Tower Hamlets Strategy for Long-Term Condition Prevention: Vital 5

Strategy Overview

About this deck

This Deck provides an overview of the strategic approach we are taking to Long-Term Conditions prevention* in Tower Hamlets. It covers:

1. Why do health and care partners across Tower Hamlets need a Long-Term Conditions Prevention Strategy focusing on the Vital 5?
2. What action will we take and what outcomes do we aim to achieve?
3. Who and how will we deliver this strategy?

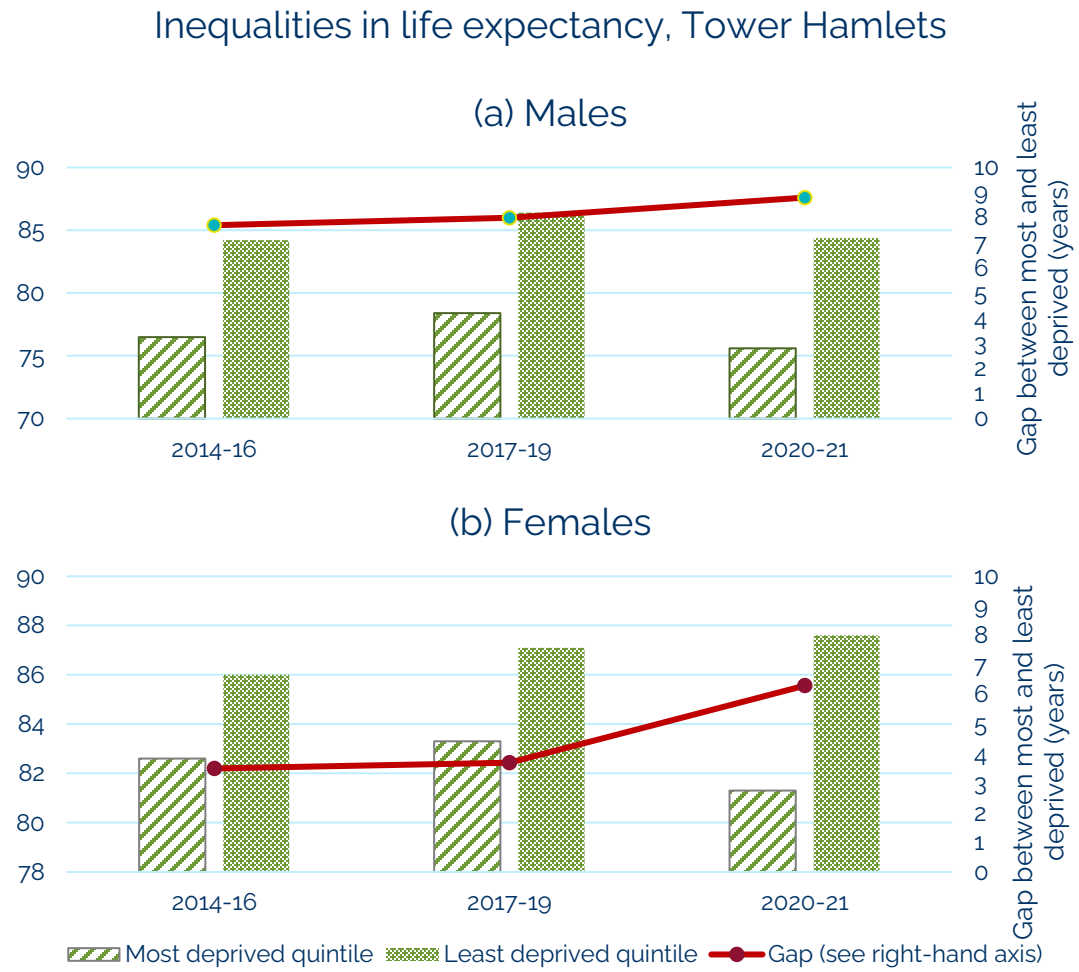
For more information on our approach, contact the Pillar Leads set out on slide 19

*In Tower Hamlets we have agreed to focus “LTC Prevention” on the conditions and risk factors that contribute most to gaps in life expectancy: cardiometabolic conditions and respiratory conditions, and the ‘vital 5’ risk factors that contribute towards them.

