



Improving public health through primary care

Betsi Cadwaladr University Health Board
Annual Report of the Director of Public Health

2017

Directors of Public Health in Wales traditionally present an annual report on the state of the population's health. These have a long tradition going back decades, and I am delighted to add my contribution to this important practice in North Wales, with this, my first report as Executive Director of Public Health for Betsi Cadwaladr University Health Board.

Preface

Welcome to the 2017 Annual Public Health Report for North Wales.



This year, I have chosen to focus the report on Primary Care and its unique role in improving health and wellbeing, and addressing health inequalities.

I reflect that this year, 2017, is a time of well-being planning in Wales, as new legislation places duties on organisations to work together with the public to promote well-being, improve services and put individuals at the centre of their care. In addition, it's an exciting year for those of us interested in health and well-being as the Public Health (Wales) Act 2017 now makes Wales a leader in public health work.

This is also the year when I've been fortunate to come back home to work in North Wales. Doing so, I've reflected lots on the work of Professor Snowden who has written about 'Cynefin'. This is a Welsh word which is similar in meaning to habitat and refers to

'the place where someone is comfortable and feels right'. Professor Snowden uses the term in his work on complex systems and decision making based on environmental conditions. It is interesting work because we all live in different environments and groups, and the fact is, we need to build healthier communities, to support resilience, and promote positive health and wellbeing.

For me, primary care has a pivotal role in supporting this well-being agenda. Admittedly, this can be challenging given the significant issues facing our primary care colleagues, but they have a central role as they are placed in the heart of our local communities and they work incredibly hard to change people's lives for the better. They treat the whole person and provide high quality care and they encourage people to make healthier choices.

Importantly for us in North Wales, we also know that good primary care activity helps tackle inequalities as our teams are in contact with many vulnerable and hard pressed individuals, and the teams act as patient advocates and provide key links to important services, such as welfare and benefits advice.

This report looks at nine important public health priority areas, where the primary care role is central. We've tried to outline why these topics are so important, some of the work currently underway, and highlight opportunities to do more on this important agenda alongside our patients and public.

I hope you find the report enjoyable and interesting. As health is everyone's business, I do hope this report prompts further discussions and I very much welcome feedback. Please do get [in touch](#) if you have any comments.

As with all Directors Of Public Health reports, a large number of people have contributed to this publication and I am extremely grateful to all. In particular I am very grateful to John Lucy for his work in bringing this report to publication, and to Heather Thomas, Jo Charles and Rebecca Masters as the editorial team; as well as the rest of the Public Health Team and partners for their contributions to the report.

*Below:
Teresa Ann Owen,
Executive Director
of Public Health*



Introduction

This report is designed to help with the process of improving health and transforming care by setting out clearly the contribution of primary care to improving health and reducing inequalities. In addition to informing the Betsi Cadwaladr University Health Board strategy, this report is intended to support planning within the health board primary care areas, cluster planning processes and also individual practice plans.

Primary care in North Wales faces similar challenges to the rest of Wales and the UK. The population is ageing, and in North Wales the projections are for a rise in the numbers of older people, and at the same time a fall in the numbers of younger people. The rise in numbers will mean increased demand for health care services. Older people are increasingly being diagnosed with more than one long term condition such as diabetes and dementia. The increasing workload in primary care is placing strain on services, and stimulates questions about how demand can be better managed, and patients more effectively supported to stay well.

Primary care is a broad concept which includes a range of professionals who provide services, including

- General Practitioners
- General Dental Practitioners
- Nursing staff- in practices and in community nurse roles
- Optometrists
- Community Pharmacists

As patients very often have social needs, primary care staff have to work closely with

social care services too, and some primary care teams include social care professionals.

Previous Public Health reports [[English version](#) / [Welsh version](#)] set out the priorities for North Wales and rationale for action. This report highlights the public health priorities for primary care that can improve population health and also reduce demand on primary care services.

The national strategy 'Our Plan for a Primary Care service up to 2018' set the broad aims of

- Developing a more 'social' model of health, addressing root causes of ill health
- Developing a preventive model of care close to home
- Working closely with partner agencies and voluntary bodies to coordinate care

BCUHB is currently developing its own longer term strategy 'Living Healthier, Staying Well'. The contents of this report will inform the new strategy, in particular the sections on Improving Health and Reducing Inequalities, and the Care Closer to Home. 'Living Healthier, Staying Well' uses the Wales

Public Health Outcomes to frame the actions the board needs to take to improve health overall. The actions in this report support this approach.

Primary care clusters are an important element by which primary care is being supported to deliver on the ambitions

within the national strategy. Clusters have been encouraged to develop their own approaches to delivering transformation in primary care services. To date clusters have largely focussed around GP services, and the contribution of other primary care contractors is still to be fully harnessed.

