North West COVID-19 Community Risk Reduction Framework

A framework to help local partnerships reduce the risk of transmission and impact of COVID – 19 on local communities

August 2020

Content

1. Introduction

- Everyone in the North West region should expect to have good quality of life and access to high quality healthcare, regardless of their race, ethnicity, age, gender, sexuality or socio-economic status. The coronavirus pandemic has injected fresh urgency into the need to turn this right into reality. COVID-19 has amplified the stark health inequalities that persist in our society.

- Like many health conditions, COVID-19 has had a disproportionate impact on people living in areas of high deprivation, on people from Black, Asian and minority ethnic backgrounds, for people from inclusion health groups such as homeless people, and people with learning disabilities. This reinforces the importance of tackling underlying health inequalities, as set out in the NHS Long Term Plan.

- Tackling wider inequalities cannot fall to the NHS alone, however the health service has a core role to play. NHS England-Improvement North West has identified this as a key priority in its overall strategy to support the recovery from the pandemic. A dedicated Task and Finish Group has developed this community risk reduction framework to drive this forward at pace.

- A key objective of the community risk reduction framework is to minimise the transmission of COVID-19 infection within the community. Delivering these actions will create a sound bedrock upon which to further develop your local action plan to address inequalities and improve outcomes. There is a need for urgent preparation to mitigate the risks of a potential second wave and a particularly challenging winter 2020/21. Help for groups more vulnerable to COVID must start now.

- It is critical to work with the most at-risk communities to identify and mitigate factors contributing to the excess burden on the most vulnerable. Our collective immediate priority actions focus on: BAME, learning disability, socioeconomic deprivation, inclusion health (homeless people and offenders) and a number of these are highlighted in the PHE review of disparities in the risks and outcomes of COVID-19.

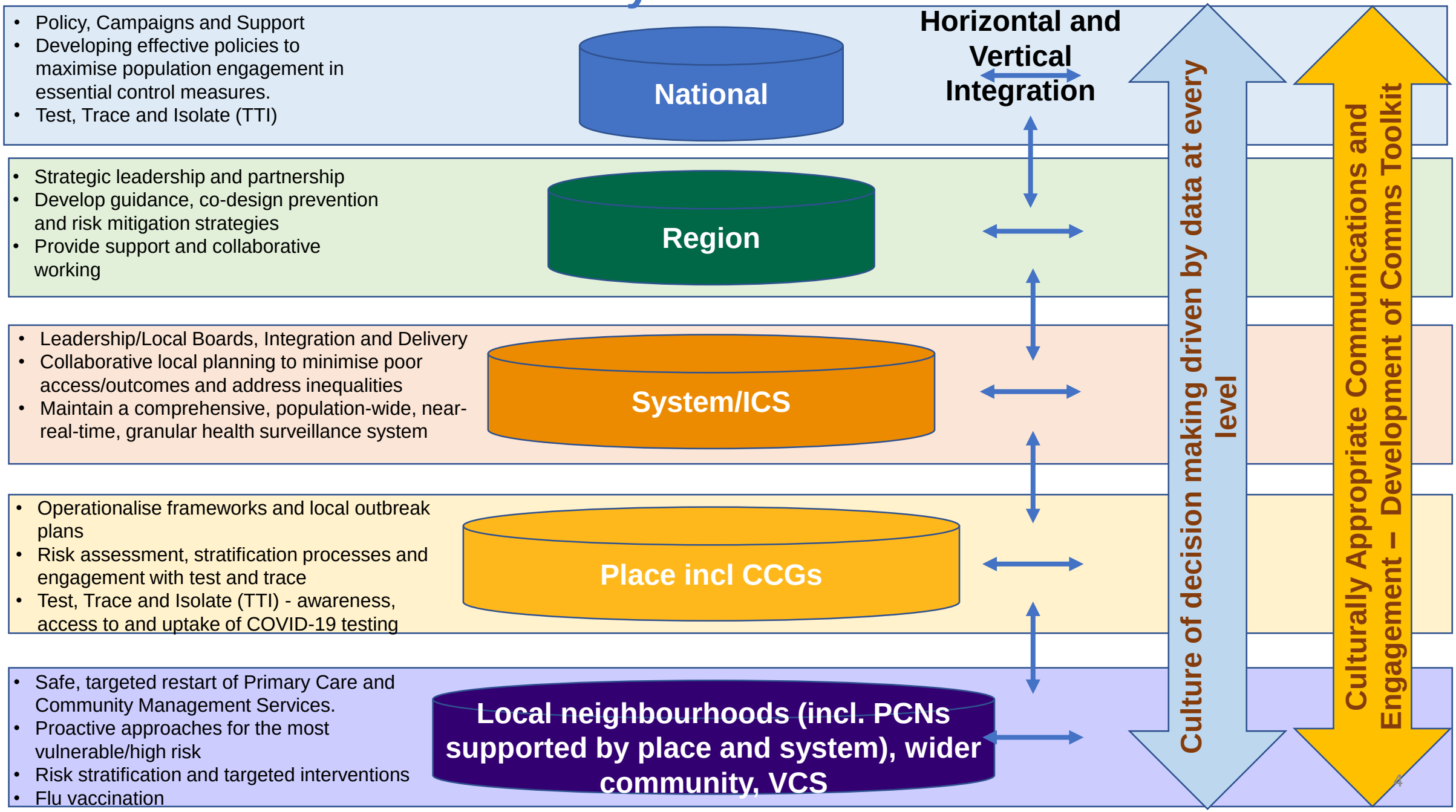
- The five vital themes and related actions set out in this framework will require strong and focused leadership from local systems, underpinned by relationships, intelligence, partnership, culturally appropriate communication and learning. Implementing the actions across the systems and places of the North West will increase the scale and pace of our collective action to tackle inequalities; and help deliver the primary care DES and Phase 3 priorities; and support local outbreak management approaches.

