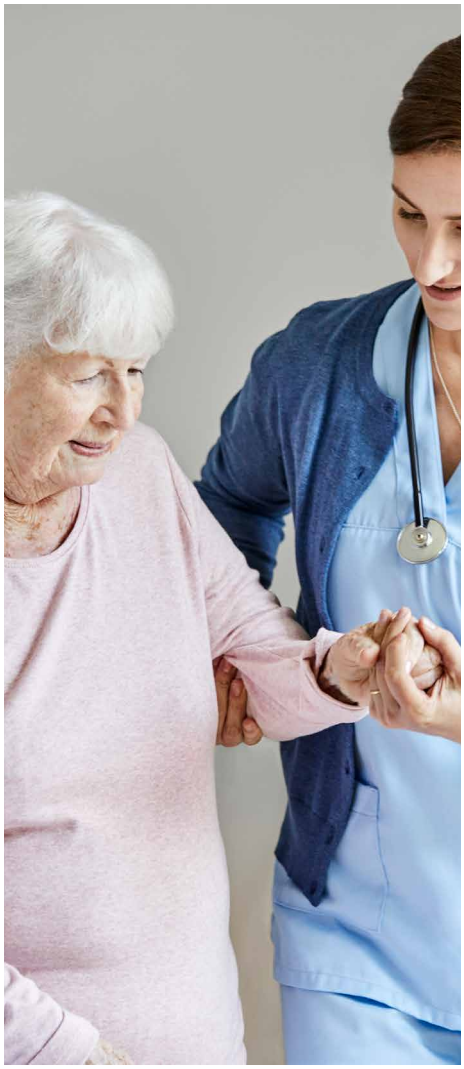
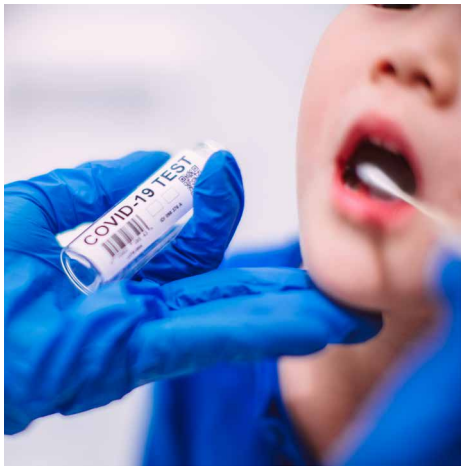




Director of Public Health Annual Report

The Role of Primary Care in Prevention, Population Health and Narrowing Health Inequalities.

2020-2021

worcestershire county council

Contents

Foreword

As the new Cabinet Member with responsibility for Health and Wellbeing in Worcestershire, I am delighted to introduce this annual report of the Director of Public Health. I wish to thank Councillor John Smith for all his hard work during this last year and for championing health and wellbeing during his term as Cabinet Member with responsibility for Health and Wellbeing.

This has been an unprecedented and challenging year, but I am excited to take on this role and build on the many achievements and challenges presented during the pandemic. I look forward to developing the relationships forged together in tackling COVID-19 and continue the focus on improving health and wellbeing. I am aware of the challenges ahead as we work to recover from the pandemic and look forward to working with Kathryn and the team.

Councillor Karen May
Cabinet Member with responsibility for Health and Wellbeing

Overall, health in Worcestershire is good, but we know there are areas where we still struggle with poorer health outcomes for our communities. As a GP and Clinical Director in Redditch, I am really pleased that this year's annual report from the Director of Public Health shines a spotlight on Primary Care. The report highlights well the role and contribution of Primary Care in prevention, and how by working better together we can maximise its impact in improving health, wellbeing and inequalities.

Dr Jonathan Wells
Clinical Director Kingfisher PCN, Redditch

"A stronger focus on prevention across all services can improve the health and wellbeing of all Worcestershire residents and narrow health inequalities".

Dr Kathryn Cobain
Director of Public Health

Executive Summary

Introduction

In March 2020, life for our residents changed dramatically with the arrival of a global pandemic. Public Health officials were faced with unprecedented challenges, which have tested resources, knowledge and skills. The pandemic also starkly highlighted the prevalence of health inequalities in our communities.

Much has been written on the negative impact of the pandemic and on the implications for the health of our communities in the longer term. None of this can be underestimated, but the pandemic has also been an opportunity for improvement, growth and greater awareness for Public Health teams and the wider agencies they work alongside.

Primary Care services are at the heart of this shift. The services have adapted and flexed throughout the pandemic, to continue to have a positive impact on ill-health prevention and improving health inequalities. This report will explore those changes, the impact and lessons to be learned and suggest how we can continue to work with our communities to grow this legacy.

Issues

Prevention is better than cure. But how do we reach communities who face the greatest discrepancies in their health and quality of life? Before COVID-19 there was already a persistent gap in life expectancy and in the number of years people live in good health between the most and least affluent areas. The pandemic has both revealed the extent of the 'health gap' and appears to have increased it. Disruption to children's education, unemployment, food poverty, and mental ill-health are all more apparent and visible. The higher number of COVID-19 deaths among people from certain ethnic minorities has started to uncover the burden of risk factors experienced by ethnic minority communities leading to worse outcomes. The 'gap' is expected to widen further following the pandemic lockdown periods and this has brought health inequalities to the fore.

It has also brought further recognition that the NHS cannot do this alone. The escalating problems need a wholly different approach. All local partners have a role to play, the best outcomes will be achieved when PCNs join other local partners in getting behind community led efforts to address the issues in the long-term. The developing District collaboratives as part of the ICS model also provide that opportunity.

Recommendations

There are a number of key factors to help us as learn the lessons from the pandemic and find better ways to serve our communities. These are set out in detail in this report, with clear steps we can take to ensure success but the main factors are;

- Maximise Primary care in preventing illness
- Create healthy places and stronger communities able to help themselves
- Focus on physical and mental wellbeing in our deprived communities and amongst people who traditionally have experienced poorer health outcomes
- Use the learnings from Covid-19

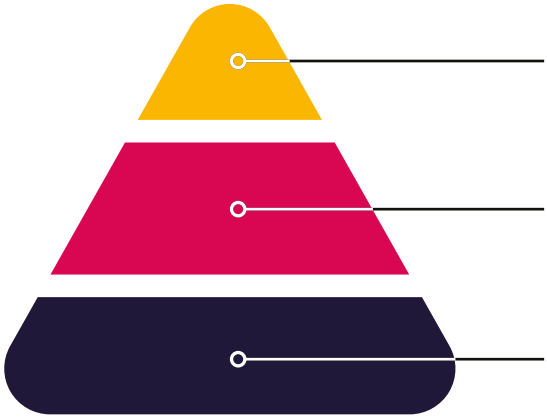
The report makes recommendations to maximise the role of Primary Care in prevention and population health, to focus on places and assets as we move to a future where we live with COVID-19, tackle the health inequalities that have been exposed, and work together with our communities and partners, as part of new local Integrated Care Systems (ICS).

Public Health Principles

Prevention Pyramid

There is strong evidence that it is better and cheaper to prevent problems before they arise. In short, that **prevention is better than cure**. Prevention includes a wide range of activities aimed at reducing risks or threats to health.

Primary prevention aims to prevent disease or ill health before it ever occurs. Secondary prevention aims to reduce the impact of a disease or ill health that has already occurred. Tertiary prevention aims to soften the impact of an ongoing illness or disease that has lasting effects.



Tertiary Prevention:
Improve quality of life and reduce further complications

Secondary Prevention:
Detect disease early and prevent it from getting worse

Primary Prevention:
Prevent ill health, often at a population scale

Health Inequalities

There is a social gradient to life expectancy. People living in more deprived areas are more likely to experience ill health and have shorter lives than those who live in more affluent areas. Health inequalities also exist between genders and different ethnic minority groups, and wider aspects of inclusion, including people who have a disability and people experiencing problems with drugs and alcohol, poor mental health, and homelessness.

Worcestershire Average:

Life expectancy average at birth for people living in Worcestershire is higher than the England average, but there are large differences between the average and most deprived females and males in Worcestershire.

Worcestershire LEAST deprived:

Worcestershire MOST deprived:

Females who live in the most deprived areas of Worcestershire have a life expectancy of 5.1 fewer years than those who live in least deprived areas. For males, there is a difference of 7.5 years.

COVID-19 has highlighted inequities in our communities, and it is likely that the longer term economic and social impacts will affect some communities for an extended period.

Inverse Care Law

People who are in least need of health services tend to use them more often and more efficiently than those in most need of health care services. First described in 1971[1], the inverse relationship between the use of healthcare and the need for it is due to a range of factors, including:

- barriers to accessing services;
- differences in the perception of risk and good health in different socio-economic groups; and
- lower availability of care in deprived areas.