Public Health priorities in Primary care

The report contains the following sections:

1. Tackling health inequalities

Poor health affects deprived areas disproportionately and has a significant impact on workloads for primary care serving these communities. Tackling the root causes is key, and primary care is well placed for this.

2. Smoking

Trends in smoking are downwards, bringing with it benefits to health in North Wales. General Practices and community pharmacies have played an important part in this, but more effort is needed particularly in deprived communities where rates remain high.

3. Obesity

Obesity rates among adults are rising, accompanied by rising rates of the linked chronic conditions. Primary care can effectively support people who are overweight through simple prompting to behaviour change, and signposting to local community activities.

4. Vaccination and Immunisation

Immunisation is a cost effective success story which prevents many deaths and much illness. Coverage varies across communities in North Wales. In some areas levels are low, and ensuring all communities have the minimum coverage for herd immunity is a priority.

5. Mental Health

There is growing acceptance of the importance of resilience as a protective factor for mental health and wellbeing. Primary care is well placed to connect people with social support that can do this.

6. Screening

Primary care has a central role in promoting uptake of screening programmes. Coverage of programmes is variable, but there are examples of good practice that could help if shared across North Wales.

7. Adverse Childhood Experiences

Adverse childhood experiences (ACE's) is an approach that describes the link between ACE's and poor health and social outcomes in adult life. Awareness of the link is key for health and social care staff, as it can be the trigger for helping patients.

8. Early Years- the best start in life

The experience of a child from conception to the age of two has a decisive impact on health in later life, and giving every child the best start is a Welsh government priority. Primary care has central role in delivering the support needed to effectively support parents and children.

9. Social prescribing

Social prescribing provides an effective way of supporting people with a range of issues that might otherwise need a clinical service. As this area of activity grows, primary care is well placed to connect patients with schemes.



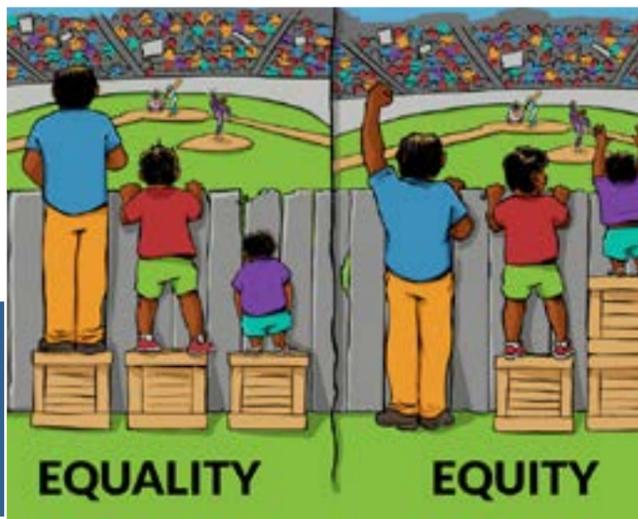
Inequalities

Why is this important?

The causes of health inequalities are well understood, and the links with income and poverty are well documented. We know that those living in our poorest areas experience significantly worse health throughout their lives than those living in the more affluent areas of North Wales. There is also a ten year gap in life expectancy, which has not improved for a number of years. Other factors can contribute to health inequalities including ethnicity and disability. Living in rural areas can drive inequalities, with the increased burden of travel and living costs affecting poorer households.

The unequal burden of disease has a significant impact on primary care workload, as inequalities mean that people on lower incomes develop chronic diseases earlier in life and in greater numbers. Those with the greatest health need are often the least able to access health care – whether it be having access to transport to get to a GP appointment, or having access to the internet to check the local late night pharmacy opening hours urgently during the weekend.

Reducing health inequalities requires action on the root causes- employment, education, poor housing, effects of gambling and more. Unless we do something to address the root causes of health inequalities, we won't reduce the health inequalities gap that exists locally. Primary care has a contribution



to make in this wider agenda- for instance through social prescribing schemes. There is also action primary care can take in GP practices or pharmacies to target effective interventions within communities of greatest need.

Patient story - Beryl

Beryl is 76 and used to attend the surgery almost every week with minor ailments. Beryl always asked Sian, the nurse practitioner, for a bandage, even when she did not require one. Sian felt that things with Beryl didn't seem quite right and thought there could be something more to this. She decided to discuss Beryl's care with the wider team, including Lesley, the team occupational therapist. Lesley met with Beryl and uncovered the real problem. Beryl was lonely, but had noticed that if she wore a bandage then her neighbours were more likely to stop and talk to her. Lesley asked Beryl about her interests, and together they decided that the local craft group would be a good place for Beryl to get out and meet others. With Lesley's support, Beryl found that she loved painting, and made new friends. Beryl and Lesley still catch up every now and again to make sure that Beryl is ok, but Beryl is much happier and her visits regarding minor ailments have reduced. Beryl's story highlights how more effective use of the wider primary care team can empower patients to find their own solutions to their problems.

