**Population health case studies (9)**

**Enhanced health check in Lancaster**

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

The issue being addressed was the need to improve population health and health equity in Lancaster, particularly in the more deprived areas. The focus was on developing an outreach service to engage people who were not accessing healthcare, especially those in deprived areas like the Rylands estate. This was necessary because many residents had high rates of unemployment, mental health problems, and addiction, and were not engaging with healthcare services due to various barriers.

**Who was it aimed at?**

The outreach service was aimed at residents of the Rylands estate in Lancaster, which is one of the most deprived areas in England. The target groups included individuals with high rates of unemployment, mental health issues, and addiction, as well as those who were not engaging with healthcare services.

**Summary of the Project**:

* **Objective**: Improve population health and health equity in Lancaster, focusing on deprived areas like the Rylands estate.
* **Target Group**: Residents of the Rylands estate, particularly those with high rates of unemployment, mental health issues, and addiction, and those not engaging with healthcare services.
* **Approach**:
	+ Develop an outreach service to engage residents who are not accessing healthcare.
	+ Use NHS health checks in a broader sense to engage people in deprived areas.
	+ Focus on patients who haven't attended the surgery in the last five years and non-engaging diabetics.
	+ Offer initial home visits to understand patients' situations better and build trust.
* **Activities**:
	+ Conduct health checks and follow-up visits.
	+ Collaborate with local residents' associations to address community concerns.
	+ Organize engagement events like well-being fairs.
* **Outcomes**:
	+ Offered about 250 health checks, with around 150 people engaging.
	+ Identified new health conditions and provided support to improve health and well-being.
	+ Addressed community issues like playground safety and waste management.

This project aims to build trust and provide comprehensive support to improve the overall health of the Rylands estate residents.

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

Partnership Approach and Involvement:

* **Lizzy Holmes**: Outreach lead practitioner for Lancaster PCN.
* **Nurse Associate**: Works alongside Lizzy Holmes, also based at Owen Rd surgery.
* **Residents' Association**: Collaborated with the Rylands estate residents' association, led by a dedicated resident, to address community concerns and support families.
* **Bay Volunteers**: Provided food deliveries to residents in need.
* **Green Rose**: Assisted with household support, including providing new appliances.
* **Population Health Team**: Involved in addressing playground and skate park safety issues.
* **Health and Well-being Partnership**: Worked collectively to support funding bids and improve community facilities.

This partnership approach aimed to leverage the strengths and resources of various stakeholders to improve health outcomes and address broader social issues in the Rylands estate.

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

* **Lizzy Holmes**: Outreach lead practitioner for Lancaster PCN.
* **Sam Moon:** HICL
* **Claire Niebieski**- ICB Population Health North Locality Lead

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

The outreach service in Lancaster started in February of the previous year. Lizzy Holmes mentioned that she was given the task last February.  The project is ongoing, as Lizzy Holmes continues to work with patients and the community, with recent activities and plans for future events and support.

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

The outreach service is delivered in Lancaster, specifically focusing on the Rylands estate, which is one of the most deprived areas in England.

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

The team delivered the outreach service through several key steps:

* **Initial Focus on Deprived Areas**: They started by identifying the most deprived areas in Lancaster, specifically targeting Rylands estate.
* **Patient Lists**: They used lists of patients who had not accessed healthcare services in the last five years and non-engaging diabetic patients to identify individuals who might need support.
* **Home Visits**: They offered initial home visits to understand the patients’ circumstances better and build trust, as many patients had complex needs and low trust in healthcare.
* **Support Services**: They provided various forms of support, including financial assistance, food deliveries, and household items, to improve patients’ living conditions and health.
* **Community Engagement**: They worked closely with the Rylands residents association to address community concerns and improve engagement, including organizing a well-being fair and addressing issues like playground safety and bin availability.
* **Persistent Follow-Up**: They maintained persistent follow-up with patients who were initially reluctant to engage, ensuring continuous support and eventually gaining their trust.

These steps collectively helped the team deliver the outreach service effectively.

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

The main outcomes and impacts for people included:

* **Improved Access to Healthcare**: Many individuals who had not accessed healthcare services for years were engaged and received health checks.
* **Enhanced Living Conditions**: Patients received support such as food deliveries, household items, and financial assistance, improving their living conditions.
* **Increased Trust in Healthcare**: Persistent follow-up and home visits helped build trust among patients, leading to better engagement with healthcare services.
* **Community Support**: Collaboration with the Rylands residents association addressed community concerns, such as playground safety and bin availability, fostering a supportive environment.
* **Identification of Health Issues**: Health checks led to the identification of new health conditions, allowing for timely intervention and support.

These outcomes collectively contributed to improved health and well-being for the residents of Rylands estate.

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

Approximately 250 health checks were offered on the Rylands estate, with about 150 people engaging and receiving support.