- We are asking systems, places and local neighbourhoods to take urgent action to help deliver this response, which builds on measures already taking place.

- Mitigation strategies should not pose further disadvantage to the most vulnerable in society, or the highest risk patients or communities. Implementation of prevention and mitigation strategies requires enhanced coordination, collaboration and data sharing between central and local initiatives. We currently have information governance flexibilities to help enable collective response to the ongoing COVID emergency with appropriate safeguarding in place.

- Whilst this guidance is intentionally focused on community risk reduction, many of the principles will be relevant to other settings and connecting services both within the NHS and outside of it.

2. Overview of action at every level



3. Overview of enablers and ways of working

**During the response to COVID-19, we have seen unprecedented digital acceleration in the health and care landscape. This has helped to ensure that essential care can continue safely. However the shift to digital may also risk exacerbating or creating new health inequalities due to digital exclusion, linked to issues around access, connectivity, confidence and skills. The next slide frames this in a way that also highlights potential enablers.*

4. Digital Enablement/Inclusion

Device accessibility	Connectivity	Digital activation (Knowledge Skills Confidence)	Digital health literacy (ease of access to & understanding of digital health resources)
Barriers: Affordability/deprivation	**Barriers:** Affordability of data ↓ access to public Wifi Poor connectivity on NHS premises Poor rural connectivity	**Barriers:** Lack of skill/experience "I don't have any interest" No perceived benefit Distrust (data security)	**Barriers:** Lack of awareness Excessive choice/confusion

Identify need: existing statistics/datasets (Ofcom, ONS, Citizens Online, Acorn)
emerging data sources (SNOMED codes, social prescribers, LRF)

Enablers: Device loan schemes Personal health budgets	**Enablers:** Pre-paid data packages Improved public Wifi	**Enablers:** Collaboration – skills partnership, libraries, adult learning, VCFSE, volunteers, campaigns	**Enablers:** Simplify the 'front door' Digital 'prescribing

- https://digital.nhs.uk/about-nhs-digital/our-work/digital-inclusion#document-content
- https://www.lancashireskillshub.co.uk/digital-skills-partnership/
- https://www.ofcom.org.uk/__data/assets/pdf_file/0027/196407/online-nation-2020-report.pdf
- https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/bulletins/internetaccesshouseholdsandindividuals/2019
- https://www.citizensonline.org.uk/gp-map/
- https://healthwatchlancashire.co.uk/wp-content/uploads/2019/12/Your-say-digital-health-report-5.pdf
- https://www.goodthingsfoundation.org/projects/nhs-widening-digital-participation-phase2 & https://uk.getonlineweek.com/

5. Priority Theme One: Proactive approaches for the most vulnerable/high risk people

Action 1: **Neighbourhood partners** (including **Primary Care Networks - PCNs**, wider primary care etc) identify **priority groups** and **wards**, using existing tools (and any new ones in development). They **integrate** multi-source data (NHS and non NHS) to drive decision making, identify high risk cohorts and scale of vulnerability. This can be supported by **rapid health needs assessment** and health impact assessment of BAME communities, including impact of **intersectionality** and **interplay** of risk factors. This risk stratification will take into account the **wider determinants** of health, optimising opportunities to **address social vulnerability**.

