Prevention Workstream Report

City of London Health and Wellbeing Board
11 February 2019

CITY OF LONDON

Hackney

NHS
City and Hackney
Clinical Commissioning Group

Prevention – overview of the ask

Support all care workstreams to embed prevention principles in their plans to achieve a system shift towards prevention and early intervention

Reduce exposure to the main preventable risk factors for health inequalities, poor health and premature mortality

Enable people to live healthy lives and manage their own health

Early identification (of risk factors)
Early diagnosis (of long-term conditions)
Early intervention

Advocacy and partnership to improve the social, economic and environmental drivers of health and health inequalities ('Marmot principles')

Summary – successes & challenges to date

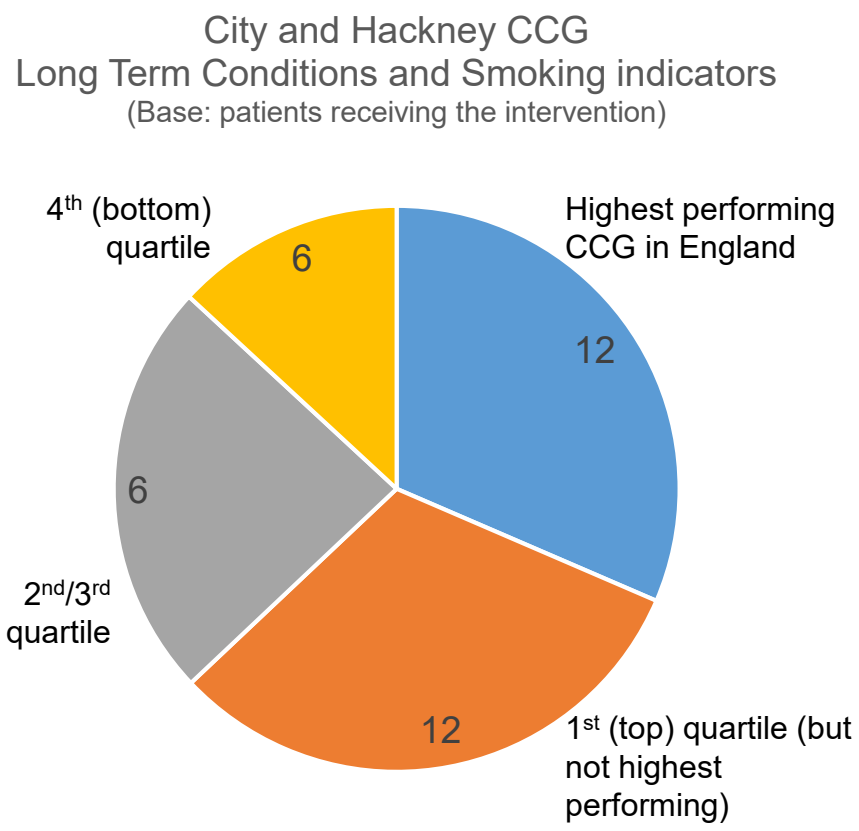
Successes

- **Management of Long Term Condition in primary care**: City and Hackney top performer on many clinical outcomes (out of 194 CCGs in England)
- High/increasing number **referrals to preventative services**: 2,000 to National Diabetes Prevention Programme and 1,200 to Social Prescribing so far; 3,500 annual referrals to weight management/exercise of referral; almost 3,000 smokers accessing support to quit each year
- **Good progress with tobacco control plans**: NHS smokefree pledge signed by Homerton (Barts since 2015), ELFT, CCG, GP Confed; smoking in pregnancy pathways established
- **High levels of sexual health screening**: high chlamydia detection rate; comparatively high HIV testing rates (=relatively low late diagnosis rates)
- Significant **improvement in alcohol treatment completions**
- 300+ people trained in Mental Health First Aid

