



Everyday interactions

Measuring the public health impact of healthcare professionals



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Foreword

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



Shirley Cramer CBE Chief Executive, Royal Society for Public Health

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.







Supportive resource section dedicated to a and validated tools to

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possible. However,

should the opportunity

arise, the impact pathway highlights the data that could be

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lable on the health implications extensive literature on the diffe

nimplications of obesity.

on the different forms is ement interventions. All h

The Public Health England intervention can take. Publi

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1 England

'All our health' has a has a list of accredited

applications

and

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service-by-service basis.

*Follow-up is optional and in many cases collected to further demonstrate impact.

DO **RECORD** Record that weight has been Using MECC principles, raise raised with individual the issue of weight Record height, weight and BMI Weigh and measure to assess (and WC) of individual [GPs/ practice nurses should record BMI and where appropriate BMI on the Primary Care obesity waist circumference (WC) Record register If appropriate, assess individual's motivation/ Record readiness to desire to enter into weight the change scoring management mum Assess fruit and vegetable intake Record fruit and ᅙ vegetable intake Assess individual's physical Φ activity either informally 으 against guidelines, or formally using a tool such as GPPAQ, to interactions Record the physical identify inactive individuals activity assessment outcome Offer brief verbal and written advice on the health consequences of excess weight and importance of a healthier diet Record that brief advice and physical activity based on the has been offered to you scores above individual are Signpost to relevant services Categorise the referral - consider both the physical location (e.g. lifestyle weight having and emotional components of management service, health weight management trainer service) and record If individual is aged 40-74 without pre-existing Record that individual conditions, and has not had a health check in the last 5 has been signposted for a health check years, signpost to GP/local authority health check service

COLLATE

If followed-up, %

change in BMI/WC

If followed-up,

% change in no.

of individuals at each

stage of readiness

to change

If followed-up,

% change in no.

of individuals

eating 5-a-day

If followed-up, %

change in no of

individuals meeting

physical activity

quidelines

If followed-up, no.

of individuals who

attended referral

and duration of

participation

No. of times weight has been raised with individuals

No. of individuals who have had their BMI (and WC) recorded

Collate

results

and

follow-up*(where

possible) to

generate

impact

assessment

No. of individuals who have had their readiness to change assessed

No. of individuals at each stage of readiness to change

No. of individuals who have had their fruit and vegetable intake assessed

No. of individuals who meet the 5-a-day recommendation

No. of physical activity assessments carried out

No. of individuals meeting physical activity guidelines

Number of individuals who have received weightmanagement brief advice

No. of individuals referred to health improvement services i.e. weight management service

No. of individuals signposted to local health check service

IMPACT

Reduction in excess weight in adults

Proportion of the population meeting recommended 5-a day

Increased percentage of physically active adults

Reduced prevalence of chronic illnesses including cardiovascular disease, type Il diabetes and cancer

Increased <u>self-</u> reported wellbeing

Reduced mortality from preventable causes

Reduced burden and cost to NHS services and social care

Cumulative percentage of the eligible population who received an NHS Health Check

Higher levels of local population meeting PHOF increased physical activity

Higher levels of local

population meeting

PHOF 5-a-day

measure

Lower levels of local population meeting PHOF numbers of people who carry excess weight

Increased detection of early signs of stroke, kidney disease, heart disease, type II diabetes and dementia