Local case study

'Healthy Prestatyn & Rhuddlan Iach' is an innovative NHS primary care service that is aiming to demonstrate how a different design of primary care service can better support the community it serves. It operates in an area of disadvantage, and provides an excellent example of how innovative use of primary care can enable patients to take control of their own health and also reduce demand. GPs are joined by other health professionals - Nurse Practitioners, Occupational Therapists and Pharmacists, to form five multi-disciplinary 'Key Teams' that each take on responsibility for caring for a specific group of patients. They offer same day services that utilises telephone assessments to ensure patients are seen as soon as possible. They also offer appointments by Skype if clinically appropriate. Their services reach far beyond those of the GP, and include a wide range of practice nurses, health care assistants, phlebotomists alongside many other specialists.

What can Primary Care contribute?

Primary care offers many complex public health interventions on a daily basis – whether they are a GP supporting a patient to quit smoking, a practice nurse undertaking a cervical screen or an ophthalmologist identifying risks for glaucoma during a routine eye exam. Primary care has a role to enable patients to take responsibility for their own health and change lifestyle behaviours that can cause them harm. Primary care contributes to reducing health inequalities in a number of ways:

- Supporting people to make improvements to their lifestyles, particularly in relation to stopping smoking and reducing their alcohol intake
- Promoting vaccine uptake – we know that those living in our poorer communities are less likely to be fully up to date with their immunisations
- Supporting patients to take control of their own health – for example closer working with occupational therapy, pharmacy, or the third sector.

Recommendations:

Primary care teams can help reduce health inequalities by

- Actively promoting and encouraging uptake of smoking cessation services – research shows that people are four times more likely to quit when using such services rather than going it alone
- Routinely promoting healthy lifestyle behaviours with patients
- Developing links with local third sector organisations that can provide non-medical support such as welfare advice, walking clubs or luncheon clubs to reduce social isolation and increase resilience.



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Obesity 3

Vaccination and Immunisation 4

Mental Health 5

Screening 6

Adverse Childhood Experiences 7

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Smoking

Why is this important?

Tobacco use remains one of our most significant public health challenges and is a major contributor to health inequalities. In North Wales, 19% of adults smoke and 7% use e-cigarettes. Smoking rates are declining steadily over time, but vary considerably between different social groups. Adults living in the most deprived areas are three times more likely to smoke (28%) than those in the least deprived (9%). Smoking makes a big contribution to the numbers of premature deaths associated with deprivation. Reducing smoking prevalence among people in routine and manual groups, some minority ethnic groups and disadvantaged communities will help reduce health inequalities more than any other public health measure. Primary care staff, including pharmacists, GPs and practice nurses has a big role to play given the contact they have. Three quarters of smokers report that they want to stop smoking, and many will do so when nudged by primary care staff.

Brief smoking cessation intervention in primary care is effective, with reported quit rates of between 2% and 3%. However, for maximum impact primary care teams should offer advice, encouragement and support, including referral to NHS smoking cessation services. Smokers are four times more likely to quit with specialist service support.

Community pharmacies provide a smoking cessation services which provide an alternative choice to smokers in their attempts to quit. They are accessible and able to meet the needs of disadvantaged and minority ethnic groups and those who may have difficulty accessing other community services.



Local case study

Clarence Medical Centre in Rhyl participated in a pilot study last year aimed at exploring the effectiveness of recruiting smokers into specialist smoking cessation services.

A personal invitation letter from a senior partner was sent to all smokers aged between 18 and 50 (excluding those with a chronic condition) to attend a smoking cessation appointment with a Stop Smoking Wales (SSW) advisor. At the appointment smokers could self refer to SSW or attend the local Pharmacy Level 3 service. A small number of patients (5%) were prompted by the letter to engage with the specialist smoking cessation services. Although small in number, these patients were highly motivated, and their quit rate was 70%. This very high quit rate suggests the intervention helps nudge those who are ready to make this change into action.

What can Primary Care contribute?

Raising awareness and promoting choice amongst their population:

- Promote [Help Me Quit](#) free phone and website by displaying posters and leaflets in the waiting areas and on TV monitor screens
- Provide 'Making Every Contact Count' training to frontline staff to equip them with the skills to communicate the benefits of healthy lifestyle choices
- Community Pharmacies to effectively promote their smoking cessation services

Supporting smokers to quit:

- Practices can set a flag on their electronic system to alert clinicians and reception staff when someone is a smoker. This can provide an opportunity for a brief intervention.
- Proactively engage with smokers by sending letter or text invitation to discuss their smoking
- Proactively talk about smoking at every contact with smoker (75% want to quit):
- Ask people about their smoking status

- Advise the smoker to quit
- Act – refer motivated smokers to NHS smoking cessation services via Help Me Quit using existing referral routes or via professional referral page on website

Recommendations:

To encourage more smokers to access cessation services:

- Practices to work within clusters to ensure that practices and smoking cessation services use proactive and intensive recruitment methods to deliver personal and tailored interventions to smokers on a regular basis
- Clusters need to connect with and support digital social marketing campaigns and other platforms to promote smoking cessation services

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Obesity

Why is this important?