Challenges

- **Sexual health**: increasing and changing demand; service fragmentation
- **Child obesity** remains stubbornly high (limited data for the City)
- Ongoing (local and national) challenge of **access to mental health services for people with substance misuse**
- **Low employment rates** among adults with learning disability and severe mental illness

Quality and Outcomes Framework performance 2017/18



Top performing CCG on 12/38 measures:

- Managing blood pressure in people with: high blood pressure; peripheral arterial disease; stroke; coronary heart disease and diabetes (2 measures)
- People with asthma and Chronic Obstructive Pulmonary Disease (COPD) who have had a review and been monitored with a recognised clinical measure (3 measures)
- People with COPD who have been diagnosed using the correct assessment (spirometry)
- People with long term conditions who smoke being offered support and treatment to stop smoking
- People with diabetes who have had a foot check in the last year

Summary – opportunities & risks

Opportunities

- Neighbourhoods – prevention focus
- Collaboration with other care workstreams to embed prevention in their plans
- Embedding treatment of tobacco dependency in NHS care pathways (in line with recent Royal College of Physicians report, '"Hiding in plan sight")
- Sexual health e-service: improving access and addressing cost pressures
- Mental health: mental health and substance misuse joint re-commissioning; NHS England funding for supported employment
- Alcohol Very Brief Advice –potential to increase screening in primary care?

Risks

- Ongoing rise in numbers of people with obesity and diabetes - service capacity to cope
- Funding not identified for a number of priorities identified through RightCare process (funding bids unsuccessful), including:
  - pulmonary rehabilitation
  - stroke vocational rehabilitation
- Spirometry accreditation: risk to future provision of service in primary care

Summary – transformation plans

- **Making Every Contact Count**
  - Final tranche of funding for training delivery confirmed (from Community Education Provider Network)
  - Programme manager appointed, recruitment of digital/comms lead underway
- **Care navigation** and supporting **self-management**
  - 2 joint Prevention/Neighbourhood projects underway/planned:
    a) care navigation (provider led working group) – mapping and strengthening the local offer
    b) community asset mapping – improving access to information about local resources that support positive health and wellbeing
  - Relevant ICT enabler funded projects:
    - Social Prescribing digital pilot
    - Directory of services
  - Opportunities to align Social Prescribing and Health Coach services through re-commissioning plans during 2019
  - Roll-out of group consultations
  - Learning from peer support pilots

Workstream asks 2017/18 and 2018/19
TACKLING PREVENTABLE RISK FACTORS FOR POOR HEALTH

Tobacco	**In the City, action on tobacco control is led by the Healthy Behaviours Steering Group.** 'Whole system' CLeaR peer assessment planned for early 2019.
Obesity	**Hackney Obesity Strategic Partnership** – multi-disciplinary partnership taking whole system action to tackle obesity. Strategic priorities: (1) working with local businesses to improve access to healthy, affordable food; (2) community insight and engagement; (3) getting people active as part of their daily lives; (4) workplace heath; (5) identifying and supporting people at increased risk of obesity-related harm; (6) school-based interventions. Learning from this whole system approach being shared with the City.
Alcohol & drugs	**In the City, oversight of substance misuse services is provided by the Healthy Behaviours Steering Group and Health & Wellbeing Advisory Group.** **Alcohol strategy** to be published in the City of London in 2019. **Substance misuse services**: joint re-commissioning of substance misuse services in the City and Hackney to commence shortly (new services in place by October 2020); currently working with ELFT and Greenhouse practice to identify mental illness earlier and develop a trauma informed model of treatment.