Wider Determinants of Health

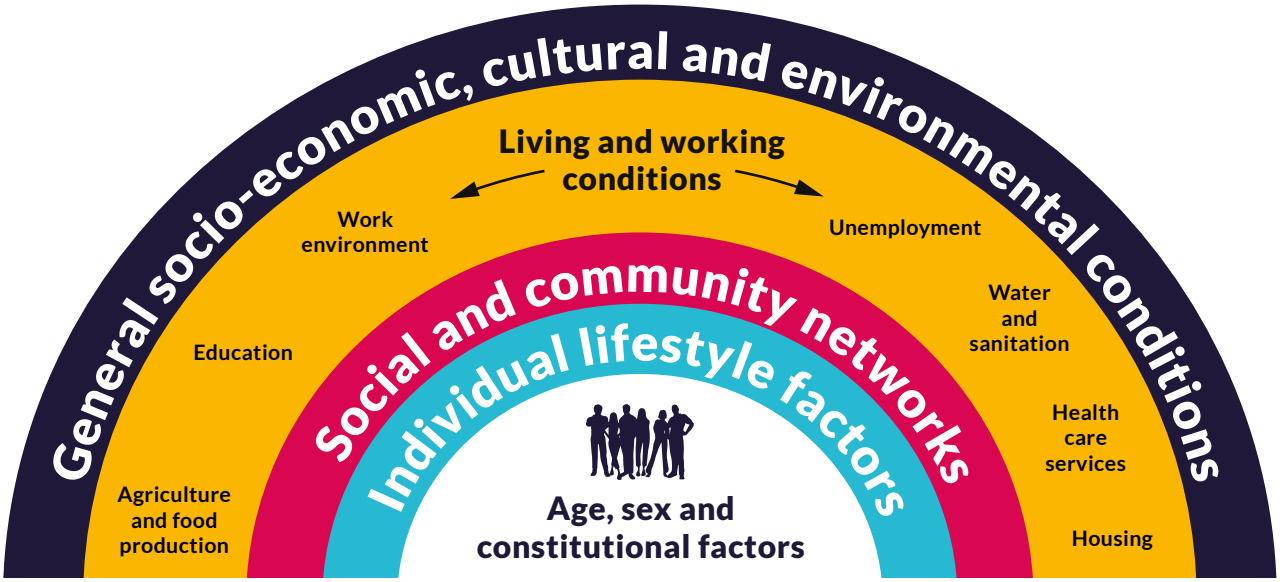
Our health is determined by our genetics, our lifestyle, the health care we receive and the impact of wider determinants such as our physical, social, and economic environment. Although estimates vary, it is accepted that the wider determinants have the largest impact on our health outcomes and only up to 20% of a person's health outcomes are attributed to the ability to access good quality health care. The wider determinants of ill health not only increase the likelihood of illness, but also reduce the likelihood of accessing treatment.

40% **Socioeconomic factors**
Education, employment, income, family & social support, community safety.

10% **Physical Environment**
Housing, access to green space, air quality.

30% **Lifestyle factors**
Diet and physical activity, tobacco use, alcohol use.

20% **Health Care**
Access to good quality health care services.



Source: Dahlgren and Whitehead, 1991

1 Tudor Hart (1971) The Inverse Care Law, The Lancet

Population Health

Substantial improvements in life expectancy over the past 100 years mean that people are living longer, healthier lives than ever before. However, as a nation we lag behind other countries on many key health outcomes, improvements in life expectancy have stalled and health inequalities are widening. To address this, we need to move away from a system just focused on diagnosing and treating illness towards one that is based on promoting wellbeing and preventing ill health.

Population health is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population. A population health approach is centred on **four pillars**:

A population health approach can be tackled at scale through General Practice and the developing Primary Care Networks (PCNs).

Proportionate Universalism

Proportionate universalism is the resourcing and delivery of universal services at a scale and intensity proportionate to the degree of need. Services are therefore universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need.

Primary Care

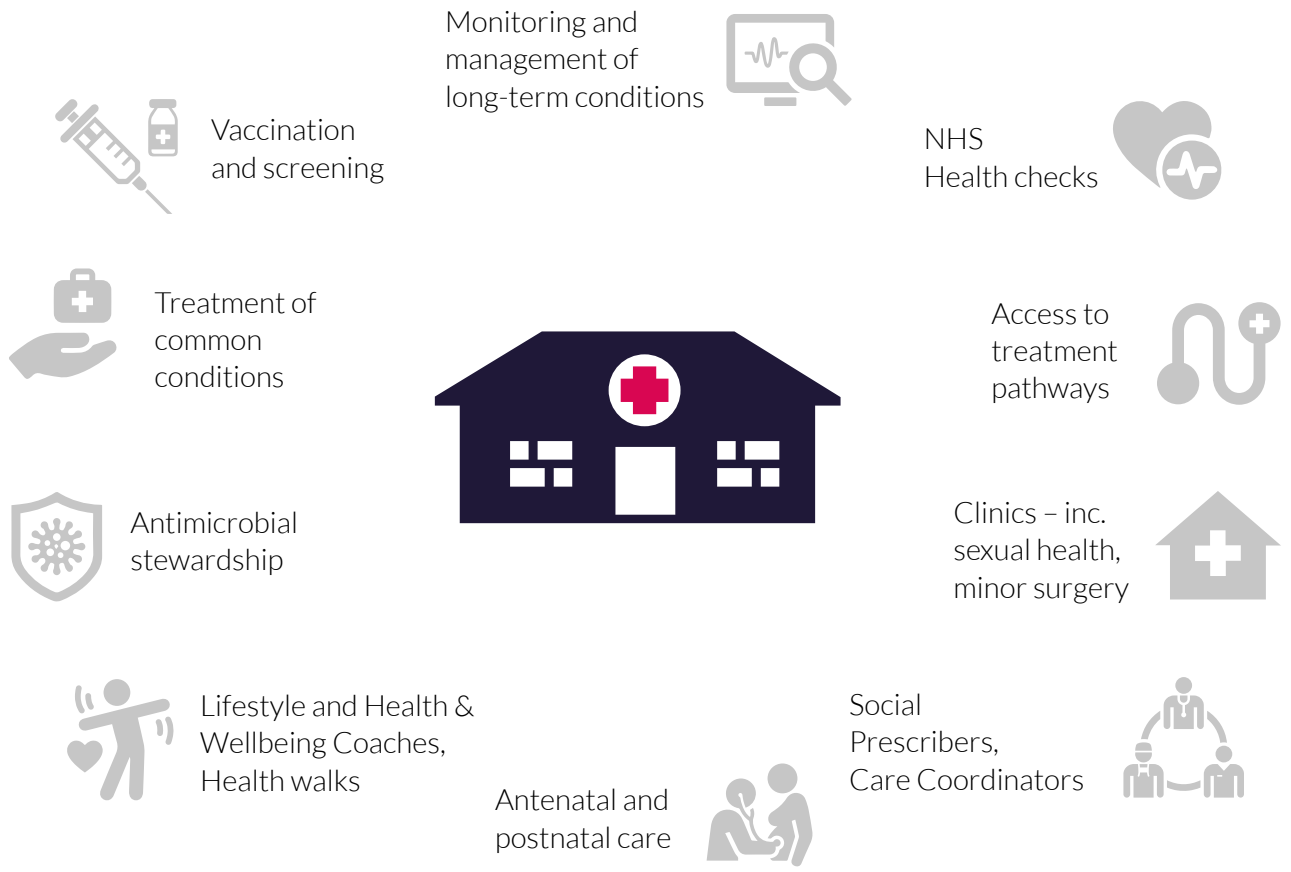
Primary Care services provide the first point of contact in a wider healthcare system. Primary Care includes General Practice, community pharmacy, optometry, and dental services. These services act as a **'front door'** to the NHS, treating common medical conditions and referring patients on for specialist or urgent services at hospitals and other services.

This report focuses on General Practice services and Primary Care Networks (PCNs). General Practitioners (GPs) and their teams look after their registered population and focus on the health of the whole person, their physical and mental health needs and the wider psychological and social influences on health and wellbeing. Over 90 per cent of all contacts with health care professionals occur in Primary Care, and most of the population is registered with a GP. GP services and PCNs provide a universal service from cradle to grave for everyone and as such, are uniquely placed to prevent poor health, promote good health and wellbeing and to tackle and reduce health inequalities.

Primary Care Networks (PCNs)

Since July 2019, almost all GP practices in England have come together to form geographical PCNs, each covering populations of approximately 30,000 to 50,000 patients. PCNs provide a wide range of services, using the skills of a range of professionals and working closely with other services in the community through multidisciplinary teams. This way of working brings many benefits for patients.

Through these developing multidisciplinary teams, pathways of care and dedicated clinics, there is an increased opportunity for prevention of ill health and early intervention. Examples of health promotion, disease prevention and early detection in Primary Care are shown in the picture below.



General Practice Facts & Figures

- In the UK, GP services provide over 300 million patient consultations each year.
- Around 8% of the total NHS budget is allocated to GP services.
- Worcestershire has 10 PCNs and 63 GP practices.
- Worcestershire GP practices look after 614,934 registered patients, although this number can change weekly, with births, deaths and people moving in and out of the area.
- The number of people registered with a Worcestershire GP (sometimes described as the 'practice population'), is greater than the resident population of 595,786. Some of this may be accounted for by people resident close to the borders of Worcestershire choosing a GP.
- List sizes vary by practice, with the largest practice having 21,183 patients and the smallest practice with 2,845 registered patients.
- There is a different pattern of usage for each patient. Some may attend regularly, for example if they have a long-term condition, while others may not need an appointment for many months or even years.