Obesity is a major concern, with over half of adults in North Wales classed as being overweight or obese¹, and the numbers are steadily increasing. It is estimated that life expectancy is reduced by around 2 to 4 years for those who are obese, and around 8 to 10 years for those who are morbidly obese.

Obesity also increases the risks of developing chronic illness. Women who are obese are 13 times more likely to develop type 2 diabetes, and 4 times more likely to develop hypertension, compared to women who are a healthy weight. Men are estimated to be 5 times more likely to develop type 2 diabetes and 2.5 times more likely to develop hypertension compared to men who are a healthy weight². These conditions contribute a large section of the workload in primary care, and increasing levels of obesity will inevitably translate into increased workload in primary care. Obesity is also responsible for significant economic costs to society due to time lost from work.

Many healthcare professionals feel daunted about tackling the issue. Time restrictions, the lack of suitable resources, and inadequate training are reasons why professionals express concerns about their role with regard to treating obesity. However there are a number of compelling reasons why obesity should be addressed in primary care³:

- Increasing recognition that obesity is a serious medical condition
- Primary care provides the opportunity to support individuals to lose weight rather than treat the consequences
- Rising levels of obesity have a big impact on primary care workload, and increasingly secondary care as well.



Local case study: Foodwise

The Clarence House GP surgery in Rhyl, as part of North Denbighshire Cluster, has been referring overweight patients to the Foodwise for Life weight management programme, a national programme delivered locally by Communities First Staff, supported by dieticians. Between January 2016 and March 2017, 6 programmes were delivered in Clarence House, and approximately 45 patients completed with an average weight loss of 2.9kg⁵ over the 8 week course. Evaluation reports also showed that 98% of participants reported making positive changes to their diet and 90% increased their activity levels.

Participants reported impacts beyond their own achievements:

'My friends have noticed my weight loss, I have explained the lifestyle changes and some are actually trying to do the things I have taken on board'

In addition participants found value from the support that the group were able to give each other:

'I think it would be useful for some of the doctors / dieticians to see how this type of course deals with how people can lose weight by community spirit rather than a leaflet: go away and read it and follow the instructions'

What can Primary Care contribute?

It isn't always easy to raise the issue of weight, but Primary Care staff have the opportunity to raise the subject of weight with patients and encourage people to make behaviour changes and can be effective in this role.⁴

- The 'Making Every Contact Count' training programme equips frontline staff with the skills to introduce weight (and other topics) into discussions and communicate the benefits of healthy choices.
- Pre-empting the conversations by uploading health messages onto screens / posters in waiting rooms can help provide the cue to discuss with patients.
- Some clusters of practices have funded additional access to leisure services, as part of the National Exercise on Referral Scheme (NERS) or funded vouchers for commercial slimming companies

- Social prescribing schemes are developing in North Wales and have great potential for connecting individuals with activities to increase physical activity, or improve diets

Recommendations:

Primary care teams can help reduce health inequalities by

- Primary care clusters should be fully engaged with work to develop weight loss services for people who are overweight and pathways into these.
- Social prescribing initiatives that help people to be more active or improve their diets should be considered for funding by primary care clusters

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Vaccinations & Immunisations

Why is this important?

Immunisation is one of the most successful and cost-effective public health interventions, and saves thousands of lives every year (WHO). The widespread implementation of immunisation programmes over the last 30 years has led to a dramatic reduction in illness and death due to vaccine preventable diseases.

The delivery of the immunisation programme is hugely complex, with hundreds of thousands of vaccines being given annually in GP practices, schools, clinics, hospitals and in people's homes

GP practices with their established relationships with families have a unique role to play in ensuring that children are immunised at the right time. Primary care has a key role in ensuring vulnerable groups and their carers are protected by the flu vaccine, and a programme is being introduced in autumn of 2017 for children. The children's flu programme is highly effective at providing herd immunity for the whole community and should be prioritised and promoted.

Health inequalities are also reflected in uptake of immunisations. Low uptake of immunisation results in low levels of community protection and can leave communities vulnerable to large outbreaks of preventable diseases. Measles is circulating widely across Europe, and Wales is at high risk of measles outbreaks. Variation in uptake rates of measles, mumps and rubella (MMR) in North Wales means some communities are less protected, and addressing low levels of uptake is a priority.