Workstream asks 2017/18 and 2018/19
LONG-TERM CONDITIONS – EARLY INTERVENTION

NHS Health Check	Cardiovascular disease risk assessment and prevention programme for people age 40-74. Managed through primary care. Good uptake in both the City and Hackney – performance has improved in recent years and compares favourably with other similar areas (see page 18). 2019/20 commissioning intention – integrate NHS Health Check within Long-term conditions contract (see below).
Long-term conditions contract	Incentivises early detection and effective management of long-term conditions in primary care. Includes 'Time to Talk' – extended consultations for patients with multiple Long Term Conditions. Continues to produce positive results on key metrics when compared with other areas – blood pressure control, Chronic Obstructive Pulmonary Disease management, support to smokers. Long Term Conditions contract incentives have supported significant improvement in performance in diabetes treatment.
RightCare	Respiratory and stroke reviews completed and recommendations for new/enhanced service pathways are being progressed – in partnership with Planned Care workstream.
Diabetes Prevention	National Diabetes Prevention Programme - new local (NEL) provider in place since May 2018. Approx 2,000 referrals to date. Homerton structured education programme for people at high risk of diabetes (XPERT Prevention of Diabetes programme - XPOD).

Workstream asks 2017/18 and 2018/19
MENTAL HEALTH

Integrated Public Mental Health/5 to Thrive Steering Group	Delivering Public Mental Health Action Plan and embedding 5 to Thrive. Public Mental Health Action Plan priorities: (1) Promote good mental health and mental health self-help, and support prevention and early identification of mental health problems through mental health services, healthcare pathways and our work with the community; (2) Design and deliver services that are tailored to meet individual needs and offer people the greatest possible choice and control over their lives; (3) Provide support that is focused on recovery and self-management; (4) Commit to delivering effective Mental Health services and respond effectively to people in crisis
Suicide prevention	Multi-agency suicide prevention groups established in City and Hackney.
Mental Health First Aid	Programme re-commissioned in Hackney and being rolled out in the City.
Wellbeing Network	Service designed to build resilience to prevent onset of mental health problems and alleviate issues such as stress, anxiety, low mood. Evaluation underway. Service redesign and re-commissioning to commence 2019/20.
Improving access to mental health services for people with substance misuse	Service User Network (SUN) group run by ELFT located in Hackney Recovery Service. PIC funding being used to develop a local approach to address this local/national issue – to inform substance misuse re-commissioning.
Supported employment	Provider-led Supported Employment Network established.
LTC IAPT service	Service based at Homerton, designed to increase referrals to IAPT (psychological therapy) for patients with physical long-term conditions.

Workstream asks 2017/18 and 2018/19
SEXUAL HEALTH

City and Hackney Sexual Health Forum	Chaired by Homerton clinician. Membership includes: Voluntary and Community Sector (Brook, Positive East), CCG, GP Confederation, Homerton sexual health services (representing Leadenhall Clinic in City), Homerton children & young people's health services (CHYPS Plus), pharmacies and Public Health.
Sexual health services	Sexual health services re-commissioned in 2017 on basis of Integrated Sexual Health Tariff for London and standard specification – cost efficiencies and consistency of service. New City clinic at 80 Leadenhall opened April 2018. Sexual Health London e-healthcare service launched - residents can now register online for an STI test kit to be sent to them in the post. Draft specification for a new primary care sexual health service has been developed with the GP Confederation. Service fragmentation remains, linked to separate commissioning responsibilities (e.g. community gynae, psychosexual services, support for people living with HIV).

Workstream asks 2017/18 and 2018/19
STAFF HEALTH & WELLBEING

London Healthy Workplace Charter accreditation	City of London Corporation (Achievement) City & Hackney CCG (Commitment) Homerton (Excellence) LB Hackney (Excellence)
City of London Business Healthy network	Provides support to improve the health and wellbeing of City workers through a dedicated website (c800 organisations subscribed) plus events/workshops focused on different aspects of workplace health and wellbeing. Research underway to better understand the health and wellbeing needs of City workers to support service development.
Hackney staff health and wellbeing partnership group	LB Hackney, Homerton and the CCG meet on a regular basis to share good practice and deliver joint activity where relevant/appropriate. Close links with City's Business Healthy team.
City of London Corporation mental health and wellbeing programme	HR Transformation Board provides oversight and leadership. A network of wellbeing ambassadors and mental health first aiders support delivery.

