ADULTS AND HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 7
19 SEPTEMBER 2023	PUBLIC REPORT

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PREVENTION IN PRIMARY CARE

RECOMMENDATIONS
It is recommended that the Adults and Health Scrutiny Committee note the following: 1. The national and local strategic direction for prevention in the NHS 2. The role of primary care in prevention

1. ORIGIN OF REPORT

1.1 This report is submitted to the Adults and Health Scrutiny Committee following a request from the Committee for a report on prevention within Primary Care.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide the Adults and Health Scrutiny Committee with an overview of the prevention activities undertaken by Primary Care.

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview Scrutiny Functions, paragraph No. 2.1 Functions determined by Council:

3. Scrutiny of the NHS and NHS providers.

4. BACKGROUND AND KEY ISSUES

4.1 <u>About Prevention</u>

The increasing cost of health and social care services demands a focus upon prevention. Much of the demand for these services arises from preventative conditions.

There are multiple risk factors associated with a person's likelihood of developing conditions that need to be identified, assessed, diagnosed, and treated as early as possible to improve health outcomes:

1. **Wider Determinants of Health:** Socio-economic factors and the environment in which people live can influence their health outcomes.
2. **Non-modifiable Risk Factors:** Age, gender, ethnic background, and family history all contribute to an individual's likelihood of developing a CVD condition.
3. **Modifiable Risk Factors (health behaviours):** Tobacco use, excess consumption of alcohol, obesity, unhealthy diet, inadequate physical activity are behavioural risk factors that can be changed and mitigated.
4. **Clinical Risk Factors and Comorbidities:** High blood pressure (hypertension), high or abnormal cholesterol levels or dyslipidaemia, irregular heartbeat (atrial fibrillation), high

blood glucose levels, diabetes and chronic kidney disease all are clinical risk factors contributing to CVD.

Population Health Management – stratifying data of all risk factors

Since the establishment of Integrated Care Systems (ICS), the NHS has evolved to take a wider view of the drivers of poor health and is using data more widely to understand the risks to the health of the population.

Population Health Management (PHM) is an important methodology to support our goals for the prevention of ill-health, tackling health inequalities, improving outcomes, and quality of care.

PHM is an approach that enables local areas to deliver the most appropriate services for local people. It uses linked datasets from health, care, and other services to plan and deliver proactive and preventative care.

Using a PHM approach drives a change in culture towards more prevention, more integration, and more provision, based on need rather than service use. NHS Cambridgeshire and Peterborough's vision is that all organisations within the ICS will have the skills, resource, and information they need to use PHM approaches, with all partners using the same database to align priorities and operationalise PHM.

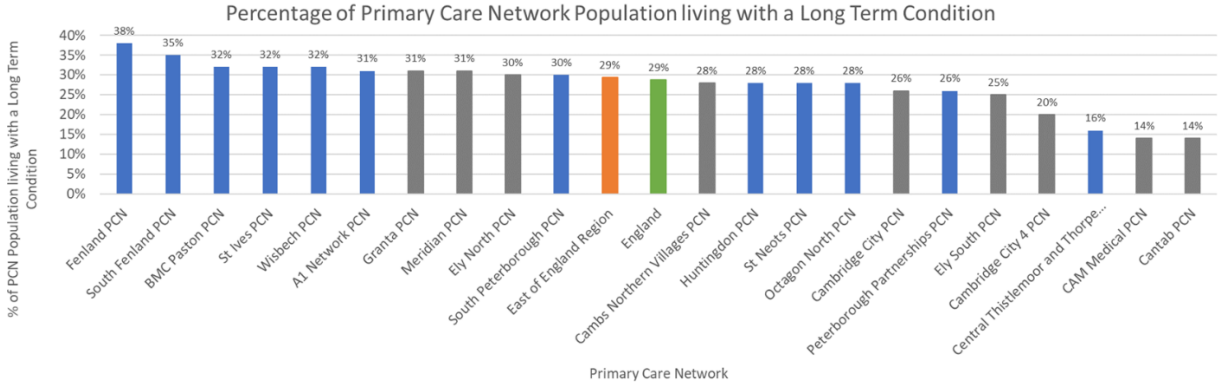
Most operational PHM will happen at Place and Integrated Neighbourhood level, but we will also use a PHM approach at system-level to allocate resource, manage risk and identify system priorities. As part of our commitment to sharing intelligence across organisations, we know that PHM data can be further enhanced by qualitative information incorporating voluntary, community and social enterprise sector and feedback from local people. This ensures it reflects community insight and knowledge, bringing rich qualitative feedback alongside quantitative data.