Integrated Care Systems (ICSs)

The next phase of change is the development of an Integrated Care System (ICS) across Herefordshire and Worcestershire. ICSs are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners, including the voluntary and community sector. The organisations collaborate and work together to plan and integrate services to meet the needs of their population on a local 'place based' scale.

"ICSs focus on places and local populations as the driving forces for improvement".

ICSs are coming together at a time when improvements in life expectancy are stalling and health inequalities are widening. They have the potential to drive improvements in population health at scale by reaching beyond the NHS to work with local authorities and other agencies to tackle the wider determinants of health, or the causes of the causes, that drive longer-term health outcomes and inequalities, such as housing, local planning and education[2].

"Day-to-day care and support needs will be met locally. The right size may vary for different areas but should reflect where meaningful communities live".

Primary Care as an Asset

"GPs should be proactive in carrying out public health activities and interventions".

Royal College of General Practitioners (2010)

General Practice is one of the most important and respected institutions in our communities; it is the foundation of the NHS. The strengths of General Practice in improving population health include:

- organising care based on a registered list, with the vast majority of the population registered with a practice;
- providing care from cradle to grave for everyone;
- knowing more than one generation in a family, having a lifelong medical record;
- having a holistic approach to care, looking after the whole person and not simply focusing on one disease or a single episode of care;
- providing continuity of care where needed; and
- managing the undifferentiated presentation of symptoms.

2 www.england.nhs.uk/integratedcare/what-is-integrated-care

As the most accessed part of the health system, GP practices and wider Primary Care services are well placed to promote health and wellbeing to their patients and support them to access other services for health improvement and disease prevention. This may include:

- encouraging healthy choices and risk avoidance (healthy diet, physical activity);
- targeting high-risk patients or groups (advising on smoking, alcohol and substance misuse);
- providing vaccination programmes to protect health and prevent disease;
- supporting screening programmes to enable early detection and treatment; and
- referring or prescribing treatments for those with illness to prevent further complications (hypertension, high cholesterol).

"As well as providing high quality care and encouraging people to make healthier choices, GPs tackle health inequalities by acting as advocates for patients and providing important links to services including housing and benefits advice".

The King's Fund (2010)

The wider determinants of health; housing, education, employment and income, often described as the causes of the causes of poor health and a driver for health inequalities, have the most impact on our health. GPs cannot address the wider determinants of health directly, but they deal with the physical, mental and social effects daily. The role of the GP as an expert at the heart of the community, means they have a pivotal role to play in combating the causes of health inequalities and dealing with their effects.

Primary Care can have a positive impact on health inequalities of their patients at a number of levels, through clinical care, wider patient advocacy, community engagement and activities and through collaboration with other agencies.

"GPs care about inequalities and want to focus on those with greatest need in their communities".

Royal College of General Practitioners (2020)

The following section celebrates the role of prevention in Primary Care, focusing on immunisations and NHS health checks. A summary of '**Pathways from Practice**' to other health improvement services and opportunities in Worcestershire is also outlined on page 20.

Immunisation

One of the most important public health interventions, vaccination, prevents people from becoming ill, saves lives and stops spread of infection. As well as the new COVID-19 vaccination programme, the NHS has a comprehensive immunisation programme that helps to protect the health of our population. Each year, millions of doses of vaccines are administered to eligible groups in England.

Many vaccinations take place in Primary Care with success measured by uptake in eligible groups. Primary Care professionals and settings have a key role in vaccine advocacy and administration.

Childhood Immunisation

The routine childhood immunisation programme protects infants and children from a wide range of infections, including Measles, Bacterial Meningitis, Polio, Whooping Cough, Hepatitis B and Rotavirus.

In England, the highest childhood vaccination coverage rates were recorded in 2012-13, since then, rates have been declining year on year. Worcestershire has historically performed better than the England average for childhood immunisations. However, for the last two years, rates have been falling and they are below the 95% target coverage rate for many types.

Receiving two doses of Measles, Mumps and Rubella (MMR) vaccine helps to protect individuals against measles and provides protection against rubella, which can cause serious effects to an unborn child if a woman contracts rubella during pregnancy.

Area	MMR Coverage (first dose)		MMR Coverage (second dose)
	Age 2	Age 5	Age 5
Worcestershire	92.9%	97.1%	88.8%
England	90.6%	94.5%	86.8%

Within Worcestershire, there is variation in MMR vaccination uptake by GP practice. Data for 2018/19 shows some practices achieved a 100% uptake of the first dose at age two, however some practices had an uptake rate of 81%. Although the overall uptake rate is higher than the national average, almost a third of practices had uptake rates lower than the national average. In 2018/19, 513 of Worcestershire children had not received their first dose of MMR vaccine by two years of age.

"It is never too late to immunise with MMR. Opportunities to check immunisation history and offer missing immunisations should not be missed. This is particularly important where doses of MMR vaccine have been missed in childhood, leaving a person vulnerable to preventable infection".

Insight with eligible groups has demonstrated that along with patient confidence in childhood immunisation programmes, practicalities in accessing appointments is also an important factor for high vaccine uptake. This includes simple processes for booking appointments and appointment times that suit[3].

Data from Public Health England's attitude surveys shows that parental confidence in immunisation of new-born babies is high and healthcare professionals remain the most trusted source of vaccination information for parents[4].

Seasonal Influenza Vaccination (Flu)

Immunisation protects older people from infections such as influenza, pneumococcal infection, and shingles. Annual 'flu jabs' are offered to people who are at greater risk of developing serious complications if they catch it. Over 65s and other vulnerable groups, including carers, people with certain health conditions and pregnant women are priority groups for receiving a flu jab each year. A school-based vaccination programme, using a nasal spray, aims to reduce transmission of flu in the wider community as well as protecting our children from illness.

GP services are pivotal to the success of the annual influenza immunisation programme for older people and vulnerable groups:

In the 2019/20 flu season:

74.8%

of people aged 65 and over in Worcestershire were immunised, just below the national target value of

75%

but above the national figure (72.4%)

For those under 65 years with underlying health conditions,

50.7%

were vaccinated, below the

55%

target but above the national figure (44.9%).

Despite the high vaccination uptake across Worcestershire, there is room to improve uptake in future cohorts, particularly in practices with lower uptake. This may be as simple as contacting patients by phone, using prompts within IT systems to identify eligible patients, having GPs who will opportunistically vaccinate and trialling different appointment times[5]. Where vaccine uptake is low due to vaccine hesitancy, health care staff are trusted sources of advice and information around vaccination.

3 Royal Society of Public Health (2019) Moving the Needle: Promoting vaccination uptake across the life course
4 PHE survey (2019) **https://www.gov.uk/government/news/phe-offers-support-to-uk-vaccine-heroes**
5 Newby et al (2016) Identifying strategies to increase influenza vaccination in GP practices

NHS Health Checks

The NHS Health Check is a regular health assessment for all adults in England aged 40-74. It is designed to assess cardiovascular risk at an early stage, to prevent:

- Stroke;
- Kidney Disease;
- Heart Disease;
- Type 2 Diabetes; and
- Dementia.

As people age, they have a higher risk of developing one of these conditions. NHS Health Checks support patients to lower this risk, to prevent progression of cardiovascular conditions and diagnose conditions earlier. All eligible adults in Worcestershire should be invited to have an NHS Health Check by their GP every five years.

"NHS Health Checks is one of the largest public health prevention programmes in the world with over six million people in England having had a check since 2013".

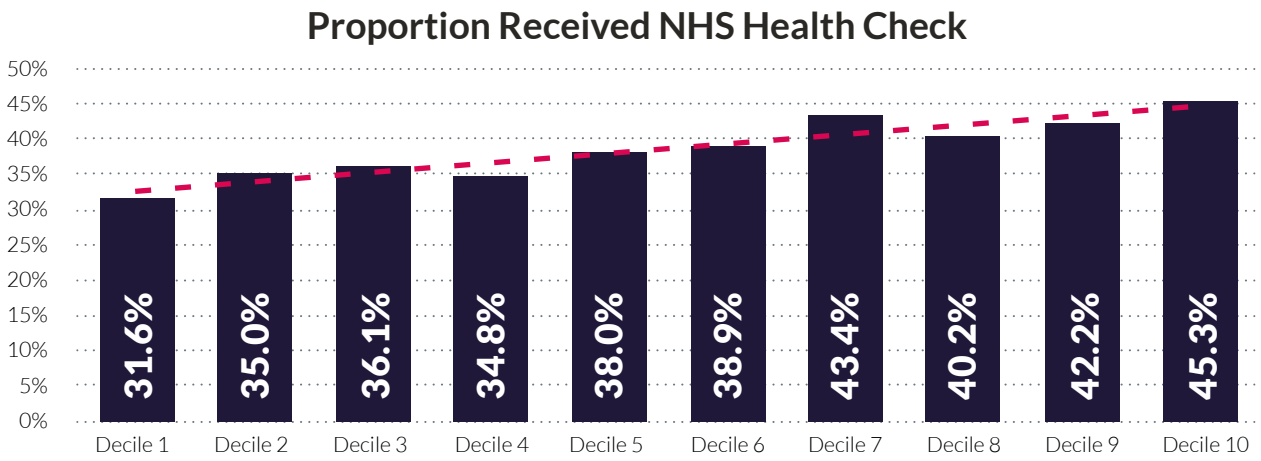
A high-quality NHS Health Check includes assessment and management of key lifestyle risk factors such as excess weight (obesity), physical inactivity, smoking and alcohol intake alongside measurements of blood pressure, blood glucose and cholesterol. There is a considerable opportunity for prevention and management of cardiovascular conditions following an NHS Health Check. Everyone having the check should be provided with individually tailored advice and signposting to relevant services (see **Pathways from Practice**) that will help motivate them to make lifestyle changes to reduce their cardiovascular risk.

