Prevention workstream update to Hackney Health and Wellbeing Board
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1. Purpose of this paper

This paper provides an overview of the Prevention workstream's key priorities and current programme of work.

Members of the Board are asked to:

1. note the report
2. consider how the work of the Prevention workstream can align with and inform the new Joint Health and Wellbeing strategy.

2. Context - health and wellbeing needs of Hackney residents

The infographic in Appendix 1 provides an overview of local health and related outcomes across the lifecourse. For a detailed analysis of the health and wellbeing needs of Hackney (and City) residents, please refer to the City and Hackney Health and Wellbeing Profile/Joint Strategic Needs Assessment (JSNA).[1]

While Hackney, relatively speaking, is much less deprived than it was 10 years ago, it remains the second most deprived borough in London (and eleventh nationally). This is linked to a range of poorer health outcomes - including lower than average life expectancy, especially among men.

The main causes of death in Hackney, as elsewhere, are cancer, cardiovascular disease (CVD) and respiratory disease (see Appendix 2). Around a third of these deaths are considered to be avoidable. The most common conditions contributing to the total burden of poor population health (including mortality and morbidity) include back pain, heart disease, depression and anxiety, lung cancer, chronic obstructive pulmonary disease, and falls.[2] All of these conditions are amenable to preventative action. According to local GP data, one in four adults in Hackney is living with two or more long-term conditions.

The main preventable risk factors for premature death and poor health are obesity and dietary factors, tobacco, low physical activity and alcohol - plus associated metabolic factors such as high blood sugar ('pre-diabetes'), high blood pressure (hypertension) and high cholesterol.

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[1] https://hackneyjsna.org.uk
[2] Global Burden of Disease Study, 2016

Estimates suggest that significant numbers of people locally are living with undiagnosed clinical risk factors for poor health (including hypertension, pre-diabetes and diabetes).

Social inequalities drive health inequalities. These inequalities are clearly evident in Hackney (see Box 1) and are likely to widen as the population continues to change and certain areas become less deprived.

Box 1: Summary of some of the key health inequalities in Hackney

- Life expectancy is 4.3 years lower for men and 4.8 years lower for women in the most deprived areas of Hackney compared to the least deprived areas.
- Smoking is the biggest cause of social inequalities in health - it is much more common among unemployed people, those with poor mental health, people who are homeless, and among certain minority ethnic groups (including men from Turkish speaking and Black Caribbean backgrounds).
- Obesity prevalence is also socially patterned, being more prevalent in more deprived areas and among Black African/Caribbean communities.
- People with poor mental health are significantly more likely to be exposed to preventable risk factors for premature mortality and poor physical health (e.g. smoking is the largest avoidable cause of premature death in those with mental health disorders).
- The risk of multimorbidity (i.e. presence of two or more long-term conditions) increases markedly with age and, among under 75s, is strongly linked to socioeconomic deprivation.

3. The role of the Prevention workstream in improving the health and wellbeing of people in Hackney

3.1 Overview

The strategic objectives of the City and Hackney Integrated Care System are as follows.

- **Deliver a shift in resource and focus to prevention** to improve the long term health and wellbeing of local people and address health inequalities.
- Deliver proactive community based care closer to home and outside of institutional settings where appropriate.
- Maintain financial balance as a system and achieve financial plans.
- Deliver integrated care which meets the physical, mental health and social needs of our diverse communities.
- Empower patients and residents.

In supporting these strategic objectives, the Prevention workstream aims to:

1. reduce the harms from the main preventable causes of poor health
2. take early action to avoid or delay future poor health
3. support and enable people to manage their own health and wellbeing.

We can only achieve these aims through close partnership working and, as such, we have set ourselves two overarching objectives to:

- support all workstreams, and other parts of the integrated health and care system, to embed prevention principles in their plans
- work with wider partners within the local authority and beyond to better understand and improve the social, economic and environmental drivers of health and inequalities.

(See Appendix 3 for a diagrammatic depiction of these high level Prevention workstream priorities.)

Some specific examples of work underway to deliver against our three broad aims are provided in Appendix 4). An overview of some of our key areas of current work is provided below. Further detail on the full scope of the Prevention workstream's programme of work is available on request.

The total budget aligned to the Prevention workstream is approximately £30m, a significant portion of this coming from the Public Health Grant (currently ring-fenced). Other commissioning budgets aligned with Prevention include a small number of prevention-focused Adult Social Care contracts, plus CCG funding related to primary care management of long-term conditions as well as Social Prescribing.

3.2 Making Every Contact Count (MECC)

MECC is about using the vast human resources across the NHS, local authorities and voluntary and community sectors to give people consistent, simple message and signpost them to services that help improve their health and wellbeing. It involves opportunistically engaging people in conversations about their health and wellbeing at scale, across organisations and populations. A MECC intervention takes a matter of minutes and is not intended to add to the busy workloads of frontline staff.

