Selby Town Population Health Management Programme

- **PCN population size:** 49,792
- **Key PCN attributes:** Significant inequalities around **poverty;** high **variation in life expectancy** between wards; high levels of **childhood & adult obesity**, high **smoking prevalence**, high levels of **CHD, stroke** and **dementia.**
- **Programme cohort size:** 418 individuals that met the criteria were randomly selected from across the PCN. From this 48 individuals took part in the initial health needs assessment questionnaire.
- **Programme cohort description**: People aged 50-64 yrs with a diagnosis of Hypertension and mild/moderate frailty..

Intervention

- **Description/rationale for intervention :** A health needs assessment approach to identify gaps in services and barriers to accessing services in this cohort; a codesign approach designed to improve awareness of services available, develop relationships with key groups, identify gaps in what is needed, and improve ability to self care to reduce or slow deterioration of conditions.
- **Wider determinants considered:** The wider determinants included employment status, income, social isolation and vulnerability, health and digital literacy, housing issues, disability issues and transport and mobility.
- **Activities undertaken as part of the initial intervention**
- An MDT approach was used to identify the patients, using the population health management data.
- The Care Coordinators led on designing a holistic health needs assessment questionnaire for a semi structured interview around the following themes: **Your health, medication, long term condition reviews, mental health and wellbeing, health family, friends and support networks, employment, volunteering and social contacts, housing, digital connectivity**. Care Coordinators and Social Prescribing Link workers contacted the identified cohort of patients via letter and then by phone to take part in the questionnaire.

Partnerships

- **Organisations and workforces involved**

Primary Care Network:
Care Coordinators, Social Prescribing Link Workers, Clinal Director, Lead GP
Vale of York CCG, Lead Officer Primary Care,
North Yorkshire County Council public health, Stronger Communities, **Selby District Council,** Head of Communities, Partnership and Customers
Two Ridings Community Foundation, - Chief Executive
York Teaching Hospital NHS Foundation Trust, Community Services

Results from the Initial Health Assessment Interview Intervention

Themes identified were: health conditions, health reviews, mental health, barriers to changing lifestyle and healthy lifestyles. **Responses included:**

- Conditions **impacting on daily life**
- The need for **longer or more frequent Long Term Condition Reviews**
- The need for education, target setting and support with food and exercise.
- Barriers around **accessibility and cost of exercise classes**.
- **Pain management** preventing exercise and weight loss.
- **Social isolation**
- **Financial security and returning to work.**
- Support with **caring responsibilities**
- The need for **a holistic and family approach**

Selby Town PCN and Partners Findings and Next Steps

Focus Groups

Partners help design and Care Coordinators and Social Prescribing Link Workers ran 3 sessions of focus groups for the 26 people who have chosen to engage further with codesign. Session 1 explored the themes identified in the interviews, sessions 2 and 3 started to look at solutions. The groups will meet with local partners to consider how they might support people with long term conditions to get active, find networks and improve health. **3 themes were focussed on: healthy lifestyles, mental health and health conditions and feedback was as follows:**

1. Healthy Lifestyles

Accessibility – of exercise classes/gyms. Need to be age friendly, hard to fit into busy lifestyle, accessibility and cost for carers.
Cost/finance – classes and food.
Healthy eating – the need for education around food/shopping
Information/communication- about what's available

2. