READING HEALTH AND WELLBEING BOARD

Date of Meeting	06 October 2023
Title	Inequalities and Prevention: Reducing Premature Preventable Mortality project
Purpose of the report	To note the report for information
Report author	Sarah Webster
Job title	Executive Place Director – Berkshire West
Organisation	BOB - ICB
Recommendations	1. That the Health & Wellbeing Board note the planned pilot aimed at reducing preventable deaths through commissioning of a Community Wellness Outreach pilot.

1. Executive Summary

1.1. This briefing seeks to update the Reading Health and Wellbeing Board on the developments to date on the Berkshire West joint project around a Community Wellness Outreach Programme, ultimately aiming to reduce premature mortality and improve our residents' health and wellbeing.

1.2. The paper sets out how the ICB 'prevention and inequalities' funding allocated to Berkshire West (covering Reading, Wokingham, and West Berkshire) totalling £2.6m over two financial years (23/24 and 24/25) will be deployed, including elements that will be consistent across the patch and elements that are tailored to the needs of local residents in each borough.

1.3. The pilot Community Wellness Outreach model will have a consistent 'core' offering across the three Local Authority areas to focus on adult cardiovascular disease prevention, the leading cause of all preventable premature deaths in the UK, along with supplementary 'local' offerings reflecting local need.

1.4. The paper sets out how the Community Wellness Outreach model will be funded which is as follows: an element of the funding is top-sliced for Berkshire-West wide elements, and the remaining funding is allocated to the three partnership Locality Integration Boards (LIBs) for Wokingham, Reading and West Berkshire to determine the most appropriate local delivery vehicle, local offerings, and local residents/communities most in need. The expectation is that the model will complement/enhance existing arrangements in place rather than be a reinvention/uncoordinated addition.

1.5. Funding allocated to the LIBs has been based on an approximate split of 52% to Reading and 24% each to Wokingham and West Berkshire using NHSE's national health outcomes calculation.

1.6. The LIBs have each developed an approach for implementing the community wellness outreach health check pilot and the HWBB will be appraised of the detail at a future meeting.

1.7. A supporting project co-ordinated by the Directors of Public Health will use the remaining funding from the £2.6m allocation (£270K) to invest in live Population Health and Prevention intelligence to inform future programmes of work.

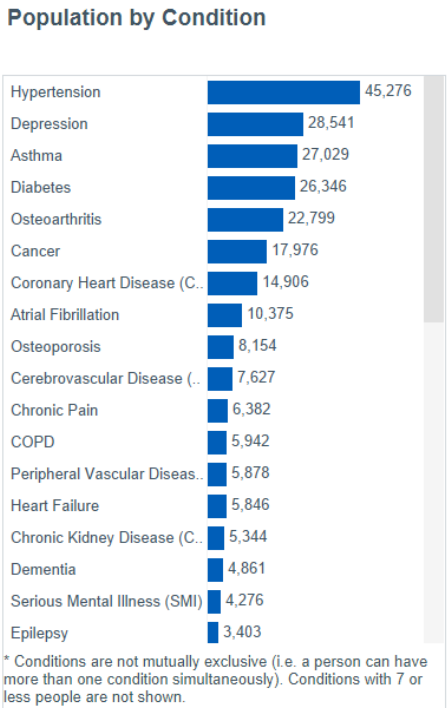
2. Background

2.1. As a Place Partnership we identified a priority around reducing preventable premature mortality across Berkshire West.

2.2. There were 3888 deaths in Berkshire West in 2021. Around 21% of these were avoidable and of those avoidable deaths around 70% can be attributed to conditions considered preventable. That means that about 570 people died from a preventable cause in 2021. The wider implications for families and communities linked to this early loss of life is also clearly significant.

2.3. Nationally, the leading cause of death is cardiovascular disease (CVD), and in areas of deprivation it is the leading cause of preventable premature mortality. People with a severe mental illness and those from a BAME background are disproportionally affected.

2.4. Across Berkshire West, hypertension is the most prominently recorded condition for those residents known to health services. A reasonable hypothesis is that this rate is the same if not higher in the cohort of residents whose conditions are not yet known to health services.



Source: NHSE National Population health Dashboard filtered to Berkshire West

2.5. Early detection of high blood pressure is key to enable the person to take preventative steps to reduce their risk of cardiovascular related events such as heart attack or stroke.