Outbreaks can impact significantly on the work load of primary care. Staff working in primary care benefit from the protection of immunisation, and also benefit patients by not passing on infection.



Local case study: Immunising Teams

Three immunisation teams have recently been recruited to the School Nursing/Health Visiting service to work in North Wales.

The teams plan, arrange and deliver the immunisation sessions which are held in primary and secondary schools for school pupils.

They have a key role in the delivery of the childhood flu programme for children aged between 4 and 8 years of age. Vaccinating children against flu provides direct protection for the child but also has a big impact on reducing flu levels circulating in the community as a whole. This in turn reduces demand for primary care and social care services, as has been demonstrated in Scotland and Northern Ireland.⁶

What can Primary Care contribute?

- There is considerable variation in the uptake of immunisations across North Wales at a GP practice level. Practices working together in clusters have the opportunity to share learning from those practices that have higher vaccine uptake in order to reduce variation.
- Primary Care, with its detailed patient records systems, are well placed to provide opportunistic and planned reminders to parents and carers of children when a vaccine is due or has been missed.
- Local practices could consider exploring innovative approaches during flu season such as running out-of-hours and easy access clinics to increase reach and uptake.
- GP practices could choose to target a specific low uptake group for flu vaccine and encourage the early vaccination of pregnant women as soon as the flu vaccine arrives.
- Health Visitors, with their special relationship with families, are uniquely placed to work closely with practices to identify individuals and families not up to date with immunisation, taking every opportunity to immunise. The Health Board's home immunisation policy can be used if necessary to support with this.
- Community pharmacies in North Wales also participate in flu vaccination and have an important role to play in enabling easy access to the vaccine.

Recommendations:

- Review immunisation uptake data at both practice and cluster level on an annual basis in order to understand variation in uptake rates and share good practice.
- Include actions to address variation in immunisation uptake to in Cluster and Practice plans.
- Health Visitors and School Nurses to work with practices to identify individuals and families not up to date with immunisation.

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Mental Health

Why is this important?

Promoting positive mental health has the potential to improve both mental and physical health. Mental health problems are very common, with one in four adults affected at some point during their lifetime. Of those who seek medical advice, the majority will do so in a primary care setting, and mental health problems make up a significant part of the workload of practices.

Within North Wales people report slightly better mental health than in Wales as a whole, the most common mental illnesses reported being anxiety and depression.

Tackling mental health problems early has big benefits in later life. Most mental illness begins before adulthood and often continues throughout life. Improving mental health early in life will reduce health inequalities, improve life expectancy, economic productivity, social functioning and quality of life. Mental health problems are linked to poorer physical health and shorter life expectancy.

Demands in primary care can be reduced by increasing the resilience of individuals and communities. One report suggested GPs spend nearly a fifth of appointment time on social issues.⁷ The 'Five Ways to Wellbeing' framework provides an evidence based framework that can reduce the risk of developing mental health problems (opposite).

There are clear benefits for patients and for reducing demands on primary care if people can be put in contact with local activities that help promote the five ways approach. Social prescribing is one approach that can support this- connecting people with support, often with voluntary groups, to help build resilience. Spending time in green spaces has a positive effect on mental wellbeing. The countryside in North Wales is an asset that can be used as part of building resilience.



Five Ways to Wellbeing



and Wellbeing

What can Primary Care contribute?

BCUHB has published its Mental Health Strategy which makes clear the importance of prevention work including primary care to promote and protect mental health. Primary care has a big role to play in supporting people to connect with support outside of the NHS that can help them build resilience and prevent mental ill health. Pharmacists, General Practitioners, Practice Nurses all have a role to:

- Develop links with local third sector services such as Citizens advice, including exploring possibilities for bringing services into practices or nearby buildings.
- Support social prescribing initiatives as the opportunities arise.
- Practices to identify a champion for the third sector and make it their role to develop practical links with local voluntary organisations and groups.



Recommendation:

- Clusters develop local links with third sector organisations to develop alternative support for people to help promote mental wellbeing.

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Screening

Why is this important?

Screening is a process of identifying apparently healthy people who may be at an increased risk of a disease or condition. Early detection of illness through screening can reduce mortality from a disease or condition and can also improve health outcomes for participants. There are seven national screening programmes in Wales (Breast Test Wales, Bowel Screening Wales, Cervical Screening Wales, Newborn Bloodspot Screening Wales, Newborn Hearing Screening Wales, Diabetic Eye Screening Wales, Wales Abdominal Aortic Aneurysm Screening Programme) and an Antenatal Screening Wales programme.

