

The importance of population health and Public Health (PH)

Reducing Health Inequalities is central to PH. Contemporary healthcare is increasingly focused on optimising patient care and outcomes at the population level. PH and individualised healthcare are essential partners rather than concepts in conflict. PH applies a broader and proactive view than traditional health care by extending the 1:1 individual approach to a targeted cohort of people (e.g. specific medical condition, community, age-group, etc.). It also adds the delivery of interventions such as public health, risk factor modification, health promotion and community engagement within the interaction of a patient and a healthcare professional. PH considers the determinants of health that fall beyond the immediate reach of the healthcare setting such as social circumstances, environmental exposures and behaviours. Chronic medical conditions such as obesity, diabetes mellitus and cardiovascular disease are suited to a population level approach. The vast majority of health determinants are associated with lifestyle, behaviours, social circumstances and environmental exposures, yet the focus is often aimed at medical care.

Defining populations

Populations can be defined by various methods e.g. geographically, medical conditions, ethnicities, disease risk factors, etc. Individuals can belong to more than one population and these can be viewed through different perspectives. PH is relevant across all the health disciplines, particularly in the disciplines that manage chronic illnesses such as general practice, psychiatry, respiratory medicine and cardiology.

What is the PCTH population health fellowship

SW HEE has agreed to support the development of Primary Care Training Hub (PCTH) Fellowships. In the initial phase 1 development 6 Fellowships will be developed 1 to each ICS/STP area in the SW. Successful applicants will embark on a year-long part-time fellowship, typically 1 days a week, alongside their permanent post.

Public Health supervision will be provided by a PH Educational Supervisor and line management from the training hub.

There will be a number of SW Central contact events including an induction event. These will be provided by the PH Head of School and the Public Health Specialist Training Programme. The contact days will be supplemented with online learning resources. Clinical fellows will also have regular educational meetings with their Supervisors these can be done also by telephone conference and Skype.

The approach to the assessment of the learning outcomes is formative (via written reports and presentations). In addition to PH competencies there is also a strong focus on leadership and management development.

The value of a population health fellowship

The programme provides an infrastructure to train future PH practitioners. The aim is to enhance Primary Care's contribution to Population Health and recruit Fellows with potential and help develop the contribution they can make to local work systems and improve patient outcomes. This should include a reduction in Health Inequalities.

Appendix 1: person specification

Applicants will be judged against these criteria relative to their level of experience.

| Type | Essential | Desirable |
|---------------|--|---|
| Academic | <ul style="list-style-type: none"> • Working in Primary Care • registration as appropriate • Degree Level Qualification | <ul style="list-style-type: none"> • Honours/distinction • Additional degree • Additional postgraduate qualification (e.g. diploma) • Awards • Presentations |
| Skills | <ul style="list-style-type: none"> • Communication • Teamwork • Creativity • Organisational | <ul style="list-style-type: none"> • Leadership achievements in healthcare • Achievements outside of healthcare |
| Understanding | <ul style="list-style-type: none"> • Knowledge of the principles of the NHS • Basic awareness of the English healthcare system (i.e. service provision, research, education, etc), its challenges and future direction | <ul style="list-style-type: none"> • Involvement in service changes in your workplace • Awareness of the top priorities of the NHS |
| Interests | <ul style="list-style-type: none"> • Research • Improving Health Outcomes • Medical education • Leadership and management | <ul style="list-style-type: none"> • Involvement in research • Led service change through audit and quality improvement projects |

Appendix 2: population health projects

A PH project is an improvement project with a focus on improving the outcomes for a group of patients. It is also similar to a SIP (service improvement) or QIP- a quality improvement project which aims to drive up the services/quality of health care for that population. It is different however, from an audit in that the focus is on identifying population-based outcomes that matter (through an analysis of patient data), developing or re-designing interventions through an understanding of the needs of a local population or community, and monitoring improvements in key outcome measures. A PH project can also demonstrate the importance of sectors outside health, particularly local government and Voluntary Sector in improving health outcomes. Of the projects outlined below.

1. Understanding and reducing the spread of MRSA in the community

Need identified:

Reduction in the spread of communicable diseases such as MRSA in the community.

Method chosen:

Working with the local infection control team to undertake a root cause analysis for each case of MRSA identified in the community. Root cause analysis requires an analysis of the patient's journey and whether any lessons for prevention could be learnt. Usually several patient journeys will be analysed at the same time to understand whether there are any trends/ patterns (such as antibiotics prescribing).

Learning points:

To understand how to perform root cause analysis- there are well established toolkits available.

Potential outcomes measured:

1. Reductions in levels of MRSA in the community
2. Reductions in variations in antibiotic prescribing.

2. Preventing COPD admissions to secondary care

Need identified: GP practice has a high proportion of patients admitted to the local secondary care service with exacerbations of COPD.

