NHS
Lancashire and South Cumbria
Integrated Care Board

Priority Wards

Population Health Team

The approach to; and learning from how we work differently with people and communities

What was the question?

Analysis by NHS England showed:

1. Communities with high levels of deprivation also have the highest use of NHS emergency services.
2. That the pattern is not restricted to a few disease areas, but is shown across a range of common conditions
3. That residents in these communities often first present as a crisis or emergency

However, if we look at wards with high level of deprivation…

- Some wards have unusually low levels of emergency demand, termed “Exemplar wards”
- Some have unusually high levels of emergency demand, termed “Priroity Wards”

How can we reduce ‘avoidable’ urgent hospital admissions from our Priority Wards?

Why look at this problem

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The NHS perspective

- Improving population health is the core business of the NHS Integrated Care Board (ICB)
- The urgent care system is under significant and unsustainable pressure
- The pattern is getting worse
- We understand the 'themes' but we need to understand the local issues and challenges
- We need to filter out the specific actions that will have **impact**, on which we can focus time and resource

Additional Population Health Team aims…

- Using local resources to explore the problem – investment (£2.5k per ward)
- Supporting communities (in their broadest sense) to describe the problems and challenges – empowerment
- Develop community prioritised actions in which we can collectively invest – greater control

Outline approach

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Phase one

- Predominantly 'desktop research' to establish a better understanding of existing data sets and wider intelligence with a view to reaching an interim set of themes and hypothesis to further explore.
- This first phase also included gathering wider intelligence from stakeholders through not only data but also qualitative sources such as interviews with local stakeholders, publications and residents surveys etc to help build tacit knowledge and further insights.

Phase two

- Centred on further exploring these initial themes as KLOEs for further data analysis, testing through community listening activities and wider stakeholder engagement.
- Community listening activities are very much an ongoing commitment and have no stipulated end point but our initial approach to this was to feedback our findings and assumptions to compare and contrast with what residents themselves felt and experienced.

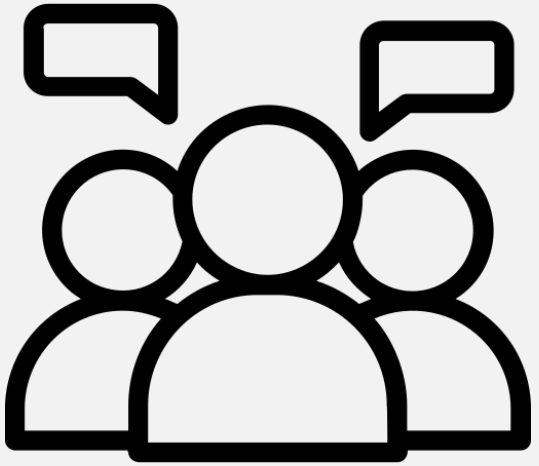
End goal being to develop a conclusive report of findings to inform a detailed action plan for appropriate short, medium and long-term interventions, owned by the newly formed place-based Health and Wellbeing Partnerships.

Listening to people and communities

- A relatively small amount of budget was signed to each priority ward to fund work led by VCFSE organisations in each place.

- A range of tactics used to reach individuals and wider community. These included, community-based focus groups and listening events, drop-in sessions, one-to-one interviews, door knocking, attendance at existing community groups and other activities, online and paper surveys etc.

- Achieved a wide reach into priority ward populations across the ICB (eg over 700 doors knocked in Blackpool, more than 600 people reached in person plus further 200 online in West Lancashire)



Fundamentally sought to get deep into the community, reaching individuals and groups beyond our traditional engagement routes

Initial findings and recommendations

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Barriers to accessing primary care

Ongoing impacts of cost of living crisis

Housing

Social isolation and wider community connections

Employment

Continuity of care

Awareness of available supporting services

Mental health

Variation in long-term condition management

So what?

- Communities feel heard and seen through their involvement in the work to date. This is not 'checking our ideas' – it is fundamentally, listening differently to what matters in our communities and the lives of those people living there.
- Corporate credibility for the ICB: listening and not responding undermines trust. This approach brings reasonable expectations of action.

Work of this nature HAS TO BE done in partnership.

- Involvement of VCFSE partners was crucial and critical to achieving a wider reach into communities, but this requires appropriate investment.

- Statutory organisations are not always the best placed to 'listen' – we must recognise this and relinquish 'control' when appropriate – place trust in those who are deep-rooted in our communities to work on our behalf.

You said, We did!

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- Does the learning from this work suggest a move away from a single cycle of engagement into a continuous cycle of involvement and improvement?
- How does the ICB prioritise this model of “deep engagement” because it may not be possible in every area or on every topic?
- What value would a “gateway” process offer in moving from engagement to action e.g.:
  - Investment Gateway (more resources are needed)
  - Disinvestment Gateway (this does not work for a community)
  - Reimagine/redesign Gateway (we can do better to serve this community)
  - Integration Gateway (we need to combine resources to be more effective in this community)
- Can we conceive of the ICB asking community organisations to lead on a strategic priority e.g Dying Well? What would that be like?

What next…

- This is an ongoing commitment to working differently with people and communities, led by what matters to them.

- Place-level Partnership and ICB-level recognition of the need to do so. Ongoing oversight in each place.

- Energy to change what has gone before and create health within the priority wards. We will build upon this and harness in the strongest sense.