Uptake of screening is variable, and is generally lower in more deprived communities. For example, uptake of bowel screening in the least deprived primary care cluster in North Wales is 58.5 percent compared to 51.4 percent in the most deprived cluster. ⁸

Primary care plays a central role in delivering the cervical screening programme, but has an important role in supporting and promoting other programmes, such as, ensuring the right people are invited to the Diabetic Eye Screening programme. Evidence shows that primary care can have a positive impact on improving participation in screening by the use of targeted letters and phone calls ^{9,10}. Project work carried out in Wales recently showed benefit of a range of interventions to increase participation in bowel screening by targeting non-responders. Pharmacies, Dentists, Community Nursing and Third Sector Organisations also have a role in promoting awareness, through the dissemination of accessible information, and having opportunistic conversations with the public about screening. Optometrists play an important role in helping to raise awareness of diabetic retinopathy screening.



Local case study: Screening Champions

To address inequities in screening uptake, the Screening Engagement Team are piloting a Screening Champion project in practices across North Wales with the lowest screening uptake. The approach is based on the 'Making Every Contact Count' methodology, whereby trained, front-line primary care staff are encouraged to have opportunistic conversations with patients about screening and to display information about screening in the reception area in line with the national campaigns.

The first cohort of Screening Champions were trained in June 2017. The training was attended by Receptionists and Practice Nurses from five GP Surgeries from GP Clusters with the lowest uptake. An evaluation will be conducted following the Screening for Life campaign and the outcomes will be shared with GP clusters across Wales.



What can Primary Care contribute?

Primary care has a central role in promoting the uptake of screening programmes. The Screening Division within Public Health Wales is available to work with clusters and practices to give staff the skills and confidence to make this part of their work.

Primary Care interventions targeting non-responders:

- Working with screening services to identify those not responding to invitations to screening and:
 - Sending a GP endorsed letter has been shown to increase uptake.
 - Phone calls can be made by trained practice staff to patients who are identified as non-responders.
 - Practices can set a flag on their electronic system to alert clinicians and reception staff to provide an opportunity for a brief intervention.

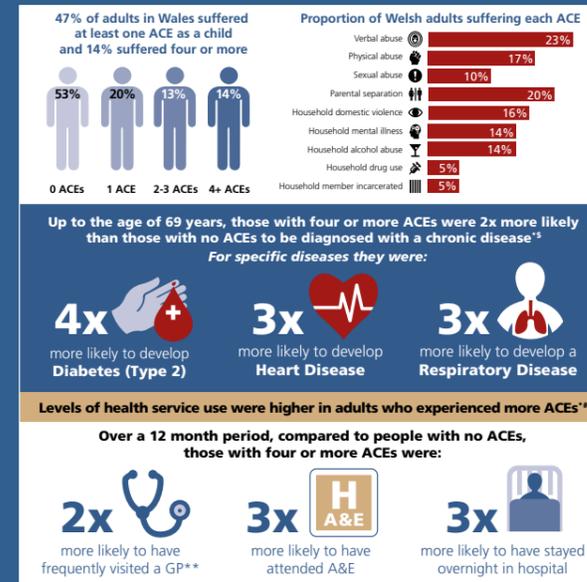
Raising awareness and promoting informed choice amongst the whole practice population:

- 'Screening for Life' training is available for your staff provided by the [Screening Engagement Team](#) of Public Health Wales.
- Display screening materials in waiting area and on TV monitor screens.

Recommendations:

- Practices to contact the Screening Engagement Team to provide screening awareness training to practice staff.
- Practices and clusters to develop and implement strategies to follow up those who have not responded to their screening invitation.

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Adverse Childhood

Experiences

Why is this important?

Adverse Childhood experiences (ACEs) are traumatic experiences that occur before the age of 18. These experiences range from experiencing verbal, mental, sexual and physical abuse, to being raised in a household where domestic violence, alcohol abuse, parental separation or drug abuse is present. ACEs have been researched in Wales and recent reports have shown a clear link between ACEs and poor health and social outcomes in later life.

Evidence shows children who experience stressful and poor quality childhoods are more likely:

- to develop health-harming and anti-social behaviours,
- to perform poorly in school,
- to be involved in crime
- and less likely to be a productive member of society.

Adults in Wales who were physically or sexually abused as children or brought up in households

where there was domestic violence, alcohol or drug abuse, are more likely to adopt health-harming and anti-social behaviours in adult life. Those who suffered four or more ACEs are more than twice as likely to be diagnosed with a chronic disease in later life compared to adults that have experienced none. They were also three times more likely to have attended Accident and Emergency units, three times more likely to have stayed overnight in hospital, and twice as likely to have visited their GP, compared to individuals with no ACEs.

This powerful evidence brings extra impetus to preventing ACEs from happening in childhood, and learning the best ways to acknowledge and mitigate the effects in childhood and in later life. Impacts are substantively mitigated by always having support in childhood from a trusted adult, a key ingredient for building resilience.