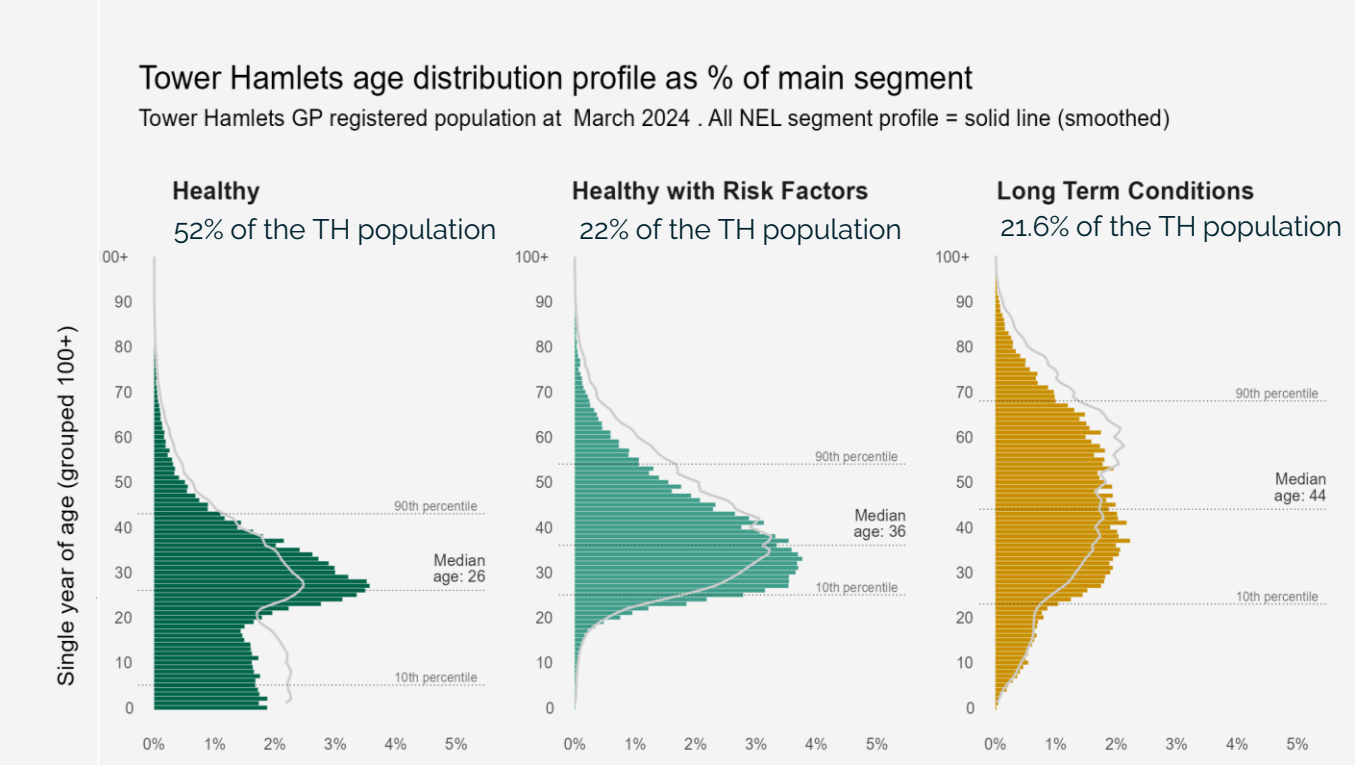
Why do health and care partners across Tower Hamlets need an LTC Prevention Strategy focusing on the Vital 5?

Poor health affects our residents unfairly, and causes unsustainable pressure on the health and care system.

- Poorer residents, and women, live shorter lives, and spend longer part of their lives in poor health.
- The life expectancy gap has widened in most recent period.
- We know the main conditions that contribute to this gap: heart disease, diabetes, respiratory disease and cancer.



In Tower Hamlets, many people get long-term conditions at a younger age than elsewhere



Tower Hamlets has a particularly deprived population.