Each Primary Care Network (PCN) working with their Integrated Neighbourhood Team is developing a plan to address the needs of their population. Those plans will align to the data tools and PHM methodologies described above.

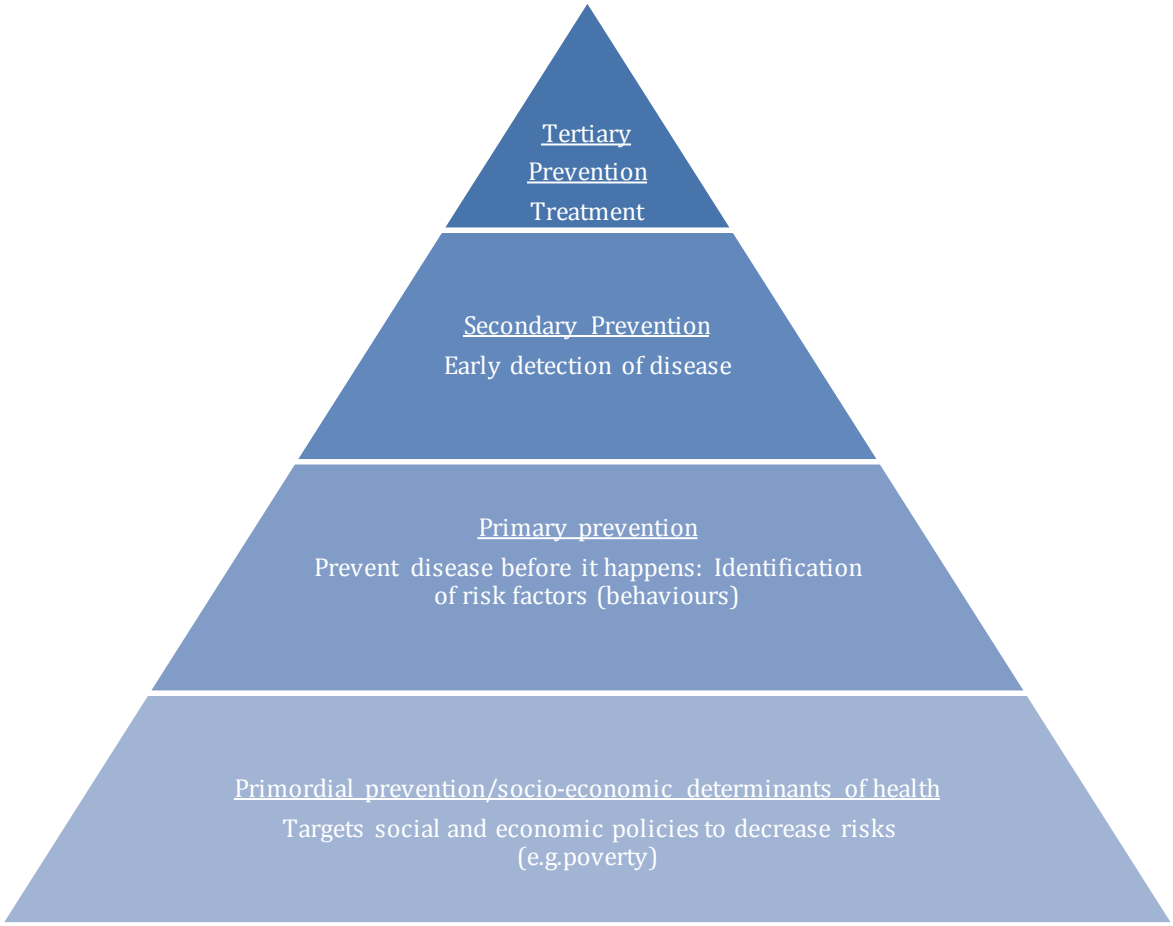
The clustering of a small number of modifiable risk factors within certain communities is a key factor which drives premature mortality, overall poor health, and health inequalities. This is a fundamental driver for the future delivery of prevention within Primary Care.