"Around 48.2% of the eligible population (89,400 people) aged 40-74 in Worcestershire received an NHS Health Check between 2015/16 and 2019/20. Although this is higher than the England rate of 41.3%, there is opportunity to increase this uptake".

Cardiovascular disease (CVD) is one of the conditions most strongly associated with health inequalities. People who live in the most deprived areas of England are almost four times more likely to die prematurely than those in the least deprived areas. CVD is also more common where a person is male, older, has a severe mental health illness, or ethnicity is of a South Asian or African Caribbean descent. CVD accounts for more than a quarter of deaths in England and is the largest cause of premature mortality in deprived areas.

The Inverse Care Law is demonstrated in analysis of local NHS Health Check data. Attendance at NHS Health Checks is lower for people living in the more deprived areas of Worcestershire, who are more likely to experience the health conditions identified by NHS Health Check.

The graph below shows the percentage of eligible 40 to 74 year olds who received an NHS Check during the five-year period 2013 to 2018 in Worcestershire. The population is split into deprivation deciles where decile 1 live in the most 10% deprived localities in the country and decile 10 the most 10% affluent. The graph demonstrates the social gradient in access to local Health Checks.



The NHS Health Check can, however, successfully engage people with the greatest health needs, actively reducing health inequalities. Individuals having a check are more likely to be diagnosed with a disease and to receive behavioural or clinical management to help them reduce that risk or manage the health condition.

Across Worcestershire there are modifications that could be made to further improve the accessibility and quality of the service. A proportionate universalism approach should be applied, to ensure the programme is primarily targeted at those communities who are either at highest risk of CVD and/or most impacted by COVID-19. These groups include Black, Asian and other ethnic minorities, those who live in more deprived communities, men, and those individuals who have notably not attended a Primary Care appointment for a significant period.

In addition to increased targeting of the service, further consideration could be applied as to where and how the service is delivered. A range of public health services are already effectively delivered in conjunction with community pharmacy, while in other local authority areas the service has been successfully delivered in health promoting settings such as opticians.

Improving the patient experience of an NHS Health Check is a key driver to ensuring that take up increases. The implementation of point of care testing has been shown to reduce the volume of missed appointments and to improve the take up of the service. Accessibility could be further improved through the increased availability of appointments at evenings and weekends.

Scheduled NHS Health Checks should be complemented by all Primary Care staff using a Making Every Contact Count approach to deliver brief, opportunistic advice on healthy lifestyles. Free **Making Every Contact Count E-Learning for all PCN staff** is available. To further enhance the impact on CVD risk for patients attending an NHS Health Check, it is also key to ensure healthcare professionals are able to successfully signpost or refer to health improvement services, such as lifestyle advisors or social prescribers as outlined in '**Pathways from Practice**'.

Spotlight on: Annual Health Checks for People with a Learning Disability

People with a learning disability are more likely to have poorer physical and mental health and have been more vulnerable to worse outcomes from COVID-19 compared to the general population. Risk of premature death is also higher amongst people with learning disabilities and in some circumstances is avoidable.

People with a learning disability often experience discrimination, communication difficulties, reduced health literacy and poorer access to healthcare. Diagnostic overshadowing, where physical symptoms are wrongly attributed to an underlying learning disability, can also result in later diagnosis of a health condition. To narrow this health inequality, a programme of Annual Health Checks (AHC) was developed in 2009 and implemented through a national Directed Enhanced Service.

Adults and young people aged 14 or over, who are on the GP practice learning disability register, should be invited by their GP practice for an AHC each year. The health check is a chance for the GP, the person with learning disabilities and support staff or family carer, if appropriate, to review the individuals' physical and mental health.

All 62 GP practices across Worcestershire are signed up to the AHC Directed Enhanced Service. Each AHC should be completed with a Health Check Action Plan to ensure the individual and their family understand their health needs and have the information and support they need to make improvements in their health. The current NHS England target is for 75% of people on the learning disability Quality and Outcomes Framework register to receive an annual health check in any given year.

In 2018/19, 56.6% (1,670) Quality and Outcomes Framework registered people with a learning disability in Worcestershire received an AHC. This was above the England average of 52.3%, but there is still room for improvement. There was also wide variation amongst practices within Worcestershire, and the percentage ranged from 18% to 100% in 2018/19.

A review of AHCs was completed in 2020. A sample of Worcestershire GP practices, people with learning disabilities and family carers, were interviewed to understand experiences and gather examples of good practice. This review supported the previous recommendations made by **Speakeasy Now**, a Worcestershire based user-led charity. The review made the following recommendations:

- A 'prevalence gap' remains across practices, where estimated community levels of learning disability and Quality and Outcomes Framework register sizes do not match. GP practices should ensure that registers for people with learning disabilities are well maintained. This will ensure all people aged 14 and over with a learning disability will receive an invitation to an AHC.
- The perceived value of learning disability health checks varies among Worcestershire GPs and there can be a high turnover of who is responsible for them. High quality AHCs take place in practices where they are valued by those delivering them. Allocating a lead role to a passionate member of the team with good knowledge of the benefits of high quality AHCs will provide a dedicated focus.
- Practices should ensure that invitations to AHCs are clear and easy to understand by the person with a learning disability. An easy read version of what to expect may be useful for a person attending their first health check. Some flexibility may also be required to amend appointments, particularly if the person would like a personal assistant to join them.
- A standard for a high quality AHC should be set to cover the full AHC experience. Templates used should be flexible to the individual but should cover all aspects of health and wellbeing. Practices should make best use of the wide range of services that can support people to improve their health and wellbeing and should ensure clear information is provided in the Health Check Action Plan and understood by the person and their carer or family member.

Much has been achieved in Worcestershire since this review. This includes a new webpage that has been created to bring together all the recommended resources for AHCs, for GPs and patients. This webpage has been cited as an example of good practice in the national NHS England "2021/22 priorities and operational planning guidance". There has also been a successful pilot of improved, more holistic AHCs in the Wyre Forest Health Partnership, demonstrating new ways of working at the PCN level.

"Since the review the uptake of AHCs across the county has increased to nearly 85% of those on the learning disability register, a huge improvement on both the preceding year's levels (54%) and the NHS England target (67%)".

The Misfits Theatre Company created a short film about how high-quality Annual Health Checks can improve health and wellbeing of a person with a learning disability:

Health Is Everybody's Responsibility – YouTube

A Worcestershire briefing on the health and care of people with learning disabilities was published in 2019 and is available here.

Personalised Care

Around 30% of adults have a long term or complex health condition. Personalised Care gives people choice and control over their mental and physical health, based on what matters to them and their individual strengths and needs. This is done through shared management of their health and care needs and recognising the role of carers and communities. The Royal College of General Physicians explain personalised care in the short video: **Personalised care for people with long term conditions: A changing GP approach – YouTube**.

A comprehensive model of personalised care is being embedded across health and care in Worcestershire. This model features six standard components, outlined in the diagram below:

Source: NHS England

Personalised care seeks to improve people's health and wellbeing and integrating services around a person is seen as critical to this. This includes health and social care as well as public health and wider services and is enabled by the development and embedding of new roles in Primary Care including the Social Prescribing Link Workers, Care Coordinators, Health Coaches, Lifestyle Advisors and Mental Health Coordinators. See '**Pathways from Practice**' on page 20 for more information about these roles.

The evidence shows that when people are more in control of their outcomes, then their outcomes are better. When personalised care is fully in place, people will have a better experience of health and care. Adopting a personalised care approach can also contribute to reducing health inequalities. Most individual long-term conditions are more common in people from lower socioeconomic backgrounds, and multiple conditions are disproportionately concentrated in these groups[6].

When people are supported to increase their knowledge, skills and confidence they benefit from better health outcomes, improved experiences of care and fewer unplanned hospital admissions [7]. People in lower socioeconomic groups can therefore benefit the most from personalised care.

6 King's Fund (2013), Long-term conditions and multi-morbidity. Available online: **https://www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-long-term-conditions-multi-morbidity**

7 Barker, I. et al. (2017), Patient activation is associated with fewer visits to both General Practice and emergency departments: a cross-sectional study of patients with long-term conditions, Clinical Medicine, 17(3), p.15

Pathways from Practice

"A wide range of services are available across Worcestershire to improve and maintain health and wellbeing. Primary Care professionals can refer or signpost patients to access these services and opportunities".

Worcestershire Mental Health Services

It is estimated that 1 in 4 people will experience a mental health problem each year. The **Worcestershire Healthy Minds** service provides a range of support options that individuals can self-refer in to, and that Primary Care can refer or signpost to. The service supports people aged 16 and over, who are experiencing difficulties such as stress, anxiety, low mood and depression. The service provides a range of self-help guides and resources, educational courses, online therapy and guided self-help, counselling, individual therapy, group therapy, and links to local solutions. GPs can complete an e-referral with the patient, allowing the patient to leave the practice with the date and time of their appointment with the service who then contact the patient directly.

