Lancashire and South Cumbria Integrated Care Board

ICB Public Involvement and Engagement Advisory Committee

Date of meeting	18 December 2024
Title of paper	Engagement on Population Health
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Agenda item	6
Confidential	No

Executive summary

This report provides the committee with an update on work undertaken through the ICB's Population Health team to engage with and involve communities and individuals across Lancashire and South Cumbria.

Particular work through the priority wards programme and embedding a health inclusion approach across PCNs has involved significant amounts of participation and engagement and helped the ICB, as well as wider partners, to gather a deeper understanding of inequalities in some of our most disadvantaged communities.

Through working with trusted partners in the VCFSE and community leaders, place-based population health teams have been able to hear from local people about the issues affecting them, barriers to accessing services and their experiences of care. This coupled with the range of data we hold on health inequalities and service activity has enabled places, through the Health and Wellbeing Partnerships, to develop action plans to address what has been found.

Work is ongoing to spread the learning from these approaches and encourage wider ICB teams to recognise the importance and value of involving individuals and communities at the earliest possible stage.

Advise, Assure or Alert

This report is provided to advise and assure the committee of work undertaken through the ICB's Population Health team to engage with and involve communities and individuals across Lancashire and South Cumbria.

Recommendations

The committee is asked to note the contents of this paper and supplementary presentation during the agenda of the meeting.

Which Strategic Objective/s does the report contribute to	Tick

1	Improve quality, including safety, clinical outcomes, and patient experience	**x**
2	To equalise opportunities and clinical outcomes across the area	**x**
3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	
4	Meet financial targets and deliver improved productivity	
5	Meet national and locally determined performance standards and targets	**x**
6	To develop and implement ambitious, deliverable strategies	

Implications				
	Yes	**No**	**N/A**	**Comments**
Associated risks			x	
Are associated risks detailed on the ICB Risk Register?			x	
Financial Implications			x	

Where paper has been discussed (list other committees/forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**

Conflicts of interest associated with this report
N/A

Impact assessments				
	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed		X		
Equality impact assessment completed		X		
Data privacy impact assessment completed		x		

Report authorised by:	Andrew Bennett, Director of Population Health

ICB Public Involvement and Engagement Advisory Committee- 18 December 2024

Engagement on Population Health

1. Introduction

1.1 This report is provided to inform and assure the committee of work undertaken through the ICB's Population Health team to engage with and involve communities and individuals across Lancashire and South Cumbria.

1.2 The Population Health team views the involvement of people and communities as key to addressing inequalities and creating health equity across Lancashire and South Cumbria. This is built upon the ethos of 'nothing about us, without us, is for us' which underpins how the population health team approaches assessing the multi-faceted issues of health inequalities and co-creating solutions to address these.

2. Working with people and communities in priority wards

2.1 This paper and the appendix provides an opportunity to update PIEAC on the work undertaken on the 'priority wards' programme in each of our four places.

2.2 For a variety of reasons, a person living in a community with higher levels of deprivation is more likely to suffer avoidable ill health, and consequently, poorer health outcomes and a shorter life expectancy.

2.3 Through the lens of service planning, we can expect areas of higher deprivation to require increased levels of health and social service support.

2.4 Analysis by NHS Right Care and Prof. Chris Bentley in 2018 showed a direct correlation between the index of multiple deprivation (IMD) score of an electoral ward and the rate of unplanned hospital admissions. The more deprived the ward, the greater the rate of admission.

2.5 Yet, the analysis showed a level of variation, suggesting that this pattern could be influenced and the rate potentially reduced. Wards with a high level of deprivation but relatively low levels of unplanned hospital admission were termed "exemplar wards", those conversely with very high rates of admission were termed "priority wards".

2.6 Across the priority wards in Lancashire and South Cumbria, we have undertaken deep listening exercises to learn what matters to the people living there to shape the strategic direction of the health and wellbeing partnerships to ensure long term improvement.

2.7 Action planning in response has also been undertaken at a place and community level. The learning has been used to influence and shape actions at a place level. This project did not have a budget for implementation, so the approach has been to collaborate and influence.

2.8 The analysis identified 33 “Priority wards” across Lancashire and South Cumbria.

- 11 in Blackburn with Darwen
- 15 in Lancashire
- 5 in Blackpool
- 2 in South Cumbria

2.9 The ICB Population Health team were keen to understand the reasons for this trend and to learn what opportunities there may be to influence and improve health outcomes and reduce urgent care demand as a result.