IMPACT DO **RECORD** COLLATE Collate Reduced alcohol-Using MECC principles, raise Record that alcohol use has been No. of times alcohol use has related admissions the issue of alcohol raised with individual been raised with individuals to hospital results If followed-up. % Reduced mortality change in individuals from preventable Record initial AUDIT score and No. of initial AUDITs who are AUDIT Perform an initial screen for Record the causes whether individual is AUDITand follow-up* performed and no. of positive as measured alcohol risk using a validated positive (e.g. score of 5 or more individuals who were by reduction in AUDIT tool (e.g. AUDIT-C) Reduced mortality for AUDIT-C) **AUDIT-positive** score from cancer Reduced incidence and mortality from number Record AUDIT score and category No. of AUDITs performed For individuals with an AUDITliver disease (Low risk: 0-7; increasing risk: positive result, offer a full 8-15; higher risk: 16-19; possible (where Decrease in the **AUDIT** No. of individuals in Reduced numbers quantity and dependence: 20+) each category of low birth weight frequency of alcohol term babies of interactions consumption and associated problems possible) Reduced cost to Offer brief advice about the No. of individuals who have the NHS Record that brief advice Increased numbers of health and social effects of received brief advice on has been given individuals in alcohol alcohol use alcohol use misuse services Reduced vears of life lost due to to generate impact assessment alcohol in males Lower individual risk and females For individuals with high of alcohol attributable you Categorise the referral Number of individuals illness (including AUDIT scores, signpost to GP alcohol attributable location (e.g. GP) referred to GP or or specialist services where Reduced alcoholare and record mental ill-health) other service they exist related road traffic accidents having Cumulative If individual is aged 40percentage of the 74 without pre-existing eligible population conditions, and has not had who received an Increased detection of early a health check in the last 5 Record that individual Number of individuals NHS Health Check signs of stroke, kidney years, signpost to GP/local has been signposted for signposted to local health disease, heart disease, type II authority health check service a health check check service diabetes and dementia

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

Supportive resoumacy, hospital set The Public Health

resources: There are e-learning training packages available tal settings and dental settings on the e-Learning for Health (lealth England (PHE) framework 'All our health' has a section

dedicated

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different

forms inter-

community phar-

on Alcohol Identification and

Alcohol Identification and Brief Advice (IBA) in primary care, website: http://www.e-lfh.org.uk/programmes/alcohol.

vention can take

Supportive The Public H

Health

h England

es: There is gland (PHE)

training

available

ailable on child 'All our health'

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child

oral

/ arise,

the impact pathway highlights

d Programme e-learning oral health, containing o

extensive literature

framework

*Follow-up is optional and in many cases on the different forms intervention can take

IMPACT **PATHWAYS** Т Child oral health (0-5 yrs

DO

Be able to recognise children at risk of developing dental decay (e.g. oral hygiene, diet, socioeconomic status, parental smoking, previous caries experience)

> Be able to offer oral health advice to all children aged 0-5

Using MECC principles, raise the issue of child oral health relating to dental decay with parent/guardian and offer brief advice on dental hygiene routine:

- · As soon as teeth erupt in the mouth brush them twice daily with a fluoridated toothpaste
- · Brush last thing at night and on one other occasion
- Use fluoridated toothpaste containing no less than 1,000ppm fluoride
- It is good practice to use only a smear of toothpaste
- The frequency and amount of sugary food and drinks should be reduced
- Parents/carers should be advised to take their children to visit the dentist

Signpost to relevant services (e.g. dentist; health visitor; healthy child programme; school nurse: children's centre). When signposting to a dentist, highlight that dental care is free for some groups, including pregnant women, mothers in the 1st year of the child's life, children under 18 (or 19, if in full time education)

RECORD

Collate

results

and follow-up*(where

possible)

ð

generate

impact assessment

Record whether teeth are brushed last thing at night and on one other occasion; whether fluoridated toothpaste containing no less than 1,000ppm fluoride is used; and whether a smear of toothpaste is used

Record the

number

<u>호</u>

interactions

you

are

having

Record if you have undertaken a conversation about limiting sugary foods and drinks to mealtimes, and not consumed more than four times per day. For 4-6 year olds, this is less than 5 sugar cubes per day

Record whether their child has attended in the dentist in the last 12 months

Categorise the services the child has been signposted to

COLLATE

If followed up, the change in child's oral health routine, including change in number of times teeth are brushed per day

If followed-up, the

% change in no. of

children who have

attended the dentist in

the past 12 months

If followed up, sugary foods and drinks would be limited to mealtimes, and not be consumed more than four times per day

No of children signposted

Fewer general anaesthetics for tooth decay

Fewer sleepless nights for children and carers

Fewer missed school days and days off for parents

Reductions in the numbers of children with tooth decay

A reduction in the oral health gap for disadvantaged families

Reduced consumption of sugar in food and drinks

More children brushing their teeth last thing at night and on one other occasion

Increased fluoride protection

No. of children having attended the dentist in the past 12 months

Proportion of five vear old children free from dental decay

Reduced prevalence of obesity in children at <u>reception</u> and year 6

Reduced hospital admissions for dental caries (1-4 years)

