A Delivery Plan for Prevention in Primary Care Settings across BLMK

An ambitious and joined up approach to prevention.
Fuller Programme - Integrated Neighbourhood Working

V3.0 January 2024

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Key messages

- This delivery plan articulates a commitment from across the BLMK Integrated Care System (ICS) to have a far greater focus on prevention across primary care settings, allocating resources to pro-actively support the prevention agenda. *Prevention first by default.*
- Delivering this plan will require organisations across the ICS to be more collaborative, with strong partnership working.
- This plan stipulates that the greatest effort and focus is on those most likely to experience health inequalities e.g., people living in the most deprived areas, people from ethnically diverse communities, LGBTQ+. Population Health Management (PHM) techniques will be used to target our preventative work across the ICS. These techniques can help to identify groups of people who have a higher prevalence of risk factors for long term conditions (LTCs), those who are less likely to attend vaccination and screening offers that they are eligible for, or where LTCs are less well managed. We can then target interventions to support these groups and reduce health inequalities in access and outcomes.
- Across primary care, we need to recognise the great potential within Community Pharmacies (particularly the Health Living Pharmacies), as well as dentistry and optometry to deliver more preventative healthcare, including in signposting or making referrals into preventative services, identification of undiagnosed long-term conditions, their role in better management of LTCs via monitoring and structured medicines reviews and earlier initiation of therapies where appropriate.
- A key thread throughout this plan is how prominent, consistent action from primary care professionals, supporting people to (re)introduce physical activity in their day-to-day lives, with an additional emphasis on enhancing social interaction, will have significant benefits across many of the common health challenges we face. The good news is that the greatest benefits and lowest risks come from when people move from sedentary to a moderate level of activity.
- We need to strengthen our support to the Voluntary, Community and Social Enterprise (VCSE) sector across BLMK to support the shift towards greater prevention and self-care.

For General Practice settings

- Have more brief, focused, and high-quality conversations with people about the importance of healthy behaviours in preventing future illness.
- More referrals into preventative services (e.g., stop smoking, weight management, drugs, and alcohol), either making the referrals or signposting as appropriate.
- More proactive management of diagnosed LTCs, following evidence-based care processes and pathways.
- Improved management of people with hypertension and care processes for people with diabetes (particularly completing urine albumin creatine ratio).
- Offer more fittings of LARC devices in primary care settings and work with public health to understand how primary care settings could deliver more stop smoking services in house with future funding opportunities.

For pharmacies

- Have more brief, focused, and high-quality conversations with people about the importance of healthy behaviours in preventing future illness.
- Increased awareness of the local and national preventative services (such as opportunities for increased physical activity, stop smoking, drugs and alcohol, weight management services) and refer into these services or signpost as appropriate.
- Offer case finding for hypertension within pharmacy settings to support with improved identification and recording of hypertension and monitoring of blood pressure.
- Further discussions with the LPC in early 2024 to agree additional interventions.

For dentistry

- Have more brief, focused, and high-quality conversations with people about the importance of healthy behaviours in preventing future illness.
- Increased awareness of the local and national preventative services (such as opportunities for increased physical activity,stop smoking, drugs and alcohol, weight management services) and refer into these services or signpost as appropriate.
- Further discussion with the LDC to agree additional interventions.

For optometry

- Have more brief, focused, and high-quality conversations with people about the importance of healthy behaviours in preventing future illness.
- Increased awareness of the local and national preventative services (such as opportunities for increased physical activity, stop smoking, drugs and alcohol, weight management services) and refer into these services or signpost as appropriate.
- Further discussion with the LOC to agree additional interventions.

For BLMK ICB

- Develop and share the Better Health branding toolkit within our system wide approach to prevention.
- Create more opportunities to support the work of the Voluntary, Community and Social Enterprise (VCSE) sector working within the system.
- Strengthen the relationships with the newly delegated pharmacy, optometry and dental services based within the ICB.
- Support primary care services with proactive management of LTCs, using population health management techniques, to identify improvement opportunities and inequalities.
- Increase the delivery of annual health checks to our eligible SMI and LD population. Continue to support primary care services to understand their cohorts living with an SMI and/or learning disability and identify which people require their annual Physical Health Checks.

For Local Authority Public Health

- Work with commissioned providers to design and deliver tailored education, training, and support for healthcare professionals across primary care settings to increase the engagement with, and referrals into, preventative services.
- Work with PH preventative services and primary care to streamline the referral process into these services where possible.
- Work with individual practices to ensure targeted uptake and delivery of NHS health checks to increase the uptake in our eligible population. Develop innovative, opportunistic approaches to promoting the NHS Health Check service and use PHM methodology to ensure that all population groups have equal access to NHS Health Checks. Maximise onward referrals into preventative services.
- Consider options for outreach to improve access for those who currently find it challenging to access the NHS Health Check.
- Support primary care services with proactive management of LTCs, using PHM techniques, to identify improvement opportunities and inequalities.

For other organisations across BLMK ICS

- Work with communities to develop meaningful relationships, especially with those communities that the NHS has traditionally struggled to engage with.
- Deliver services and projects that support individual health needs.
- Have confidence in commencing conversations with people about the importance of healthy behaviours in preventing future illness. Deliver culturally competent communication to raise awareness of health promotion and preventative services.
- Increase awareness of the local and national preventative services (such as stop smoking, drugs and alcohol, weight management services) and refer into these services or signpost as appropriate.
- Utilise social prescribing to connect people to interventions provided by the VCSE such as befriending services, practical information including benefits and financial advice, community activities, arts, and culture, and those that take place in nature.