There are a range of mental health and emotional wellbeing services for children and young people, all part of **Worcestershire Child and Adolescent Mental Health Services** (CAMHS). Primary Care can signpost or refer to a range of services for young people, including **Kooth** on-line counselling, **Reach 4 Wellbeing** short-term group programmes and **Specialist CAMHS** multidisciplinary mental health teams. CAMHS has specialist mental health workers trained to work with mental health difficulties that are impacting on activities of daily living for children and young people. Referrals can be sent to CAMHS SPA (Single Point of Access) by Primary Care where there are significant concerns regarding a possible mental health illness.

Worcestershire Drug and Alcohol Service in GP shared care

Cranstoun Worcestershire provides a local drug and alcohol service, which includes many drug and alcohol practitioners based in GP practices in addition to their specialist prescribing service. Across Worcestershire, currently 28 out of 62 GP practices deliver shared care between the local GP and a dedicated Cranstoun worker is linked to the practice.

GPs and patients provide very positive feedback about this arrangement, which enables patients to access specialist prescribing and psychological treatments close to their home. It also allows for improved co-ordination between individuals and health care professionals to facilitate better communication, access to other health promotion, illness prevention and consistent care for associated complex physical or mental health conditions. Patients can access this system via GP reception, online booking or GP/nurse appointment.

Health Walks

Health Walks aims to improve Worcestershire's health and wellbeing by encouraging more people to become more physically active through one of the simplest forms of exercise, walking. As well as improving physical health, organised walks can help improve mental wellbeing by providing an opportunity to socialise and a distraction from everyday stress.

Health Walks are free, easy and local. They are open to all adults in Worcestershire and usually last between 30-90 minutes led by a trained Walk Leader. Health Walks are part of the national **Walking4Health Programme** and are locally supported by Worcestershire County Council Countryside Service and Public Health.

In Worcestershire there are over 30 groups available across the County offering a range of walks.

Strength and Balance for falls prevention

The aim of the Strength and Balance service is to reduce the number of falls in older people, through strength and balance exercise classes across Worcestershire.

The Strength and Balance works directly with older people, to improve their strength and balance through a course of specific, tailored exercise classes which include resistance training, some impact exercise and balance training to reduce the risk of falling.

The service supports participants with appropriate information and advice and signposting to other services where appropriate, to promote health and wellbeing and maintain independence. To book onto a course you can either self-refer or get your GP or Health Professional to contact the Sports Partnership. For more information visit the **Worcestershire County Council falls prevention webpage**.

Libraries

There are 21 public libraries across Worcestershire and two community run library links. Libraries bring together community services through library co-locations.

Libraries provide a range of services available to all, including;

- Free access to the internet
- Reading well books
- Job clubs
- Digital Inclusion support
- Digital Library Hub available
- 24/7 Mobile Library visiting 175 rural locations

As trusted, safe and welcoming community spaces, libraries offer a route for public services to reach communities, providing access to information, social spaces for people to come together and access services that encourage learning and aspiration, improve skills and confidence, promote wellbeing and independence.

Social Prescribing

Embedded in GP teams, social prescribing link workers connect people to wider community assets and opportunities which that can help improve their health and wellbeing and to engage and deal with some of their underlying causes of ill health. Social prescribing link workers are becoming an integral part of the multi-disciplinary teams in PCNs. There is growing evidence that social prescribing can lead to a range of positive health and wellbeing outcomes for people, such as improved quality of life and emotional wellbeing and can lead to a reduction in the use of NHS services.

Social prescribing can link people with many services in the community. These may include:

- Healthy lifestyles and active lives
- Arts, music, outdoors and creativity
- Befriending, counselling and other support groups
- Housing benefits and financial support and advice
- Employment, training and volunteering
- Education and learning
- Getting involved in local groups and activities
- Accessing specialist services and support.

For social prescribing in the following areas:

Bromsgrove, Wychavon, Wyre Forest, Worcester City; **Onside Advocacy**

Redditch: **Carers Worcestershire**

Malvern: **Citizens Advices**

People Like Us (PLUS)

People Like Us (PLUS) is a service that works across Worcestershire to support adults of all ages who are experiencing loneliness or isolation. PLUS enables individuals to connect with others and supports them to become more active and engaged in their communities.

The PLUS service is open to everyone who is:

- 18 years+
- Registered with a GP Practice in Worcestershire
- Experiencing significant loneliness

Anyone can make a referral, including self-referral. Referrals can be made by phone to the access team or using a simple **referral form**.

Worcestershire Integrated Carers Hub

The **Worcestershire Integrated Carers Hub** supports unpaid adult carers across the County and builds on **Worcestershire Association of Carers** current provision, by providing a one stop shop for carers, which includes a Carers Hub Helpline. Experienced Carer Pathway Advisors can assist by providing local information and advice on all aspects of caring. Carers can **self-refer** or be **referred**.

Lifestyle Advisors

The **Lifestyle Advisor service** is integrated within PCNs across Worcestershire and aims to support service users to make positive changes to their lifestyle, through the use of behaviour change techniques. Lifestyle Advisors can support with a range of issues including, but not limited to, healthy eating, increasing level of physical activity, smoking, reducing alcohol consumption, mental health and wellbeing.

The Lifestyle Advisor service can offer support on a one-to-one basis, as well as group-based support.

The service works alongside services such as NHS Health Checks and Social Prescribing to provide a suite of wellbeing services embedded in Primary Care.

Living Well in Later Life Worcestershire

The Living Well in Later Life project stems from the ICOPE (Integrated Care for Older People) initiative, aiming to create a unified systemwide approach to promoting and embedding active/healthy ageing for the over 50s in Worcestershire.

Living Well in Later Life is introducing a Worcestershire LifeCurve™ website and App; a self-assessment tool to help people understand how well they are ageing and what this means to their future health. By using the LifeCurve™ to make a few small daily lifestyle changes, physical ability can be maintained or improved.

The project is also piloting the use of resistance bands (an exercise aid) to improve muscle strength and functional ability. In a variety of setting, a 12-week resistance band programme offers an effective means to gaining muscle strength and balance.

For more information email: **laterlife@worcestershire.gov.uk**

Worcestershire Advice Network

The **Worcestershire Advice Network** provides supported access to a variety of information and advice. The overarching aim of the service is to provide accessible, accurate, high quality and locally relevant information, advice and guidance for all adults in Worcestershire to help prevent ill health, promote good health and wellbeing and delay the need for care. The network is a partnership of local agencies and helps with everyday problems such as benefits, housing and debt, and to help individuals understand how care and support services work locally and the care and funding options available.

This service especially provides early intervention through good quality and timely information and advice to vulnerable adults and those with protected characteristics. Sessions are delivered on a one-to-one basis from various geographical locations across the whole of the county.

Here2Help Worcestershire

Here2Help is a community action scheme, originally dedicated to helping those who needed support during the COVID-19 pandemic. Here2Help can offer support and coordinates those who are able to volunteer to offer support. Worcestershire County Council is now evolving the service so that it offers advice, support and help to a wide range of services across Worcestershire. Here2Help provides support for people of all ages and is available for both residents and organisations to access information, advice, tools, guidance and local support available to them or others in the local community based on their needs. Here2Help is developing a community directory.

Starting Well Partnership

Starting Well provides information, support and advice for families, parents, children and young people across Worcestershire. The partnership provides the full range of Public Health Nursing services, parenting support and community health connectors. Starting Well provides universal Health Visiting and School Health services who deliver the Healthy Child Programme to identify and address health and wellbeing needs. The partnership provides a range of parenting programmes and peer support and empowers families and young people to access support networks and groups in their local community. Some of the services, clinics and groups are delivered in Family Hubs as well as community centres, health centres and schools.

Our communities

The 2020 Joint Strategic Needs Assessment (JSNA) summary focused on the health impacts of COVID-19 on Worcestershire communities.

In general, the population of Worcestershire is healthy and there are many health-related measures where Worcestershire performs consistently better than the national average. However, there are places in Worcestershire where people's health is not good, and the average measures reported at County and District level masks inequality in health outcomes in some communities. Almost 28,000 Worcestershire residents live in the top 10% of deprived areas in England. People living in these communities are more likely to experience ill health and report poorer wellbeing.

Worcestershire has an ageing population, and it is expected that the number of people in the very oldest age groups is expected to grow in future years.

The map of Worcestershire Districts below shows where outcomes are significantly worse than the England average. This is based on data included in the 2020 **Joint Strategic Needs Assessment (JSNA) summary**.