Fluoride varnish applications via FP17s

Reduced burden and cost to NHS services

Reduced numbers of children with decayed, missing or filled teeth

> Reduction in procedures to extract teeth

No of children who have attended the dentist in the past 12 months

The no. of children

offered oral

health advice

The no. of

conversations about

limiting sugary

foods and drinks to

mealtimes, and not

consumed more than

four times per day

to other services

IMPACT

Follow-up is optional and in many cases will not be possible. However, should the opportunity arise, could be collected to further demonstrate impact. *Wild 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. The Public Health England (PHE) framework 'All our health' has a section dedicated to dementia, containing extensive literature on the different forms dementia for people with learning disabilities RECORD DO Collate results and follow-up*(where possible) to **ve resources: There is training available on <u>dementia awareness,</u> the issues around <u>young-onset dementia</u> and the increased Understand the risk factors associated with dementia and those at greatest risk of it Record the number of interactions Using MECC principles, offer brief advice to at risk groups to Record that brief advice has been encourage behaviour change (use offered and note which behaviours the smoking, physical activity, have been discussed obesity and alcohol impact pathways as appropriate) If individual is aged 40-74 without pre-existing conditions, and has Record that individual has been not had a health check in the last 5 signposted for a health check , the impact pathway highlights the data that years, signpost to GP/local authority you are having generate impact assessment health check service For individuals with suspected Record that individual has been dementia or mild cognitive referred to their GP impairment (MCI)* refer to GP

IMPACT

Reduced number of people who develop dementia

COLLATE

If followed-up,

use the smoking,

physical activity,

obesity or alcohol

impact pathways as

appropriate to record

change in behaviour

No. of individuals

who have received

brief advice on

dementia prevention

Number of

individuals

signposted to local

health check service

The no. of individuals

referred to GP

Increased physical activity, increased numbers of people with healthy weight, improved diet.

Reduction in use of cigarettes and alcohol

Increased detection of early signs of stroke, kidney disease, heart disease and type II diabetes

Improved early diagnoses of dementia, including young-onset dementia

Improved overall rates of dementia diagnoses

Reduced <u>dementia</u> mortality rates

Improved quality of life for older people

Reduced health inequalities in men and women

Improved mental health and reduced prevalence of depression

Reduced cost to the NHS and wider society

Cumulative percentage of the eligible population who received an

Reduced mortality from preventable causes

NHS Health Check

Supportive resources with Falls (Slips) has a

resources: Training in falls awareness lips) has a series of assessment forms

<u>≤</u> <u>s</u>

nich are appropriate

Southwark and Lambeth Integrated Care Pathway for Older People ppropriate to use with the timed up and go test: it is advised that yo

appropriateness and utility

of each

I that you

use the General Assessment Form alongside

the GUP test

but each

RECORD DO **IMPACT** COLLATE Collate results Identify individuals at risk of falling Reduced hospital admissions from falls at 65 and over; 65-79; and 80 and over Using MECC principles, ask older individuals No. of falls' Record the number of interactions whether they have fallen in the past Record fall history and histories taken year, including frequency, context and Reduced incidence characteristics of the fall(s) of hip fractures in follow-u No. of individuals people 65 and over; whose balance/ 65-79; 80 and over gait have been Record details of the observed. No. of tests Older individuals reporting a fall or considered observation and the p*(where administered at risk of falling should be observed for outcomes of the test Reduced mortality balance and gait deficits. Tests for balance The no. of individuals rates from and gait could be administered if appropriate with balance/gait accidental falls deficits identified [search: falls] possible) Older individuals at low to moderate risk of Record details of the Reduction in No. of individuals If followed-up, no. Increased life falls should be offered a strength and balance exercise programme of individuals who number and referred to a strength ---expectancy at 65 in severity of falls exercise programme attended a strength referral q and balance exercise men and women and balance exercise you are programme generate impact programme Improved balance and mobility Improved mental Older individuals at high risk of falls (those health and reduced having who present for medical attention because prevalence of depression due to of a fall, or report recurrent falls in the past social isolation year, or demonstrate abnormalities of gait and/ Record that individual Number of If followed-up, no. of or balance) should be offered a multifactorial has been referred individuals who have individuals referred falls risk assessment. This assessment should to a specialist falls assessment accessed a specialist to a specialist falls be performed by a healthcare professional service falls service service with appropriate skills and experience, Improved quality of life for older people normally in the setting of a specialist falls service

different forms intervention can take The Public Health England (PHE) framework 'All is optional and in many cases at could be collected to further demonstrate our health' has a section dedicated to falls, the impact pathway highlights