Introduction

Foreword

Many people across Bedfordshire, Luton, and Milton Keynes (BLMK) spend many years in poor health, with people living with more complex illnesses for longer.[iii] The increasing prevalence of long-term conditions (LTC), increasing multi-morbidity and an ageing population is leading to an ever-increasing demand for health care services.

The pressures on primary care and the wider NHS services are significant and growing. Without an ambitious, joined up approach to prevention, these services eventually risk becoming overwhelmed. Preventative health care is cost effective and has the potential to reduce future need and demand for health care.[iii,iv] A shift to a greater focus on prevention and preventative healthcare is therefore crucial to improving the health of the whole population, reducing inequalities across BLMK, and helping to secure the health and social care services we value and rely on.

We know that good or bad health is not simply the result of individual behaviours, genetics, and medical care. Housing, education, work arrangements, access to and affordability of good quality food, air quality and social connections all have a significant impact on our health and wellbeing as shown in Figure 1. Whilst recognising this, we want to empower people to look after and improve their own health and wellbeing. Each of us has a responsibility to look after our own health and wellbeing so far as we can, taking responsibility for that which we can influence. This is not easy, and it is harder for those with lower household wealth or with other challenges, so this plan takes a proportionate universalism approach, underpinned by population health management techniques. This is the resourcing and delivery of universal services at a scale and intensity proportionate to the degree of need, directed intelligently using population wide datasets.

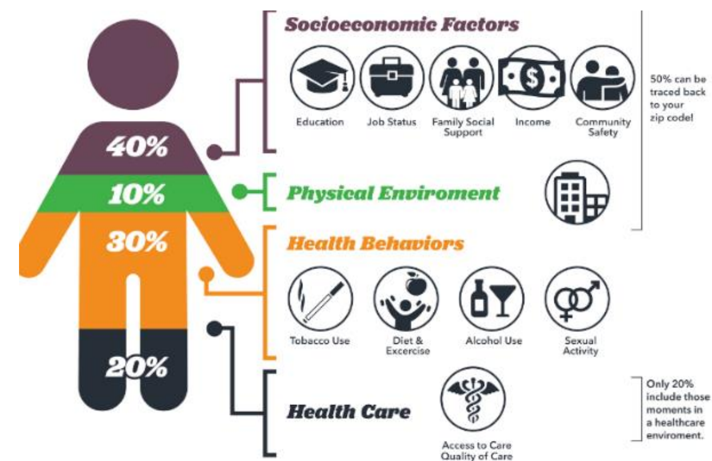


Figure 1: Determinants of health.

Frontline professionals working in primary care settings are in a unique position to highlight, influence and support people towards healthier behaviours.[v] In addition, frontline professionals play a key role at

identifying conditions at an early stage and supporting the ongoing management LTCs, in line with evidence-based guidance.

This prevention plan articulates a commitment for a far greater focus on prioritising the prevention agenda across primary care settings.

Recognising the different determinants of health, this delivery plan has been developed with colleagues from across the Integrated Care System (ICS) including pharmacy, Public Health, the Voluntary, Community and Social Enterprise (VCSE) sector and through wider consultation.

Craig Lister
Associate Director of Primary Care and Prevention
Bedfordshire, Luton, and Milton Keynes
Integrated Care Board

Aims

This delivery plan outlines an **ambitious and joined up approach** to prevention within primary care settings across the BLMK footprint, as part of the Fuller neighbourhood programme of work.

There is a significant amount of work being done on prevention across different primary care settings and across different organisations. This delivery plan takes stock of the current preventative work occurring across primary care settings and outlines general priorities that apply to prevention. It also highlights where the gaps are and how to maximise the value and effectiveness of prevention work by greater co-ordination and collaboration across the ICS.

These documents are aimed at key professional partners across the ICS who deliver, commission, or influence primary care services, and allied services that support prevention in primary care settings.

Scope

This delivery plan focuses on **primary, secondary, and tertiary prevention** within **primary care** settings across BLMK. Primary care settings include general practices, community pharmacies, NHS dental practices and optometry practices.

NHS England delegated the commissioning of pharmacy, optometry and dental (POD) services to the ICB in April 2023. The focus in year one (2023/24) will be to stabilise existing contracts, with further work in 2024/25 and 2025/26 to improve access to POD services including targeting inequalities in access, experience, and outcomes. The focus of this delivery plan will therefore focus primarily on GP practices and pharmacies initially with the view to embed more prevention work in optometry and dental settings in future. A task and finish group has been established to progress prevention discussions in POD services.

Prevention in secondary care is not within scope of this delivery plan, but it does take into consideration the interface between primary and secondary care services and NHS community services (e.g., ELFT, CNWL, CCS).

Whilst this delivery plan intends to improve access to primary care in the longer term by reducing the demand for primary care services through prevention, other work is being completed across the ICS to address access to primary care more broadly which is not outlined in detail in this

prevention delivery plan. For more information on this work, please contact Craig Lister (Craig.lister4@nhs.net).

We have not focused in detail on many of the traditional 'wider determinants' of health. These are workstreams that are being focused on elsewhere in the system and across the ICS. Please see links to related strategies and plans in the Appendix, including the place plans which have a strong focus on prevention. This delivery plan focuses on **specific actions** that can be carried out **within primary care settings** and those that are under the control or gift of colleagues working in these settings to strongly influence.

