Frimley Health and Care

Reducing Health Inequalities Update June 2023

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ASCOT • BRACKNELL • FARNHAM • MAIDENHEAD • NORTH EAST HAMPSHIRE • SLOUGH • SURREY HEATH • WINDSOR

Health Inequalities

"Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. There are many kinds of health inequalities, and many ways in which the term is used. This means that when we talk about 'health inequality', it is useful to be clear on which measure is unequally distributed, and between which people." (The Kings Fund)

The importance of tackling health inequalities

"Reducing health inequalities is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life." (Marmot)

Frimley Health & Care ICS Strategy

Our ICS goal is to **increase healthy life expectancy** and **reduce health Inequalities**. We will do this through coordinated actions at system and place.

Across our ICS, Health inequalities and Prevention is not seen as a stand alone programme, but a golden thread running throughout all of our work programmes. Our priority will be to ensure we target those who have the greatest need and the poorest health and wellbeing outcomes.

THE CORE20PLUS5 Approach

Tackling health inequalities are at the heart of our ICS strategy and CORE20PLUS5, covers key aspects and different lenses on health inequalities.

- Leveraging our ICS Strategy as an established delivery vehicle for the implementation of both our locally identified priorities and those which would meet the CORE20PLUS5 ask.
- There is significant engagement and momentum around the CORE20PLUS5 strategic approach as a mechanism for reducing health inequalities.

Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement.

- We are currently working with partners across the system to finalise our plus groups, using both data and experience of our staff and patients to inform these groups.
- We aim to work iteratively with Plus groups, where the focus may change over time but in a structured way.

This is an opportunity to accelerate and augment implementation of the Core20PLUS5 approach, to improve health outcomes

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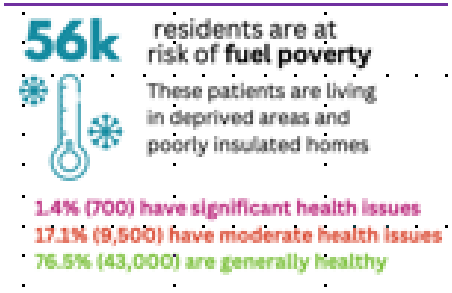
Reducing Inequalities

Fuel Poverty

- Combining our shared care record data with information from the Land Registry,
- **Identified 56K at risk of fuel poverty**
- Fuel Poverty Sumit in Nov 2022 & worked with LAs to mitigate risks
- Cost of Living support to local populations using Public Health / NHS joint financial support



Digital Weight Management Programme

- Now well embedded, working in collaboration with Local Authority offers of support
- **Our ICS at one point was the highest performing system in the South East in terms of uptake**.
- The weight management services one pager and the ICS webpage is being **shared as an exemplar of good practice across the country**.
- **Easy read Information on provision for people with learning disabilities** and this information is now on our website for the public.
- More acceptable and accessible to some groups than others; forms part of a range of services for weight management to ensure equity.
- **Links in with the work of several of our 'places'** which have embarked on a whole systems approach to obesity and physical activity

Smoking

- **In-House In-Patient and Maternity programme** at FHFT to deliver Tobacco Dependence Treatment in line with the NHS LTP commitments, full converage across the trust
- A high level maternity model has been agreed with the initial pilot deployed in Slough.
- **Systematic screening** of all relevant patients for smoking status, making **a rapid offer of support and medication with follow-up treatment appropriate to the pathway**.
- Frimley Health **Smokefree Steering Groups** established
- Working with Local Authority/Public Health partners to improve linkages and coherence of the tobacco control and stop smoking offer across the ICS patch.
- Aligning work to the **CORE20PLUS5** approach as the five clinical areas of focus are all impacted by smoking..

Reducing Inequalities

NHS Health Checks

- **In Slough** which is our most deprived place, the reach of health checks has been increased, by working closely with their community champions programme. There are around **40 volunteers** from diverse backgrounds, speaking **14 languages** to support the programme
- **NHS HC activity** has recovered to pre-pandemic levels in Surrey. On average 64% of HCs delivered across Surrey are to someone from a priority group.
- **LD Health Checks** improving - LD health check achievement was 85.7% and meant we were the 4th highest achieving ICB in the country out of 43 ICB's.
- BP checks and wider NHS Health Checks have been taking place at a **range of community venues,** including vaccination centres and job centres.