2.10 Within each place:

- We worked closely with partners to analyse the data we held.
- We reviewed existing evidence and research.
- Listened to residents in these wards, working through trusted partners in the VCFSE.

2.11 The Population Health team then shared high level findings with ICB teams and wider stakeholders and more detailed place level analysis with local authorities, community partners, residents and the VCFSE.

3. Responding to the findings

3.1 Across the priority wards we have undertaken deep listening exercises to learn what matters to the people living there to shape the strategic direction of the health and wellbeing partnerships to ensure long term improvement.

3.2 Action planning in response has also been undertaken at a place and community level. The learning has been used to influence and shape actions at a place level. Detailed examples of work undertaken in each place can be found at Appendix A.

4. Involving marginalised communities through inclusive approaches

4.1 In addition, during the course of 24/25 the population health team has encouraged Primary Care Networks (PCNs) to transition towards health inclusion approaches for their own populations in order to address known inequalities and in-line with NHS England’s inclusion health framework.

4.2 Inclusion health is an umbrella term used to describe people who are socially disadvantaged and/or excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence, and complex trauma (these are the groups referred to as the 'Core20plus' in the national Core20plus5 frameworks). These could be people who live within our most deprived areas (IMD 1 and 2 areas), those who experience homelessness, drug and alcohol dependence, vulnerable migrants, sex workers, people in contact with the justice system and victims of modern slavery. It also includes communities such as the Gypsy, Roma and Traveller community and people of BAME heritage who may not necessarily have more complex health issues but face additional barriers to accessing health care and require tailored approaches to ensure equitable experience and outcomes relevant to their needs.

4.3 People belonging to inclusion groups, tend to have very poor health outcomes, often much worse than the general population and a lower average age of death. This contributes considerably to increasing health inequalities.

4.4 Poor access to health and care services and negative experiences can also be commonplace for inclusion health groups due to multiple barriers, often related to the way healthcare services are delivered.

4.5 Inclusion health groups are relatively small but significant populations with high needs for healthcare, but who face a range of barriers in accessing healthcare services. Whilst numbers may be small, the cost is high to individuals and systems.

4.6 The intention is to increasingly improve our ability to address health inequalities and to enable PCNs and practices to be responsive to the needs of their specific community through inclusive approaches. Ultimately our goal is to break down barriers to accessing services and increasing individuals' opportunity for good health and wellbeing.

4.7 At the end of Q3 in 2024/25 there are already a number of examples from across Lancashire and South Cumbria whereby PCNs have engaged with specific population groups and begun to develop different service offers, amended existing ways of working and, or radically changed their approach. One example of this has been that of Greater Preston PCN whom in July 2024 launched a new outreach service for individuals rough sleeping in Preston which is already demonstrating significant improvements in the experience of healthcare and overall health and wellbeing of individuals supported. Other positive examples from PCNs across Lancashire and South Cumbria include outreach sessions in foodbanks, community centres and veterans' coffee mornings, 'door knocking' to target people in areas of high disadvantage but not regularly engaging with services, plus many more.

5. Spreading this work

5.1 The core principle of involving individuals and communities in population health is a core component of the learning shared via the Population Health Academy Leadership Development programme. The ICB team also continually encourage other teams and directorates to think differently about our approaches to engaging communities and how we utilise trusted sources within the VCFSE and local district councils.

5.2 Joint team-to-team sessions have been held between population health and the communications and engagement team to share learning and expertise, maximise resource and effort as well as understand each differing skillset and relationships.

5.3 An ICB-wide celebration event was also held in September 2024 with the aim of promoting the good practice outlined above and spreading this type of work, whilst acknowledging the efforts of those involved.

6. Recommendations

The committee is requested to note the contents of the report and further detailed examples of work undertaken is to be presented during the agenda of the meeting.

Jonathan Bridge

December 2024

Appendix A – Responding to findings in priority wards

South Cumbria Examples

Barrow-In-Furness. Building on the existing programme of place work, the priority wards analysis has initially led to several pieces of project work which are being undertaken by partners at place, examples include:

- Self-Harm: The Mental Health Team has convened partners in Barrow to review how we support residents with high levels of non-suicidal self-harm. Mental Health Investment fund monies have allowed us to increase counselling services that are delivered within the wards. We are capturing lived experience and ensuring this informs service design. We are working with leaders such as Hilary Cottam to explore an alternative relational model of care which we hope to develop and pilot in the next 12 months. This will lead to reduce A&E attendance and non-elective admissions.

