**Population Health Case Studies - 4**

**Priority Wards in Barrow**

**What was the issue we were trying to resolve/why was it needed?**

The issue being addressed in this project urgent care demand in Barrow, specifically focusing on understanding the drivers behind this demand, using a population health approach. The goal was to identify and address the underlying causes of health problems, rather than just managing the demand for services. This approach aimed to shift the focus to non-NHS issues that impact health, such as social determinants and health inequalities, to improve overall health outcomes and reduce avoidable admissions.

**Who was it aimed at?**

The initiative was aimed at the communities in Barrow, particularly the wards of Central and Hindpool, which were identified as having high levels of urgent care demand and health inequalities. The work involved collaboration with various stakeholders, including the local NHS, primary care, local authorities, public health teams, voluntary sector partners, and the residents themselves. The goal was to create conditions conducive to good health and address the specific needs of these communities.

**Summary of the project**

**Objective**:

* Address urgent care demand in Barrow using a population health approach to understand and mitigate underlying causes of health problems.

**Key Activities**:

* **Data Analysis**: Examined hospital admissions, A&E data, and 111 data to identify patterns and key drivers of urgent care demand.
* **Community Engagement**: Conducted outreach programs, pop-up stalls, and surveys to gather lived experiences and insights from residents.
* **Multi-Agency Collaboration**: Formed a team including NHS, primary care, local authorities, public health, and voluntary sector partners to develop and implement strategies.

**Findings**:

* High rates of chronic obstructive pulmonary disease (COPD), diabetes, self-harm, and childhood illnesses were identified as major contributors to urgent care demands.
* Social determinants such as housing, pollution, and economic deprivation significantly impacted on health outcomes.

**Action Plan**:

* **COPD Management**: Improve physical environment, support smoking cessation, enhance primary care management, and increase voluntary sector involvement.
* **Self-Harm Prevention**: Engage with community and voluntary agencies, provide counseling and support, and explore relational models of healthcare.

**Outcomes**:

* Initiatives such as community-led cleanup projects and outreach workers for smoking cessation were launched.
* Enhanced collaboration among stakeholders to address complex health issues and improve service delivery.

**Who was involved – partnership approach for example?**

**Partnership Approach**:

* **NHS Lancashire and South Cumbria ICB**: Led by Gary O’Neil, focusing on population health strategies.
* **Barrow Integrated Care Community (ICC)**: Bridged gaps between acute, primary, and voluntary care, providing care coordination and community engagement.
* **Local Authorities**: Included public health and community development teams, contributing to data analysis and community outreach.
* **Primary Care**: Involved in identifying and managing health issues within the community.
* **Voluntary Sector Partners**: Engaged in outreach programs and provided support services, including organizations like Love Barrow Families and Safer.
* **Residents**: Actively participated in providing lived experiences and leading community initiatives.

This collaborative approach ensured a comprehensive understanding of the issues and facilitated the development of targeted interventions.

**Core Project Team:**

**Gary O’Neill**: Associate Director of Population Health in South Cumbria.

* **Vicky Jackson:** Population Health Project Manager
* **Maxine Baron**: Development Manager at Barrow ICC
* **Ash Kshetrepal**: Clinical Lead at Barrow ICC
* **Scott Johnson** - Senior BI Analyst (Midlands and Lancashire CSU)
* Selina Pritchard - Senior Business Intelligence Analyst (University Hospitals or Morecambe Bay)
* **Gary Malone**: Place Lead for Adult Mental Health – South Cumbria
* **Simonetta Tiribocchi** - Community Development Officer (Westmorland and Furness Council)
* **Katherine Taylo**r - Public Health Manager (Westmorland and Furness Council)

These individuals played key roles in various aspects of the project, from leadership and coordination to community engagement and mental health support.

**When did it start/finish (is it ongoing)?**

The project started in January 2023 with a launch workshop involving multiple agencies and community partners. The initial report was compiled in July 2023. The project is ongoing, with continued efforts in community engagement, outreach, and developing action plans based on the findings.

**What area was/is it delivered in?**

The project is being delivered in Barrow, specifically focusing on the Central and Hindpool wards. These areas were identified as priority wards due to their high levels of deprivation and urgent care demands.

**How did the team go about delivering it?**

The team delivered the project through a multi-agency approach, involving:

* **Formation of a multi-agency team**: This included Barrow Integrated Care Community, the hospital, primary care, local authority representatives, public health, and community development teams.
* **Community engagement**: Outreach work was conducted through pop-up stalls, sessions at community centres, targeted work with families and schools, and collaboration with local voluntary sector partners.
* **Data collection and analysis**: The team gathered hospital data, A&E attendance data, 111 data, and contextual information about the wards. They also collected lived experiences through surveys and direct engagement with the community.
* **Development of hypotheses and action plans**: Based on the collected data and community feedback, the team developed hypotheses about the drivers of urgent care demands and created action plans to address key issues such as COPD and self-harm.

The project continues to evolve with ongoing community involvement and collaboration with various stakeholders.

**What were the main outcomes/impacts for people?**

The main outcomes and impacts for people included:

* **Increased community engagement**: The project empowered local residents to take action, such as getting involved in the "Healthier Streets" initiative where community champions led efforts to clean up their neighbourhoods.
* **Improved access to services**: Initiatives like the funding of outreach workers for smoking cessation and the development of a more visible primary care presence aimed to improve access to health services.
* **Enhanced support for self-harm prevention**: Investment in charities and community organizations to provide counselling and support for individuals at risk of self-harm.
* **Addressing environmental and housing issues**: Collaboration with local authorities and businesses to improve the physical environment and housing conditions in the targeted wards.
* **Increased awareness and utilization of pharmacy services**: Efforts to educate families about available pharmacy services to reduce unnecessary A&E visits.

These outcomes aimed to address the root causes of health inequalities and improve overall health and well-being in the community.

**Are there any comments/statements from people it helped?**

* **Parents**: Some parents mentioned taking their children to A&E to demonstrate to social services that they were caring for them properly.
* **Community members**: Many people shared their struggles with pay-as-you-go phones and lack of broadband, which made accessing telephone triage services difficult and expensive, leading them to prefer going directly to A&E.
* **Elderly patients**: Elderly patients without mobile phones faced challenges in securing early morning appointments, often having to walk through town to get to the practice on time.
* **School teachers**: Teachers reported that parents would call them in the evenings for help with parenting issues, such as getting their children to sleep and managing device usage.

These comments highlight the various challenges faced by the community and the impact of the project's efforts to address these issues.

**How many people were seen or accessed support?**

* Worked with 17 charities across Barrow
* Held 13 events in the local community
* Engaged with over 250 residents at these events
* Held 2 workshops with over 50 stakeholders
* 102 surveys completed