Our ambition is to empower the entire local health and care workforce to routinely have conversations with patients and the public about their health and wellbeing, to help embed prevention across the system for lasting and sustainable population health benefits. MECC is therefore a key mechanism for achieving the aspirations of the City and Hackney Integrated Care System to shift focus and resources towards prevention.

A two year programme of work is being developed to scope, co-design, test and embed a local approach to MECC across Hackney and the City.

3.2 Community navigation and Social Prescribing

Enabling people to better manage their own health by supporting easier access to local preventative resources is a key priority for the Prevention workstream. Community navigation is also central to the local ambition for Neighbourhoods, with these roles/functions envisaged as part of the core neighbourhood team. A joint Prevention workstream/Neighbourhoods project on community navigation, which seeks to build on current good practice and address gaps in provision, is currently underway - a network of local care navigation providers has been convened to take forward this work.

3.3 Supported employment

Improving employment rates for people with mental illness and learning disability is another key priority for the Prevention workstream, working in partnership with the Mental Health Coordinating Committee and Planned Care workstream. A provider-led network, chaired by a VCS representative, is taking forward a programme of work to improve access to employment opportunities for these groups, focusing on three main areas: employer engagement; provider accreditation; and developing a 'supported employment passport' for service users. A project manager has just been appointed to develop this work programme.

3.4 Whole system action to tackle the major preventable risk factors for poor health and inequalities

Two examples of the 'whole system' approach that the Prevention worksteam is taking to tackle the main preventable risk factors for poor health are provided below, for tobacco and obesity. A similar programme of work has begun to implement the actions outlined in the Hackney Alcohol Strategy, published in 2018.

3.4.1 Smoking

Hackney Health and Wellbeing Board is the 'de facto' Tobacco Control Alliance locally, providing strategic oversight of our tobacco control plans.

The current Hackney Tobacco Control Plan focuses on the following priorities:

1. preventing young people taking up smoking
2. communicating/educating on the harms from using tobacco
3. 'de-normalising' smoking and protecting people from second hand smoke (through smokefree policies)
4. motivating every smoker to quit
5. delivering high quality stop smoking services
6. reducing the availability and supply of cheap/illegal tobacco.

All local NHS partners (Homerton, ELFT, GP Confederation and the CCG) signed the NHS Smokefree Pledge in September 2018, and plans are underway to embed the treatment of tobacco dependency within care pathways (the NHS Long Term Plan signalled a clear intention to progress this at national level). Local Stop Smoking Services (SSS) continue to provide high quality support for smokers to quit – the NHS Quality Premium target for number of quitters was

exceeded in 2017/18, and plans are on track to ensure 2018/19 targets are met. Provision of high quality SSS is a Hackney manifesto commitment.

A deep dive self-assessment and peer review of our local action to tackle smoking was undertaken at the start of 2019, using the CLeaR framework.[3] CLeaR is a Public Health England led process which enables a comprehensive review of local tobacco control efforts against latest evidence-based practice. A peer-led workshop was held on 14 February, bringing together a range of different organisations - including those represented on Hackney HWB Board. At the workshop, we heard about action on smoking being taken by Homerton, ELFT, Hackney SSS (delivered by Whittington Health in partnership with the GP Confederation), LB Hackney Trading Standards and Public Health. Challenges raised included the need for a more effective model to lead and monitor tobacco control activity in the borough. A comprehensive report, with recommendations for local action, is expected from the CLeaR team by the end of March 2019.

3.4.2 Obesity

The Hackney Obesity Strategic Partnership is leading and convening a programme of work to tackle the individual, social and environmental drivers of obesity. It is chaired by the Council Chief Executive, Tim Shields. The current strategic priorities of the Partnership are as follows:

1. community insight and engagement
2. working with local food outlets to improve access to healthy, affordable food
3. getting people active as part of their daily lives
4. school-based interventions
5. workplace health
6. identifying and supporting people at increased risk of obesity-related harm.

The Partnership is currently reviewing what has been achieved to date and developing its future ambitions, with the local Healthy Weight Strategy being refreshed this year. A whole system workshop is planned for 7 March to inform this process.