Supportive has a section *Follow-up is optional and in many cases the data that could be collected to further DO ortive resources: There section dedicated to hea Identify pregnant women or mothers of newborn babies and understand the importance of healthy beginnings and the impact of the wider determinants of health on healthy beginnings (e.g. housing, education, employment) ere is training available in <u>healthy beginnings</u>. The Public Health England healthy beginnings, containing <u>extensive literature</u> on the different forms For pregnant women, use MECC principles to raise the following issues as appropriate: will not be Smoking status; Maternal mental wellbeing; · Alcohol use: Physical activity: Weight management.; Breastfeeding: · Domestic abuse: • Oral health and free dental care; Use other impact pathways as appropriate opportunity

to further demonstrate

/arise,

impact pathway highlights

(PHE) framework 'All intervention can take

For women with young children, use MECC principles to raise the following issues as appropriate:

Use other impact pathways as appropriate

you are having Where appropriate ask parents to perform an ages and stages questionnaire: ASQ-3 or ASQ:SE-2 to assess fine motor skills, gross motor skills, communication, problem solving and social/emotional skills

Based on questionnaire scores/health needs identified above, signpost to relevant services (e.g. stop smoking services; health visitor). Consider the wider determinants of health in any referral, for example, housing; employment; education; cultural factors

RECORD

Record

the number of interactions

and Record which issues were raised and nd follow-up*(where p whether other impact pathways were used

Collate results

possible)

ō

generate impact

ssess

iment

Record which issues were raised and whether other impact pathways were used

Record the questionnaire score(s) and discussions about next steps

> Categorise the referral location

COLLATE

If followed-up, use

the relevant impact

pathway (e.g.

smoking, mental

wellbeing) to record

change in behaviour

If followed-up, use

the relevant impact

pathway (e.g.

smoking, mental

wellbeing) to record

change in behaviour

The no. of brief interventions carried out concerning healthy beginnings for pregnant women

The no. of brief interventions carried out concerning healthy beginnings for women with young children

No. of individuals who have completed child development *questionnaires*

mothers and new other services

IMPACT

Improved life chances for children

Increased breastfeeding rates

Improved nutrition and diet of mother and child

Reduction in smoking in pregnancy and postpartum

Reduced social isolation for mother and child

Improved linguistic. emotional and social development of child

Increased breastfeeding initiation and at 6-8 weeks postpartum

Reduced rate of mothers who smoke at time of delivery

Reduced number of term babies born at low birth weight

> Lower infant mortality

Increase vaccination coverage: MMR; hepatitis B; Dtap/ IPV/Hib: Hib/Men C booster

Reduced smoking status at time of delivery

Reduced hospital admissions caused by unintentional and deliberate injuries in children 0-4 years

Proportion of children offered the ASQ-3 as part of the healthy child programme (2-2.5 years)

> School readiness: the percentage of children achieving a good level of development at the end of reception

- · Maternal smoking status;
- · Maternal mental wellbeing;
- Alcohol use:
- · Breastfeeding and child nutrition;
- · Child oral health and free dental care:
- Child immunisations:
- · Domestic abuse:

No. of expectant mothers referred to Supportive rest our health' has a

resources: There is

training

on understanding

a section dedicated

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mental wellbeing, containing extensive literature on the different forms intervention

The Public Health England (PHE) framework 'All

can take.

across all subpopulations:

impact pathway highlights

ability to deliver them

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to assess mental wellbeing across all should be used appropriately across

There are a number of validated WEMWBS/SWEMWBS. These and

These and tools

*Follow-up is optional and in many cases the data that could be collected to further

