will determine the success of the NHS 10-year plan. For example, Centre for Population Health partners as equals with charities, communities, the voluntary and third sector, and those in frontline caregiving positions rather than big organisations who are traditionally in or close to power on an ongoing basis to create opportunities, understand what is needed, co-create

solutions, help to oversee change, and to keep going with this as a continuous journey (rather than one-off or series of steps). We look for under-represented groups and under-heard voices and give opportunities for them to lead. We go to community venues to understand their lived realities and to hear their messages however hard this may be. We measure our impact based on how successful they say we are in our efforts, seeking to deliver meaning rather than just activity. This should be the approach that the NHS 10-year plan also takes.

[E] Duality of Focus – getting this right will take a duality of focus approach – making improvements in the immediate term, whilst also creating time and focus to turn things around for the longer term. It is important to recognise the immense pressure that staff are under in the NHS, councils, charities and other organisations. This should be seen not as an either-or approach but a both-and approach instead, sensitive to these pressures. Hence the national enabling and supporting function of the NHS and wider political system needs to demonstrate kindness, and understanding, and take a guiding and nurturing role across England for progress for population health and equity. There is much good work already done to build on and much good will that exists from so many sectors. How this will be skilfully utilised to move forwards, not backward, will be key.

2. What are the biggest challenges for moving care from hospitals to the community?

These are the three biggest challenges we heard for moving care to the community from hospitals:

- A risk of increasing illness in the population by trying to pursue this shift in sub-optimal ways out of hospital and an under-estimation about the scale of the challenge – for example missed or delays in diagnoses / insufficient or inadequate physical, digital and staffing infrastructure to do this well particularly across the boundaries of care / more challenge in ensuring good regulation and provision of quality and equity / variation that currently exists
- A lack of belief that investing in out of hospital services will really help. There is a lack of an economic case at present link to the shifts that demonstrates how making this shift will actually save resources overall. And also a lack of trust that savings made will be clear and then used to reinvest into improving health and care rather than wasted or used on other things.
- A concern that the NHS does not understand the power of the voluntary and community sector, and of the communities themselves, and will therefore remain limited in its approach by only staying within the traditional remit of the NHS and NHS community services.

3. What are the biggest enablers for moving care from hospitals to the community?

The biggest enabler without doubt is something that attendees reflect in their response to this question directly: "*We are. A group of authentic professionals who people can believe in*." We at Centre for Population Health believe this is true. Our conference was designed to bring together community organisations as equal partners in a genuine and meaningful way to think alongside health and social care leaders as experts in their sector (which we hear is often not the case, even on integrated care boards where their remits are often limited, poorly understood or tokenistic). These leaders are indeed the biggest enablers for change.

To take this shift forward, it is essential that staff and communities are allowed to work together to co-create solutions in each area, and that national and local leaders help to convene these conversations, provide support and resources, and enable them to deliver the changes. This is something that has been written about by our Associate Samira Ben Omar[x]. The tips provided in her blog (image below) can aid this work greatly.

It is also important for the government and national leaders to realise that this will take time, and that a multi-year plan is needed to ensure this can be nurtured. There needs to be a review of the evidence and learning from what has been tried previously to ensure that this plan builds on efforts, for example Sure Start initiatives, Poly Clinics, Vanguards and New Models of Care, and more. Centre for Population Health teams up with universities and experts for this, learning lessons about change and how to embed change for the longer term. We have published recommendations from Professor David Hunter[xi] who has supported efforts by World Health Organisations for change, and examples from Leigh Elliott, CEO of Children Northeast[xii] and Ellie McNeill who is CEO of YMCA Together[xiii] about their inspiring work in this area that can help the Change NHS work.

To really understand this requires open-mindedness as this is not about activity or the way things have been done before, but about system leadership, quality improvement, design methodologies, and human-centred values-based transformation practices. This means at a national level also there

will be things to unlearn to deliver the change needed, and there must be humility to accept this if we are to move forward to get it right.

A robust national and local funding formula that not only incentivises prevention and shift resources to the community is needed. Currently, investment in prevention interventions in the community suffers from 'chronic pilotitis', meaning that while there is frontline evidence that it improves individual patient health, the right sort of evidence (eg. simulation modeling and impact evaluation) has not been generated to understand the population impact over time and how the resource can be shifted from the NHS to local government and voluntary sector where much of the interventions are delivered. Failure to generate such evidence means that current investment in prevention will not be sustainable from one year to the next. This requires expansion of current population health management principles, where mature analytical partnerships between NHS and local government to undertake a range of advanced analytics utilising integrated datasets at local ICS level containing NHS and non-NHS data.