We know that the patients living with Chronic Conditions are not spread evenly across our geography. The chart below shows the percentage of each Primary Care Networks (PCNs) population that are living with chronic conditions. It shows that 7 out the top 10 are PCNs from the North of our system. Overall, 30% of our population in the North are living with a chronic condition compared to 24% in the South.

Figure 1: Primary Care Networks: percentage living with a long tern condition



4.2 Prevention Figure 2: The tiers of prevention



4.3 Prevention and Local Strategic Priorities

The wider determinants of health have the biggest impact upon population health outcomes and play a role in determining health behaviours that are addressed through primary prevention.

Secondary prevention focuses upon early detection of health conditions and treatment. Whilst tertiary prevention focuses upon treatment and the prevention of any deterioration.

For a system to actively prevent poor health, all areas need to be addressed and organisations will have traction in particular areas. In Cambridgeshire and Peterborough, the Integrated Care System along with the Health and Wellbeing Board have developed and are implementing a joint Health and Wellbeing, Integrated Care Partnership Strategy.

The joint strategy has three main ambitions:

1. Reducing inequalities in deaths in under 75s
2. Increase the number of years people live in good health.
3. Getting Better Outcomes for Children

Four priorities have been developed to achieve those ambitions:

1. Ensure our children are ready to entre education and exit prepared for the next phase of their lives.
2. Create an environment to give people the opportunity to be as healthy as they can.

3. Promote early intervention measures to improve mental health and wellbeing.
4. Reduce poverty through better employment and housing.

This reflects the strategic direction that the NHS and its partners have set to focus more on prevention and reduction in health inequalities.

4.4 National Strategic Priorities

The NHS Long Term Plan

Improving the population's health, and preventing illness and disease is key to reducing health inequalities. At the heart of the NHS Long Term Plan is the ability to catch the causes of ill health as early as possible to prevent, or reduce, the chances of them leading to more serious conditions. This has been a focus for the NHS for some time.

Many conditions which contribute to shorter healthy life expectancy are preventable. While the factors which can lead to these conditions are many and varied, and often beyond the sole control of health services, the NHS is taking action to help people improve their own health, from targeted support to help people reduce their dependency on alcohol or tobacco, to offering alternative weight management services, to prescribing statins to prevent heart attacks.

NHS England has set out several initiatives that form part of a prevention programme specifically looking at the early detection of disease and support for people taking their own action to better health through supported self-management. For the NHS, this means tailored help for tobacco addiction, alcohol, and obesity, with treatment to reduce the risk of early ill health and diseases such as cancer, cardiovascular disease, stroke, respiratory disease, and mental ill-health.

Core20PLUS5

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

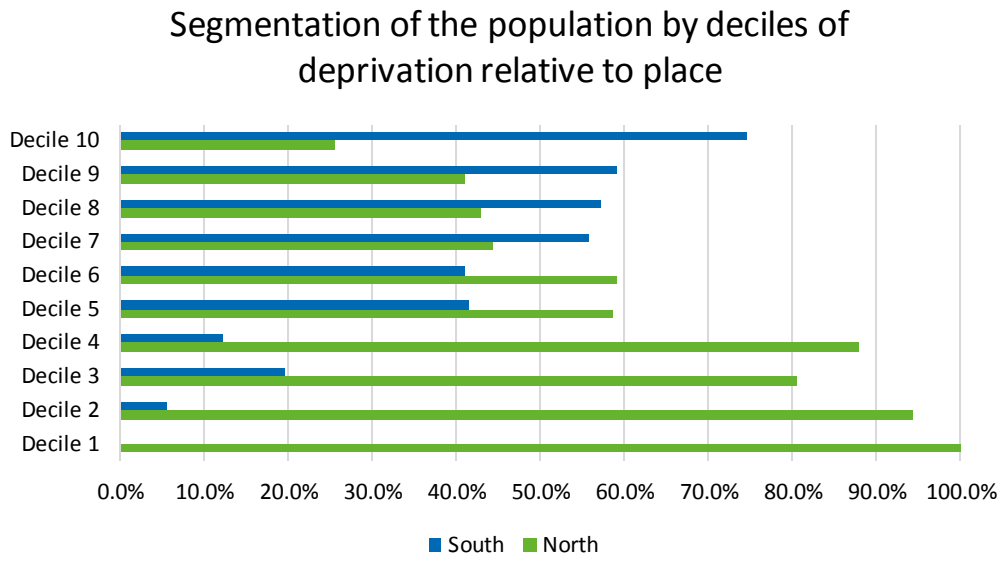
The approach, which initially focussed on healthcare inequalities experienced by adults, has now been adapted to apply to children and young people.

