AGENDA ITEM

REPORT TO HEALTH AND WELLBEING BOARD

24TH MAY 2022

REPORT OF CHIEF EXECUTIVE, H&SH / DIRECTOR OF PUBLIC HEALTH, SBC

LINKING COMMUNITY ASSETS AND PRIMARY CARE

SUMMARY

This report outlines work to develop an approach to linking community assets and primary care, based on existing work and learning from the Covid-19 pandemic, as part of the Board's work to taking a community assets-based approach.

RECOMMENDATIONS

The report recommends that the Board:

1. Receives the update on the developing approach

DETAIL

1. Primary care delivers services right in the heart of communities and are often a close link to more underserved populations. As well as healthcare provision, primary care providers, particularly GPs, often have a close understanding of the issues in their local communities and a relationship with whole families as well as an understanding of their patterns of service use. Pharmacy provision is also key within communities, though this briefing focuses more of provision through GP practices as a first step, with the potential to consider support through pharmacy provision further in the future. The introduction of practice groupings (known as Primary Care Networks) covering communities of 30-50,000 people gives a structure for working with local people at the right level of scale for the right services and support in primary care. This structure reflects the importance of general practices for continuity of care, PCN for communities and neighbourhoods and at-scale provision via Federations for place or population level.

2. Some communities also continue to find access to healthcare provision and support to be challenging due to a range of factors e.g. physical access to services, cultural / language barriers, challenges around trust in professionals, leading complex lives and managing a range of challenging priorities and issues alongside poor health.

3. Those experiencing poorer health outcomes are often the communities that find it more difficult to access or receive healthcare support, with access to healthcare being stratified according to levels of deprivation. Communities experiencing barriers to accessing healthcare and support are also those who are not always able to access healthcare in the most appropriate ways e.g. present with conditions later and are therefore less able to benefit from prevention and early intervention opportunities; may make more use of emergency care provision e.g. A&E attendances. Those communities with poorer access to healthcare support will also often be the same communities requiring other support from e.g. social care.

4. There is a range of existing work in place between SBC Public Health and primary care, to promote and support health and wellbeing in the community through prevention e.g. the NHS Health Check and Lung Health Check (COPD). Through the very difficult circumstances of the Covid-19 pandemic, there have also been opportunities to develop even closer joint working, the vaccine inequalities work being a good example of this.

<u>Vaccine inequalities work</u>

5. Throughout the rollout of the Covid-19 vaccination programme, primary care and public health have worked closely in partnership to increase the access to the vaccine for communities across the borough. This has included:

    - Use of public health intelligence, experience from previous vaccination programmes and emerging evidence on the rollout of the Covid-19 vaccination to help understand uptake of the vaccine across different communities

    - Close joint working with the Covid community champions and the VCSE to understand attitudes and perceptions around Covid and the vaccination in different communities, and to develop different ways of removing barriers to access through conversations with community groups, work with community leaders, development of bespoke communications materials etc.

    - Development and running of vaccination clinics delivered into communities, to increase visibility of and access to the vaccine. The GP Federation, Hartlepool and Stockton Health (H&SH), has lead the development of these bespoke clinics in Stockton-on-Tees, jointly with SBC public health who have facilitated a joint approach with specific organisations such as substance misuse services, housing, hostels, asylum seeker accommodation providers and refugee and BAME organisations. Clinics have particularly included walk-in provision in the borough which have been very successful in boosting uptake in more vulnerable / at-risk / underserved populations particularly the younger population, males, areas of greater deprivation e.g. Stockton town centre, BAME groups and homeless people. The clinics have included provision across the town centre / areas of greater deprivation, the mosque, the substance misuse community, homeless individuals and sixth forms.

- Close working with the care sector to provide information and advice, myth-busting and the opportunity for direct conversations between care staff and clinicians to address any concerns around the vaccine in staff.

- Effective examples include working as a team to offer accessible, friendly vaccination services in local hostels, working with staff, local authority teams, specialist providers such as CGL and trained nursing teams from H&SH to provide approx. 75 vaccines in one session.

6. The approach has been a good example of joined up working, ensuring universal provision but with collective information being brought together to address the needs of more at-risk communities in a targeted way (i.e. proportionate universalism). Joint planning, intelligence and the softer intelligence from communities have been key in enabling this.