2.6. Reducing the rate of heart attacks, stroke and early death also has a significant secondary impact on the wellbeing of those indirectly affected, including the avoidance of associated family and childhood trauma and improving healthy lifestyles of the whole family.

2.7. Earlier detection and management of the causes of cardiovascular related events could have a material impact on the rate of illness and death in our communities.

2.8. In late February 23 the ICB confirmed a fund of £2.6m was available for Berkshire West over the two financial years to March 2025, to be used to support local prevention and inequality priorities alongside the core ICB prevention priority around CVD. It has since been confirmed that any unspent allocation in year one will be made available in year 2, noting the time required to develop and mobilise any proposals.

2.9. A working group of all partners in Berkshire West has been meeting regularly since March 23 to agree:

2.9.1. a preferred use of these funds; and

2.9.2. the best governance route to manage the funds and oversee delivery.

The section below summarises the resulting proposals.

3. Proposal

Main Proposal: Community Wellness Outreach programme.

3.1. Objective: To take prevention initiatives and signposting to the heart of our communities in a way that best suits local need, in the form of an enhanced heath check delivered by trusted community champions. Building on existing services/initiatives and based around existing community assets where these exist, and establishing new ones where needed. Provide a consistent 'core' offering around CVD prevention, supplemented by additional 'local' offerings based on local needs.

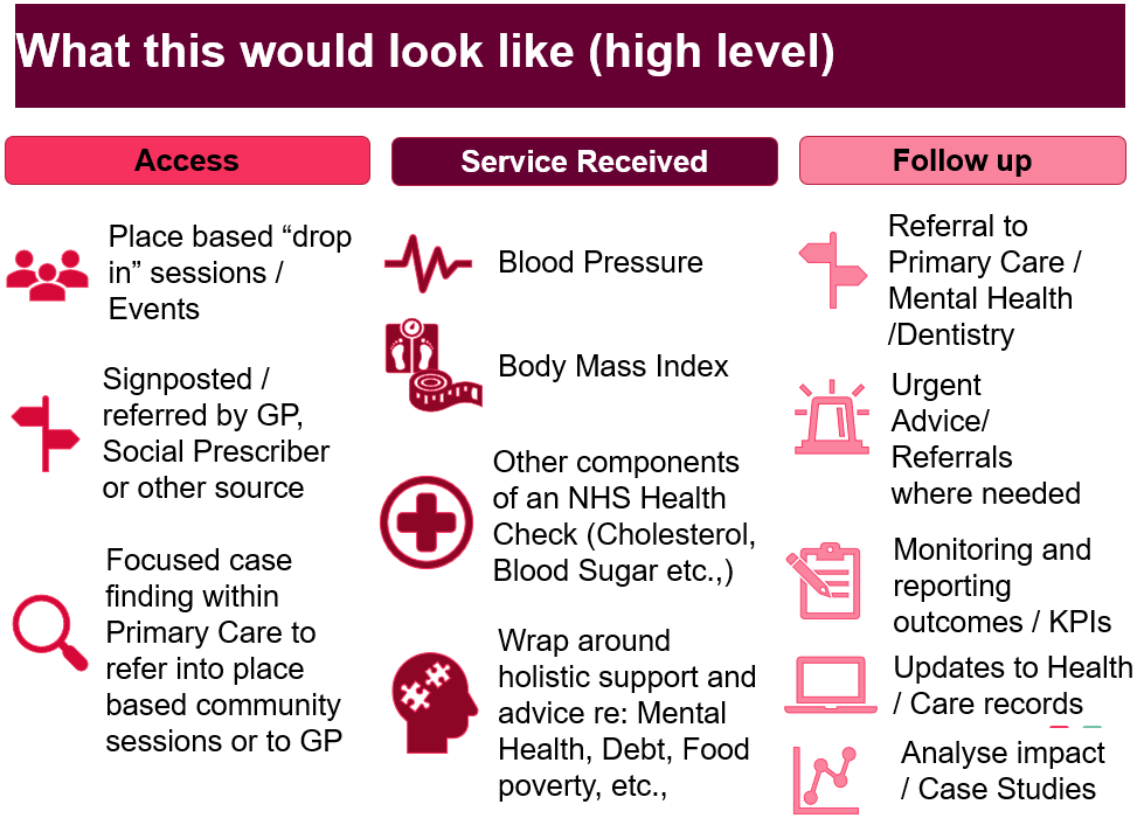
3.2. A sum of £2.33m (89.6% of the overall funding) over the two years will be allocated to the outreach health check service across the three boroughs.

