**Population Health Case Studies - 6**

**Living well in Burnley: Enhanced Health Checks**

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

The issue being addressed in the project was the challenge of providing accessible healthcare services to the residents of Burnley, particularly those in deprived areas and priority wards. The need for this initiative arose from several factors:

* **Geographical Barriers**: Burnley's town centre is surrounded by hills, making it difficult for people to reach services. The motorway also acts as a barrier, dividing the town and complicating access to services.
* **Deprivation and Health Inequalities**: Burnley is a deprived town with high levels of fuel poverty, poor nutrition, and unhealthy lifestyles, leading to higher hospital admissions and increased crime rates.
* **Outreach and Accessibility**: The Enhanced Health Check program aimed to build on existing outreach efforts to provide health checks and support to underserved populations, including the homeless, refugees, and asylum seekers.

The goal was to improve health outcomes by addressing social determinants of health and making healthcare more accessible to those in need.

**Who was it aimed at?**

The initiative was aimed at several key groups within Burnley:

* **Residents of Deprived Areas**: Particularly those living in the four priority wards identified in the Priority Ward report.
* **People Facing Geographical Barriers**: Individuals who find it difficult to access services due to the town's hilly terrain and the dividing motorway.
* **Homeless Individuals and Those with Drug and Alcohol Problems**: Supported through charities like Church on the Street.
* **Refugees and Asylum Seekers**: Assisted by the charity New Neighbours Together.
* **General Population with Health and Social Needs**: Including those who may not fall into traditional priority groups but still present with significant health and social needs.

The program aimed to provide enhanced health checks and support to these groups to improve their overall health and well-being.

**Summary of the project**

**Burnley Enhanced Health Check Program**:

**Key Takeaways/Decisions**:

* **Objective**: Improve healthcare access and outcomes for residents in deprived areas of Burnley, addressing social determinants of health.
* **Target Groups**: Residents of priority wards, individuals facing geographical barriers, homeless people, those with drug and alcohol issues, refugees, asylum seekers, and others with significant health and social needs.
* **Challenges**: Geographical barriers, high levels of deprivation, unhealthy lifestyles, and increased crime rates.
* **Approach**:
  + Formed a core project team with health inequality leads, clinical directors, and PCN managers.
  + Conducted outreach through various community venues like Downtown, New Neighbours Together, and Lancashire Community Farm.
  + Provided training to PCN staff and collaborated with social prescribing teams.
  + Offered health checks and support services, including social prescribing, at outreach clinics.
* **Results**:
  + Conducted 526 health checks across 13 outreach venues.
  + Identified and addressed various health and social needs, including those of individuals not falling into traditional priority groups.
  + Facilitated access to healthcare and social services, improving overall well-being.

**Future Plans**:

* Continue offering Open Access outreach clinics and increase engagement with practices for referrals.
* Measure and analyze data to improve service delivery and outcomes.
* Collaborate with universities for quality improvement projects and service evaluations.

The project aims to create a sustainable model for providing holistic and accessible healthcare to underserved populations in Burnley.

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

The project involved a partnership approach with several key stakeholders:

* **Health Inequality Leads**: James Fleming and Lucy Astle
* **Clinical Directors**: Yasara Naheed and Katie Clark.
* **PCN Managers**: Paula Crake and Hazel Swarburk.
* **Primary Care Networks (PCNs)**: Burnley W and Burnley E PCNs.
* **Charities**: Church on the Street (supporting homelessness and drug/alcohol issues) and New Neighbours Together (supporting refugees and asylum seekers).
* **Community Partners**: Burnley Football Club in the community, Downtown (community grocery and uniform shop), and Lancashire Community Farm.
* **University Collaboration**: University of Central Lancashire (UCLan) medical students worked on quality improvement projects and leaflet design.

This collaborative effort aimed to leverage the strengths and resources of various organizations to address health inequalities and improve access to healthcare services in Burnley.

**Full names of people who supported with the project**

The full names of people who supported the project are:

* **James Fleming**: Health Inequality Lead Burnley West PCN
* **Yasara Naheed**: Clinical Director, Burnley East PCN.
* **Katie Clarke**: Clinical Director, Burnley West PCN.
* **Paula Crake**: Operations Manager , Burnley West PCN.
* **Hazel Swarbrick**: Digital & Transformation Manager
* **Burnley East Primary Care Network**
* **Helen Arthur**: Associate Director Population Health
* **Associate Director of Population Health Lancashire/East Lancashire**
* **NHS Lancashire and South Cumbria Integrated Care Board:** Provided information for the Priority Ward report from the ICB.
* **Cather Robertson:** Population Health Manager
* Population Health Improvement Manager  
  NHS Lancashire and South Cumbria Integrated Care Board. Provided information for the Priority Ward report from the ICB.

These individuals played significant roles in supporting and driving the project forward.

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

The Enhanced Health Check programme started in September 2022. The project is ongoing, with plans to continue offering Open Access outreach clinics and increasing engagement with practices.

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

The project is delivered in Burnley, focusing on various locations within the town, including:

* Burnley town centre
* Priority wards in Burnley
* Specific venues such as Downtown, New Neighbours Together, and Penn, Lancashire Community Farm.

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

The team delivered the Enhanced Health Check programme through a collaborative approach involving various stakeholders and strategies:

* Formed a core project team with health inequality leads, clinical directors, and PCN managers.
* Conducted team training around health inequalities and enhanced health checks for staff in various roles, including nursing associates, health and well-being coaches, and care coordinators.
* Worked closely with social prescribing teams and kept member practices informed through emails and meetings.
* Adopted an outreach approach, offering health checks at various community venues and events, such as Downtown, New Neighbours Together, and Penn, Lancashire Community Farm.
* Ensured that social prescribers were present at outreach clinics to provide immediate support and follow-up.
* Utilized medical students for quality improvement projects and leaflet design to simplify communication with patients.
* Measured and evaluated the activities and outcomes of the outreach clinics to inform future strategies.

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

The main outcomes and impacts for people from the Enhanced Health Check programme in Burnley included:

* Conducted 526 health checks across 13 outreach venues, addressing both health and social needs.
* Provided holistic support, including immediate referrals to social prescribers and assistance with practical issues like housing and benefits.
* Helped individuals who were not registered with a GP or had undiagnosed conditions, improving their access to healthcare services.
* Addressed social determinants of health, such as nutrition, housing, and mental health, through direct links to social prescribing and community resources.
* Offered support to vulnerable groups, including refugees, asylum seekers, and people with mental health difficulties, ensuring inclusivity in health checks.
* Facilitated access to healthcare for individuals facing barriers, such as language difficulties and lack of resources, by providing interpreters and simplified communication.

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

Barry (names have been changed to protect identity) a patient from on the street clinic reported “its nice to see staff who care, don’t judge and understand”

Barry is a 52 year old man who attended one of our living well clinics at Church on the Street (COTS). He was recently released from prison and had moved to Burnley. He had a known diagnosis of asthma but had no inhalers or medication and was not registered with a GP. The team supported him to complete an online registration form, completed an Enhanced Health Check and Asthma review and liaised with the new GP for him to be able to obtain his inhalers. They also supported him to seek help for his housing and benefits support.

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

A total of 526 people were seen and accessed support through the Enhanced Health Check programme across 13 separate outreach venues.