Action 2: **General Practice**, working with analytical teams and wider system partners, including social care and voluntary sector organisations, should use the capacity released through the modified QOF requirements for 2020/21 to develop priority lists for preventative support and long-term condition management, such as for **diabetes** and **hypertension** from **1 September**. They should ensure that these conditions are actively **prioritised**, interventions are **targeted** and **care plans** are updated. CCGs may want to consider locally enhanced service payments and other support to practices such as helping with identification of priority groups.

Further thoughts

*Consider how to systematically identify high risk cohorts and utilise **multidisciplinary team approaches** to ensure the care plans and medications for high risk patient cohorts are up to date.*

*Consider the role of **social prescribing** to support high risk cohorts for their social vulnerability.*

*Consider embedding **Patient Activation Measures (PAMs)** for understanding where patients are at in managing their condition and to tailor the interventions for a better chance of improving their **outcomes**.*

The following guidance and information may be useful:

Tackling obesity: government strategy - GOV.UK

Beyond the data: understanding the impact of COVID-19 on BAME groups

Targeted and enhanced midwifery-led continuity of carer

5. Priority Theme One: Proactive approaches for the most vulnerable/high risk people

Action 3: **Flu vaccination** – **Primary Care Networks (PCNs)** and **Partners** maximise uptake of flu vaccination at every location for those at risk. Flu planning and implementation actively considers **health inequalities**, especially for people from BAME communities, inclusion health groups, those in deprived communities and people with a learning disability.

Action 4: **Learning disability** – **general practice** ensures everyone with a learning disability is captured on their register, that their **annual health checks** are completed using the comprehensive evidence-based tool, and access to screening and flu vaccinations is proactively arranged.

Action 5: Neighbourhoods **support** vulnerable local people to get help to **self-isolate** (e.g. encouraging neighbours to support, identifying relevant community groups and drawing on use of **NHS Volunteer Responder/ local volunteers**) and ensuring services meet the needs of diverse communities e.g. providing culturally appropriate **humanitarian support**.

The following guidance and information may be useful:

Annual health checks and people with learning disabilities (Public Health England, 2016)

Health checks for people with learning disabilities toolkit (Royal College of General Practitioners)

Stay Well This Winter - Flu (Public Health England, 2020)

5. Priority Theme Two: Data driven action and integration

Action 1: Ensure **access** to **comprehensive** and **timely** data with appropriate Information Governance (IG) arrangements given the rapid changes in **risks** and **service provision** brought about by COVID-19. Organisations should review the consistency and accuracy of their data on patient ethnicity and ensure these are recorded for all patients by **31 December 2020**.

Action 2: **GP Practices and Providers** review the **consistency and accuracy of their data** on patient ethnicity and systematically record and update data about **potential risk factors for all individuals** so that, as risk prediction and stratification tools are refined, those at greatest risk can be quickly and correctly identified.

Action 3: **Integrated Care Systems** to work with **multi agency partners** to further develop and embed a **systematic** approach to high risk patient cohorting (all age) based on **population health principles t**o assist with prioritisation of patients.

Action 4: **System metrics** should aim to include measures in relation to patients from the 20% most deprived neighbourhoods (nationally and locally, using the Index of Multiple Deprivation) as well as those from Black, Asian and minority ethnic communities where data is available.

The following guidance and information may be useful:

What does population health really mean? (Kings Fund, 2019)

'Where to look' packs - North West (NHS RightCare, September 2019)

Shielded Patients List: guidance for General Practice (NHS Digital, 2020)

5. Priority Theme Three: Culturally appropriate communication and engagement with local communities

Action 1 : Engage communities - neighbourhood, places and systems identify community champions and influencers to help local organisations better understand what COVID messages are needed and how best to tailor them. **Culturally competent** health promotion and disease prevention approaches, reaching communities differently through tailored and appropriate messaging, social marketing, social prescribing, use of ACORN/MOSIAC.

Action 2: Operationalise **North West Communication and Engagement Toolkit** to inform campaigns drawing on local learning. This work must recognise and draw on the **responsibility**, **capacity** and **experience** of community engagement residing in **local government**.

