South East London Integrated Care System

Prevention & Health Equity

NHS South East London

Overview of our current system

Health equity is the absence of unfair and avoidable or remediable differences in health among population groups reducing health inequalities is at the heart of this work. Across South East London there are known differences in life expectancy across and within our boroughs, linked to deprivation. Furthermore, physical inactivity, obesity and smoking rates are higher than the national average in a number of our boroughs. All these factors can be addressed by effective approaches to prevention. Many prevention services have been in place for several years and have delivered significant positive impacts for our residents including cervical screening, diabetic retinopathy and bowel screening as well as childhood immunisations and vaccination programmes. However, some service arrangements can feel fragmented, complicated and disjointed, resulting in variable uptake and our current service arrangements often miss the opportunity to integrate part of every conversation on health and wellbeing with a focus on early intervention especially around obesity, smoking and drugs and alcohol.

Strengths / opportunities

- Clearly defined ICB/ICP priority
- Clear evidence base and demonstrable positive outcomes
- Delegation to Local Care Partnerships for out of hospital services - Local Care Partnerships membership includes local partners, links to Health and Wellbeing boards and strategies
- Collaborations and relationships at hyperlocal level, including with Voluntary, community and social enterprise sector (VCSE) Community pharmacy clinical services such as vaccinations, BP checks, stop smoking and contraception services.
- Ways of working and relationships established during pandemic with communities
- PCNs moving to integrated neighbourhood teams
- Developing community pharmacy offer
- Strong partnership with local authorities and potential for much more
- Established Director of Public health network
- The delegation of dental, optometry and pharmacy to the ICB from NHS England

Challenges

- National agreed contracts which brings inflexibility
- Some commissioned services are income generating for some providers, for example flu vaccination, and therefore business models are predicated on receiving this income
- Changing behaviours, ways of working that have been in place for a considerable amount of time
- Reducing complexity
- Demand can often outstrip capacity resulting in increased waiting times
- System has moved to be reactive to manage demand especially with some of the national and regional vaccination programmes
- Aligning commissioning function as historically has positioned in different parts of the system
- Lack of trust with statutory services for some of our communities
- Securing the bandwidth, operationally and financially, to support a clear and systematic focus on prevention programmes

What we've heard from the public

Local people have repeatedly told us in engagement work across the system that they want a more holistic approach to their health and care, an increased focus on the 'whole person' and 'whole family', and that wider determinants of health need to be addressed. We heard this again during our engagement work to develop the SEL integrated care strategy and the SEL working with people and communities strategy 2022. We have heard that we must address access issues to prevention services, which are not just due to a lack of capacity but also due to a lack of suitable services for people, and that people want us to design and develop solutions in partnership with them. We have also heard we must work in partnership with the Voluntary, community and social enterprise sector.

Some of our prevention services

Most women go to their GP practice for their cervical screening while others attend a local sexual health clinic

Diabetic eye screening services are provided by a single provider in South East London in a variety of settings

Women aged 50-71 will often attend breast screening services at various community and hospital settings

Bowel screening home testing kits are sent out automatically

Annual health checks for people with severe mental health conditions will take place at either GP practices or community mental health services

Adults and young people aged 14 or over with a learning disability will attend their GP practice for their annual health check

NHS Health checks are available to those aged 40-74 at their GP or local pharmacy or at another community location

Most adults attend their community pharmacy or GP Practice for their winter vaccinations, such as flu, covid, pneumococcal and shingles

Children may attend their GP Practice for their childhood vaccinations and immunisations. School aged children often receive their vaccinations at school.

Our vision and objectives

Our vision

For all our citizens to have the same opportunity to lead a healthy life, no matter where they live or who they are, through equitable, convenient and effective access to health and prevention services, experience of care and outcomes for our population, to prevent and detect at an early stage disease and illness.

This vision is underpinned by a commitment to: (i) reduce health inequalities; (ii) take a life course approach to the design and delivery of care; (iii) ensure parity between mental and physical health; (iv) reduce the factors that contribute towards ill health (primary prevention); (v) increase earlier detection and diagnosis of disease (secondary prevention); and (vi) support people living with long term conditions (tertiary prevention).

Our key objectives – what we want to achieve over the next five years SEL

★ ICS Strategic Priority

Over the next five years, we want to:

1. **Establish a systematic prevention programme,** focussed on early detection and intervention and associated with the key population risk factors in South East London for both adults and children and young people, embedding targeted population health approaches.

2. **Establish a systematic secondary prevention programme targeting patients with long term conditions** to prevent the development of multiple or more severe long term conditions.

3. **Define, develop and embed a population health management approach** to design and delivery of our health and care services across South East London, that secures the demonstrable targeting of our work around prevention and inequalities on a population basis.

4. **Improve the way in which we work with residents and community groups** to ensure we understand barriers and issues, resulting in the development and implementation of co-produced solutions which meet the needs of our population.