3.3. An element of this funding will be allocated to elements that are consistent across the three boroughs (e.g. project costs, training costs, primary care capacity).

3.4. The remainder of the £2.33m has been allocated to each of the three partnership Locality Integration Boards (in Reading known as the Reading Integration Board, or RIB) according to the NHSE national health outcome calculations[1]: 52% to Reading, 24% to West Berkshire, and 24% to Wokingham.

3.5. For Reading, this resulted in £811k of funding over the two years being allocated directly to the RIB to determine the best vehicle for taking enhanced health checks into the hearts of the communities most in need.

3.6. The RIB has agreed the following service outline (note: the specific delivery vehicle is still under discussion, in collaboration with all partners including VCSE):



3.7. It is proposed that a further update is brought to the next Health and Wellbeing Board to update members on the specific service details once these are finalised.

[1] This takes into account relative population needs including socio-economic factors

Supporting Proposal: Population Health & Prevention Intelligence Coordination.

3.8. Objective: Develop a coordinated approach to Population Health and Prevention Intelligence across Berkshire West, enabling us to consider this intelligence in a strategic way to inform future programmes of work. Develop a Berkshire West-wide live intelligence report with supporting Local Authority Level report. Include intelligence on wider determinants of health such as deprivation, environment, crime and housing.

3.9. Funding: A sum of £270k (10.4% of the overall funding) over the two years will be invested in Population Health Analytic Support arrangements across Berkshire West. Discussions are underway with Directors of Public Health on how best to deploy this funding, noting a core requirement will include undertaking an impact evaluation of the Community Wellness Outreach model noted above.

Key Performance Indicators

3.10. A table of the proposed KPIs to monitor the impact, outcomes and outputs of the outreach service is included in Appendix 3.

3.11. It was also agreed that LIBs might wish to agree their own measures of success and LIBs will be expected to monitor service quality.

3.12. The model and pathway has been developed on the assumption that approximately 9000 residents across Berkshire West will directly benefit from the service over the two years (5200 from Reading). Indirect benefits are also anticipated through influencing family and social networks.

	West Berkshire (24%)	Reading (52%)	Wokingham (24%)	Berks West Total
23/24 (6 months)	534	1157	534	2225
24/25 (12 months)	1866	4043	1866	7775
Total	2400	5200	2400	9000

Current position

3.13. Each of the Locality Integration Boards were asked to dedicate their July meetings (each took place w/c 17th July) to a workshop format to further develop the local approach to delivering the Community Wellness Outreach Service.

3.14. The meeting invitees were broadened to include wider representation from Community Leaders, the Berkshire West Primary Care Alliance, Community Pharmacy and the RBFT Equalities Team.

3.15. The RIB approach is set out above.

3.16. Sub-groups are now in place considering:

3.16.1.1. Training – a draft proposal for training the community workers is being developed with the University of Reading

3.16.1.2. Data integration & interoperability – with a pilot underway in the Tilehurst Surgery, Reading, to test functionality linked to use of the Joy app.

3.16.1.3. Procurement – ensuring that standing orders are adhered to for the pilot building where appropriate on existing contracts,

3.16.1.4. Service Model & Primary Care Integration – consideration of the actual 'vehicle' for taking this service into the community, along with a consistent health check pathways and training requirements.

3.16.1.5. Risk stratification – The approach to targeting the population cohort relative to each local authority.

3.16.1.6. Outcome measures – Including a core set to measure across the three LAs, with each LIB developing specific KPIs relevant to their populations.

3.16.1.7. Community Wellness Outreach Pilot evaluation – linking to the supporting proposal and funding for Population Health Analytic Support referred to earlier in this paper.

4. Contribution to Reading's Health and Wellbeing Strategic Aims

- Reduce the differences in health between different groups of people
- Support individuals at high risk of bad health outcomes to live healthy lives
- Help children and families in early years
- Promote good mental health and wellbeing for all children and young people
- Promote good mental health and wellbeing for all adults

4.1 This approach both directly and indirectly supports the broad strategic Health and Wellbeing strategic aims through its vision and ambition to reduce inequalities through a targeted approach to engage with communities.

4.2 Furthermore, this pilot directly supports the identification of residents at risk of the largest cause of preventable death in the under 75 years cohort, CVD.

5. Environmental and Climate Implications

5.1. There are no immediate Environmental and Climate Impacts arising from this report although the community targeted model may reduce carbon footprint as bringing care closer to home via communities.