Action 3: As part of the toolkit, agree 4-5 key messages* for Communications and Engagement team to tailor and weave through local plans/campaigns in a **culturally appropriate** way covering, for example:

- *Ongoing daily actions to reduce risk of infection, and actions to take in event of COVID symptoms*
- *Actions to reduce personal risk of infection and symptoms for risk factors such as diabetes*
- *Flu vaccination; building on national campaign with a tailored local campaign e.g. through local community champions, local languages.*

**Specific examples to support community engagement included in Appendix One*

5. Priority Theme Four: Increase awareness, access to and uptake of COVID-19 testing

Test, Trace and Isolate (TTI) will only be effective if it is carried out quickly, accurately, is acceptable to the public, and encompasses a high proportion of **symptomatic** cases. Awareness, access to and uptake of **COVID-19 testing** must be equitable across all social and economic groups and disparities must not be widened in the implementation of the national **NHS Test and Trace Service**.

Action 1: Harness the substantial opportunities for **Test, Trace and Isolate** to act **synergistically** with a broader **surveillance system**, local outbreak investigation and management teams, and local public health teams along with the NHS for healthcare outbreaks. **Surveillance systems** can help identify key risk groups for **TTI systems** to prioritise tracking and tracing, and support predicting and prevention.

Action 2: Increase **awareness** and **uptake** by **addressing barriers** working with communities and groups on programme development, provision of support services and developing options to overcome barriers to engagement, particularly in populations most affected by COVID-19. Address the potential barriers, including:

I. **lack of knowledge** about health conditions, screening benefits and how to access them;

II. **access**, including language, translation facilities, low social support, time and financial constraints, anticipated discrimination and culturally insensitive messaging; and

III. **beliefs and attitudes** towards healthcare systems, fatalism and the usefulness of screening.

Train contact tracing teams to ensure conversations are culturally sensitive and can be delivered in appropriate languages.

Action 3: **Local Testing deployment** – ensure **readiness** and **visibility** to **deploy** mobile testing units to **high risk locations** – e.g. define how to prioritise and manage deployment: proactive engagement and tailoring guidance for commercial, public and domestic properties on optimising indoor environments particularly where high risk of transmission. **More** testing capacity may need to be provided in areas of greater deprivation.

5. Priority Theme Five: Leadership and Local Boards – Integration and Delivery

Action 1: Clear and accountable leadership. To address health inequalities will require **clear**, **inclusive** and **accountable** leadership. Each partner organisation locally will identify an Executive/Corporate lead for tackling inequalities, including PCNs, CCGs, community services, mental health services, acute services and local authorities.

Action 2: Collaborative local planning and delivery. ICSs and ICPs have a particularly important role in understanding the **needs** of their **populations** and bringing together the coalitions of partners from all sectors needed to respond to these. **Effective collaborative leadership** will help ensure that place-based plans are updated to **improve** healthcare **access** and **outcomes** for groups disproportionally impacted by COVID-19: BAME, learning disability, socioeconomic deprivation and inclusion health. These plans cover how inequalities will be addressed, with access to the **data** and **insight** necessary to **understand** and **respond** to local need, informed by meaningful conversation with local communities.

Action 3: Strategic leadership - translation of **policy into practice,** influencing development of policy and ensuring appropriate linkage with national teams/bodies.

6. Regional Support Offer

1. **PCN Complete Care Communities** * **–** A small number of early demonstrator sites in the North West will be part of this key national programme. The Regional Team will provide **dedicated support to PCNs and systems to operationalise** the sites and **provide funding** for the identified PCNs to enable full participation. Learning from the demonstrator sites will be evaluated via the national programme and resources and outputs will be shared on an on-going basis on the North West Community of Practice workspace managed by the Regional Team.

2. **Wider primary care – The Regional Team will continue work to harness the contribution of wider primary care to the transformation and health inequalities programme by **providing strategic leadership and dedicated support** for pharmacy, dental, optometry to operationalise bespoke programmes of work.

3. **Section 7a profiles:** These are being developed by the Regional Public Health Commissioning Team for use by Primary Care Networks. The Regional Team will provide **dedicated strategic support** to PCNs/CCGs/systems as part of a collaborative effort to **operationalise their use** and enable them to be used to their full potential in local communities.

4. **Priority Wards – The Regional Team will provide **support to match each priority ward** to its corresponding PCN(s).