7. There significant potential to use this approach further, in the planning and delivery of further approaches and programmes to improve the health and wellbeing of the population through primary care, working with the community. This will also help maximise the role of GP practices as community assets in themselves and crucially will help address health inequalities.

Linking community assets and primary care - examples

8. Work to build on and roll out this approach has already commenced. Examples are set out as follows.

9. Discussions are underway regionally and locally on how to maximise the learning from the roll-out of the Covid-19 vaccination programme to inform future rollout of existing routine vaccination programmes such as the seasonal flu vaccination and future Covid booster progeammes. Primary care and public health are involved in these discussions, along with colleagues in NHS England and UKHSA.

10. As part of the work to maintain enhanced health protection practices developed through the pandemic, particularly in preparation for the coming Autumn / Winter and the pressures this will bring, there is ongoing work to maintain robust infection prevention and control (IPC) practices in the care sector. This includes planning work between H&SH and SBC public health around support to settings such as learning disability homes; and IPC training sessions have already been delivered in children's homes and for care at home providers.

11. Discussions are underway between H&SH and SBC public health to further develop the provision of the NHS Health Check in the community. The Health Check is commissioned by public health and delivered by GP practices, offered to 40-74yr olds and is designed to detect early signs of cardiovascular disease and kidney disease to enable intervention and support. Further work is underway between H&SH and public health to look at the potential for additional provision of health checks at weekends, and to maximise the role of the community champions in increasing access to the health check for our most at-risk communities.

12. The national Lung Health Check programme is being rolled out across Tees Valley by the CCG starting in Stockton-on-Tees. It aims to raise awareness of COPD (Chronic Obstructive Pulmonary Disease) while offering free lung checks for those who are eligible (current or former smokers aged 50-80yrs). The programme also aims to improve earlier diagnosis of lung cancer - which continues to be a main cause of early mortality for the borough – and offers another opportunity for people to access support to stop smoking. Public Health is working jointly with the CCG to link the development of the programme with community networks such as the community champions, to help enable access to the programme for our most vulnerable communities in a planned way and to help mitigate against inequality in access to this programme. This includes identifying easy access community locations from where the diagnostic van can deliver services; and work with communities to shape messaging and promote understanding of the programme.

13. Social prescribing has evolved across the system as a way of supporting people to access broader community-based support that meets their wider needs linked to health and wellbeing, in particular around long term conditions, mental wellbeing, those who are lonely or isolated and those with complex social needs. Social prescribers connect people to both community groups and statutory services for practical and emotional support. GP practices refer to social prescribing support as do social care and SBC public health has commissioned a community social prescribing programme particularly to help address loneliness and social isolation (exacerbated through the pandemic). Public health has worked across with primary care and social care to bring together the various forms of social prescribing support in a social prescribing network to clarify how they work together. Local people are able to be referred across organisations to access the best support for their needs. Examples of the impact of this personalised care include teamwork between H&SH Social prescribers, VCSE colleagues and PCN nursing staff to offer holistic support in areas such as menopause care.

14. As previously reported to the Board, the CCG is leading work with the primary care networks (PCNs) to develop their plans to address health inequalities, supported by public health. Stockton-on-Tees PCNs have selected healthy weight as their initial priority and the CCG and SBC public health are providing business and public health intelligence, as well as an overview of evidence base and a summary of existing programmes and interventions to inform next steps on interventions in the community by GP practices as part of the broader whole-systems approach addressing healthy weight across the lifecourse. PCNs are now employing a small (virtual) team of Health and Wellbeing coaches via H&SH to support this initiative across Stockton. Public Health is also supporting through sharing local campaigns and information to support healthy weight.

Next steps

15. Public health will continue to develop the commissioned community champions network to support Covid recovery, address health inequalities and support health and wellbeing outcomes, linking with primary care colleagues and wider partners. The work described above will also be progressed, across primary care and public health.

16. It is proposed that the work set out here is used to further develop an approach to linking and embedding a community assets-based approach to delivering population interventions in the community through primary care. There is the opportunity to develop this further to undertake co-production with communities, which could start with specific interventions and programmes and use the learning to in the further development of this approach.

17. The development of this community assets-based approach will inform the wider work of the Board in its work to adopt a community assets-based approach as a system.

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