6. Community Engagement

6.1 LIBs to ensure delivery plans include community engagement and co-production.

7. Equality Implications

7.1. To be assessed as part of project planning.

8. Other Relevant Considerations

8.1. Not applicable.

9. Legal Implications

9.1. LIBs considering procurement requirements.

10. Financial Implications

10.1. No direct funding implications to Reading HWBB. Funding arrangements described above.

11. Timetable for Implementation

11.1. We are working towards implementing the service during Q3 23/24

12. Background Papers

12.1. None

13. Appendices

Appendix 1 - Draft key performance indicators

Appendix 2 - Draft training requirements

Appendix 1 – DRAFT Key Performance Indicators

Indicator Type	Indicator	Measures including target	Frequency	Source
Longer Term				
Outcomes	Number of cardiovascular 'events' including heart attacks and strokes	Actual number Target tbc, decrease	Annually	CSU/ Connected Care? (Exploring with CVD leads if this is possible)
Medium Term				
Impact	Patients (aged 45+ yrs), who have a record of blood pressure in the last 5 yrs (denominator incl. PCAs)	Proportion % Target tbc, increase	Annually	QOF, NHS Digital
Impact	Hypertension: QOF prevalence (all ages)	Proportion %	Annually	QOF, NHS Digital
Short term/ Operational				
Outputs	Number of Community Wellness Outreach sessions held	Actual Number. Target TBC on mobilisation	Quarterly	LIBs
Outputs	Number of residents identified for invitation to Community Wellness Outreach session	Actual Number. Target TBC on mobilisation	Quarterly	LIBs
Outputs	Number of residents invited to Community Wellness Outreach session	Actual Number. Target TBC on mobilisation	Quarterly	LIBs
Outputs	Number of VCSE organisations supporting Community Wellness Outreach Sessions	Actual Number. Target TBC on mobilisation	Quarterly	LIBs
Outputs	Number of public sector organisations (including private/ independent sector contractors of public serices) supporting Community Wellness Outreach Sessions	Actual Number. Target TBC on mobilisation	Quarterly	LIBs
Outcomes	Number of patients who attended Community Wellness Outreach session, broken down by protected characteristic, registered practice, other health inclusion group	Actual Number. Target TBC on mobilisation	Quarterly	LIBs

Outcomes	Total number of residents attending a Community Wellness Outreach session who report increased awareness of the importance of early identification of CVD and the Risk Assessment programmes available to them.	Actual number and % of attendees	Quarterly	LIBs
Outcomes	Total number of residents attending a Community Wellness Outreach session who report increased awareness and understanding of health behaviours that impact CVD risk.	Actual number and % of attendees	Quarterly	LIBs
Outputs	Number of eligible residents attending a booked NHS Health Check	Actual Number. Target TBC on mobilisation	Quarterly	LIBs
Outcomes	Total number of referrals to Health Behaviour Change Support (Lifestyle) and workers, or other support services, from Priority Population Groups broken down by intervention/type	Actual Number. Target TBC on mobilisation	Quarterly	LIBs
Outcomes	Number and % of residents who have a Health Check and are referred to their GP Practice for further assessment	No and %	Quarterly	LIBs
Impact	Case Studies summarising impact of Community Wellness Outreach Service	Case Studies Target tbc	Quarterly	LIBs

Appendix 2 - DRAFT Health and Wellbeing Checks Training Requirements

PCNs, working with public health and the provider organisations, must ensure that the outreach workers that deliver the health checks have the appropriate level of core competencies, clinical skills competencies, and programme competencies[2].

Core Competencies	**Clinical Skills Competencies**	**Programme Competencies**
1. Personal development 2. Effective communication 3. Equality, diversity and inclusion 4. Duty of care 5. Safeguarding 6. Person-centred care and support 7. Handling information 8. Infection prevention and control 9. Health and safety 10. Moving and assisting 11. Basic life support 12. Privacy and dignity 13. Understanding your role	1. Pulse measurement and rhythm 2. Blood pressure measurement 3. Height and weight measurement 4. Waist measurement 5. Point of care testing for cholesterol and Hb1Ac	1. Health Inequalities and NHS Health Check programmes knowledge 2. Information governance and data flow 3. Risk assessment 4. Interpreting results 5. Communication of risk 6. Brief intervention/signposting/referral 7. Communication with general practice 8. Behavioural change (for outreach workers and clinicians)

[2] Based on PHE NHS Health Check Competency Framework, updated July 2020

End of report