- Case Finding and LTC support: Population Health monies have been provided to Barrow PCN so that they can proactively seek out and engage patients in the priority wards. The initial focus is on those patients with LD, SMI and a known LTC who have not engaged with primary care in the last 12 months. The PCN will also work with the VCFSE to engage other high-risk residents who are not known to primary care, so that we can work upstream and avoid future demand. This will increase our compliance with NICE guidance, QOF (Quality Outcomes Framework) and lead to earlier detection of issues such as hypertension.

- The Healthier Streets project is led by residents and community champions in the Hindpool ward. Working with community-led Love Barrow Families, the project is supporting residents to address issues such as the environment, litter, housing repairs etc. within 4 key streets. The project enables greater community power and is creating a sense of belonging and 'neighbourliness' to combat loneliness, social isolation and to support mental health. This will support a reduction in attendance at both A&E and GP practices. Residents are working with a local media company to video and document progress.

- Respiratory Outreach. Working with Primary care, ICCs, and NHS community services, we are seeking to expand our outreach work into community hubs and venues. We know that many COPD patients are not accessing support or managing their condition optimally; by moving services into pubs and community centres we can improve condition management and reduce A&E and non-elective activity.

- Pharmacy First. Although residents can access free services in their wards, the uptake is very low. Population Health and Medicines Management are working with local schools to educate and support parents on the paediatric and adult pharmacy services available. This will contribute to a reduction in A&E attendances for over-the-counter drugs such as Calpol.

- These projects are further underpinned by the learning from two Poverty Truth Commissions in South Cumbria, funded jointly by Population Health and the

Local Authority. This ensures lived experience from the representing varied populations across South Cumbria are included in our thinking and service response.

- The learning from our Priority Wards work has also been shared with government departments as part of the Barrow Delivery Board programme. The £200 million investment announced for Barrow has a strong focus on work and health and includes targeted activities in our Priority Wards which will help support children and families, those in work with a long-term condition, and those furthest from work.

Lancashire Examples

In Rossendale, working closely with the PCN and Borough Council we collaborated with local community leaders and champions who could reach parts of the community we don't always hear. We developed a model of surveys and supported interviews delivered by community leaders and small organisations that work with people in our communities that face additional barriers to living healthy lives – through unemployment, living with deprivation or being of BAME heritage for example. This approach is helping us to build networks between decision making at partnership level and those in the community we most need to hear from. We learned that a lot of the solutions lay in communication and education around both primary and urgent care services, and what voluntary support services were available. In terms of improving physical or mental wellbeing, it was wider support that was most sought, such as accessible low intensity physical activity and talking groups. The Health and Wellbeing Partnership in Rossendale is now writing a physical activity strategy which will incorporate this learning.

Short term initiatives have been provided additional funding to provide much needed support in the here and now such as:

- In Preston, we supported community volunteers to reopen a disused church in order to establish a much-needed community hub in the Lea and Larches ward. The St Bernards Hub is now a warm, welcoming space offering free advice and support on managing the cost of living, a community fridge and food hub and opportunities for local children, young adults & local adults to access activity for healthy living and recreation in a safe, inclusive environment. Local social prescribers from the PCN regularly utilise the hub with patients they support also.

- We also worked with Preston Care and Repair to undertake 125 'Healthy Homes Assessments' across Lea and Larches. This is a a person-centred approach looking at the whole home environment and what improvements can be made to improve health, safety, and wellbeing within the key themes of; staying safe, staying secure, staying warm and staying independent. On evaluation, 100% of people felt more safe at home, every individual also reported a better understanding of other services available to help them continue to live independently and how to access these as well as 93% reporting improved mental health through reduced anxiety and worry as a result of the assessments.

- Within the same Lea and Larches ward, local GP practices are also actively identifying and providing focused support to patients identified as frail and/or living with respiratory conditions in-order to prevent increased hospital admissions

- Skerton West & Poulton focused wards: Over the last year, Lancaster PCN and Bay PCN have been funded to roll out inclusion health approaches and they have focused on two areas of disadvantage. The approach has seen a health outreach programme (including door knocking) across the Ryelands Estate in Skerton West ward in Lancaster and in the disadvantaged streets near the coast in Poulton Ward in Morecambe. The outreach programme has reached over 200 residents (who had previously had no contact with their GP setting for over 5 years), who have agreed to and received a health check or some kind of health and / or non-clinical intervention (help with crisis / food parcels etc). Examples of people that have been reached are people with undiagnosed pneumonia and cancer who are now receiving the right care and some people have received help to address alcohol issues, smoking cessation, debt and receiving correct benefits.