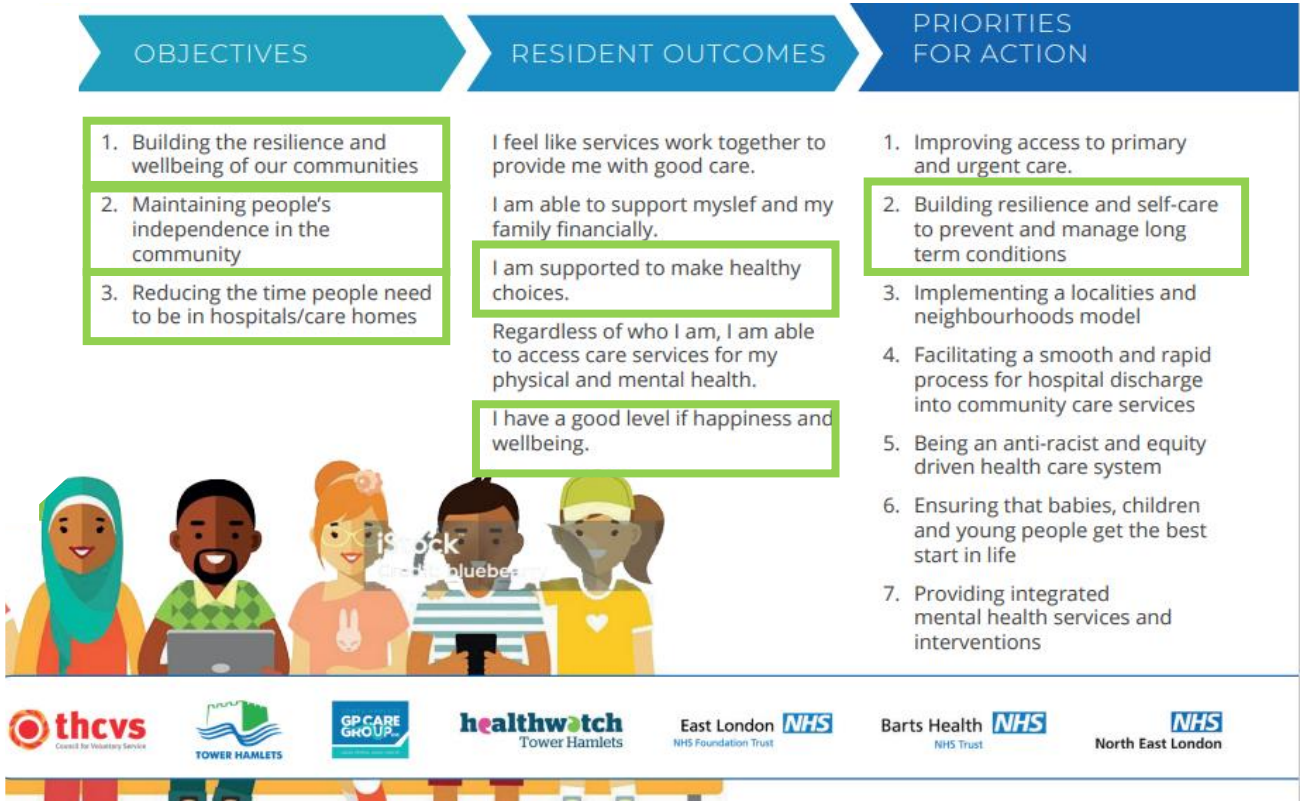
LTCs affect people much younger in Tower Hamlets than elsewhere. This is known to translate to poorer progression and outcomes.

Certain long-term conditions like heart disease, diabetes, lung disease and cancer, contribute to a large amount of the inequality in healthy life expectancy.

High rates of long-term conditions, and 'multi-morbidity', place major strain on the health and care system.

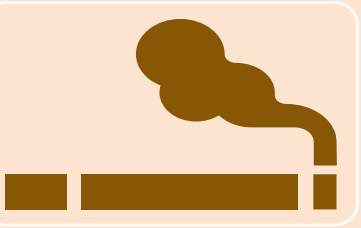
Tackling health inequalities, and reducing pressure on local health services, require us to prevent poor health early.

- Preventing poor health among our residents is essential to achieving our collective aims in Tower Hamlets and reducing strain on local health and care services
- For example, over 1 in 4 beds in RLH are occupied by people with complications relating to type 2 diabetes.
- We need an evidence-based approach to reducing inequalities in long-term conditions.