4. What are the biggest challenges for moving care from analogue to digital?

These are the three biggest challenges we heard for moving care from analogue to digital:

- Change is hard! People (staff and communities, including national leaders and organisations) are familiar with how we always have done things. Change is unfamiliar and the skills for working through times of change are not well taught through programmes and professional education. So when change happens we heard from respondents (who are predominantly health, social care and community staff) that we become the problem, Us the professionals not adapting it. There is a training and familiarity gap as well as a narrative that change is intermittent when the reality is that change is a constant. Improvement is a constant endeavour and it is important that culture and narrative changes to reflect this.
- Current systems are clunky and contracts vary in length and conditions. This is one of the reasons many existing digital innovations have become limited – because they have been commissioned in such a way that things are bolted on and as such we are locked into fixed contracts or with providers or within systems that are no longer fit for purpose or ideal for current needs and do not speak easily with one another or flex easily for modern needs, but are tricky to replace and adapt. Often systems were built during times of silo working where now there is a real need to work beyond boundaries to bring together datasets from different sectors to together optimally give insights about population health needs and allow monitoring of impacts of initiatives to meet these.
- Finally, and essentially, is the inadequacy of current digital solutions and data sets to accurately reflect the needs of everyone in the population. For example, we know there is a lack of female representation at senior levels in the digital and AI workforce. Whilst this is improving, it is slow, and means there is a gap in the current suitability of design and delivery of technology and workforce solutions to meet the needs of all genders equitably. Similarly, there is a problem in terms of data equity across population groups – deprivation, coastal and remote, ethnicity, and inclusion health groups, both in terms of data capture and data use. This risks exacerbation of the problem when designing solutions as they will not take into account the needs of these communities and groups, and be building interventions on insufficiently equitable data in the first place.

5. What are the biggest enablers for moving care from analogue to digital?

Our respondents again highlight the workforce as the key enabler to making this shift happen saying "*Us! We just need to do it*.". Whilst this is true and any digital solutions must be jointly created by the people they are serving and those who are using it daily, it is also important to consider the following enablers also – which are things we heard in our work on digital and AI in collaboration with Health Innovation Kent Surrey and Sussex and NHS England:

- Learning from the leaders across other sectors – for example we heard examples from education, business, military and government across different countries globally and there is much learning that can be applied from those into the NHS. Our joint work is being published later this year and we would be happy to share more from this if it would be helpful.
- Many quick wins that are already being used for example AI innovations to remove the note taking burden in primary care or use of AI as the second reader for radiological diagnoses. There are many innovations underway in the NHS that can help already.
- Manual bringing together data in the first instance whilst work is happening in parallel to bring together datasets and modernise infrastructure. It is important that this work is not paused whilst waiting but continues. There is a need to differentiate between data collection and integration for direct care planning / share care record development vs data for population health / advanced analytics linked to population health management principles and more work is needed to bring this thinking together into one single approach.
- Many resources exist from public health teams nationally that are still under-utilised (eg fingertips tools, joint strategic needs assessment reports, atlases of variation and more).
- NHS Digital App is a big asset and already being utilised by many – there is much more that can be done.
- Population Health Management tools and techniques could be used more routinely to support integrated care boards and partnerships to deliver on their plans for improving population health and equity across their areas.
- Data and insights (including qualitative data) is still under-recognised and utilised for the value that it brings. It is important that this is better incorporated into the plans for reform.
- The need for embracing the technological revolution – it is happening and the narrative must be clearer that the NHS must keep up. It has been relatively slow to innovate (in part for justifiable reasons) but needs to accelerate (safely and equitably) now.
- The public must be brought along with these changes and skills training provided for staff and communities – this exists in pockets but there is a real potential from enhancing this.
- There is also a huge potential from working with schools and young people to bring into the NHS the future generation of digital leaders – currently this work is relatively under-focused but there needs to be more effort to develop this pipeline especially amongst young women and under-represented groups. Similarly there must be greater focus on digital in the undergraduate clinical curriculum to ensure emerging NHS workforce groups are optimally skilled on use of digital
- There is also a great potential of building our specialist core group for the NHS nationally to, for example, build methods for predictive modelling and intervention including economic considerations as well as population health and equity impacts that could then be applied at a local level. Some of the national data visibility and interpretation was lost in the move from Public Health England to local areas and should be built up again.