RECORD DO Collate Understand the risk and protective factors for mental wellbeing Record results Record that mental wellbeing has been Using MECC principles, raise the issue The no. of times mental the raised with the of mental wellbeing and social isolation, and including antenatal/postnatal mental wellbeing individual number if appropriate follow-up*(where Record that brief Offer brief advice about the things that can advice has been improve mental wellbeing (e.g. five ways to of interactions offered on improving wellbeing) mental wellbeing Offer a self-assessment of mental wellbeing to Record the outcome interested individuals and use the findings to of the quide discussions possible) self-assessment you Signpost to relevant opportunities to improve Record the are mental wellbeing (e.g. physical activity, opportunities to social activities, psychological support, Q which the individual having social support, welfare services via social has been signposted generate impact assessment prescribing)

IMPACT

Increased

awareness and

self-awareness of

mental wellbeing

Reduced stigma

associated with

mental health

Improved mental

wellbeing and

reduced risk of

mental ill-health

Increased self-

reported mental

wellbeing

If followed-up.

average % change

in mental wellbeing

self-assessment

scores

If followed-up, no.

of individuals who

have engaged in

opportunities that

improve their mental

wellbeing

COLLATE

wellbeing is raised with

individuals

The no. of brief

advice interventions

carried out about

mental wellbeing

The no. of mental

wellbeing

self-assessments

carried out

The no. of individuals

signposted to

opportunities that

improve their mental

wellbeing

Increased self-reported wellbeing

Improved healthy life expectancy in men and women

Reduced health inequalities in men and women

Reduction in individuals with depression and anxiety

Decreased social isolation and improved quality

services

Reduced inequalities in life expectancy at birth for men and

of life

Reduced burden and cost to NHS

women

on the different forms intervention can *Follow-up is optional and in many cases The Public Health Supportive DO **RECORD** Collate results Using MECC principles, raise the issue of Record that physical resources: There is training available physical activity with the individual activity has been raised England (PHE) framework 'All our health' has a section dedicated to physical activity, including extensive literature with the individual Assess individual physical activity either Record the physical further demonstrate Record the number of interactions you informally against guidelines, or formally and activity assessment using a tool such as GPPAQ, to identify outcome inactive individuals will not be possible. However, should the opportunity arise, impact pathway highlights the follow-up*(where on the health benefits of physical impact. Record that physical Deliver and follow-up brief advice on physical activity brief advice activity based on the scores above has been offered to the individual Record the possible) Provide signposting to local opportunities opportunities to which to be physically active including the individual has walking and cycling been signposted ಠ generate Refer sedentary/inactive individuals with Record where the a health condition or other risk factors to are individual has been an exercise referral scheme. For high risk referred service/rehabilitation service individuals, refer to cardiac rehabilitation or having pulmonary rehabilitation impact assessment For individuals aged 40-74 without pre-Record that the No. of individuals signposted existing conditions and who haven't had a individual has been to local health check service health check in the last 5 years, signpost to signposted for a health check GP/local authority health check service

IMPACT

COLLATE

If followed-up,

change in no.

of individuals

meeting

physical activity

auidelines

No. of times physical

activity has been raised

with individuals

No. of physical activity

assessments carried out

No. of individuals meeting

physical activity guidelines

No. of individuals who have

received brief advice on

physical activity

Number of individuals

signposted to local physical

activity services

No. of individuals engaged

with an exercise referral

Reduction in national prevalence of obesity in adults

Reduction in the precursors to chronic disease, including hypertension and high cholesterol

Reduced prevalence of chronic illnesses including cardiovascular disease, type II diabetes and some cancers