Bromsgrove

- Hip fractures in people aged 65 and over
- Breastfeeding Initiation

Malvern Hills

- Hip fractures in people aged 65 and over
- Dementia Diagnosis (aged 65 and over)
- Breastfeeding Initiation

Redditch

- Hip fractures in people aged 65 and over
- Dementia Diagnosis (aged 65 and over)
- Alcohol Admissions
- Adults Overweight or Obese
- Breastfeeding Initiation
- Average Attainment 8 Score

Worcester City

- Life Expectancy at Birth (male)
- Under 75 Mortality from Cardiovascular Disease
- Dementia Diagnosis (aged 65 and over)
- Breastfeeding Initiation
- Statutory Homelessness

Wychavon

- Dementia Diagnosis (aged 65 and over)
- Alcohol Admissions (Under 18s)
- Breastfeeding Initiation

Wyre Forest

- Life Expectancy at Birth (male)
- Dementia Diagnosis (aged 65 and over)
- Alcohol Admissions
- Physically Active Adults
- Adults Overweight or Obese
- Smoking at time of delivery
- Breastfeeding Initiation
- Children in low income families
- Average Attainment 8 Score

Data taken from: **Local Authority Health Profiles – Public Health England**

Primary Care Network Profiles

The JNSA includes profiles for each of the 10 PCNs across Worcestershire. The profiles provide a snapshot across a range of indicators and are designed to support a shared understanding of health inequalities within each PCN, enabling a collaborative approach to decision making and allocation of resources and to identify interventions to reduce inequalities.

A link to the profiles is provided below where information is updated and added regularly:

www.worcestershire.gov.uk/info/20862/nhs_intelligence

Community Assets

There is growing recognition that although disadvantaged social groups and communities have a range of complex and inter-related needs, they also have assets at the social and community level that can help improve health and strengthen resilience.

Through COVID-19 response, communities have pulled together in new ways to support the most vulnerable. Local authorities and the NHS can support the legacy of this by supporting emerging community-based assets and strengths and aiding the recovery of assets that have been adversely affected by COVID-19.

Together with partners, Worcestershire County Council are scaling up an Asset Based Community Development (ABCD) approach.

Spotlight on: Asset Based Community Development in Worcestershire

The Asset Based Community Development (ABCD) team has been funded for three years to lead on the adoption of ABCD as a way of working with communities in Worcestershire. This will involve working with partner organisations and communities to identify neighbourhoods where it can be embedded through a test and learn approach. The team will also support learning through facilitating communities of practice and developing monitoring and evaluation frameworks.

The ABCD approach has been successfully adopted by a number of areas across the UK and there is now a wealth of evidence that community and social networks have a fundamental and positive impact upon health and wellbeing. ABCD does this by inverting the existing model of needs and deficits, instead focusing on the skills, knowledge, resources, connections and potentials within the community. It is about building on what is working and what it is that people care about.

The ABCD approach is concerned with building people's social support networks, enabling reciprocity, making best use of the resources and assets which are available in the local area and making sure that people who use services, including people with long-term conditions, get a chance to pursue their own interests and contribute to community life. It is about enabling community self-help and social solidarity to flourish.

ABCD also creates the conditions for developing more effective co-production between people who use services and practitioners. Effective co-production makes full use of the assets and skills that local communities and people who use services can bring to the table alongside those of practitioners.

The ABCD team has been working through local partnerships in district council areas and have identified a number of neighbourhoods where the Test and Learn approach has potential to be developed. At the time of writing these are Woodrow in Redditch, Catshill in Bromsgrove, Droitwich Westlands in Wychavon, and Tolladine in Worcester City. The ABCD team has secured training from Nurture Development, the leading ABCD experts in the UK, which is being delivered to district council partners. This initial training cohort will also form the basis of the first ABCD Community of Practice. Additional planning is being scoped to scale up other ABCD projects and to develop and test community builders.

Challenges and Opportunities

There are a number of challenges facing Primary Care in the future. PCNs will play a key part within ICSs and work collaboratively with statutory and voluntary sector partners, and directly with communities, to tackle these challenges and maximise opportunities.

This section describes the challenge of the expected increase in demand on the health and social care system and the opportunities for Primary Care and the wider system to manage demand through a social model of health.

Opportunities to improve access to Primary Care through a digital offer are described and the development of an **Integrated Wellbeing Offer** for Worcestershire residents is outlined.

Nationally, there has been a reduction in numbers of GPs due to:

- **reduced proportion of funding for General Practice;**
- **period of lower recruitment to GP training schemes; and**
- **increasing number of GPs reaching retirement age.**

The Inverse Care Law can also apply to General Practice itself where "the availability of good medical care tends to vary inversely with the need for it in the population served"[8]. There can be an uneven distribution of GPs in relation to health need, resulting in some areas having less GPs to meet patient need. Individuals with long-term conditions and multiple conditions are more common in areas of increased deprivation. In addition, levels of knowledge, skills, health literacy and confidence to manage their health tend to be lower in such areas. Appointment times are in turn, also likely to be longer for some of these patients.

8 Tudor Hart (1971) The Inverse Care Law, The Lancet

Demands on the Health and Social Care System

The number of people with complex or long-term conditions is expected to grow as the number of older people increases. This is coupled with additional factors such as the development of new technologies, drugs and treatments, high expectations of patients and a period of lower investment in Primary Care. The impact of COVID-19 and COVID-19 recovery will also affect demands on the health and social care system, certainly for the next 10 years.

Mental health issues account for almost a quarter of General Practice consultations and around half of all GP appointments are related to people with long-term conditions.

The table below shows the expected effect of the ageing population on the numbers of older people with key health conditions. Numbers are projected to increase between 2020 and 2035. This increase in numbers is likely to lead to a substantial rise in the demand for social care and health services in future years.

Projected Numbers of People Aged 65 Plus with Key Health Conditions	2020	2035	% change
Dementia	9,757	14,273	46%
Depression	11,835	15,469	31%
Cardiovascular Disease	43,997	58,264	32%
Bronchitis/emphysema	2,342	3,060	31%
Fall	36,685	49,751	36%
Continence (have a bladder problem at least once a week)	22,620	30,349	34%
Visual impairment	4,134	5,920	43%
Hearing loss	84,098	113,619	35%
Mobility (unable to manage at least one mobility activity on their own)	25,264	35,536	41%
Obesity	41,875	54,365	30%
Diabetes	17,228	22,408	30%

Source: Projecting Older People Population Information System

People from lower socio-economic groups are much more likely to have one or more long-term conditions than people in the most affluent groups and they are more likely to become unwell with a long-term condition at a younger age.

Not everyone has felt the impact of COVID-19 equally. The greatest impacts of COVID-19 have fallen on those who are the least privileged. COVID-19 has made the existing differences in health between groups worse. A local survey conducted by Healthwatch Worcestershire[9] found people under 44, carers, people with disabilities and people from the 'White Other' ethnic group were more likely to report COVID-19 was having a great deal or a lot of impact on their mental health. Findings suggest that the impact on people's mental health and emotional well-being may continue to increase. An increased demand for mental health support for children, young people and adults is expected.

Through proactive and preventative health care education, advice and treatment, Primary Care has a responsibility to provide accessible and good quality clinical care to their patients, enabling them to

9 Healthwatch Worcestershire (2020) Peoples Experiences of Health and Social Care Services: **https://www.healthwatchworcestershire.co.uk/wp-content/uploads/2020/09/Covid-19-Survey-Final-Report-Vs-1.0.pdf**

manage long term conditions taking a personalised care approach. Patients should also be supported to live a healthy lifestyle and access other services that support good health and wellbeing.

Alongside access to health services, the wider determinants of health; the places people live, work and play have an impact on a person's ability to make healthier choices and function well. A stronger focus on prevention, developing assets and taking a place-based approach with the wider system will help to reduce demand in the longer term.

Improving Access through Digital Solutions

The pandemic has brought about an unprecedented situation for Primary Care services across the country. Lockdowns requiring people to stay at home, coupled with understandable nervousness around attending services face to face, amplified the need for a variety of technologies to be implemented rapidly and at scale to ensure services continue to remain accessible and effective.

Herefordshire and Worcestershire Clinical Commissioning Group, in partnership with many other organisations across our county and beyond, engaged with colleagues across Primary Care, as well as people. The aim has been to better understand residents needs with technology and what might help improve their access.

This engagement led to improvements such as online and video consultation systems in practices, iPad provision and training for care homes to support clinicians conducting virtual consultations with residents, enablement of direct appointment booking with practices when calling 111 and investment in practice telephony systems to improve citizen experience and signposting to the most appropriate service.

Since February 2020, there have been over 49,000 online consultations and over 45,000 video consultations taking place, demonstrating a strong level of uptake and usability in accessing services digitally. For the coming year, these technologies and many others will continue to be embedded and enhanced, including additional telehealth solutions for care homes, a patient portal to enable citizen access to a single care record that covers all care settings, and additional analytical capacity to enable practices and partners to target health and care interventions in areas of greatest need.

Although the use of digital solutions to increase access to health services and management of health conditions is positive, there is a potential negative impact on people who are digitally excluded.

A high priority should be placed on Digital Inclusion programmes that support those who may still be digitally excluded. This should include training and access to the internet through community assets. Services should consider that not everyone can access the information and support they need online.

"In an increasingly digital age, those who are not engaging effectively with the digital world are at risk of being left behind. This is often termed 'digital exclusion'. Digital exclusion can be down to a lack of means to access the internet or due to lacking the digital skills to use the internet competently, safely and confidently".

Developing an Integrated Wellbeing Offer

Access to an Integrated Wellbeing offer (IWO) can help empower people to live well, by addressing the factors that influence their health and wellbeing, building their capability to be independent, resilient and maintain good wellbeing for themselves and those around them. Such an offer moves beyond focusing on single issues and takes a holistic and person-centred approach, addressing the psychological determinants of health behaviour.