Context

The importance of prevention within primary care settings is becoming more recognised than ever within national healthcare policy- for example Green Paper on Prevention (2019) and Core20Plus5. [vi,vii,viii] Our work within the BLMK system is shaped by progression within NHS programmes, focused upon proactive, preventative, and outcome-focused care.

The NHS Long Term Plan has a strong focus on the treatment and prevention of illness by supporting people to adopt improved healthy behaviours. We are taking forward the specific commitments set out in the NHS Long Term Plan whilst supporting the NHS to drive a consistent focus on prevention across all services. This is an exciting and significant challenge.

The 'Next Steps for Integrating Primary Care: Fuller Stocktake Report' has provided the mandate for BLMK to develop a detailed vision for integrating primary care, improving access, and improving the experience and outcomes for our residents. Delivering effective primary care services requires close working between partners across health and care, including (not exhaustive) Public Health, Local Authorities, community, and mental health services, acute hospitals, and the voluntary sector. In BLMK, we see this being achieved through an operating model that draws inspiration from the Fuller Stocktake Report for Integrated Primary Care. In essence this means our work to transform primary care will be anchored firmly at "place" with Primary Care Networks (PCNs) and stakeholders owning and driving the plans.

There is strong emphasis at all levels for ICSs to utilise place partnerships, integrated neighbourhood teams and provider collaboratives to improve both allocative and technical efficiency.

Current health of our population

Current picture across BLMK ICS

The resident populations of Bedford Borough, Central Bedfordshire, Milton Keynes, Luton, and part of Buckinghamshire are within the geographic BLMK ICS footprint.

The Joint Strategic Needs Assessment for Bedford Borough, Central Bedfordshire and Milton Keynes can be found here: https://bmkjsna.org/. Luton can be found here: https://www.luton.gov.uk/Community_and_living/Lists/LutonDocuments/PDF/JSNA/jsna-overview-health-social-care-needs-2022.pdf and for Buckinghamshire can be found here: https://www.buckinghamshire.gov.uk/health-wellbeing-and-sports/joint-strategic-needs-assessment. If you are viewing this as a hard copy, you can access the Joint Strategic Needs Assessment (JSNA) for each Place by going onto the relevant Local Authority website.

Please note that this section will be developed further from January-March 2024. Population projections and future demand modelling are being performed as part of the BLMK Health Services strategy and the outputs of the work will be incorporated into this primary care prevention plan. This modelling will consider the scale of potential mitigation through preventative interventions.

Health Inequalities BLMK

Figure 1: Health Inequalities BLMK 2022. Infographic produced by Anna Mizen, George Akomfra, Population Health Evidence, and Intelligence- Public Health team Bedford Borough, Central Bedfordshire, and Milton Keynes Council. Data sources: Fingertips, Office for Health Improvement and Disparities (https://fingertips.phe.org.uk/indicator-list/view/HrZA8XXUES) for alcohol related hospital admissions, self-harm admissions, preventable mortality, under 75 circulatory disease, under 75 cancer mortality, life expectancy at birth, healthy life expectancy at birth, COPD admissions, GP deprivation score, breast cancer screening. Arden & GEM, SMITH model data 30/09/22 for hospital activity unplanned admissions and A&E attendances. Local Stop Smoking Reporting, MSOA level (as of 16/02/22) for successfully quit smoking. Local NCMP reporting, MSOA level (as of 16/06/2022) for excess weight data.

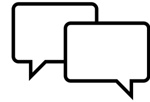
Overall goal and priorities for preventative work

Overall goals

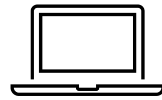
- Place prevention at the heart of primary care.
- Decrease or halt the increase in the prevalence of LTCs.
- Improve quality of life for our residents.
- Decrease health inequalities.

Reduce the variation in our population including in:

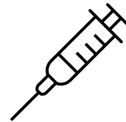
- Risk factors for long-term conditions e.g., smoking rates, physical inactivity, excess weight.
- Access to preventative and primary care services.
- Uptake of screening and immunisation offers.
- Management and outcomes of



More conversations with people about the importance of healthy behaviours in preventing future illness.

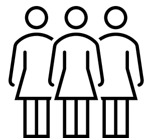


More referrals into preventive services e.g., opportunities for increased physical activity, stop smoking, weight management and drug and alcohol services.



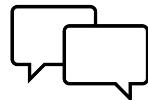
More people attending the vaccination programmes they are eligible for and reduce the variation in uptake across our population.

Better access to contraceptive services including more LARC fittings offered within primary care.

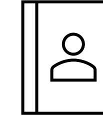


Support women to have the healthiest pregnancy possible through good preconception health and healthcare.

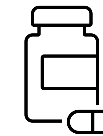
Ensuring health inclusion groups are registered with primary care.



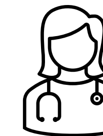
Promote social prescribing to support wider determinants of health.



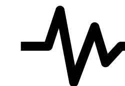
More people attending the screening programmes that they are eligible for and reduced variation in uptake.



Medicines optimisation and a reduction in waste. Reduce polypharmacy.
Regular medication reviews.



Increase delivery and uptake of NHS Health Checks and annual LD/SMI health checks. Appropriate follow up and treatment/management of any LTC or risk factor identified.



Earlier identification of risk factors for, and/or the presence of LTCs. In particular, improved recording of blood pressure monitoring within primary care settings.

Enhanced management of LTCs. In particular- improving hypertension management; improving diagnostic capacity for common chronic respiratory conditions; improved evidence-based management of diabetes.