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Our principles

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★ ICS Strategic Priority

Ways of working: Embedding Sustainability and Leveraging Opportunities

Ensure prevention is an integral part of every conversation on health and wellbeing with a focus on early intervention and not a standalone agenda for our residents and their families

Working to one goal with one voice: a multi-system approach working with partners across organisational boundaries and in collaboration as we all need to work together to improve health and wellbeing in our communities

Permission for and encouragement for innovation and creativity: to explore new ways of working and thinking more holistically about prevention for whole communities

Freedom and funding to explore different approaches: at a ICB, LCP and hyperlocal level and to develop a plurality of approach and a responsive offer to population need

Amplifying impact through an evidence approach: a commitment to continue to collect, evaluate and share outputs to ensure and to be able to evidence equitable access, value for money and the best use of resources

Spot light on whole life course

A focus on a whole life course: enables consideration of the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing.

Population Health Approach

Placing people at the centre of delivery: improving access for all to prevention services taking a holistic approach

Core 20 plus 5 plus: targeting our approach and actions for this group of adults and children

Systematic risk identification and intervention approach to tackling inequalities in health outcomes for populations

Committing to community first and community driven approaches: enabling communities to take a driving role in the co-design and co-development of services.

Diversity, Equity and inclusion

Focus on equity at all stages: and therefore reducing the unfair, avoidable or remediable inequalities among our residents in SEL and focusing on root causes rather than effects

Building strength through diversity: and therefore fostering innovation and problem-solving by pushing everyone to look at things from different perspectives.

Our priority actions

Our priority actions – what we will do

★ ICS Strategic Priority

1. **Prevention and Health Equity Principles:** Co-develop and agree a set of prevention and health equity principles building on existing work and evidence with a focus on reducing inequalities. The purpose would be to give a framework for all programmes, workstreams and networks to integrate the prevention approach into their planning and delivery of services.

2. **Communication and Engagement:** Through the various networks and collaborations deliver and support the delivery of meaningful local engagement with communities, local groups and their representatives to enable them to co-develop and design future services and approaches. Ensuring that they are at the core of the programme especially those marginalised groups who's voices are not always heard.

3. **Increase the uptake of all prevention services**: Pilot innovative ways to engage local communities in accessing services including dedicated health and wellbeing centres, mobile units, out reach and community pharmacy. Providing opportunities for partners to deliver holistic services in creative and sensitive ways.

4. **Reducing confusion and complexity**: Produce a generic information guide that can be adapted locally to inform and guide residents on what is available to them and when they become eligible for NHS Services, what is available in their local area through health and care, and other partners

5. **Vaccination and Immunisation Strategy:** Co-develop with Local Care Partnerships, LA partners, NHS England and UKHSA an agreed South East London immunisation strategy which supports and provides resources required for each place to deliver their vision, defines roles and responsibilities of all system partners, and considers alternative settings for vaccination delivery such as community pharmacy and schools.

South East London Integrated Care System

Our key prevention deliverables for 23/24

- with further development through our integrated care strategy

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★ ICS Strategic Priority

Reduction in preventable vaccine disease		Screening		Health Checks		Other	
Area	**Objective**	**Area**	**Objective**	**Area**	**Objective**	**Area**	**Objective**
Childhood immunisation	SEL increase in overall take up of 5%, with at least a 7% increase for the Core20 population Launch joined-up Childhood Immunisations and adult vaccination campaigns; specific community-informed comms	Bowel Screening	Increase of 4% in the uptake of bowel screening in the eligible population Increased awareness of the change in eligibility to include 50+	SMI Physical health checks	Across SEL, 13,500 health checks completed by end of Quarter 4	Vital 5	increasing awareness, opportunity and coverage of community blood testing (Know Your Numbers) promoting the community pharmacy hypertension service
Adult winter immunisation	5 % increase for flu and covid for eligible population and 7% increase for core 20 population Launch joined-up, audience-centred campaign covering all immunisations including outbreaks + surges	Cervical Screening	Increase uptake by borough to 80% of eligible population Improving quality and therefore reducing rejected samples	LD Annual health checks	Over 75% of annual health checks completed for all individuals on the LD register	Obesity and exercise	Promoting healthy weight in health and social care settings Reducing the risk of childhood obesity by promoting breastfeeding Focusing on prevention through addressing maternal obesity Supporting consistent provision of Tier 2 weight management services in SEL
		Breast Screening	Increase uptake to 80% of the eligible population (50-70 year olds)	NHS Health Checks	to target health inequalities such as Black, Asian and Minority Ethnic communities and groups with high risk of T2 diabetes and onward referral to the National Diabetes Prevention Programme.	Smoking/ Tobacco	Equitable Access across SEL Sustainable rollout of NHS Long Term Plan funding (screening all smokers in hospital) A SEL wide Tobacco Strategy