**Population health case studies (10)**

**Lancaster District Enhanced Health Check/Health Inclusion Model**

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

The aim of the work is to tackle the lack of engagement in healthcare from hard to reach (CORE20PLUS) groups in order to tackle health inequalities and achieve equity for the population of Lancaster District.

**Who was it aimed at?**

The population of focused wards in the Lancaster District where there are a disproportionate number of emergency admissions recorded. In particular people who:

* Don’t want to use services
* Don’t know how to use services
* Don’t know they need to use services
* Use services in the wrong way
* Are too overwhelmed to use services

**Summary of the project**

To work together with vulnerable communities to find and better support people to improve their health and wellbeing through the lens of respiratory conditions, engaging with the hardest to reach people.

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

The work involved a partnership approach from L&SC ICB, Integrated Care Community leads for Lancaster and Bay, Community Outreach nurses from Lancaster and Bay PCNs, Community leaders, VCSFE and Lancaster CVS.

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

Work began in 2023 and continues to date. Future work will be directed by the Targeted Demand Model.

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

The focussed wards in Lancaster District:

1. Poulton
2. Westgate
3. Skerton West
4. Harbour
5. Heysham North
6. Overton

Specific work was delivered in Skerton West (Ryelands estate), Westgate and Poulton.

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

* They prioritised and organised the work.
* Used local opportunities as a way to engage including pop-ups in the park, activities in schools, community groups, school health day with partners and knocking on doors.
* Worked independently with communities and VCSFE.
* Identified and worked with community leaders and community settings.
* Took collective action from many systems, places, sectors and organisations.
* Used intelligence to target population groups using data, geographical information and tacit knowledge.

Specific work involved offering enhanced health checks, targeting children and families in damp and overcrowded housing, targeting high intensity users of services (especially in urgent and emergency care) and working together to create health by developing community play/communal spaces.

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

Established trust and built relationships with colleagues from health and other services which encouraged attendance at health checks and wider support. Outcomes included:

* New diagnosis and condition management
* Medical optimisation & new medication commenced
* Access to mental health support (in Health and the community)
* Support with finance including debt, PIP, carers allowance and much more
* Access to appropriate health and social care services and support
* Many referrals to over 50 local support services
* Connection with wider community & family support in place
* Improved mental health and wellbeing
* Support with housing & rehousing
* Engagement with screening and vaccination programmes
* Engagement with substance misuse support

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

Data demonstrates that for those streets in Poulton Ward targeted with a health inclusion / EHC approach the data is indicating a comparative 11% reduction in UEC attendance and a comparative 7% reduction in UEC cost when compared with the remaining like for like streets that haven’t received the same approach.

**Please see case study below:**

|  |  |
| --- | --- |
| Return on Investment for Steve   * The EHC intervention has enabled Steve to access services more effectively. * He has put on 6kg in weight – healthier lifestyles * His mental health and wellbeing has improved, becoming visibly more cheerful * Improved mortality via cancer screening and medications | Unsustainable cost for people like Steve   * Without intervention Steve’s health would have continued to decline – poor lifestyle, lack of food, lack of hygiene, poor housing, etc. This would increase A&E attendances, LOS, delayed discharges, increased HCAI, etc * There would also be a higher risk of multiple LTC and associated costs. * Needing social care and support |
| HWB Improvements  Referrals   * Foodbanks * Fire Service * GP – Mobility and alcohol, scan, respiratory, antibiotics, ? cancer * Community therapy * Egg Cup (food) * Benefit enhancements   Able to Trust People   * Outreach and home visits * Flu / Covid vaccinations * Feeling that people care enough to consistently support him. * On medication (Thiamine and Folic Acid) and not had an alcoholic drink in a week! | HWB Declines  Financial demands   * Telephone calls * Transport   Lack of essentials   * Food, heating * Housing / household appliances   Addictions   * Lack of support |