The Vital 5 are a set of risk factors that underpin our approach to Prevention

- These five risk factors are leading causes of death and disease in London.
- Their unequal distribution means that they explain a large amount of health inequalities in Tower Hamlets.
- This is why the Vital 5 are the framework to underpin our system-wide approach to prevention



Smoking

Leading cause of preventable death in England.

Overweight & Obesity

Associated with 1 in 6 heart and circulatory disease deaths.

High Blood Pressure

Associated with half of all CVD cases.

Mental health

1 in 6 adults have experienced common mental illness in the past week.

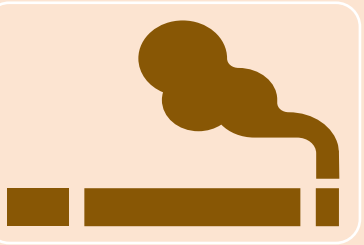
Alcohol

Drinking, smoking, and drug use linked to premature heart disease.

The
in one borough

Levels of Vital 5 in Tower Hamlets: many residents suffer from high risks, and these are unfairly distributed

TOWER HAMLETS



Smoking

Smoking rates at 11.7% are similar to London, but rates in BAME and routine/manual workers (34.2%) worse than London.

30,000 residents smoke

Overweight / Obesity

48% of adults are overweight or obese, similar to London.

Rates of healthy diet and of physical inactivity are worse than London.

118,000 residents are overweight or obese

High Blood Pressure

Hypertension diagnosis gap 8.1% is similar to London/England, % of GP patients with a BP recording is lower than national average

20,000 residents have undiagnosed hypertension

Mental health

Estimated prevalence of Common Mental Illness– 22.8%– worse than England.

50,000 residents have common mental illness

Alcohol

Overall admission rates for **alcohol** are better than England but have increased in recent years

55,000 residents drink at harmful levels

The best of London in one borough

What action will we take and what outcomes do we aim to achieve?

Our system-wide LTC prevention approach

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Preventing long-term conditions and the harms that are caused by 'Vital 5' risk factors requires a system-wide approach. All parts of the health and care system can have a role to play.

We have structured our approach into four "Pillars", which are themselves underpinned by two cross-cutting enablers.

1. Linking to better support around 'wider determinants' of health

2. Community-centered prevention and health promotion

3. Detection and enabling self-care to reduce the risks that cause poor health

4. Active management and secondary prevention for those with identified clinical risks & diseases

Vital 5 Communications

Insight: Vital 5 Epidemiology and Outcomes Framework

The best of London in one borough

Pillar 1: Linking better to enable residents to access support around underlying factors that drive poor health

***Overall Aim**: Residents and patients are enabled to access support around the underlying factors that drive poor health - like housing, employment, income and social connection.*

What have we done so far?	What do we want to achieve?	What difference will this make?
• Completed review of Social Prescribing; • Pilot of Social Welfare Advisors in all practices in TH; • A range of services exist to support residents with wider needs – such as council Resident Hubs.	Implement new digital tools to enable a range of social prescribing and connector roles to link people to support. Strengthen the social prescribing workforce, including through continued co-working, collaboration and knowledge sharing. Develop new triage systems and referral pathways to manage service demand and ensure capacity meets demand. Establish strategic coordination for the range of link-workers in the borough – ensuring resource is deployed well.	More efficient referral pathways, reducing wait times for residents; Increased awareness and utilisation of a range of community connector / link-worker roles Social prescribing is well-understood, utilised and coordinated. Sustainability of support services that SPLWs can refer to. **Residents and patients are supported to access help with the underlying factors that cause poor health.**

Pillar 2: Community-centred prevention and health promotion to enable people to live healthily

***Overall Aim**: People at most risk of LTCs are empowered to take action to reduce their risk, and conditions are created for people to be as healthy as possible regardless of their circumstances.*