Workstream asks 2017/18 and 2018/19
IDENTIFICATION & SUPPORT FOR VULNERABLE GROUPS

Carers	City of London in process of drafting a new strategy for carers. Strong co-production focus - carers network and City Healthwatch are shaping the development of the strategy.
Recently bereaved	Service provided by St Joseph's. Non-recurrent funding secured to expand age eligibility criteria. Options for sustainable funding under review.
Socially isolated	Social Prescribing and other care navigation services relevant here. City of London Social Wellbeing Action Plan to tackle social isolation. The 2019/20 Healthier City & Hackney Fund includes a 'tackling loneliness in under 50s' strand – learning from awarded projects will inform future service plans.
Rough sleepers	Recent review of the healthcare needs of rough sleepers in the City identified a number of key priorities which are being taken forward by the Corporation, in partnership with the Prevention workstream and Mental Health Coordinating Committee.
'Complex' needs	Multiple Needs Service continues to produce excellent outcomes – both for service users and in reducing utilisation/cost of crisis services. Other services providing a similar 'case worker' model of care for people with complex/chaotic needs includes PAUSE, Open Doors, HIV Clinical Nurse Specialists.

Supporting a system shift to prevention
Joint projects with other workstreams

Children, Young People & Maternity	• Integrated child obesity pathway • Maternal obesity pathway • Smoking in pregnancy • Teenage pregnancy self-assessment
Mental Health Coordinating Committee	• Substance misuse and mental health joint re-commissioning • City rough sleepers care pathway • (Supported employment) Individual Placement and Support (IPS) NHSE wave 2 funding bid
Planned Care	• Refresh of diabetes centre support to primary care • Integrated adult obesity pathway • Review/recommissioning of post-stroke community rehab pathway • Collaborative approach to commissioning women's community health services (including gynae and contraception services)
Unplanned Care	• Neighbourhoods projects – care navigation, community asset mapping • Falls prevention pathway • Frequent attenders (TBC)

Local alignment and progress towards STP plan

STP Prevention priorities

- Diabetes prevention and self-management – for local plans and progress see pages 8 and 16
  - 2 NHSE funding bids secured: City & Hackney structured education; NEL wide support for achievement of “triple treatment” target
- Smoking & tobacco control – for local plans and progress, see pages 7 and 18
  - Focus on smokefree NHS estate, smoking in pregnancy pathways, embedding treatment of tobacco dependency in care pathways
  - NB: City & Hackney Prevention Workstream Director is STP smoking/tobacco control lead
- Workplace health - for local plans and progress, see pages 11 and 22

Relevant STP Mental Health priorities

- Supported employment (Individual Placement and Support) – see pages 9 and 20
- Mental Health First Aid – see page 9

Prevention commissioning intentions

Incorporate NHS Health Checks (commissioned by Public Health) into the single GP Confed contract - alignment with LTC contract
Update KPIs and targets within LTC contract (business as usual)
Re-commission Social Prescribing service to better integrate with other care navigation services in City and Hackney, including Health Coaches (commissioned by LBH Public Health)
Embed the following CQUIN targets (acute & mental health) as service KPIs: preventing ill health by risky behaviours – alcohol and tobacco (screening advice / support & referral) *Proposed as a NEL commissioning intention*
Work with the Planned Care and CYPM Workstreams to develop and implement an obesity pathway for City and Hackney
Support the Planned Care Workstream to review the post stroke rehabilitation pathway to ensure patients are effectively supported in the community after having a stroke
Support the Planned Care Workstream to implement recommendations from the Type 2 Diabetes Healthcare Needs Assessment to ensure services are aligned with models of best practice and are providing optimal care for people living with type 2 diabetes in City and Hackney
Better support patients with psychosis to stop smoking and lose weight through the introduction of specific targets in our contract with ELFT (embedding 2018/19 CQUIN targets as service KPIs)
Complete a review of City and Hackney substance misuse services to inform re-commissioning plans for 2020/21 – including options to improve access to mental health support for clients with substance misuse
Progress work to develop the local Individual Placement & Support (IPS) offer in accordance with strategic work at an STP level