What can Primary Care contribute?

There is a growing recognition in Wales that early intervention and collaborative working are essential to reducing the impact of ACEs. It is useful for all relevant professionals, and Primary Care staff have particular role to play. Further work is needed to be clear how primary care staff can contribute, but the starting point is to be ACEs aware. Health Visitors and GPs have a key role to play here.

For the future, a simple and brief process called Routine Enquiry, carried out with adults in primary care and in other settings, has shown promising results, and major trials are ongoing.

A [short \(five minute\) animated film](#) has been developed to raise awareness of ACEs, their potential to damage health across the life course, and the roles that different agencies can play in preventing ACEs and supporting those affected by them.

Recommendations:

- Consider how your service could contribute to preventing or mitigating any of the ACEs. Some GPs have found it helpful to sensitively ask questions about childhood experiences to patients who attend frequently with non-specific ailments. The evidence suggests just acknowledging that this can have long term positive effects
- Raise awareness of ACEs with all primary care staff using this [short \(five minute\) animated film](#).



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Early Years

Why is this important?

There is strong evidence that the things that happen to a person in the first 1000 days of life have a decisive impact on health through childhood and later life. The time period from conception to age 2 years offers a unique window in which to deliver the most effective and best value health interventions. Improving outcomes in the first 1000 days of life is a high profile national priority for Wales. Primary care is a natural setting for much contact with services during this period.

A range of primary care services support women through pregnancy and both parents and children in the early years of parenthood. Effective care relies on good communication between disciplines and services to ensure problems are picked up early, and appropriate help offered.

Essential **building blocks for health** are laid down in the first 1000 days. Primary care makes a major contribution across the whole pathway (highlighted in red in the shaded blocks):

Actions which may be in primary care

Actions for other professionals

A planned pregnancy gives a woman the chance to make sure she is a healthy weight and not a smoker before conception

Advice about preparing for pregnancy

Good nutrition and regular physical activity in pregnancy, alcohol-free, with folic acid and vitamin D supplements from the start

Advice at the start of pregnancy, including at pregnancy testing

A breast fed baby gives life-long benefits for mother and child.

Advice during pregnancy and postnatal support

A safe and supportive home and loving parents/family

School education about healthy relationships

Local case study: Resources for breastfeeding and weaning

Parents want to do the right thing for their babies but can be bombarded with conflicting advice from families, friends and social media. Primary care is a place that many will turn to for help in deciding what they should do. Betsi Cadwaladr University Health Board has made it easy for professionals to give advice about breastfeeding and weaning by compiling comprehensive web pages for the public. There is more detailed clinical information and relevant policies on the health board's intranet site, accessible from the home page.



Here is an example from the weaning pages:

[Breastfeeding advice pages](#) for the public in English
[Breastfeeding advice pages](#) for the public in Welsh

[Weaning advice pages](#) in English
[Weaning advice pages](#) in Welsh

Fully immunised child according to the schedule
Systems ensure maximum take-up of immunisations

Good mental wellbeing in parents, and rapid help with any mental ill-health, supports good attachment and positive parenting

Mental health screening and referral in pregnancy and for new parents

Plenty of sleep and regular bedtime routines for babies and children
Advice from community nursing and other parenting support

Healthy weaning at the right time, when the child is ready, around 6 months
Advice to parents

Active play (including playing outside every day), social interaction and spoken communication
Prompt referral for speech and language difficulties

Limit screen time, promote books and encourage curiosity
Advice from community nursing and education

Recommendations:

- Support implementation of the Healthy Child Wales programme to prioritise evidence based interventions in the first 1000 days of life. High impact population health interventions include; folic acid, booking by 10 weeks of pregnancy, smoking in pregnancy, breastfeeding, immunisation and perinatal mental health support.
- Maximise opportunistic contacts with women of child-bearing age who may be planning a pregnancy to offer advice and support. The [Every Child Wales website](#) is a helpful resource.

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Social prescribing

What is social prescribing?

Social prescribing is a term used to describe ways of connecting people with support in their community as an alternative to a healthcare intervention.

Social prescribing promotes self-help and enables a person take more control of their own health. In the primary care setting, this can improve the patient experience and outcomes through offering opportunities such as volunteering, arts activities, group learning, and a range of sports and social activities. There is promising evidence that the approach can make a positive contribution to managing demand in primary care at the same time as more effectively helping people. Many of the long-term conditions that are associated with primary care appointments stem from increased social isolation and poor physical and mental health. Social interventions which link patients to community based sources of support enables them to take ownership of their own conditions and to benefit from a community support structure.