'Core20'

The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

For Cambridgeshire and Peterborough, 62 Lower Super Output Areas (LSOAs) are in the 20% most deprived LSOAs when calculated nationally; 46 are in Peterborough, while 11 are in Fenland. In total, 13% of our population live within the most deprived quintile with the geographical distribution varying considerably: 95% (107,000) living in the north or Cambridgeshire and Peterborough compared with 5% (5,000) in the south as shown in

Figure 3 Segmentation of the population, by deprivation and place



PLUS

PLUS, population groups are identified at a local level. Populations identified include ethnic minority communities; people with a learning disability and/or autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, known as inclusion health groups and other groups where there may be small areas of high deprivation hidden amongst relative affluence.

Inclusion health groups include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

PLUS 5

There are five clinical areas of focus which require accelerated improvement for both the adults and children and young people approaches. For adult, the following priorities constitute the 5 of which items 2, 3 and 5 are delivered in a primary care setting whilst item 4 is strongly facilitated b primary care:

1. Maternity – continuity of care for 75% of women from Black, Asian, and minority ethnic communities and from the most deprived groups
2. Severe mental illness – ensuring annual health checks for 60% of those living with SMI.
3. Chronic respiratory disease – a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of Covid, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
4. Early cancer diagnosis – 75% of cases diagnosed at stage 1 or 2 by 2028.
5. Hypertension case finding and optimal management and lipid management – to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

In addition to the five clinical priorities listed above, smoking cessation has been identified as a cross cutting priority which positively impacts all key areas.

For children and young people, the following priorities constitute the 5. All represent prevention improvements and are facilitated by primary care:

1. Asthma - Address over reliance on reliever medications and decrease the number of asthma attacks.
2. Diabetes - Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds and Increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.
3. Epilepsy - Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.
4. Oral health - Tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under.
5. Mental health - Improve access rates to children and young people's mental health services for 0–17-year-olds, for certain ethnic groups, age, gender, and deprivation.

Over the last century we have seen significant improvements in healthy life expectancy driven, by improvements in the wider determinants of health but improvements in secondary prevention have also play a role, however there are still significant inequalities

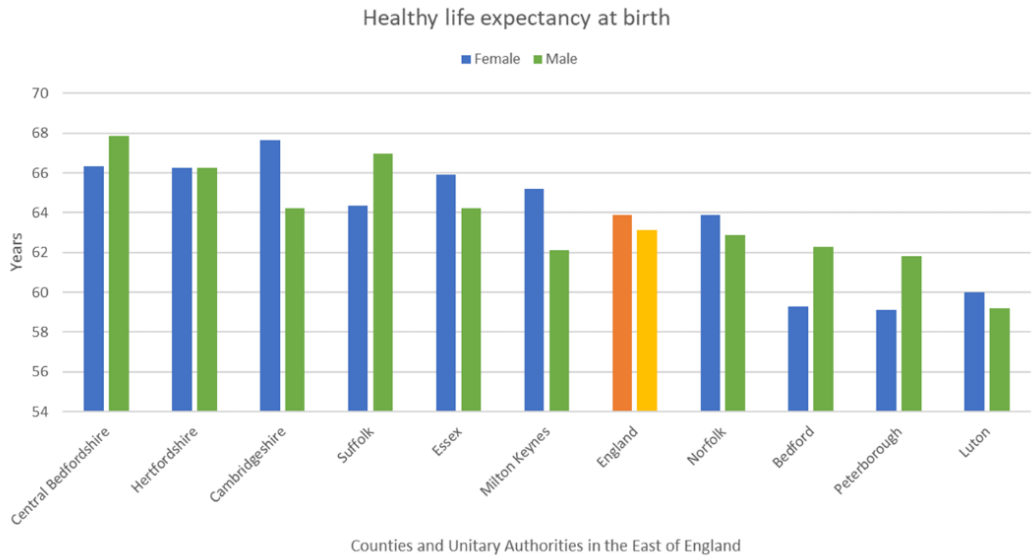
4.5 Health Outcomes and Health Inequalities in Peterborough