Further improve completion of care processes for LTCs (e.g., diabetes care processes), stroke rehabilitation and transformation of heart failure pathways.

Cross cutting themes and enablers

Population health management and reducing health inequalities

- Data-driven approach to intelligently tailor and direct interventions for residents and patients to maximise efficiency and outcomes.
- This can support a proportionate universalism approach, where universal services are resourced and delivered at a scale and intensity proportionate to the degree of need – a key method for addressing health inequalities.
- Use PHM principles (including segmentation and risk stratification tools) to target preventative work- identify a group of people (cohort) with shared characteristics who could benefit from more proactive or joined-up preventative support and then co-produce an intervention or support to meet their needs. Test interventions, measure their impact and then act on the learning.
- The recent establishment of a BLMK wide population health intelligence unit (PHIU) will be an enabler to achieve this.

Social prescribers

- Social prescribers are already connecting people to interventions provided by the VCSE sector such as befriending services, practical information including benefits and financial advice, community activities, arts, and culture, and those that take place in nature can alleviate issues relating to loneliness, stress, mild to moderate depression, and anxiety. Improvements in mental health and wellbeing, confidence and community knowledge have been reported in people attending social prescribing programmes.

Self-care and personalisation

- Self-care is about people keeping fit and healthy, understanding when they can look after themselves, when a pharmacist can help, and when to get advice from their GP or another health professional.
- For those living with a long-term condition, self-care is about understanding that condition and how to live with it. However, some people might require additional support with self-care and management of their long-term condition. Social prescribing and VCSEs, as outlined above, could provide some of this additional support.
- Personalised care, meaning that people have choice over the way their are is planned and delivered. Based on what matters to them, individual strengths and needs (NHSE).

Enabling the VCSE sector

- The Voluntary, Community and Social Enterprise (VCSE) sector in BLMK is essential to supporting a greater shift towards prevention and self-care.
- Our population is growing rapidly and tackling the growth in demand and complexity is only possible if we work together in partnership with our colleagues in the VCSE.
- There are estimated to be 4000 such organisations in BLMK, bringing diverse expertise, insight, and a range of services to the area.
- Harness the power of our communities, work more closely with our communities to build solutions together.

Enivronmental sustainability

- By preventing illness, we can reduce the need for healthcare services – which are typically environmentally damaging, with high emissions and high waste. The BLMK ICS Green Plan (2022-2025) and associated Health Impact Assessment provide further information on this topic.
- It is noteworthy that those living in the most socioeconomically deprived areas tend to be those most at risk of the impacts of climate change, therefore promoting environmental sustainability will naturally support a reduction in health inequalities.

Quality Improvement, Research and development

- Quality Improvement (QI) is a key tool we can use in the delivery of this workplan. QI is the use of methods and tools to continuously improve the quality of care and outcomes for patients and can be used to target and reduce health inequalities (Kings Fund).
- Research and development to understand barriers to accessing services and the effectiveness of preventative interventions to reduce the prevalence of risk factors, long-term conditions and reduce inequalities.

How are we going to do this?

Detailed actions for how the ICS can more strongly embed these prevention priorities are outlined in a live action plan. For each of the key areas of focus, this specifies the actions, the relevant organisations that need to be involved, timescales and progress measures. Please email Craig.lister4@nhs.net for an up-to-date copy of the action plan. Key actions are highlighted below.

General Practice settings

Health improvement and promoting preventative services	• Be aware of, and promote, free local and national resources that support healthy behaviours and are available to everyone. For example: Better Health, Every Mind Matters, Couch to 5k. • Have more conversations with people about the importance of healthy behaviours in preventing future illness using MECC principles (e.g., opportunities for increased physical activity, stop smoking, weight management, recommended alcohol limits, low carbon diets, harms of UV exposure and staying safe in sun). There will be local training offers from Public Health to support this. • Encourage and support referrals into preventative services, such as smoking cessation support (the Stop Smoking service, Total Wellbeing Luton), exercise on prescription, Tier 2 weight management programmes (MoreLife, Total Wellbeing Luton, NHS Diabetes Prevention Programme, NHS Digital Weight Management Programme); Drugs and Alcohol services (Path 2 Recovery (P2R), Addiction Recovery Community (Arc) Milton Keynes, SAMAS and ResoLUTiONs). This includes making referrals or signposting people to complete a self-referral where appropriate. There will be local training offers from PH to support this. There are Enhanced Service payments available for referral into Tier 2 weight management services. • Particularly target and support cohorts of the population who have a higher prevalence of the modifiable risk factors, using proactive practice level data and population health management techniques to support this. To achieve this, have better monitoring and completion of records which are maintained and as up to date as possible e.g., opportunistic BP and BMI measurements. • Increase access to contraception services, particularly to long-acting reversible contraception devices through increased fitting of LARC devices in primary care settings. Increase access to post-natal contraception. Encourage self-care around testing for STIs and protected sexual intercourse, sign-posting people to the local service website (iCASH). • Promote BLMK ICB pre-conception resources to service users; consider referral to the Preconception Counselling Clinic (PCC) for service users who are thinking of becoming pregnant and have one or more of the risk factors: a BMI over 35, hypertension, diabetes, a mental health condition, are taking any medications. • Actively advertise information on the mental health support available, particularly crisis provision and signpost to local services/resources (MH Directory BLMK).