Improved strength and mobility

Improved weight management

Higher levels of

people meeting

physical activity

guidelines

Lower number of

inactive adults

Improved sleep

quality

Improved emotional and mental health

Increased

detection of

early signs of stroke, kidney

disease, heart

disease, type

Il diabetes and

dementia

Reduction in osteoporosis and associated hip <u>fractures</u>

Reduction in falls and associated injuries

Reduced mortality causes

Increased life

Reduced burden and cost to NHS services

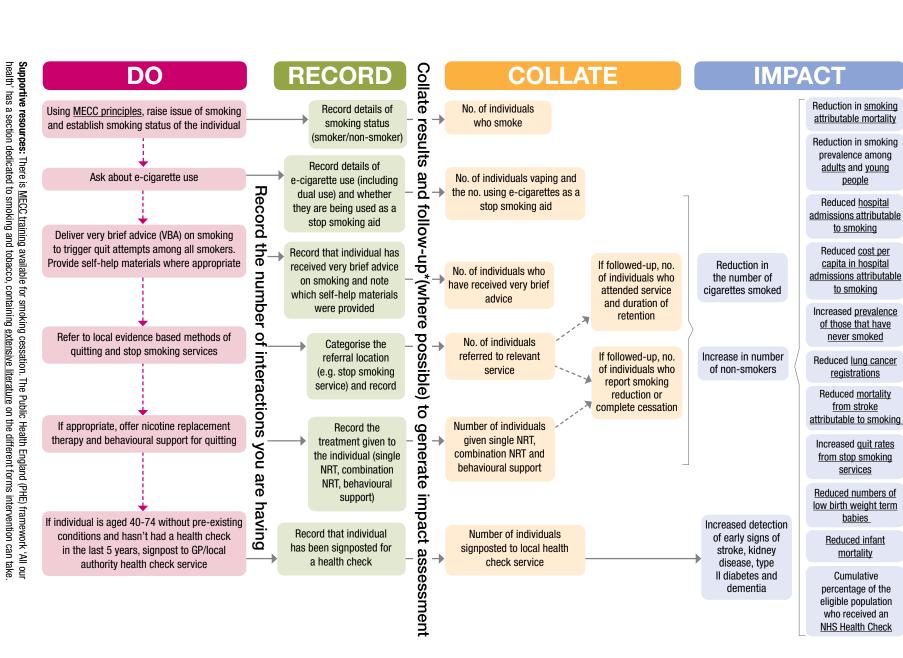
Cumulative percentage of the eligible population who received an NHS Health Check

from preventable

expectancy at 65

In other choice (*Follow-up is optional and in many cases the data that could be collected to further has a section dedicated to The actions taken will depend on the setting. In some settings tests, treatment and partner notif **RECORD** DO **IMPACT** COLLATE Collate results (especially in Understand the key groups at risk of STIs, HIV, unplanned pregnancy and those for whom HPV, hepatitis B (HBV) and hepatitis A (HAV) Increased gonorrhoea) contraception vaccination might be appropriate prescribing [search sexual health and HIV, containing extensive 'sexual health'] ₽ Record that sexual The no. of times sexual Record the Using MECC principles, raise the issue of health has been and health has been raised sexual health raised with the Reduction in rate with individuals NHS England's Antibiotic Awareness Campaigr of conceptions individual follow-up*(where Decreased in females aged unplanned <u>15-17</u> Offer brief advice about contraception, Record which areas The no. of individuals who have conceptions Ξ. abortion, sexual health and HPV/HBV/ of sexual health the received brief advice on sexual number of HAV vaccinations as appropriate. Suggest brief advice has Reduction in and reproductive health Reduction in individual takes a sexual health knowledge covered and outcome **HIV diagnosis** unmet need for (especially late quiz and/or a quiz to assess the need for an of guizzes if used contraception The no. of chlamydia diagnoses) HIV test screenings undertaken Record the outcome interactions Increased detection stewardship in possible) Reduction in total of the screening test The no. of individuals who rates of chlamydia Where appropriate suggest a STI diagnoses Public screened as positive for locally self-administered chlamydia screening test chlamvdia If followed-up, the Health Record that the no. of individuals Increased Decreases in sexual health individual has been who subsequently diagnoses and The no. of individuals sexual health Where appropriate encourage use of the free ð າ England signposted to HIV treatment for HIV signposted to HIV home used these associated cancers HIV home sampling service and/or local online you home testing/online and other STIs (genital and generate impact assessment services testing/online STI testing STI testing services the STI testing cervical) (PHE) may be intervention are impact pathway highlights also framework No. of individuals in a Record that Consider raising issue of controlling/coercive undertaken having Increased HPV controlling/coercive controlling/coercive relationships with individual vaccination relationships have relationship who would like coverage ₹. been raised. Record to seek help 'All our health' whether individual Signpost to relevant sexual health services, Improved selfwould like to seek help including services providing free condoms and reported sexual Reduced abortions health and vaccination services. Signpost individuals in under 10 weeks wellbeing controlling/coercive relationships to relevant Record and categorise No. of individuals signposted organisation (e.g. Women's Aid) where the individual has to sexual health/other relevant been signposted

services



*Follow up is optional and in many the data that could be collected to

cases /

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.