- There is growing evidence which suggest that multiple poor health-related behaviours and the wider determinants of poorer health can be addressed either simultaneously or sequentially by developing integrated wellbeing models, that prioritise key factors such as good employment, education and living well at older ages.
- There is clear strategic direction across Worcestershire and by the new ICS to move to an integrated and joined up approach to prevention and wellbeing across the health and care system at a place-based level. This will require asset-based approaches, working across health and care systems, and co-production with the voluntary and community sector and the public. This will be a systems approach, aligning resources and skills to build a new offer for Worcestershire. The Integrated Wellbeing Offer (IWO) will be tested at local levels through PCNs and developing District Collaboratives which will be key in local design and implementation.
- A multiagency steering group will work collaboratively to support the design and implementation of the IWO. The group is co-chaired by the Director of Public Health and will include local residents, the Voluntary and Community sector, PCNs, other NHS leads, District Councils, and the County Council.
- It is expected that the IWO will deliver at scale, enabling people to self-help, giving access to comprehensive information and advice, and joining up a wide range of services. The programme will particularly target activity on the poorest health outcomes, supporting the local community and building on local assets.

It is expected that the developing IWO will help to:

- develop a whole system approach to wellbeing in Worcestershire;
- improve health and wellbeing at all ages;
- increase community engagement and support using an asset-based approach;
- build resilient communities;
- enhance local assets and reduce gaps in provision;
- increase proactive support for mental health and wellbeing;
- provide a comprehensive digital platform including signposting to local assets;
- reduce loneliness and isolation;
- tackle health inequalities; and
- provide integrated services and groups to support people to live well at all stages in life.

"Following its creation and implementation four months ago in response to COVID-19, Here2Help has since provided a range of support to over 5000 individuals including emergency food parcels, medication collections, food collections and delivery. It has significantly grown the volunteering offer and strengthened relationships with districts, partners and the Voluntary Community Sector who have worked together to provide a One Worcestershire response. Following this success, there is now an opportunity to build on the Here2Help foundation by developing and evolving the service as part of the IWO".

An Integrated Wellbeing Offer empowers people to live well, by addressing the factors that influence their health and wellbeing and building their capability to be independent, resilient and maintain good wellbeing for themselves and those around them.

We can achieve this by:

Building resilient and thriving communities, utilising local strengths and assets → Empowering individuals with comprehensive and accessible information and advice to self-help → Providing individuals with supported information and advice → Joining-up and integrating services, taking whole system approaches

Built upon the principles of; evidence of need, tackling health inequalities, prevention, co-production, asset-based approaches, and personalisation.

System enables; governance and linkages with ICS and LTP, collaborative commissioning, cultural change and new ways of working.

HERE 2 HELP WORCESTERSHIRE

Primary Care Networks and District Collaboratives

Population health is about improving health across the entire population, this requires both individual and place-based action and activities to improve health, prevent ill health and reduce health inequalities.

To improve health and reduce long term demand PCNs will need to engage beyond the NHS, with other care agencies, the voluntary sector and with their local communities. Local communities are all different, their needs and assets are different requiring differing and tailored approaches and solutions.

To better understand needs, priorities and improve population health, Population Health Management (PHM) techniques can be used by PCNs to understand current, and predict future, health and care needs and to tailor better care and support and design more joined up and sustainable health and care services. PHM uses data to understand what factors are driving poor outcomes amongst different groups as well as to test the impact of new proactive models of care. This could be by stopping people becoming unwell in the first place, or where this is not possible, improving the way the system works together to support them. PHM techniques includes segmentation, stratification and impactability modelling to identify local 'at risk' cohorts and, in turn, designing and targeting

interventions to prevent ill health and to improve care and support for those with ongoing health conditions and reducing unwarranted variations in outcomes.

PHM can help PCNs understand people's health and care needs and how they are likely to change in the future, but PHM can be more effective when applied in partnership across other public services and the voluntary sector. In Worcestershire, the development of emerging District Collaboratives as part of the ICS structure provides the opportunity for PCNs to work with partners and the Voluntary Community Sector using PHM approaches to tailor, join up and improve the local health and care system.

"According to a recent report from the Royal College of General Practitioners, developing the community health function of General Practice is one of three features of the COVID-19 response that has the potential to transform General Practice radically and permanently. And PCNs are NHS England and NHS Improvement's chosen vehicle to drive engagement between Primary Care and communities, supported by the network directed enhanced services contract".

PCNs will build on the core work of current Primary Care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care for communities. PCNs are formed via sign up to the Network Contract Directed Enhanced Service contract. The contract enables more health professionals such as pharmacists, physiotherapists, paramedics and social prescribing link workers to work across PCNs, as part of community teams, providing tailored care for patients allowing GPs to focus more on those patients with complex needs. The new roles available through the additional roles reimbursement scheme (ARRS) will also help PCNs engage further with their communities, such as Health and Wellbeing Coaches, Care Co-ordinators, Mental Health Practitioners and Social prescribers.

Enabling people to increase their levels of control and confidence, through meaningful and constructive contact with others, helps to build protective factors and keeps people as healthy and productive as possible. PCNs need to build on local community assets and help to strengthen and develop their communities. PCNs should work together with communities and local partners to build relationships, and align their collective efforts, to address health inequalities through community strengthening and action on the wider determinants of health. In Worcestershire, the development of emerging District Collaboratives provides the opportunity for PCNs to work with partners, the Voluntary Community Sector and communities using an asset-based approach for that locality.

"Lasting reductions in health inequalities will only be possible through working in genuine partnership with communities… by seeing them as part of the system and a significant part of the route to lasting solutions".

(Royal College of General Practitioners 2020)

Conclusion

Primary Care is well placed to impact on prevention and inequalities, both at the individual clinical care level and at the wider population health level. GPs already provide a large proportion of prevention and health improving activities, and in Worcestershire, achieve good levels of immunisation and screening uptake. These programmes could be further used as an opportunity to engage patients within a practice area who are not currently actively managing their health and wellbeing.

The status of the GP, having long term and repeated contact with families or individuals at risk, puts them in an ideal position to understand and address the underlying and wider causes of ill health, whether they be medical or social. There are a wide and growing variety of medical and social activities and other services that patients can be signpost or referred to across Worcestershire as demonstrated under **'Pathways from Practice'** on page 20 which should be maximised.

One of the most effective methods Primary Care can undertake for ill health prevention is to take a population-based approach to the health of their 'patient list', by monitoring patients on their list who are judged to be in relative ill health or at risk of becoming so and coordinating a proactive response.

PHM capacity, tools and techniques are being developed in the NHS Clinical Commissioning Group and across the ICS. The risk stratification and monitoring tools that enable GPs and PCNs to fully understand health inequalities within their area could be further promoted and utilised, including providing appropriate training and support to practices. It is vital that these tools and approaches allow data and information to be easily shared with and by other local services to improve and integrate the systemwide response to health and care.

PCNs have a new opportunity to change the way they deliver services to support their local communities. They can explore their own data, develop a thorough understanding of the health needs of their populations and redesign services accordingly using PHM approaches. They can recruit to additional roles, such as social prescribers, to help deliver and provide their communities with services or support recognising the importance of taking a more holistic view of people's health.

PCNs can ensure that people are seen by the right member of the team, and at the right time. Being at a local level, they can engage effectively with other organisations working in their patch, such as the community and voluntary sector, secondary care, and local authorities. The District Collaboratives will also offer additional opportunity to develop effective collaborations with housing, education, social care, economic development and sports and cultural teams.

The development of the IWO, the Here2Help directory and self-help digital platform will further support Primary Care and PCNs to work better together with all local health and care services, voluntary sector organisations and community groups and activities to support their patients.

Before COVID-19 there was already a persistent gap in life expectancy and in the number of years people live in good health between the most and least affluent areas. The pandemic has both revealed the extent of the 'health gap' and appears to have increased it. Disruption to children's education, unemployment, food poverty, and mental ill-health are all more apparent and visible. The higher number of COVID-19 deaths among people from certain ethnic minorities has started to uncover the burden of risk factors experienced by ethnic minority communities leading to worse outcomes. The 'gap' is expected to widen further following the pandemic lockdown periods and this has brought health inequalities to the fore.

It has also brought further recognition that the NHS cannot do this alone. The escalating problems need a wholly different approach. All local partners have a role to play, the best outcomes will be achieved when PCNs join other local partners in getting behind community led efforts to address the issues in the long-term. The developing District Collaboratives as part of the ICS model provide that opportunity.

To support this population health approach, an asset-based model of primary and community care is beginning to be adopted in Worcestershire. One that taps into the existing skills and resources in people and places to help people lead as independent and rich a life as possible. Asset-based care is both a philosophy of how you provide care and a tangible set of interventions and approaches. It does not remove the need for high quality clinical care or health and social care professionals but identifies opportunities for people to help themselves and each other which ultimately reduces pressure on statutory health and social care services. These can be broadly defined into five categories:

1. Holding asset-based conversations with patients for example, understanding motivations, care planning, coaching and shared decision making.
2. Connecting individuals to community assets for example, peer support, social prescribing and link workers.
3. Mapping and growing community assets for example, asset mapping, directories of community assets and seed funding for voluntary sector organisations (ABCD).
4. Mobilising place-based assets for example, local neighbourhood networks.
5. Working with communities to develop local provision for example, co-design and collaborative commissioning.