3.5 Opportunities for joint commissioning to support our prevention aims

We are constantly seeking opportunities to integrate commissioning plans across the local authorities and the CCG to improve population health outcomes and reduce inequalities. Examples include:

- plans to jointly re-commission current Social Prescribing (CCG funded) and Health Coach/Community Navigation (LB Hackney Public Health funded) services to improve the reach of current provision and make the most of synergies between the two services[4]

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[3] CLeaR = **C**hallenge, **Lea**dership, **R**esults

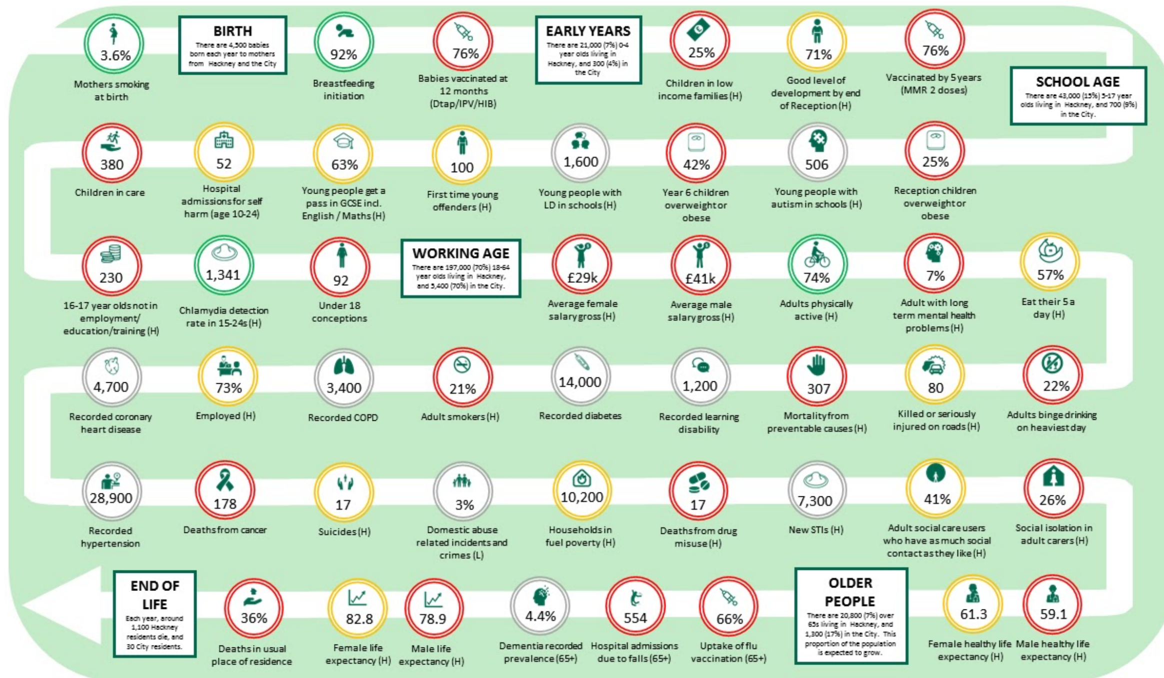
[4] These plans are on hold while the implications of the new Primary Care Network contract, including provision for one Social Prescriber per network, are worked through.

- a commissioning intention to integrate the NHS Health Check[5] (funded by Public Health and delivered by the GP Confederation) with a CCG contract (again with the GP Confederation) which incentivises evidence-based primary care management of a range of long-term conditions (including CVD) - integration provides opportunities to further improve the performance of both contracts and strengthen local action on CVD prevention.

We are also working closely with other workstreams, the Mental Health Coordinating Committee and Primary Care commissioners to join up our plans to maximise efforts to embed prevention across the system. Examples include work to integrate local obesity care pathways (for adults and children), potential for joint commissioning of substance misuse and mental health services, and work to better align commissioning around falls prevention.

[5] NHS Health Check is a CVD risk assessment and management intervention for 40-74 year olds. It is a mandated Public Health service. More information is available at https://www.healthcheck.nhs.uk/