The referral routes into social prescribing schemes do not have to be exclusively from primary care, with

sectors such as housing also having a significant role to play. This is an area for collaboration between primary care and other partners to develop networks that can provide support to people before they even approach primary care for help.

Social prescribing programmes are a different approach to supporting people, and can and can be a catalyst for the wider change needed to build a community-focused approach to supporting individuals and communities.

What do social prescribing schemes aim to address?

Typical outcome:

- Strengthening an individual's social networks.
- Reduction in the use of health care.
- An improvement in psychosocial problems.
- A positive impact on healthy behaviours and use of preventative services.
- Improvement in mental well-being.
- Improvements in clinical outcomes and quality of life measures.
- Improvements in the self-management of long-term conditions.

The evidence base

There is a growing evidence base to suggest that empowering patients to manage their own conditions, and engaging with communities to develop a social model of health, brings tangible benefits to patients and to the traditional health and social care services that support them.^{11,12}

Some successful social prescribing programmes have demonstrated that the cost of managing patients with long-term conditions could be reduced by up to 20%, and that there could be a three-fold return on the initial financial investment in services that are delivering positive outcomes.¹³ The recent evaluation of a North Wales social prescribing programme demonstrated that there was a positive social value return of £3.42 for every £1 invested.¹⁴

Social prescribing in North Wales

Within North Wales, there are a number of social prescribing schemes operating, ranging from signposting schemes to in-depth one-to-one work with a social prescriber. Work is beginning to bring different organisations across the health,

social care, education and third sector together to develop best practice and a consistent approach. There is a vibrant arts and health network in North Wales which has a track record of imaginative support to individuals and communities.

Social Prescribing initiatives in North Wales

Social Prescribing in South Flintshire Cluster; 2 GP Practices in South Flintshire agreed to trial an approach whereby patients were identified through risk stratification where there was a high risk of them attending surgery on a regular basis, where clinical management was not their primary need and/or a more holistic approach could be beneficial	Click here for Details or see further information links at the end of this report
Arfon Cluster, Gwynedd (Area West); Mantell Gwynedd: A community link officer is the first point of contact for patients referred from GP surgeries / Primary care / community nurses etc with social, emotional or practical needs to range of local, non-clinical services	Click here for Details or see further information links at the end of this report
Anglesey; Service established during 2016-17 to provide support and signposting to various community based support groups and activities for individuals to improve health and wellbeing as well as information on practical support	Click here for Details or see further information links at the end of this report
Social Prescribing in North West Wales; 3 Individual Projects 1 Anglesey short breaks for disabled children with learning disability 2 Anglesey Men's Sheds 3 Arfon leisure centre activities for adults with learning disability	Click here Short Breaks Click here Men's Sheds Click here LD Hub or see further information links at the end of this report

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4. NICE Guidance NG7: Maintaining a Healthy Weight available at: <https://www.nice.org.uk/guidance/ng7>
5. National Average figures, RBA Report Card Foodwise Communities First 2016-17 available at: <http://senedd.assembly.wales/documents/s61664/PC%2034%20Welsh%20Dietetic%20Leadership%20Advisory%20Group%20Annex%20156%20and%207.docx.pdf>
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Further Information

- ACEs web pages in English available at: <http://www.wales.nhs.uk/sitesplus/888/page/88504>
- ACEs web pages in Welsh available at: <http://www.wales.nhs.uk/sitesplus/888/tu-dalen/88518>
- Anglesey LD Hub available at: Anglesey LD Hub
- Anglesey Men's Sheds available at: Anglesey Men's Sheds
- Anglesey Short Breaks available at: Anglesey Short Breaks
- Conwy West Community Navigator available at: Conwy West Community Navigator;
- Health Education England, Social Prescribing at a glance: A scoping report of activity for the North West, (March 2016) available at: <https://www.hee.nhs.uk/sites/default/files/documents/Social%20Prescribing%20at%20a%20glance.pdf>
- Health Inequalities and Population Health available at: <https://www.nice.org.uk/advice/lgb4/chapter/introduction>
- Help me Quit website available at: <http://www.helpmequit.wales/>
- Intervention and prevention services for Children (LD & CCN) Anglesey available at: Anglesey Social Prescribing
- Link Officer; Arfon Cluster, Gwynedd available at: Arfon Community Facilitator
- Screening Engagement Team Web pages available at: Screening Engagement Team
- Social prescribing a pathway to work? (Work Foundation 2017) available at: http://www.theworkfoundation.com/wp-content/uploads/2017/02/412_Social_prescribing.pdf
- Social Prescribing in South Flintshire Cluster available at: South Flintshire Social Prescribing
- Social Prescribing Projects by Area available at: <http://www.primarycareone.wales.nhs.uk/social-prescribing-projects-by-area>
- World Health organisation: Immunisation available at: <http://www.who.int/topics/immunization/en/>

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