The place where children are born and grow up has a direct impact on their life chances and health in later life. Currently, a boy growing up in the poorest part of Peterborough has a life expectancy of 75.8 years, however a boy growing up in the richest part of Cambridge has a life expectancy of 85.2 years; a difference of 10 years. The gap has increased by 0.9 years between 2011-13 and 2015-17. The NHS can help reduce the gap through more equitable prevention, diagnosis, and treatment since it has been estimated that health care contributes 15-43% to health outcomes.

Whilst the inequalities in life expectancy across Cambridgeshire and Peterborough are stark, below is the breakdown of the life expectancy gap between the most and least deprived quintiles within Peterborough by cause of death, 2020 to 2021 (Provisional). As detailed circulatory conditions (i.e., hypertension) are the biggest driver of the inequality in life expectancy in Peterborough for both men (40.3%) and women (31.9%).

Healthy life expectancy is the measure of years a person will on average remain in good health. Across the East of England, Peterborough has the lowest healthy life expectancy at birth for women and the second lowest healthy life expectancy for men.

Figure 4: Healthy Life Expectancy at Birth



The disparity in life expectancy across Cambridgeshire and Peterborough of approximately 10 years between those living in the least and most deprived areas of the system coupled with the health life expectancy in the same area, means that a female born in Peterborough has a life

expectancy of 82.5 years but can only expect to live 59.1 years in good health. This means they will spend more than 28% of their life not in good health.

Tackling health inequalities is a core priority for the NHS and Cambridgeshire and Peterborough ICS. People from more deprived backgrounds are more likely to have long term health conditions and suffer poor health. Those people living in the most deprived 20% of the population, on average, develop multiple long-term conditions 10 years earlier than those in the least deprived 20%.

4.6 The Role of Primary Care

Members of the population who present to primary care will have health behaviours or socio-economic factors that are or potentially will pose risks to their health. Primary Care has an important role as clinicians provide advice about health-related behaviours and referring them to appropriate services for support e.g., stop smoking services, weight management services, drug and alcohol services or local authority opportunities for physical activity. Some GP practices provide space for behaviour change services which provides convenient access for their patients.

Rates of people living in poverty have escalated through the impact of the COVID -19 pandemic on ongoing health and the cost-of-living pressures associated with inflation. Social prescribers who work alongside primary care clinicians provide to support patients who have socio-economic issues that are or could affect health. They are playing an important role in helping patients identify and access organisations that offer help, this may be for example local authority, voluntary sector, or employment support agencies. In addition, the Integrated Care Board has given grants to Peterborough City Council to support people to improve their lives which has also led to closer working with GP practices.

Primary Care has a key role in secondary prevention, that is the detection of risk and management of the risk. There are national expectations that the "clinical risk factors associated with some poor health outcomes are identified and managed to prevent progression to a health condition. For example, regular blood pressure checks to ensure any high blood pressure is identified and treated to decrease the risk of stroke, or the identification of cholesterol which is a particular risk for cardiovascular disease which can be lowered through treatment with statins.

Public Health works closely with the local NHS including primary care in support of prevention, which includes population health management, strategy development and commissioning. Public Health commissions Stop Smoking Services and NHS Health Checks from GPs both key to the prevention of cardiovascular disease, diabetes, and cancers. NHS Health Checks provide an assessment of the risk for cardiovascular disease which includes identification of obesity and diabetes as well as health behaviours harmful to health. GP Public Health services were affected by the COVID-19 pandemic when practices limited their services and ongoing workforce capacity These have affected prevention in primary care and although there has been some improvement primary care commissioned public health services more is required to meet the national targets for NHS Health Checks which are required to have a measurable impact on cardiovascular diseases. Public Health also commissions Long Acting Reversible Contraception from GP practices and Emergency Hormonal Contraception from community pharmacists.