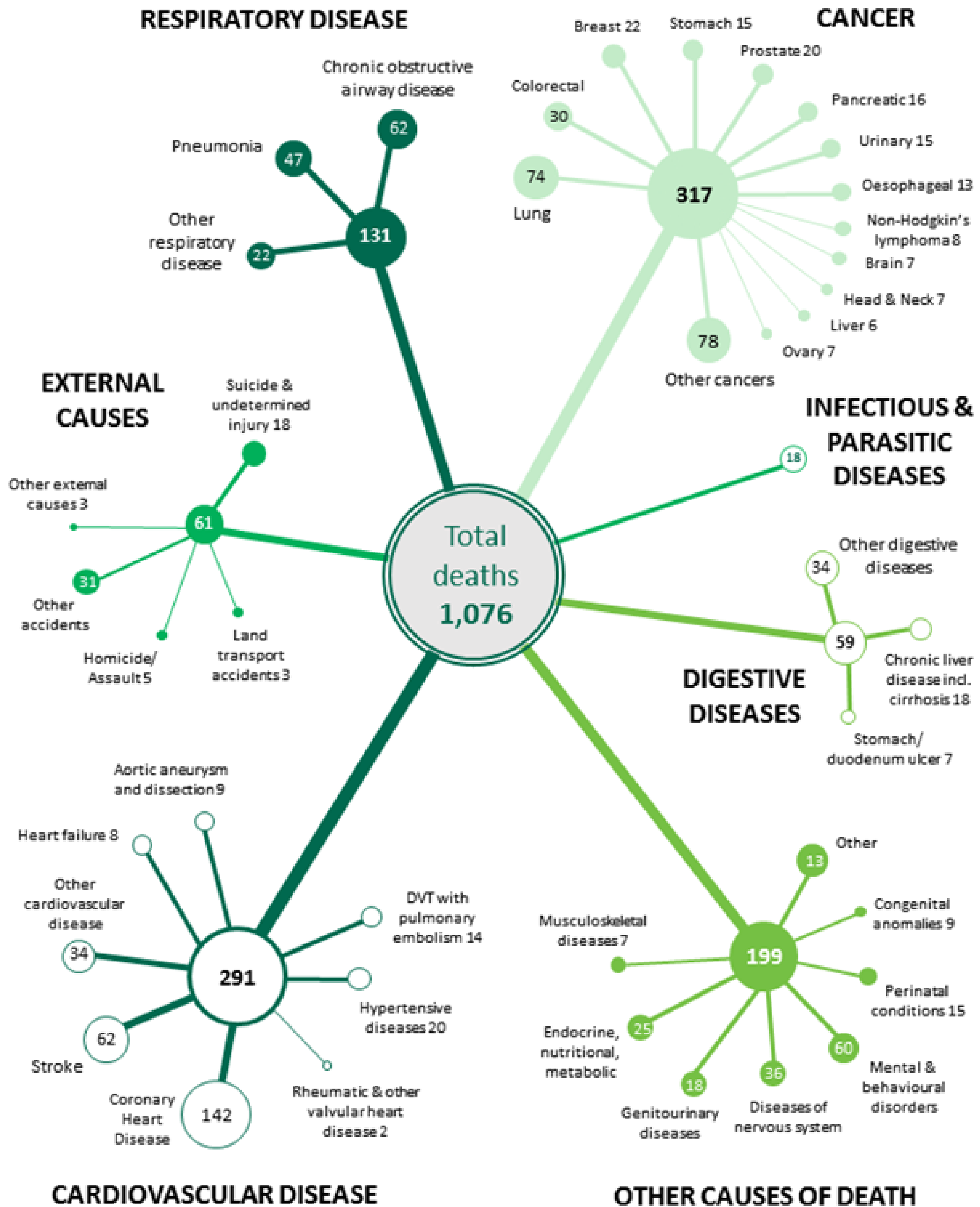
Appendix 1: Indicators of health across the life course in Hackney (and the City)



Source: Public Health Outcomes Framework[6]

[6] Public Health England. (2016). *Public Health Outcomes Framework.* Accessed February 2019 from: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

Appendix 2: Average annual number of deaths in Hackney residents, by main recorded cause



Source: Primary Care Mortality Database (2012–16)

Appendix 3: Prevention workstream priorities

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

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

Appendix 4: Key Prevention workstream programmes

Reduce harms from the main preventable causes of poor health	
Smoking	Multi-agency tobacco control plan, including: high quality and accessible stop smoking services; action to reduce the availability of illegal tobacco; smoke free spaces; prevention activity in schools
Obesity	Hackney Obesity Strategic Partnership (CCG, education, planning, transport, housing, parks, leisure, regen, environmental health, comms, public health) - leading a whole system approach to tackling obesity
Physical inactivity	Exercise on referral and classes/activities in community centres Planning policies to promote active travel
Alcohol	Hackney Alcohol Strategy Alcohol 'identification and brief advice', treatment services Public Health input into licensing decisions
Take early action to avoid or delay future poor health	
Primary care	Long-Term Conditions contract with GP Confederation – very high performance in City and Hackney compared to other areas
Cardiovascular disease	Maximise uptake of the NHS Health Check to identify and reduce the risk of stroke, kidney disease, heart disease, type 2 diabetes and dementia
Diabetes	National Diabetes Prevention Programme Structured education for people newly diagnosed with diabetes
Sexual health	Easy access to testing and treatment - new sexual health clinic in the City of London, e-service
Mental health	Public Mental Health Steering Group Suicide Prevention Action Plan Improving access to mental health support for substance misusers
Support people to manage their own health and wellbeing	
Social Prescribing	Service based in GP practices, supporting patients to improve their health and wellbeing and access local community services
Community navigators	Based in the community, supporting residents to improve their health and wellbeing and signpost to relevant local services
Peer support pilot	Facilitated group sessions for people with long-term health conditions
Time To Talk	Extended GP appointments for people with 2+ long-term conditions
Support for carers	Co-production of a new model of support for adult carers in Hackney