	• Ensure that health inclusion groups are registered with primary care e.g., people who are rough sleeping, statutory homeless or from the Gypsy, Roma, Traveler community. • Have more conversations with service users who are at risk of falling, promoting factors that improve bone health e.g., a balanced diet, medication if required; strength and balance training; recommending regular eye and hearing checks. Earlier identification and earlier intervention for those who are risk of falling or who have recently had a fall, referring to falls services or signposting for self-referral.
Immunisations, cancer screening and non-cancer screening	• Build on current work to promote vaccinations and screening including the delegation of vaccinations to ICB from 2025 • Have a strong focus on targeting populations that are traditionally harder to reach and those at risk, including those who are under-vaccinated or do not attend screening in your practice. Use a population health management approach to identify and target these groups of people, with proactive follow up with these cohorts.
NHS Health Checks and annual LD and SMI health checks	• Targeted work to increase the uptake of NHS Health Checks for eligible population and annual health checks for people with SMI and LD. Use PHM techniques to target communications, engagement, and outreach events to increase uptake in populations where we know uptake is low. • Maximise opportunities from these health checks to refer onwards to preventative support if applicable and for onwards management of LTCs. Management of abnormal blood pressure, lipids, and blood glucose results as per local pathways. • Work with the ICB and LA Public Health to reduce the inequalities in uptake of health checks across our population.
Early identification of, and evidence-based management, of LTCs	**Earlier identification:** • Earlier diagnosis of LTCs such as respiratory conditions (asthma, chronic obstructive pulmonary disease [COPD]), cardiovascular disease (including hypertension and atrial fibrillation) and Type 1 and Type 2 Diabetes management; mental health support and onwards referrals to secondary care and community services as applicable. Focused work supported by the ICB and LA Public Health to improve blood pressure monitoring and recording. • Earlier identification of risk factors that may make people more likely to experience mental health difficulties, as outlined in the supporting document. Earlier intervention and support for people experiencing mental health difficulties, including referral into NHS Talking Therapies. Increased awareness of, and identification of people who are in crisis and/or experiencing suicidal ideation. Referrals for crisis support including crisis cafes. • Increased testing for sexually transmitted infections and referral to sexual health services if required, for treatment, contact tracing and specialist support. Increased awareness of clinical indications to test for HIV (e.g., shingles), earlier testing for HIV within GP settings by testing individuals identified as higher risk (e.g., new registrants) and adding an HIV test where conditions or symptoms might be associated with HIV. If applicable, referral into specialist HIV services for support and treatment. • Earlier identification of drug and alcohol harms (using tools such as AUDIT-C), recognising risk factors in a service user that might make them more likely to misuse drugs and alcohol or where they might be used as a coping mechanism e.g., when someone has experienced trauma or mental health difficulties. Identification of service users who are at greatest risk of drug-related deaths. Clearer pathway and

actions following identification. Acknowledging that treatment is not just substitute opioid prescribing or medication for alcohol dependency, refer to drugs and alcohol services for specialist support, including psycho-social interventions.

- Targeted work to support with Drugs and Alcohol secondary and tertiary prevention as per supporting document and action plan.

LTC management:

- Ensuring that local pathways for LTC management are being followed and optimised, in line with NHS England Secondary Prevention guidelines on high impact interventions- working with BLMK ICB and LA Public Health to do:
    - Focused work on cardiovascular disease, improve hypertension management (adopting the revised local BLMK hypertension pathway) and lipid optimisation for secondary prevention of CVD. Follow heart failure pathways, including rapid initiation/up titration of key evidence-based therapies.
    - Focused work on respiratory disease, including increasing spirometry recording in people with asthma/COPD diagnosis, supporting the management of asthma in people with highest risk of exacerbations, admissions and poor outcomes and having an asthma plan for children.
    - Greater adoption of inhaled therapies for managing common respiratory conditions with reduced environmental impact – for example increasing uptake of propellant free short acting B agonist inhalers (SABAs) and better disease control through inhaled corticosteroids.
    - Further improve the completion of all 8 care processes for diabetes management, particularly focusing on improving completion of urine albumin-creatine ratio. Improved evidence-based management of diabetes as per supporting document.
    - Focused work to improve glycaemic management, CV risk reduction and adequate planning for pregnancy in people with young onset type 2 diabetes.
- Use a population health management approach to identify cohorts with suboptimal management of their LTC for proactive follow up. For example, where diabetes care processes not being met e.g., urine albumin-creatine ratio, hypertensive people with BP outside target range. Greatest effort on those mostly likely to experience health inequalities e.g., people from ethnically diverse communities, LGBTQ+, people living in the most deprived areas.
- Earlier identification of when a patient needs more comprehensive mental health support, with pro-active referrals into mental health community services if appropriate (ELFT, CNWL) and then onward referral into inpatient services if it is required.
- Regular medication reviews, including reviews into whether preventative or secondary care services are required. For example, performing regular reviews for people who are taking anti-depressants to assess whether psychology support is required or support from other services e.g., drugs and alcohol services, support from social prescribing.
- Take a compassionate community type approach to end-of-life care and prevent unnecessary suffering e.g., through preventing pressure sores.