To support the development of prevention strategies by ICSs, NHS England set out advice on the most impactful interventions relating to the prevention and management of CVD, diabetes, and respiratory disease. This is summarised below:

Modifiable Risk Factors

- Tobacco dependence identification and treatment in secondary care – The Committee previously received an update on the Treating Tobacco Dependency Programme
- Weight management services for people with diabetes and/or hypertension
- Alcohol care teams.

Respiratory

- Spirometry in diagnosis of asthma and chronic obstructive pulmonary disease (COPD)
- Inhaler and medicines optimisation
- Pulmonary rehabilitation for COPD
- Personalised asthma action plan for all children and young people with asthma.

Diabetes

- Structured education
- NHS Diabetes Prevention programme
- Delivery of 9 diabetes care processes.

CVD

- Community pharmacy hypertension case finding is a well-established service.
- Cholesterol search and risk stratification is being used to risk stratify the population and identify where individuals may be at risk of developing conditions based on the risk factors.
- NHS health checks are delivered through primary care services.
- Optimisation of hypertension treatment
- Optimisation of heart failure treatment through annual reviews
- Optimising management post ACS, including lipid management.

Public Health has worked closely in the development of the Integrated Care System Cardiovascular Disease Strategy. The strategy brings together primary and secondary prevention. Although the clinical risks sit very much with primary care there are interfaces which mean the prevention of CVD can be achieved in advance of a patient entering the healthcare system.

In support of the CVD Strategy, and the "Create an Environment to give People the Opportunity to be as Healthy as they Can" objective of the Joint Health and Well /Integrated Care Partnership Strategy, Public Health has allocated funding of £200,000 to primary care to increase their prevention activities. A primary care "service agreement" is under development by Public Health and the Integrated Care Board for primary care that includes weighing adult patients when they visit their GP practice along with piloting an approach to the identification of patients with high blood pressure and cholesterol.

The Public Health team is commissioning behaviour science insights research for a number of health behaviours. Behavioural insights are how people perceive things, how they decide, and how they behave. They are generated by from behavioural science research which identifies the factors that influence our health-related behaviours. It is now very well developed as a behavioural science and is used across different sectors to understand and target behaviours.

Behavioural science will enable us to tailor our interventions at a population level, both in wider prevention, but also in primary care. This is especially important where there is a need to understand the barriers and enablers for prevention and treatment in areas /groups where modifiable risk behaviours exist.

As part of the wider work on tackling obesity, the NHS long term plan sets out commitments for action the NHS will take to support individuals to achieve and maintain a healthy weight. It does so while recognising that a comprehensive approach to preventing and tackling obesity also depends on actions that spans individuals, companies, communities, systems, and national government.

As indicated above general practice can play a key role in identifying people who are obese and supporting them to access support from the variety of weight management programmes and for example physical activity programmes. Current local weight management programmes are jointly funded locally the ICB and Local Authority Public Health addition the national NHS Digital Weight Management Programme offers online access to tier 2 weight management services for people living with obesity who also have a diagnosis of diabetes or hypertension or both. With three levels of support and a choice of Providers, it is designed to offer patients a personalised level of

intervention to support them to manage their weight, improve quality of life and improve longer term health outcomes.
The programme will work alongside existing weight management services provides a greater choice for service users.

The programme aims to reduce health inequalities by providing additional human coaching for people with characteristics that suggest they may be less likely to complete behavioural and lifestyle change programmes to reduce and manage their weight. This includes people of younger (working) age, people from black, Asian, and ethnic minority backgrounds, men, and people living in more deprived communities.

Community Pharmacies (CP) represent the most commonly utilised part of primary care. CPs are pivotal in the provision of healthcare services within our system and to the health and wellbeing of our population, providing services to prevent disease, promote health and reduce inequalities.

Data shows on average, a community pharmacy consults with 19.2 patients per day. Therefore, across the 145 CPs in C&P, there are approximately 16,704 consultations per week (6 days per week) or, nearly 868 608 per year. For our system, this represents an avoidance of over 432,566 GP appointments per year by patients having access to their local community pharmacy.