Hypertension

- **System wide CVD Prevention Board** focused on prevention, improving detection, monitoring, and treatment of hypertension.
- **Local leadership** integral in making a difference and responsibility for action is **distributed beyond just health partners.**
- The largest improvements have been in BP recording. Our latest data shows **14 practices within our ICS, having achieved the target for hypertension of 80**%.
- Last year, one of our practices in **Slough**, achieved one of the **highest rates of BP recording in the ICS** ending the year above system average and hit 80% before winter pressures by significant use of automation/ digital technology
- **Continue to strengthen relationships with our Community Pharmacies** to support the detection
- Different **community hypertension pilots**, including: making blood pressure monitors available in targeted community locations, for potentially vulnerable or isolated people to use; a 'blood pressure bus' of trained professionals

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Living Well – Hypertension awareness and Reduction

Overview of Initiatives

We have developed a bespoke webpage
www.frimleyhealthandcare.org.uk/bloodpressure

- Campaign work, running specific campaigns and targeting engagement with groups at higher risk.
- ICS webpage for CVD prevention.
- NHS health checks.
- Digital Weight Management Programme.
- CORE20PLUS5 - hypertension case finding.
- Community hypertension bus pilot.
- Community pharmacy blood pressure (hypertension) service.

- AccruRx Florey.
- BP@Home.
- Health Checks at vaccination sites.
- Community hypertension pilot - devices in community
- Omron hypertension plus.
- Lakeside hypertension focussed days.
- 24-hour Ambulatory Blood Pressure monitoring and holter service.

Example Approaches

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A coordinated campaign with supporting resources

Bespoke resources created to provide information in printed, online and video format, with simple, straightforward messaging and advice. Tested with local people whilst in draft form. Designed to link with national and global hypertension awareness campaigns and provided in a comprehensive resource pack to staff and partners for use in their own communities.

GP and clinician based interventions

GPs and local community pharmacies are identifying patients at risk of hypertension (but as yet undiagnosed) and offering a BP check or BP monitor for home readings. Health checks offered at the beginning of the year to those attending vaccination centres.

Community based monitors

Placing monitors in community venues where local people can more easily access them with the support of their community leaders and peers and in a safe, familiar and trusted environment.

Staff support and awareness

Staff encouraged to attend drop in sessions throughout May measurement month and get to know their numbers. Campaigns and resources highlighted throughout staff communications and in staff meetings.

Case study	What we did	Impact
Taking a community approach to tackling high blood pressure – The Hope Hub	The Hope Hub, a registered charity dedicated to preventing and ending homelessness in Surrey Heath Borough and surrounding areas, agreed to host a blood pressure monitor for six weeks, in order to support service user and staff wellbeing, to raise awareness of the dangers of hypertension and encourage service users and staff to take their own readings and get to know heir numbers.	Reached vulnerable people High-risk cases identified Created starting point for healthy lifestyle discussions Viewed as a success and monitor now integral in living well programme

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Interventions - NEHF

HIV Pilot - partnership with Solent Sexual Health Terence Higgins Trust and Hampshire County Council **Reduce late diagnosis HIV, promote normalisation of HIV testing, and identify an HIV champion for the area**. Successful 'Texting for Testing' completed at **Cambridge Practice Aldershot during HIV Testing week - 16,000 texts sent**. **Pilot now extended to 6 other GP**

Mental Health: Questionnaire sent to primary care and community teams to **raise awareness of IAPT services to treat low level MH problems** in order to increase referrals to sleep service, employment service, carers support etc. **Digital communications campaign and referral rates for psychological therapies back to pre-pandemic levels**

Aldershot Community Hub
Andover Way agreed with Vivid, Aldershot PCN to lease site for community activities for youth, CAB, social prescribers youth groups etc

Physical Activity: **Intersectoral meetings** - Local Authority, voluntary sector and community organisations to establish free and **low cost offers and promote new initiatives** such as community health walks in areas of deprivation. **Rushmoor Whole Systems Approach to tackle Obesity** also supporting increase offers by provider, 'Energise Me' in areas of deprivation.