What have we done so far?	What do we want to achieve?	What difference will this make?
• A range of community-centred initiatives relevant to LTCs exist, especially within the VCS • Communities Keeping Well established • Localities and PCNs are delivering community-centred health promotion	Ensure the voices of residents from the most deprived communities in the borough inform action Maximise the ability of existing community-centred initiatives to promote health and impact on Vital 5. For example: health champions, the Mayor's Grants Programme, Communities Keeping Well, and other initiatives. Enable community settings to support health promotion and Vital 5 prevention: for example faith settings, family hubs, community centres, women's centres. Develop standard approach to evaluation and monitoring for community-centred health promotion	Programmes and services will have a greater impact on LTC prevention, better meeting the needs of at-risk residents. New resident-led initiatives will support residents to prevent ill=health in a way that works for them. A greater number of settings will support LTC prevention. We will better understand the impact of our work in a consistent way, helping to make better informed commissioned decisions. **People at most risk of LTCs are empowered and enabled to to take action to be as healthy as possible**

Pillar 3: Detection and identification of Vital 5 risks and enabling self-care to reduce the risks that cause poor health

***Overall Aim**: People with Vital 5 risk factors have those risks identified, are enabled to understand the implications, and are supported reduce these risk factors.*

What have we done so far?	What do we want to achieve?	What difference will this make?
• Launched new Workplace healthchecks pilot • Developed MECC training offer for workforce • Strengthened pathways • Increased capacity for smoking cessation support and specialist weight management.	Ensure universal and targeted services to detect Vital 5 risks – like health checks, CVD checks - are available to, and accessed by, those who need them most. Ensure Vital 5 risks are recorded in health records and visible to health and care staff. Empower frontline staff to Make Every Contact Count: to have motivating conversations around health and the Vital 5, and to signpost / refer to appropriate support. Increase the accessibility of support services like smoking, weight management and alcohol support – by improving outreach and co-location where appropriate Develop and pilot innovative and embedded approaches to support with reducing Vital 5 risks.	Levels of un-identified Vital 5 risks are reduced. Residents are offered support at a time, place that is appropriate, increasing uptake. Health and care staff are enabled to promote good health. Tailored and culturally appropriate support is available to reduce Vital 5 risks; there are reduced inequalities in accessing this support. **Health inequalities in the Vital 5 are reduced (including inequalities in access to prevention services)**

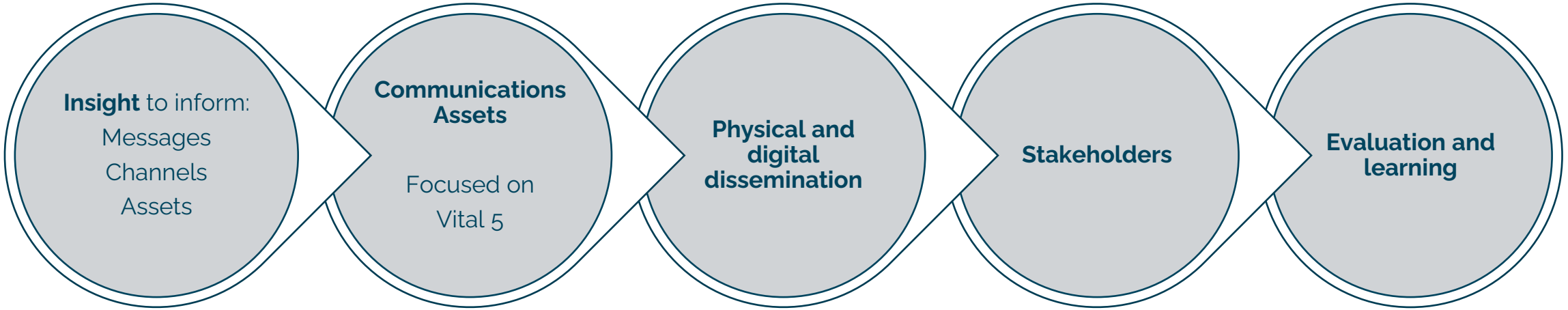
Pillar 4: Active management and secondary prevention for those with identified clinical risks & diseases

***Overall Aim**: People with diagnosed conditions or risk factors are supported with effective secondary prevention to reduce the harm caused by their condition.*

What have we done so far?	What do we want to achieve?	What difference will this make?
- A strong LES offer in primary care to manage long-term conditions. - We have a range of services in health and community settings to support prevention – e.g. T2DAY, NDPP, Good Moves.	Strengthen secondary prevention and management for people who are diagnosed with common long-term conditions (LTCs) Reduce unwarranted variation in LTC management across primary care Work with community and acute services to improve prevention and support for those with LTCs Ensure that health initiatives to support people with LTCs are tailored to our communities and equitably used. Improve referrals and uptake to evidence-based secondary prevention interventions	LTC support services are aligned to the real needs of local people Unwarranted variation in support for people with LTCs is reduced Systems and pathways of care are effective for proactively meeting residents' needs and reducing risk