- Skerton West Focused Ward: As a result of the health inclusion work on Ryeland's estate; population health, health inequalities clinical lead and the health inclusion outreach nurse have been working with Ryeland's residents' association to determine the issues that are important to them to be able to help support some of the wider determinant issues that impact on the residents of Ryeland's estate. The residents have clearly communicated that a children's playground and community open space where people can come together is what they want and have made a clear connection between this and wider health. The issue has been brought to the health and wellbeing partnership and multi-agency work is progressing to support the residents to get the much-needed communal space on the estate to help the community thrive. Through this work many positive relationships and much trust has been built between the residents and agencies, particularly the NHS.

- Focused disadvantaged wards: As a result of adults' respiratory issues being identified as a clinical area of focus disproportionately driving ED attendance in the six focused ward, a Lancaster District system wide workshop was held on Tuesday 21st May to highlight the issues and to get buy in from the system to help provide some of the solutions. The workshop was very well attended by over 40 stakeholders (including people with lived experience) and all stakeholders have pledged the action they will commit to and what they feel needs addressing in the six focused wards. Next steps re this are to engage with the communities in each of the wards to determine what they feel would help them and then develop a system wide action plan focusing on the most impactful priority areas to tackle the causes.

- Focused disadvantaged wards: We are working with Lancaster District Poverty Truth Commission to enable people with lived experience of poverty to support us in identifying the issues by challenging the system so we can work together to tackle poverty. We are joining this work up to the focused wards.

Blackburn with Darwen Examples

Working in partnership with Blackburn with Darwen Borough Council to maximise the impact of the 4 Family Hubs, this has included a full programme of assisted tooth brushing in nurseries and schools, innovative approaches to improving immunisation and vaccination. The ICB and Local Authority have worked in partnership to hold a series of engagement and listening events with parents and carers with the aim of improving the service provision through the Family Hubs but also understanding barriers to accessing wider health and care provision. The Family Hubs are now engaging with Primary Care to improve relationships and ensure a complete understanding of services offered and how to connect people to wider services offered through the VCFSE sector.

Working in Priority Wards we have adopted a multi-agency approach to engaging with residents of Houses of Multiple Occupation and Asylum Seekers and Refugees. Our lead GP and Health Inequality Clinical lead has led the implementation of a coordinated stakeholder drop-in session to work with individuals and families to coordinate care and support. The care and support can come from several different agencies and therefore streamlining the offer has led to an improved up take and levels of engagement.

Blackburn Central ward has significantly higher non-elective attendances for people aged 20-64 and those people admitted to hospital have a significantly longer length of stay. The ward is home to a complex population which incorporates the town centre. A multi-agency stakeholder group is being established to work with communities to understand the underlying causational factors leading to non-elective care and this is being aligned to the UEC Delivery Board access plan for 2024/25.

Darwen East is a ward with a high concentration of our older population and the population make up is different from the rest of BWD. The area experiences higher levels of +65 attending hospital through non-elective routes. We have commenced work with Ash Grove, a community group who have recently grown its membership and are determined to improve the lives of people in the Ward. The community group are engaging with the Primary Care Neighbourhood, which includes Primary Care, elected members, VCFSE and Local Authority representatives. The community group are developing an understanding of how they communicate the challenges they face and influence change in service provision to meet the needs of residents.

Blackpool Examples

Blackpool has a significant number of residents experiencing multiple disadvantage (substance misuse, domestic violence, contact with the criminal justice system, homelessness, mental health issues). Recognising that these residents often struggle to access traditional services, Blackpool, Fylde and Wyre have established a trauma informed, peer-led system delivery model which supports individuals experiencing severe and complex multiple disadvantage in accessing health and care services. The clients within this service include people experiencing homelessness, drug and alcohol dependence, poor mental health, domestic abuse, and/or contact with the criminal justice system.

The golden thread of this delivery model is the Lived Experience Team, who are an outreach-based team providing peer support who, through their network of volunteers, have personal experience of issues such as homelessness, mental health, offending and substance misuse, are skilled in building trust with, and advocating for, people facing multiple disadvantages. They work collaboratively with health, social care and voluntary organisations and continually adapt their approach to meet individual client need, actively providing support and guidance in the continued development of services using their creative thinking to embed positive change. This enables delivery of effective services, placing complex people at the heart of everything we do.