Community pharmacy teams are increasingly delivering a wide range of public health interventions such as healthy living services, blood pressure checks, stopping smoking support, sexual health services, alcohol interventions, flu and covid immunisations and more.

There is widespread recognition of the role of community pharmacy teams in improving health. With their presence in most high streets, many rural communities, and in the places where people shop, access healthcare, and enjoy leisure time, community pharmacy teams are a local health and social asset interwoven with people's daily lives.

Whilst the delivery of prevention programmes in primary care continue in the mainstream sense, and by utilising new and evolving methodologies to optimise the approaches, data demonstrates the need to reach more people in places and ways that suit them. This requires co-production and creativity.

In September 2023, co-working with the North Place Partnership, ICB, Peterborough City Council and the Light Project Peterborough, prevention programmes will start to roll out in more accessible ways to homeless populations across Peterborough via the Health Outreach Bus.

The Peterborough Health Outreach Bus will provide health and care assessments to those experiencing homelessness as well as giving on-going access and referrals to a range of necessary NHS health and care services, provided by NHS Cambridgeshire and Peterborough, part of the Integrated Care System.

Typical treatment aboard the bus will range from dry blood spot testing (for what people will not know what you to flu vaccinations, and basic eye tests to minor medical treatments such as dressing wounds and treating infections.

The Health Outreach Bus is led by Light Project Peterborough and was originally funded by NHS Charities Together. NHS Cambridgeshire and Peterborough and Peterborough City Council are continuing to fund the mobilisation of the bus to

<u>Other Prevention</u>

Prevention does not end with primary care, whilst the majority of secondary prevention is delivered within this setting, programmes of prevention are being delivered in acute settings:

Alcohol Care Team Optimisation is part of the NHS Long Term Plan aiming to provide teams of alcohol specialist clinicians based in acute hospitals to provide specialist support, predominantly to alcohol-dependent patients. Working in partnership with local authority funded community

alcohol services, alcohol care teams in general district hospitals can reduce length of time spent in hospital, reduce alcohol related admissions, and improve outcomes for patients, their families, and their communities.

In 2021 Cambridge University Hospitals NHS Foundation Trust was selected to become a Wave 2 site for the ACT optimisation by NHSE; the programme started in October 2021 and expands the current specialist alcohol treatment team (Liaison Psychiatry) at Addenbrookes hospital, provided by CPFT. A review of the ACT at CUH is underway with an ambition of establishing something similar at NWAFT in the future.

The Treating Tobacco Dependency Programme (TTDP) is a prevention initiative funded by NHSE to support the introduction of new tobacco cessation pathways in secondary care settings and maternity patients. Being in hospital is a significant event in someone's life and people can be more open to making healthier choices. The overarching ambition of the TTDP is that by 2023/24, NHS-funded tobacco treatment services will be offered to:

1. Anyone admitted overnight to hospital who smokes.
2. Pregnant women and members of their household
3. Long-term users of specialist mental health services

The recommended inpatient (acute) model is based on delivering systematic in-house treatment of tobacco dependence in secondary care. Patients are provided with behavioural support, nicotine replacement therapy (NRT) or other pharmacotherapy during their hospitalisation, with onward referral to community stop smoking services and follow-up post-discharge. The acute inpatient pathway is underpinned by published evidence on the Ottawa Model for Smoking Cessation and based on work undertaken in Greater Manchester as part of the 'CURE model'.

5. CONSULTATION

5.1 Consultations have been undertaken that relate to different interventions described in this paper.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The ambition for this Report is that it will secure the support of members for the described programmes described and identify any support that they can provide when working with their communities.

7. REASON FOR THE RECOMMENDATION

7.1 It is a statutory requirement that the NHS must comply with any requests from the Local Authority to scrutinise any of its services.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 N/A

9. IMPLICATIONS

Financial Implications

9.1 *N/A*

Legal Implications

9.2 *N/A*

Equalities Implications

9.3 These are described in the body of the report.

Rural Implications

9.4 These are described in the body of the report.

10. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

10.1 The NHS 5 Year Plan

11. APPENDICES

N/A

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