Improvement and Assessment Framework (IAF)

2017/18 CCG IAF Assessment Diabetes – 'good' performance
This is an **improvement** on 2016/17 (assessed as requiring improvement

IAF indicator: **103a Diabetes patients that achieved all NICE recommended treatment targets**

Latest outturn (2017/18): *Data not available at time of writing*

Actions and plans:

- Ongoing target within the LTC contract with the GP Confederation to call in and treat patients who are currently not meeting the NICE treatment targets.
- NHSE funded nurse (via STP) focusing on Type 1 patients.
- Work in progress to align local reporting to better reflect national data

IAF indicator: **103b People with diabetes diagnosed <1 year who attend structured education**

Latest outturn (2017/18): *Data not available at time of writing*

Actions and plans:

- Diabetes specialist nursing team now directly coding attendance into EMIS records
- Successfully applied for NHS England funding, which is being used to (a) increase the number and accessibility of structured education courses available locally (584 additional places funded so far) and (b) employ a psychology assistant to call non-attenders to ascertain reasons and encourage future attendance.

Improvement and Assessment Framework (IAF)

IAF indicator: **102a % Year 6 children (age 10-11) who are overweight or obese**
Latest outturn (2017/18): 40.2% Performance in lowest quartile for England, relatively stable since measures began (2006/7)
Actions and plans: • Whole system action to tackle obesity being led Hackney Obesity Strategic Partnership – see page 7 • Child obesity services re-commissioned in **2017**; re-procurement of physical activity services underway • Healthy Weight Strategy will be refreshed in 2019, taking a co-production approach (series of engagement events plus design workshop planned)
IAF indicator: **108a Proportion of carers with a LTC who feel supported to manage their condition**
Latest outturn (2017): 59.6% Performance in lowest quartile for England and 2nd quartile of peer group. New indicator – no trend data.
Actions and plans: • Re-commissioning of carer support services underway in Hackney (see page 12) • Long-term conditions contract supports early detection and effective management of long-term conditions in primary care

Other key indicators (1)

Indicator	Latest outturn	Actions and plans
Smoking prevalence	**Hackney** Latest outturn (2017): 21.4% Significantly above England average (14.9%), comparable to most 'similar' areas No data available for the City	Comprehensive tobacco control plan in place – see page 7
Uptake of NHS Health Check (PHOF 2.22V)	**Hackney** Latest outturn (2013/14-2017/18): 60.2% of eligible population received Health Check **City of London** Latest outturn: 56.5% Significantly above London average (49.3%)	City of London and LB Hackney contracts continue to incentivise uptake and reduce variation Opportunity to better align with Long Term Conditions contract
Sexual health – chlamydia detection rate age 16-24 (PHOF 3.02)	**Hackney** Latest outturn (2017): 4,463 per 100,000 pop **City of London** Latest outturn: 1,183 per 100,000 pop (*NB: based on very small numbers)* London average: 2,199 per 100,000 (Higher detection rate assessed as 'better' on PHOF)	Service re-commissioning supports continued high performance on these metrics – see page 10

Other key indicators (2)

Indicator	Latest outturn	Actions and plans
Alcohol and substance misuse (PHOF 2.15i & 2.15iii)	**City & Hackney** Significant improvements in successful **alcohol** treatment completions in recent years. Latest outturn (2017): 39.5% Slightly above England average (38.5%) Successful treatment completions for **opiate users** also in line with England average. Latest outturn (2017): 7.1% Slightly above England average (6.5%)	Planned re-commissioning will support continued improvement on these metrics – see page 7
People with a Long Term Condition feeling supported to manage their condition (NHSOF 2.1)	**City & Hackney** Latest outturn (2016/17): 60% Very similar to London average (59%), slightly below England average (64%)	Various initiatives to improve support for self-care - see page 6 +Other services led by Planned Care (e.g. rehab programmes, embedded psychologists in diabetes/COPD/sickle cell community services, IAPT for people with LTCs).