6. What are the biggest challenges for moving care from focus on sickness to prevention?

These are the three biggest challenges we heard for moving care from focus on sickness to prevention:

- Politics is the first consideration participants told us would be a challenge. Research into evidence of "solutions" that are not profitable is limited and unlikely to gain traction from politicians and companies involved who often hold great power – even if the research shows benefits for the population. *"Cauliflower, local farm meat, local produce, group consultations. None of these will double the GDP of a country so no one will invest in the research (and good meat is wrapped up in political arguments that don't hold sway)".*
- The next challenge is time, remit and ability to measure impact directly. Especially for primary prevention (arguably the type of prevention that holds most potential to improve population health and equity overall) interventions will take time and is hard to directly attribute changes in the health of a population to these interventions. Additionally, it is often not within the direct remit of the NHS (much more held in councils, industry, community organisations and communities themselves) and therefore less likely to be seen by the NHS as part of its role. However, without due focus this will create an accumulation of ill health and burden on the NHS down the line. So rather than not seeing it as part of the NHS, it would be worth ensuring every NHS organisations understands the anchor agenda and plays its part as a partner in place, supporting and enabling change, even if it does not have a direct role in leading this. It will be important for the integrated care structures to take a lead role in this. There is much learning from the London Anchor Institution Network (LAIN) that can be help.
- Third is the fact that, especially for reasons outlined above, focus on prevention can be unpopular. Worry about risk of nanny state, lack of being able to demonstrate politic achievements for the electorate, or risk of impacting on economic potentials for businesses whose services may be aligned with the opposite (eg sugary drinks, tobacco, pharmaceuticals, etc) means that whilst there is spoken commitment, there may be in reality less focus on this in practice. However, with this shift should also be a shift in opportunity through focus on health creating methods and if that happens it may mitigate the risks.

A lack of real time intelligence within ICSs as part of population health management caused by limited system level IG capacity and capability, is possibly the biggest challenge. This involves the capacity and capability of utilising integrated NHS and non-NHS data to undertake a range of advanced analytics, from risk stratification, impact evaluation to funding model development. The datasets we use are currently too high level, aggregated or not real time enough.

7. What are the biggest enablers for moving care from sickness to prevention?

There are many examples of where this has worked particularly from numerous public health interventions that have taken place over decades. It is important to learn from these examples and apply them to the current challenges and opportunities faced for prevention. One example Donal Collins (winner of our poster presentation prize) outlined is work that demonstrated reduction in fatty liver within 4 weeks. He says that Type 2 Diabetes Mellitus improvement can happen in 45-50% of people who are activated in 4 months. There are many other examples also (see the 14 posters on our website: 2024 Conference | Centre for Population Health).

Our CEO Professor Durka Dougall has written about the opportunity to focus on avoidable mortality and morbidity[xiv]. There should be much greater awareness about this and action against the high impact areas. She outlines the need to focus on prevention opportunities particularly facing under-represented groups to tackle health inequalities overall. For example, we have written about how this can be achieved through focus by hospitals on their roles in tackling health inequalities for prevention[xv], and she has previously published work on how allied health professionals can tackle health inequalities[xvi]. Focus on building workforce capability and understanding and supporting them to enact steps for prevention in practice will be key.

The NHS needs to use its position as a powerful advocate and partner in place to promote and accelerate efforts for population health and equity. For example being active in building themselves as Anchor Institutions, taking an active part in emerging crises such as a climate change emergency, and for championing change in the areas for example that come unnecessarily to hospitals when there is a win-win in addressing these issues upfront through prevention measures. For example to improve damp housing which cause respiratory illnesses in children and vulnerable adults – something that our Associate Dr Kaneez Shaid has found through her work with communities in Grimsby working in collaboration with Rethink Mental Illness and the Common Good Foundation using community organising approaches[xvii].

Finally, learning is needed from the Grenfell Tower tragedy[xviii], infected blood inquiry[xix], numerous other inquiries[xxxxixxiixxiii], COVID pandemic, and more about the experiences of staff[xxiv] and communities, the need to support them properly, understanding the power they hold for prevention (eg vaccination uptake increased in collaboration with community leaders) and to understand the great responsibility upon all of us to act. All 72 Grenfell Tower deaths were sadly avoidable if greater action had been taken to listen to community concerns and take steps earlier to improve the housing conditions. So, importantly, into any prevention plans linked to the NHS 10-year plan should be built more efforts to listen and work alongside communities and staff – not tick box engagement but ongoing dialogue and genuine partnership. To aid this, we have published various blogs and articles that can aid efforts including a joint piece about transformation needed to aid change[xxv] and a national survey of how NHS boards can support[xxvi].