Medicines optimisation	• Consider non-pharmacological treatments and promote healthy diets, reducing physical inactivity, smoking cessation, and increased social interaction as a key component of long-term condition management. • Optimise medications such as inhalers and a reduction in medicines waste. As per section above, use medications with reduced environmental impacts (e.g., propellant SABAs). • Reduce polypharmacy through regular medicines reviews. • Support service users with Medicines Concordance- support and education to service users so that they better understand their medical condition, the treatment options and so that they actively participate in shared decision making. • Further work with medicines optimisation team to be completed in 2024.
Wider determinants of health and social prescribing	• Recognise where the wider determinants of health are having a current impact, or could have a future impact, on people's physical and mental health and health behaviours. Either signpost or refer into sources of support e.g., Citizens Advice Bureau, housing associations as applicable and work with PCN and practice social prescribers to support registered population. For example, where the cost of living, relationship breakdowns, social isolation, might increase a patient's risk of suicide or use of drugs and alcohol, refer to appropriate support. This principle is also applicable to the secondary and tertiary prevention principles where these wider determinants might already be having a detrimental impact on their mental and physical wellbeing. • Where possible, proactively identify people who might benefit from social prescribing support or other sources of support using data and intelligence about resident population. • Consider further support for social prescribers in holding conversations with service users about financial challenges. • See ICB and LA Public Health sections on wider determinants of health.

Pharmacies

Health improvement and promoting preventative services	• Be aware of, and promote, free local and national resources that support healthy behaviours and are available to all people/the public. For example: Better Health, Every Mind Matters, Couch to 5k. • Have more, focused, and high-quality conversations with people about the importance of healthy behaviours in preventing future illness using MECC principles (e.g., opportunities for increased physical activity, stop smoking, weight management, recommended alcohol limits, harms of UV exposure and staying safe in sun). There will be local training offers from PH to support this. • Signpost people into preventative services where it is appropriate, such as smoking cessation support (Stop Smoking service, Total Wellbeing Luton), exercise on prescription, Tier 2 weight management programmes (MoreLife, Total Wellbeing Luton, NHS Diabetes Prevention Programme, NHS Digital Weight Management Programme); Drugs and Alcohol services (Path 2 Recovery (P2R), , SAMAS, Addiction Recovery Community (Arc) Milton Keynes and ResoLUTiONs) and signpost to sexual health services (iCASH). There will be local training offers from PH to support this.

	• For those pharmacies who have signed up to the PH Enhanced Service (PHES), continue to offer emergency hormonal contraception for all age groups and increase the number of pharmacies signed up to the PHES to improve community access. Increase testing for Chlamydia within the community and refer onto specialist sexual health services where applicable. • Support women with pre-conception health by making Diabetes UK Patient Information packs available within local pharmacies- these provide specific information for planning a pregnancy for people living with diabetes. • Continue to develop the role of Healthy Living Pharmacies, ensuring that the pharmacy team are informed and aware of all services offered by their service. These teams are well placed to offer advice and support to patients effectively with accurate signposting and referral when the need arises.
Immunisations	• Continue to promote vaccinations, having a strong focus on targeting populations traditionally harder to reach and those at risk, including those who are under-vaccinated.
NHS Health Checks	• Work with ICB and primary care colleagues to maximise opportunities from the NHS Health Checks to identify and manage LTCs, including clinical management and onward referrals to preventative services.
Early identification of, and evidence-based management, of LTCs	• Continue to work with the ICB and Local Authority Public Health to understand the great potential that Community Pharmacy has for the early identification and management of LTCs and strengthen this prevention work. For example: - Identification of undiagnosed diabetes. - Management of LTCs via structured regular medicines reviews for patients with patients with CVD, Hypertension, AF, Heart Failure, Asthma, COPD, and diabetes. • Focused work, with the support of the ICB and Public Health, to support with improved identification of hypertension via community case finding and onward monitoring and management. • Continue pilot work (with ICB) looking at earlier initiation of therapy e.g., treatment of hypertension confirmed by ambulatory blood pressure monitoring.
Medicines optimisation	• Consider non-pharmacological treatments either instead of medicines or alongside medicines as an equally beneficial treatment. Many long terms conditions – such as chronic pain, diabetes, cardiovascular and respiratory conditions benefit from a holistic approach from the clinician and shared decision making with the patient as to what can help them manage their condition. • Support service users with Medicines Concordance- support and education to service users so that they better understand their medical condition, the treatment options and so that they actively participate in shared decision making. • Further work with medicines optimisation team to be completed.

BLMK ICB

Health improvement and promoting preventative services	• Lead on the development of MiDoS, a professional and a public facing directory which covers organisations supporting primary and secondary prevention. • Develop the Better Health branding toolkit within our system wide approach to prevention. • Drive and support action within primary care to support people, including staff, to increase physical activity and decrease sedentary behaviour. • Deliver the Treating Tobacco Dependency programme to pregnant women and their partners, with a new smokefree pregnancy pathway including focused sessions and treatments. • Ensure that all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services. • Recognise the importance of good bone health to support health ageing and ensure appropriate services and pathways are in place. Continue ongoing work on falls pathways. This also includes promoting referrals into local falls services, encouraging the earlier identification and earlier intervention of residents who are at risk of falls. Promote referrals from health care professionals and raise awareness of the risk factors across BLMK residents, encouraging self-referral to falls services if appropriate. Continue the GaitSmart work (sensor-based motion analysis)[1]. 4 pilot sites are due to 'Go Live' early 2024, these include: discharge to assess beds at a care home, a falls team, a new 'Keeping Well' (Frailty clinic) and offered at an NHS Health Check. The pilots will be evaluated over a 12-month period with support from Health Innovation East. • Continue work being undertaken in the BLMK LMNS 'Preconception Planning for Pregnant Project' which is work across the ICS to promote women to have a healthy pregnancy and healthy baby (healthy mothers', healthy pregnancy). See supporting document for details of the range of activities included within this work programme.
Immunisations, cancer screening and non-cancer screening	• Work across the ICS to increase the number of people across BLMK taking up the offers for all immunisation and screening programmes (cancer and non-cancer screening) that they are eligible for. • Continue to use a community engagement approach to maximise uptake. • Continue ongoing work on cancer prevention, including earlier diagnosis, supporting timely presentation (awareness raising to people and health providers), risk stratification. Expand on innovation across the system, including faster diagnosis programme and greater use of genomics and personalised treatments. • Maximise the offer and take up in primary care for all age immunisations including COVID vaccinations and delivery of the annual flu campaign, especially in the 'at risk' and typically under-represented groups. • Assess the variation across PCN populations of screening and immunisation uptake to allow targeted promotion. Case finding by proactive clinical systems searches and using a Population Health Management approach including segmentation and risk stratification tools.