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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).

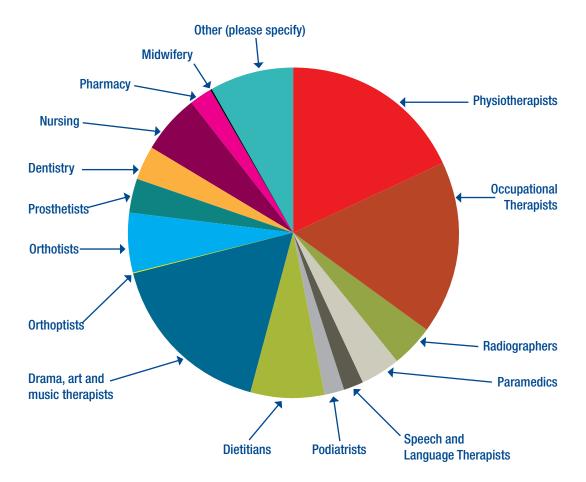


Figure 1: The breakdown, by discipline, of healthcare professionals who responded to the survey.

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.

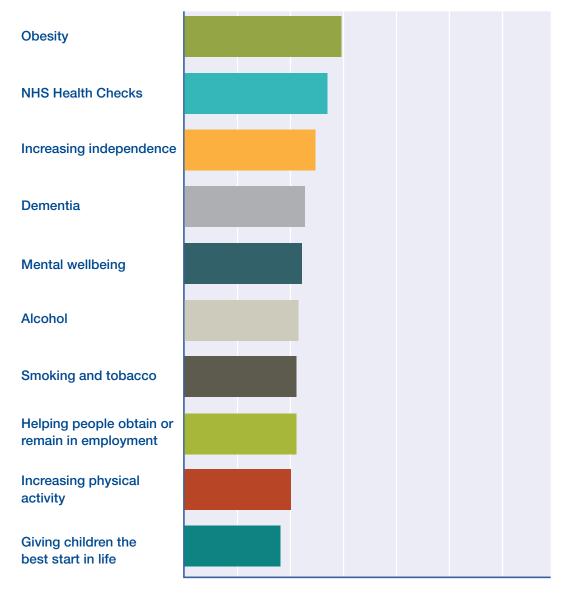


Figure 2: The public health priorities that respondents said they do not currently address, but feel they could contribute to.

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 h	ealthcare profe	essional or a c	ommissioner o	t healthcare se	ervices?
	☐ Healthcare Profe	essional (Allied	Health Professi	ional, Dentist, N	lurse, Pharmac	cist, Midwife)
	Commissioner					
	Neither					
2.	Which of the followin	g healthcare pr	ofessions are y	/ou/do you curr	ently work in?	
	$\ \ \square \ \text{Physiotherapist}$					
	Occupational Th	erapist				
	Radiographer					
	Paramedic					
	Speech and Lan	guage Therapis	st			
	Podiatrist					
	Dietitian					
	Drama, art and ı	music therapist				
	Orthoptist					
	Orthotist					
	Prosthetist					
	Dentistry					
	Nursing					
	☐ Pharmacy					
	☐ Midwifery					
	U Other (please sp	ecity)				
3.	To what extent do yo important in your pro		following com	ponents of the	public's healt	h to be
		Largely Unimportant	Somewhat Unimportant	Neither	Somewhat Important	Largely Important
	Preventing ill-health					
	Promoting health					
	Protecting health					
4.	If public health is not	t considered im	nportant, why o	do you think th	at is?	

5.		ch of the following public health priorities would you say you actively engage in either enting, 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 y	ou currently measure your public health impact?
		Yes
		No
		Don't know
7.		do you measure the public health impact of your interventions? i.e. are there any rics 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.		ne public health priorities that you do not currently address, which do you feel that you d 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.		at are or could be the constraints on recording and measuring the impact of your rvention 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.	Wha	at 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

١.١	wnici	n of the following nealthcare 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.	Wha	at setting best describes where you mainly work?
		Primary care
		Secondary care
		Local Authority
		Community
		Academia
		Other (please specify)
3.		ald you be able to apply this tool in your practice? (There will be similar models for other lic health priorities)
		Yes
		No
		Don't Know
4.	ls 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