Communications cross-cutting: Linking better to support around upstream 'causes' of LTCs

***Overall Aim**: To improve residents and professionals understanding of the Vital 5 and the work underway to address them.*



Insight (cross-cutting)**:** Development of enhanced evidence base and metrics to inform and monitor progress

***Overall Aim**: To ensure an evidence-based approach informs our strategy, enabling us to target intervention where it's most needed, and to keep track of our progress*

Vital 5 epidemiology, inequalities and targeting insight

- Evidence base to inform the whole of the Vital 5 / LTC prevention strategy
- Provision of detailed insight to inform targeting of primary and secondary Vital 5 initiatives.
- Development of interactive tools for additional operational insight.

LTC Prevention Strategy Outcomes Framework

- Establish agreed metrics and outcomes to monitor success of the Vital 5 Prevention Strategy
- Develop dashboards and tools to assess our progress.

Who and how will we deliver this strategy?

What will we deliver in 2025 to achieve these aims?

Pillar 1
Linking to better support around 'wider determinants' of health

- A new digital platform (Joy) to integrate data across services (2024/25)
- New triage systems within primary care (2025/26)
- Tailored training programmes for front line staff (2025/26)
- Recommission social prescribing services (2025/26)
- Launch community awareness campaigns (2025/26)
- Strategic Steering Group and Working Groups to oversee the above. (2024/25)

Pillar 2
Community-centered prevention and health promotion

- 7 Health Fairs delivered, focussed on at-risk population groups.
- Communities Keeping Well programme supported 80+ resident-led Vital 5 projects
- Community Champions established, with training on V5 messages.
- Culturally appropriate healthy eating plate developed and used by residents.
- Common set of metrics agreed and used to evaluate community centred approaches to LTC prevention.
- 2 trusted VCS organisations commissioned to coproduce LTC prevention project with at risk residents.

Pillar 3
Detection and enabling self-care to reduce the risks that cause poor health

- CVD Checks pilot to deliver 4,000 healthchecks in Workplace and Community settings.
- MECC training programme for frontline staff to enable motivating conversations about V5.
- Redesign of local NHS Health Checks programme.
- Co-location of vital 5 services (eg QRTH) into settings with high users.
- Capacity increased for QRTH smoking cessation and development of new offer.
- Tobacco and Alcohol CLeaR assessments to identify gaps
- Weight management services re-procurement

Pillar 4
Active management and secondary prevention for those with identified clinical risks & diseases

- Pathway improvement for High blood pressure and Diabetes
- Weight management and smoking cessation services referral pathway improvement
- Launch Respiratory hublet pilot to improve diagnosis of COPD
- Engagement work to improve referral and uptake rate of diabetes initiatives and the *Self-management support service* for residents with an LTC
- Launch project with Be Well leisure services to extend physical activity offer for eligible patients with diabetes.

Vital 5 Communications

- Insights work with LBTH communities to clarify messaging.
- Development of assets and delivery of comms campaigns across V5.
- Establish residents' panel to input into comms.
- Develop culturally appropriate resources for engagement on Vital 5 (eg EatWell plate etc).

Insight: Vital 5 Epidemiology and Outcomes Framework

- Detailed report on Vital 5 inequalities to inform targeting: covering inequalities in undetected Vital 5 risk factors and in Vital 5 harms.

How and by whom will this be delivered

- This Tower Hamlets Strategy for Long-Term Condition Prevention is a system-wide strategy, setting out the role of health and care partners in Tower Hamlets. The whole system can have a role to play in delivering against the aims.

- The Strategy is overseen by the Tower Hamlets “Living Well” group.
- Working Groups aligned to the different Pillars are being stood up to coordinate action across the THT system around each of the Pillars.
    - Note Pillar 3 and Pillar 4 plan to work together and establish joint delivery across their pillars.

- Implementation of the strategy is led by four Pillar Leads. For information and to collaborate within any Pillar, contact as below:
    - Pillar 1: matthew.quin@towerhamlets.gov.uk
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