[1] GaitSmart is an innovative technology that provides an objective measure of gait/walking ability in a patient friendly report. It is quick and easy for trained staff to use in a range of settings and provides an opportunity to improve muscle strength and balance and reduce the risk of falls.

LD and SMI health checks	• Work with primary care settings (and other settings e.g., Housing Associations) to increase the delivery of annual health checks to our eligible SMI and LD population. Continue to support primary care services to understand their SMI cohorts and identify which people require Physical Health Checks. • Promote our enhanced and outreach Physical Health Check services throughout the system to increase referrals and uptake. • Collaborate with VCSE sector colleagues to raise awareness of SMI Physical Health Checks through their networks and contacts in the community, with specific focus in communities where uptake is low. Continue to prioritise the promotion of Learning Disability Annual Health Checks through collaborative work with primary care, health facilitation, NHS trust and local authority partners. • Explore opportunities to deliver Learning Disability Annual Health Checks and SMI Annual Health Checks simultaneously for those with a dual diagnosis.
Early identification of, and evidence-based management, of LTCs	• Undertake focused work with Primary Care and LA Public Health on the secondary and tertiary prevention of cardiovascular, diabetes and respiratory disease as highlighted in the General Practice table. • Case finding (e.g., undiagnosed hypertension, undiagnosed diabetes), by proactive clinical systems searches and using a Population Health Management approach including segmentation and risk stratification tools. • Support primary care to use a population health management approach to identify cohorts with suboptimal management of their LTC for proactive follow up. An example would be a targeted collaborative PHM project between PH, housing, ICB and primary care to proactively identify children who have had multiple admissions to hospital, notify housing providers and proactively offer support to that family via social prescribers (including assessing the home for signs of damp or mould). • Address unwarranted variation in the prevalence of primary CVD risk factors and management of LTCs and preventable hospital admissions to inform targeted secondary prevention activity. • Explore digital support offers to lead to improved self-management of hypertension. • Develop process for data flow from Sisu machine to GP to enable appropriate follow up of people with potential hypertension (LB).
Medicines optimisation	• Build on government recommendations to develop integrated templates that support referrals for culturally competent, evidence-based alternatives to a medicine (including physiotherapy, talking therapies, local social prescribing options) which support Shared Decision Making and which can be adapted for local use.
Governance	• Have oversight of, and monitor, prevention activities and priorities for **primary care settings** across the ICS via BLMK Prevention Delivery Group, reporting to the BLMK Primary Care Medical Services Delivery Group. • Once this delivery plan has been finalised, work with the ICB place leads and Public Health teams to ensure that the action plan is localised to place. • Continue strategic conversations regarding the role and opportunities of prevention within primary care settings, linking with ICB clinical strategic leads, PCN Clinical Directors, Strategic Long-Term Conditions ICB lead, pharmacy leads, Local Pharmacy Committee.

Wider determinants	• Continue leading collaborative work across the ICS to consider how the NHS supports wider social and economic development, including environmental sustainability to promote health and wellbeing and with a strong focus on prevention. • Continue working with partners to maximise the value of our Anchor organisations to improve the wider determinants of health e.g., employment, housing sector, income, education, wellness promotion, occupational health, nature, built environment.

Local Authority Public Health

Health improvement and promoting preventative services	• Design and deliver tailored education, training, and support for healthcare professionals across primary care settings to increase the engagement with, and referrals into, preventative services such as opportunities for increased physical activity, weight management services, smoking cessation, drugs, and alcohol services. Target training for those practices with highest need e.g., those with higher prevalence of risk factors, those that are in areas of higher deprivation, have lower referral rates or less complete disease registers. • Offer training on 'see the signs' suicide prevention for professionals working in primary care settings. • Review and streamline referral process from primary care settings into preventative services where possible. • Promote preventative services during outreach engagement events, which are often targeted in areas of greater deprivation. • Work with primary care settings to understand how primary care settings could deliver more stop smoking services in house with future funding opportunities.
Immunisations, cancer screening and non-cancer screening	• Provide data and analytical capabilities to support the ICB in their work to assess the variation across PCN populations of screening and immunisation uptake to allow targeted promotion. • Support the ICB with their work to increase the uptake of all age immunisations and screening by promoting uptake through outreach and engaging with community partners, focusing on groups with the lowest uptake.
NHS Health Checks	• Work with individual practices to ensure targeted uptake and delivery of NHS health checks to increase the uptake in our eligible population. Develop innovative, opportunistic approaches to promoting the NHS Health Check service, building on the Making Every Contact Count approach. • Use population health management methodology to ensure that all population groups have equal access to NHS Health Checks. • Work with ICB and primary care colleagues to maximise opportunities from the NHS Health Checks to identify and manage LTCs, including clinical management and onward referrals to preventative services. • Consider options for outreach to improve access for those who currently find it challenging to access the NHS Health Check.
Early identification of, and evidence-	• Undertake focused work with Primary Care and ICB, focusing on the secondary and tertiary prevention of cardiovascular, diabetes and respiratory disease as highlighted in the General Practice table. • Provide data and analytical capabilities to support the ICB and primary care with addressing unwarranted variation in management of LTCs and preventable hospital admissions to inform targeted secondary prevention activity.