5. **Webinars** and **Workshops** – The Regional Team will organise workshops and webinars to share **learning, expertise** and **approaches.**

6. **North West Communication and Engagement Toolkit** to support community risk reduction. To maximise effectiveness it will be informed by engagement with patients, carers, the public and healthcare professionals.

7. **Community of Practice Resource** – The COP resource is already live within the North West region and a **dedicated workspace is being developed specifically for the Health Inequalities Programme.** This is a useful resource that primary care can access across the North West and it will be **managed and maintained by the Regional Team**. It will facilitate sharing, learning, and spreading of good practice across the North West.

**It is proposed that PCNs and Local Authorities operating with the guidance of their Integrated Care System/Place could work together to co-design a project demonstrating the joint working arrangements required to deliver improved population health and wellbeing through a team-based approach, focussing on population segments characterised by their debility related to deprivation. In this way the overall integrated partnership approach should be enhanced.*

7. Implementation

Implementation Partners

- Implementation of the framework involves multi-agency approach through summer/autumn 2020/21 building on any existing actions and mechanism
- National, regional, sub-regional
- General practice, working with analytical teams and wider system partners, community pharmacy, social care and voluntary sector organisations
- Integrated local systems, places and neighbourhoods
- Matching each priority ward to its Primary Care Network and integrated neighbourhood.

Elements to drive implementation

- Nationally agreed metrics for measuring health inequalities
- Undertake a baseline assessment (for example at neighbourhood level) and gap analysis of selected actions to ascertain level of resource/support required to achieve demonstrable outcome
- Share case studies and progress on new initiatives to address health inequalities
- Promote existing resources – community based approaches to public health, place based approaches to reducing inequalities
- Learning resources/sessions – for example on completing equality and health inequalities impact assessments.

Next Steps

- Agree with key partners and stakeholders at system level which **actions** they will focus on
- Integrated Care Partnerships and Integrated Care Systems (ICPs/ICSs) agree with their local communities the set of metrics for their **local priorities**. This will complement national data on health inequalities, for example Health Inequalities **Indicator 106a**
- Develop outline plans and approaches – building on existing plans around health inequalities - in advance of a workshop mid-August 2020 which will be used to **share ideas, expertise** and **approaches**.

8. Further Resources

- COVID-19: Review of disparities in risks and outcomes. PHE, June 2020.
- Beyond the data: Understanding the impact of COVID - 19 on BAME groups (PHE, 2020)
- COVID-19 place based approach to reducing health inequalities overview
- COVID-19 Summary of Guidance and support for vulnerable groups
- COVID-19 Suggestions for mitigating the impact on health inequalities at a local level*
- COVID-19 Health Equity Assessment Tool (HEAT) for local areas
- COVID-19 Data tools to support local areas
- COVID - 19: How to include marginalized and vulnerable people in risk communication and community engagement (Interagency Standing Committee, 2020)
- Menu of evidence-based interventions and approaches for addressing and reducing health inequalities
- Place-based approaches for reducing health inequalities: main report. PHE, July 2019.
- Guidance for NHS commissioners on Equality and Health Inequalities legal duties. NHSE, December 2015.
- Tobacco Smokling and COVID - 19 infection (The Lancet, May 2020)
- Preparing for a challenging winter 2020/21 (The Academy of Medical Sciences, July 2020)

9. Appendix One: Examples of key messages to support community engagement

- *Ongoing Proactive engagement and emphasis on prevention – "We are still amidst a pandemic. Maintain social distancing. Keep washing your hands. Be a responsible mask wearer."*
- *COVID-19 Prevent - Get yourself winter/2nd wave ready – lose some weight, plan your support networks now for your food, your medicines and your social contacts.*
- *Don't ignore symptoms. Unusually thirsty? Weeing a lot? Breathless? The NHS is open for business – talk to your GP.*
- *If you have symptoms, even if you think you've had them before, even if the seasons change and "it's just a cold"… stay home. Get tested.*
- *Have your flu jab. Build on national campaign with a tailored local campaign e.g. through local community champions, local languages*

10. Appendix Two: Community Risk Reduction Framework – Task and Finish Group

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Lucinda McArthur, Senior Adviser, West Lancashire Clinical Commissioning Group

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Dr Julie Higgins, Joint Chief Officer, East Lancashire and Blackburn with Darwen CCGs

Eileen O'Meara, C&M Population Health Clinical Lead and Director of Public Health and Public Protection for Halton and Warrington

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