Other key indicators (3)

Indicator	Latest outturn	Actions and plans
Proportion of adults with a learning disability in paid employment (ASCOF 1E)	**Hackney** Latest outturn (2017/18): 3.7% (zero return for City of London – very low numbers) This compares with a London average of 7.5%	A new in-house service has been commissioned for LBH via Hackney Works with targets that would bring Hackney in line with the London average. Supported Employment Network – see page 9
Proportion of adults in contact with secondary mental health services in paid employment (ASCOF 1F)	**Hackney** Latest outturn (**2017/18**): 3.0% (zero return for City of London – very low numbers) This compares with a London average of 6.0%.	A new in-house service has been commissioned for LBH via Hackney Works with targets that would bring Hackney in line with the London average. Supported Employment Network – see page 9 Preparing bid for Individual Placement and Support (IPS) NHSE wave 2 funding

Quality Premium

Metric: **number of successful smoking quitters**

- 2017/18 target: 1398
- 2017/18 outturn: 1402 (exceeded)

- 2018/19 target: 1350
- Activity to achieve 2018/19 target: Stop Smoking Service KPIs

CQUINs

	2017/18 targets	2017/18 achievement
Staff health & wellbeing	• 5 percentage point improvement in selected staff survey questions	Partially achieved (ELFT) Not achieved (Homerton)
Healthy food for NHS staff, visitors and patients	• 70% drinks sugar free • 60% confectionary <250kcal • 60% pre-packed meals <400kcal/<5g sat fat per 100g	Achieved (Homerton) *N/A ELFT*
Flu vaccination uptake for frontline clinical staff	• 70%	Achieved (ELFT & Homerton)
Risky behaviours – tobacco & alcohol screening, brief advice, referral	• Tobacco screening – 90% • Tobacco very brief advice – 90% • Tobacco referrals/medication offer – 30% • Alcohol screening – 50% • Alcohol brief advice & referrals – 80%	ELFT: • Partially achieved • Achieved • Partially achieved • Achieved • Achieved *N/A Homerton – introduced in 2018/19*
Personalise care & support planning	• Systems in place • Patient cohort identified • Staff trained	Achieved (Homerton) *N/A ELFT*

Prevention budget – overview (month 8 position)

Fund type: Pooled vs Aligned	CCG £'000	LBH £'000	CoLC £'000	TOTAL £'000
Pooled Budgets				
Pooled - Prevention	50			
Aligned' Budgets				
Aligned - Prevention	3,386	24,492	2,349	30,227
Total Contribution into **'Aligned'** budgets	**3,436**	**24,492**	**2,349**	**30,277**
Total Annual Budget	**3,436**	**24,492**	**2,349**	**30,277**
Forecast Actual	**3,436**	**24,491**	**2,546**	**30,472**
Forecast Variance	**0**	**1**	**(197)**	**(195)**

Co-production and resident engagement

Our approach

- 2x resident representatives as full workstream members (in process of replacing one of these)
- User engagement plan template developed for use in planning relevant projects
- Ad-hoc engagement with existing patient/public groups as appropriate
- Seeking to recruit a cohort of 'champions' to call on for specific engagement activity/shape specific projects

A few examples

- Patient engagement on group consultations
- Sexual health re-commissioning - waiting room survey and focus groups with local service users
- Carers network and City Healthwatch are shaping the development of the carers strategy
- Making Every Contact Count – co-production approach to business case development, to continue as programme evolves
- Advice sought from Patient User Experience Group on appropriate targeted engagement activity to improve hypertension outcomes
- Public engagement on commissioning intentions at Staying Healthy event (Nov 2018)

Questions, comments?

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