based management, of LTCs	• Support primary care to use a population health management approach to identify cohorts with suboptimal management of their LTC for proactive follow up. An example would be a targeted collaborative PHM project between PH, housing, ICB and primary care to proactively identify children who have had multiple admissions to hospital, notify housing providers and proactively offer support to that family via social prescribers (including assessing the home for signs of damp or mould).
Wider determinants of health	• Continue working with partners across the ICS to improve the wider determinants of health e.g., employment, income, education, wellness promotion, occupational health, nature, built environment, air quality. See health and wellbeing strategies and place plans in the appendix for further detail about priorities and ongoing work in these areas.

Other organisations across the ICS

Health promotion and promoting preventative services	• Be aware of, and promote, free local and national resources that support healthy behaviours and are available to all people/the public. For example: Better Health, Every Mind Matters, Couch to 5k. • Be confident in commencing conversations with people about the importance of healthy behaviours in preventing future illness using MECC principles (e.g., opportunities for increased physical activity, stop smoking, weight management, recommended alcohol limits, harms of UV exposure and staying safe in sun). • Signpost people into preventative services where it is appropriate, such as smoking cessation support (Stop Smoking service, Total Wellbeing Luton), exercise on prescription, Tier 2 weight management programmes (MoreLife, Total Wellbeing Luton, NHS Diabetes Prevention Programme, NHS Digital Weight Management Programme); Drugs and Alcohol services (Path 2 Recovery (P2R), , SAMAS, Addiction Recovery Community (Arc) Milton Keynes and ResoLUTiONs) and signpost to sexual health services (iCASH). • Deliver culturally competent messaging around health promotion and preventative services (e.g., vaccination uptake, NHS health checks, structured diabetes education) to increase understanding and uptake.
Medicines optimisation	• Continue to support with certain elements of medical prevention, either by supporting the timely transfer of care around medicines, supporting shared decision making, and enabling deprescribing by offering non-medical interventions through social prescribing.
Wider determinants of health and social prescribing	• Connect people to interventions provided by the VCSE such as befriending services, practical information including benefits and financial advice, community activities, arts, and culture, and those that take place in nature. • Recognise where the wider determinants of health are having a current or could have a future impact on people's physical and mental health and health behaviours. Either signpost or refer into sources of support e.g., Citizens Advice Bureau, housing associations, where applicable and work with PCN and practice social prescribers to support registered population. For example, where the cost of living, relationship breakdowns, social isolation, might increase a patient's risk of suicide or use of drugs and alcohol, refer to appropriate support. This principle is also applicable to the secondary and tertiary prevention principles where these wider determinants might already be having a detrimental impact on their mental and physical wellbeing.

Monitoring and evaluation

The BLMK Prevention Group (to be established) will be responsible for the operational delivery of this plan and will report to the BLMK Primary Care Medical Services Delivery Group. This work programme will be monitored by the BLMK Primary Care Commissioning and Assurance Committee using outcome measures outlined in the action plan. A process evaluation of the primary care prevention work programme will be conducted in a year.

Updates on delivery will be reported to the BLMK Health Inequalities Steering Group on a quarterly basis.

Much of the work that is already being done will report to the established board (e.g., cancer board) therefore, the purpose of the BLMK prevention group is to co-ordinate and bring a summary together to review and share learning.

Conclusion

This delivery plan outlines a coordinated ambitious approach to prevention across primary care settings, involving professionals working across the ICS who deliver, commission, or influence primary care. Whilst undertaking these actions will require time and effort, prioritising, and maximising opportunities for prevention across primary care will have a positive impact on the health and wellbeing of the BLMK population. Such a focus on prevention should lead to a reduction in future demand on primary care settings.

Appendix

Related documents

Health and wellbeing strategies

Central Bedfordshire Health and Wellbeing

Luton Health and Wellbeing Strategy 2(

Milton Keynes Health and Wellbeing Strateg

Bedford Borough Joint Health and Welll

Please note that the BB and CB health and wellbeing strategies are currently being refreshed.

Place based plans

Bedford Borough Place Based Plan 201(

The Luton Place Based Plan.pdf

Central Bedfordshire: Our Strategic Plan:
https://www.centralbedfordshire.gov.uk/info/27/about_your_council/1108/our_strategic_plan_2022-27/4
Luton Place plan: available on request

ICS documents

BLMK Joint Forward Plan.pdf

BLMK Health and Care Strategy.pdf

BLMK ICS Green Plan 2022-2025.pdf

Health Impact Assessment BLMK ICS

Additional BLMK ICB strategies are available here:
https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/our-strategies/

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[v] Let's Talk About Weight Step-by-Step guide. Public Health England. 201 [cited October 23] Available from: https://assets.publishing.service.gov.uk/media/5b8d54d2e5274a0bd7d11928/weight_management_toolkit_Let_s_talk_about_weight.pdf

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