Cross-sectoral data linkage remains an important enabler[xxvii] and should include focus on the following:

1. Extending and simplifying routine access and use of the NHS number for data linkage for local government and VCSE organisations
2. Improving the legal gateway for ICSs to accelerate data sharing and linkage between NHS and non NHS organisations where needed to support PHM activities
3. Reducing public suspicion and risk-averse organisational cultures by undertaking more patient and public engagement around the importance of data sharing and linkage

8. What are your policy ideas for driving change in the short term (1year)?

In the short term, the following will be needed:

- Clarity about the population health and equity plan nationally that this 10-yearplan fits into
- Working to create a narrative for change that includes things outlined above including gathering some recommendations for core actions that should be taken at a local level (with room for adaptation locally)

- Work with local systems (integrated systems and partners with support to ensure equity in composition and contribution) to build delivery plans
- Support systems to embed some of the things that work in places
- Demonstrate and evaluate quickly then spread widely- needs a social movement.
- We need to join with others who share our authentic mission (for example we at Centre for Population Health would be glad to join a national taskforce to support this work and know many others would also)
- Be careful to ensure anyone with significant financial conflicts of interest are either not allowed to influence policy or that they have a limited role in doing so.

9. What are your policy ideas for driving change in the medium term (2-5 years)?

Invest and spread the things above – give it time even if it means it goes beyond the current political cycle as it will take this time to start to work. Measure impact and share this with the public to ensure sustained buy-in.

10. What are your policy ideas for driving change in the longer term (5+ years)?

This requires the narrative to be right and shift minds from thinking that these things are single interventions and that change is staccato. The reality is that change is a necessary constant for continuous improvement and anything being created now needs to embed that principle into every stage. We have created an overarching plan to support taking action across all our organisations in a phased way and would be happy to share this with you also if that would be helpful.

Overall, this is a huge opportunity to drive important changes to improve the lives of countless people across England and beyond. We welcome the national direction and shifts and this opportunity to input into Change NHS efforts. We hope that our input in this response is helpful in aiding your thinking. We believe that what happens from here will be key – so please know that our team would be delighted to support in any way that would be helpful for this.

[ii] 50 years of the inverse care law - The Lancet
[ii] The NHS founding principles are still appropriate today and provide a strong foundation for the future | The BMJ
[iii] The NHS is not an island—tackling racial disparities in healthcare | The BMJ
[iv] Tackling bias in medical devices: the Equity in Medical Devices Independent Review is welcome, but could have gone further | The BMJ
[v] RHO-Neonatal-Assessment-Report.pdf
[vi] RCGP calls out devastating impact of health inequalities
[vii] The multidimensional clustering of health and its ecological risk factors - ScienceDirect
[viii] Towards health equity: a framework for the application of proportionate universalism - IHE
[ix] Reimagining How We Live Well Together
[x] Creating Fairer Systems and Healthy Places
[xi] A New Era, a Reset for Population Health
[xii] Learning from 10 Years of Poverty Proofing by Children North East
[xiii] Health inequalities - The Third Sector as part of the solution
[xiv] A Moment for Change in Health and Social Care?
[xv] What can hospitals do to tackle health inequalities?
[xvi] My Role In Tackling Health Inequalities: A Framework For Allied Health Professionals | The King's Fund
[xvii] New group launches in bid to bring positive change to North East Lincolnshire - Grimsby Live
[xviii] Phase 2 report | Grenfell Tower Inquiry

[xix] The Inquiry Report | Infected Blood Inquiry
[xx] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - GOV.UK
[xxi] Learning lessons from the Letby case | Healthwatch

[xxii] North West nurse wins landmark case against NHSE&I for racial discrimination | News | Royal College of Nursing

[xxiii] Oliver McGowan | Oliver's Campaign |
[xxiv] Covid inquiry hears harrowing evidence of effects on ICU staff | The BMJ
[xxv] A roadmap for health equity and social justice? By Roger Kline, MaryAnn Ferreux, Durka Dougall and Randeep Kaur Kular – The official blog of BMJ Leader
[xxvi] NHS Board Leadership for Equity and Inclusion 2024
[xxvii] https://ijpds.org/article/view/2166