Smoking reduction for whole NEHF: New Smoke Free Hampshire Strategy launched and Tobacco Control Group being established

Fuel Poverty Working Group
Meeting of stakeholders including emergency services and education
Currently working on **coding for fuel poverty and food insecurity**. Plan to assist winter pressures by sending **AccuRx text** to the whole population to coincide with 2023 Flu campaign. Answers to be coded into records and **people who self identify to be at risk of cold during the winter and of food insecurity to be contacted by care co-ordinators/social prescribers**. Place team working up a model for a Social ICT (Introductions made by Kings Fund)
Social prescribers receiving '**Hitting the Cold Spots' training** to provide support offers to those at risk of fuel poverty

Community engagement and meet the people

- **Walkabouts to most deprived wards,** with PCN CDs, Councillors and Housing Officers to Aldershot Park, Wellington Ward, and Cherrywood Ward
- **Sandy Hill Estate Project** Farnham PCN working with Community Centre, Bernados and engaging with residents.
- Health and physical activity survey carried out, **Stop Smoking services introduced, COPD and Thai Chi** community classes introduced. One year **Health & Wellbeing Coordinator post** funded from Better Care Fund.
- **Needs assessment for Nepali and Veteran population** completed, June 2023
- Meet and greet for **Ukrainian asylum** seekers hosted on how to access the NHS
- **Asylum Seeker** Hotel in Rushmoor. Serious health inequalities identified. Teams co-ordinating efforts to resolve

Interventions - Slough

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Case study	What we did	Impact
Mental Health and Inequalities In seldom heard Communities	To build upon local intelligence, bringing together community groups, primary Community MH Teams (CMHT) and clients, to understand how best to access MH services, to meet the needs of Asian, Black and other ethnically diverse people and seldom heard communities.	• Main themes identified: • Stigma within certain cultural group • Lack of awareness, traditional practices amongst Ethnic Minority groups • Absence of Ethnic Diverse specific services and lack of Ethnic Diverse involvement in clinical services • List of recommendations on further slides
Multi-generational Household pilot	Identified families living in **multi-generational households with low uptake of children's immunisation** Offered health checks to all the other members within the household if appropriate (phase1)	• Increased immunisations uptake in the last month of QoF – 68 extra injections completed as part of the pilot within 2 weeks. • Other health checks completed such as blood pressure, diabetic check, asthma reviews, SMI review, adult immunisations as well as increased uptake of breast and cervical screening. Social interventions offered. • Development of the multi-generational pilot phase 2 – multi-generational households with < 40% QoF indicators completed as of the 31st March 2023.
Reducing Health Inequalities in underserved populations in Slough	Engaged with 3,300 individual from the underserved population in **Slough (decile 2-4).** Holistic needs assessment (DiPCare-Q) completed focusing on the wider determinants of health. Social Interventions offered.	• Increased uptake of chronic health check and a reduction in urgent care activity • Patient reported outcomes supported the development of the mental health and wellbeing programme and fuel poverty phone line programme.
Growing A Healthy Slough	Identified **pregnant women and families with children aged 0-2** to support with health messaging	In progress
Digital Buddies (NHSE funded project, Proactive Care)	8.8% of the population identified with **digital inequity concerns** Development of a digital literacy programme implemented by the Slough Voluntary sector to improve use of digital services within the NHS and improve overall health and wellbeing.	• 124 participants • 30 NHS logins achieved • 16 workshops • 2 café across Slough opened to improve access to the internet • Reaching out to different community groups • Still in progress for full evaluation
Claycott's School programme	**GP educational sessions with parents** Aim is to reduce school absences (23.95%) and empower the parents	• Under evaluation • Qualitative Feedback
Slough Poverty Forum	Host a monthly Poverty forum. A diverse group of partners and community groups come together to share updates on projects and news available to support residents. Slough foodbank regularly provide updates around activity seen.	• Cost of living resource pack created • Community workers are working closely alongside social prescribers to support residents with complex requirements • Warm kits - Green Doctors South have distributed 50 warm kits to vulnerable elderly residents in Slough during winter

Conclusion

- System  Place

- Holding our focus on tackling HIE in all the transformational work to improve access, experience and outcomes for our population