In every community there are many groups, organisations and networks that are fully bought into tackling health inequalities; addressing the wider determinants and supporting the social processes involved in creating health which mainly happen in people's homes, neighbourhoods, workplaces and wider networks. They are enabling individuals and communities of all ages to have better physical and mental health and a good life and the networks between them have been strengthened, not weakened, through COVID-19. This brings greater opportunity to further build an asset-based approach to primary care.

Recommendations

1. Maximise the Role of Primary Care in Prevention

The 2018 Director of Public Health Annual Report "Prevention is Better than Cure" laid down a call to action to take a systemwide approach to prevention. Primary Care has a key role to play in advocating, and in directly facilitating collective action on prevention. This report makes specific recommendations for Primary Care to maximise their role in preventing ill health.

Primary Care can identify and mitigate behavioural (smoking, physical inactivity) and clinical risk factors (hypertension, obesity). Primary Care provides or facilitates vaccination programmes mainly for influenza and childhood scheduled immunisation and screening programmes for early detection of cancers and other conditions where early intervention can improve outcomes. Primary Care is a universal and key asset within communities and should also identify and mitigate wider social and wellbeing risk factors through the developing integrated wellbeing offer.

Ingredients for success:

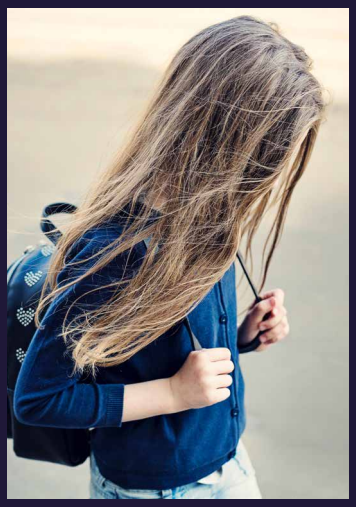
- Make every contact count by routinely delivering healthy lifestyle information to enable patients to engage in meaningful conversations about their health and to direct them to local services and support.
- Increase opportunities to support patients holistically with their health, wellbeing and wider social needs supported by social prescribers, lifestyle advisers, digital and the wider developing integrated wellbeing offer.
- Opportunistically ask about vaccination, screening and Health Checks intent and use these programmes to engage patients who are not currently actively managing their health and wellbeing.
- Increase access to and uptake of Health Checks, weight management and other lifestyle or behaviour change programmes.
- Dedicated PHM and Public Health resource, with appropriate knowledge, experience and skills to enable proactive and targeted approaches.

2. Creating Healthy Places and Stronger Communities

Improving population health requires place-based approaches that utilise and grow existing assets and integrate the wider health and care system within communities. Use Asset Based Community Development approaches to work across partners and directly with communities to grow existing and new assets, creating places for good health and wellbeing. This will support the aims of the developing District Collaboratives and Integrated Care System to take place-based approaches to health and wellbeing and make a positive impact on the wider determinants of health.

Ingredients for success:

- Strategic direction and support provided through the Integrated Care System and Health and Wellbeing Board and delegated to District Collaboratives.
- Expansion and strengthening of community assets and asset-based approaches by connecting individuals to community assets e.g. peer support, social prescribing, health coaches and link workers.
- Recognition and support for communities and assets that responded and shone in the face of COVID-19 and supported recovery of assets negatively affected.
- Scaling up the use of Asset Based Community Development (ABCD) and community builders as a way of working with communities and to strengthen communities to develop, and expand assets available to them.
- Working with communities, voluntary sector and partners to collaboratively co-design holistic provision.

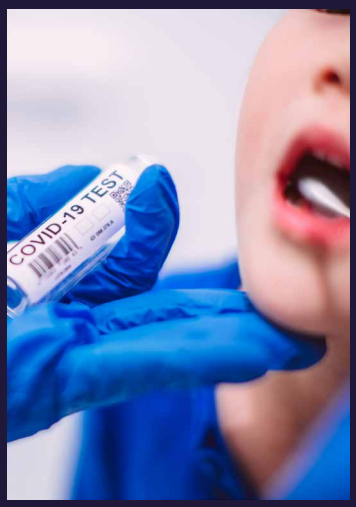


3. A Greater Focus on Inequalities and Deprived Communities

Although inequalities have always been a focus when planning and delivering services, the previous year has demonstrated that existing inequalities were linked with worse health outcomes. A greater focus should be given to improving the physical and mental wellbeing of more deprived communities, older people, children, people with learning disabilities, Black, Asian and other ethnic minority communities and people experiencing problems with drugs and alcohol, poor mental health and homelessness. This will be achieved by working with the communities and social networks in which they live, learn and work in and by improving their access to, and experience of healthcare and other services.

Ingredients for success:

- Focused effort and resource on people, vulnerable groups and communities with the worst health outcomes and commitment to working with communities and vulnerable groups on the aspects of their lives that make them feel good and function well.
- Partners employ equality impact assessment tools and health equity assessment tools in the design, development and improvement of services.
- Learning from COVID-19 is applied, including how Primary Care adapted access to services and the vaccine inequality programme to improve and tailor health and wellbeing communications and improve access and engagement with services.



4. Applying learning from COVID-19

Learn the lessons from the COVID-19 pandemic and continue to build on the enhanced working relationships with internal and external partners and our new partnerships with communities and workplaces.

Ingredients for success:

- Systems are in place for recording and sharing learning and partners are engaged with COVID-19 recovery activities.
- Population needs are well understood and insights from our communities are used to target and focus support for COVID-19 recovery, health and wellbeing.
- Systems are ready and able to provide a local response to the ongoing COVID-19 situation and other possible future public health emergencies, in partnership with the new UK Health Science Agency.

Acknowledgements

Thank you to all our partners across the local primary care networks, and those who contributed to this report:

Brett Jarman, Digital Project & Analytics Manager – Digital Strategy & Infrastructure, NHS Herefordshire and Worcestershire CCG

Emma Fisher, Senior Manager – Personalised Care, Prevention and Population Health Management, NHS Herefordshire and Worcestershire CCG

Misfits Theatre Company, Bristol and Redweather Productions, Bristol for The National Development Team for Inclusion for 'Health is Everybody's Responsibility (YouTube content)

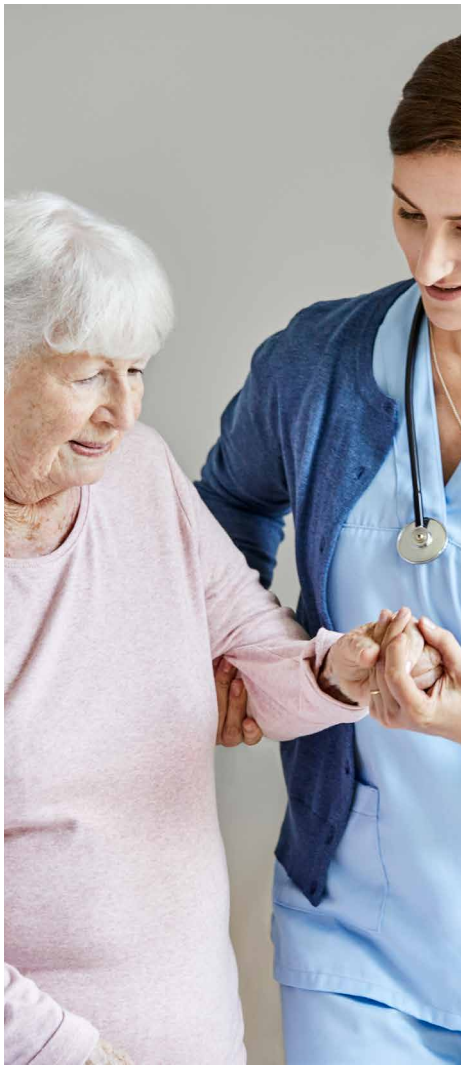
NHS England and NHS Improvement for 'Primary Care Networks Animation' (YouTube content)

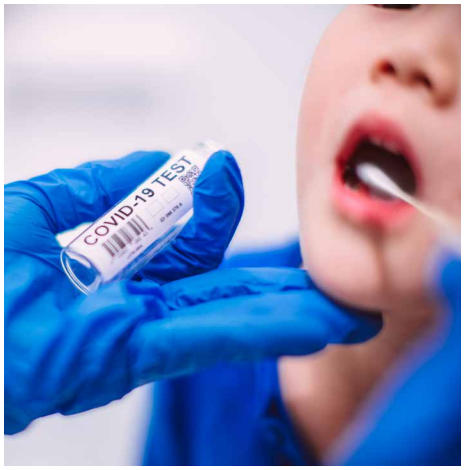
The Royal College of General practitioners for 'Personalised care for people with long term conditions: A changing GP approach' (YouTube content)

Liz Altay and Rachael Leslie, Public Health Consultants, and the wider Worcestershire Public Health Team

Notes on data:

This report utilises the most recently available published information from a variety of data sources as of May 2021. Data for both Herefordshire and Worcestershire is used for some indicators.




COVID-19 TEST