Potential reasons identified:

1. Lack of guidelines and training for clinicians managing COPD exacerbations
2. Lack of engagement with local rapid response community COPD team
3. Lack of discussion about end of life care for COPD patients with severe disease
4. Lack of access to smoking cessation interventions a) for people with COPD and b) for those patients who have not yet developed COPD

Interventions:

1. Development of practice guidelines based on local and national information;
2. System for linking at-risk patients with a named GP to improve continuity of care for vulnerable individuals;
3. Educational sessions involving practice GPs, nurses, district nurses, and community COPD liaison nurse;
4. Referrals to community COPD team to improve patient education on managing exacerbations, assessing psychological health, and preventing social isolation;
5. Information on accessing rapid response community COPD team made available to all through practice intranet;
6. Liaison with local palliative care consultants in education on end-of-life care for those with severe end-stage COPD.
7. Education for patients and carers so they can better manage their own condition and recognise and treat an exacerbation at an early stage
8. Smoking cessation advice tailored for this patient population [it is never too late – significant improvements in health outcomes can be achieved by quitting smoking at any age

Outcomes measured:

1. Number and cost of admissions for exacerbations of COPD
2. Smoking quitters among patients with COPD

3. Addressing the health needs of people with serious mental illness: a practice-based initiative

Context & Aims:

People with mental illness often have severe chronic physical illnesses, which can be neglected. My practice in Surbiton has a high prevalence of patients on the mental health register (0.98%); 20% more than the national average. NHS England and the Department of Health have recommend that these patients have annual physical health checks, which are part of the Quality Outcomes Framework (QOF). However, these patients can be difficult to engage and can be slip through the net. Sharing of patient information with the Community Mental Health Team (CMHT) at my practice is variable and could be streamlined. It is possible that by improving communication with patients they may be encouraged to focus on improving their health and wellbeing. I wanted to address these issues to improve uptake of the health check and involve the patients and their specialists to combat the health inequalities observed in this population.

Methods:

I set up a new programme to invite patients for annual physical health checks and to share this information with their specialists. The system is based on patient survey responses, meetings with the CMHT and with the practice team. It involves an initial nurse appointment, followed up by an extended doctor's appointment a week later. There are processes in place to facilitate patient attendance and information sharing with secondary care and the patient themselves.

Results:

The programme has been running since April 2014 and so far there has been a good response from staff, patients and the CMHT. A provisional assessment has been promising and helped to identify some early problems that have been addressed. A more detailed review is planned at the end of July 2014.

Conclusion:

If this innovative programme continues to be successful, there is potential for the idea to be rolled out to other practices in the CCG to help reduce health inequalities in this vulnerable group of patients.

Appendix 3: aims and competencies to be achieved

The broad aims of this fellowship are to encourage and develop attributes and attitudes focused on a systematic approach to care of a group of patients or residents. Where possible these competencies should be linked with to the assessed needs of the Population they are working in.

Health status assessment

The clinical fellow will demonstrate experience and competence in conducting a health status assessment on a group of patients that have been categorised appropriately, including monitoring of health trends:

- Identify and describe the significant long term conditions affecting this group including prevalence and resource utilisation.
- Identify and describe the health, social, environmental, and political determinants that influence this group of patient's burden of disease and community access to health services
- Define and describe health inequalities locally and nationally
- Demonstrate use of epidemiological information from a wide range of sources. PH Supervisors can advise on this.

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Health planning

The fellow will demonstrate competence in designing and implementing a targeted service improvement project that includes:

- Identifying and describing the significant gaps in population outcomes arising from an analysis of relevant population data
- Developing and describing interventions that seek to reduce gaps in this population's outcomes (including those affecting vulnerable groups in society) based upon most appropriate and cost-effective interventions
- Work with other relevant professionals, within the healthcare organisation and local healthcare economy, to implement a service improvement project
- Evaluate the outcomes of service improvement project with a particular emphasis on population-based clinical outcomes
- Reflecting on the structural changes affecting the NHS and the implications this can have on health care planning

Professional and ethical role

The fellow will demonstrate experience and competence in:

- Utilising information technology systems to extract population and individual data for assessment and planning of health strategies focused on reducing inequalities in population outcomes
- Understand and routinely utilise approaches to behaviour change when interacting with patients in order to promote patient empowerment and partnership
- Describing the ethics of allocation of limited health care resources, and the tensions of advocating for individuals as well as populations; and the concepts of prioritisation within a limited state funded system of healthcare
- Demonstrating the ability to work as a part of a team, both within your healthcare organization and with health professionals outside your healthcare organisation in ways that actively seek to reduce inequalities in health outcomes
- Being familiar with literature that informs discussion about health inequalities in England

Appendix 4: competency matrix

| PH curriculum area | Covered by |
|---|--|
| Identify and describe the significant long term conditions and the social, environmental, and political determinants of health in their allocated population. Consider the literature on health inequalities and implications to local and wider populations. | <ul style="list-style-type: none"> • Access to PH material and resources • Support from their healthcare organisation IT system • Content experts • Projects • Online resources |
| Use of epidemiological information(local and national) to help identify the significant gaps in population outcomes and describing interventions that seek to reduce gaps | <ul style="list-style-type: none"> • SW Seminars and Webinars • Support from their healthcare organisation IT system • Online resources <p>Project</p> |
| Work with other relevant professionals, understand approaches to behaviour change in individuals and in teams | <ul style="list-style-type: none"> • SW Seminar and Webinars • Discussion with supervisor • Content experts • Project • |
| Evaluate the outcomes and reflect on the structural changes affecting the NHS and the implications this can have on health care planning | <ul style="list-style-type: none"> • SW Seminar and Webinars • Content experts • Discussion with Supervisor • Project |
| Ethics of allocation of limited health care resources | <ul style="list-style-type: none"> • SW Seminar and Webinars • Discussion with trainer • Project |

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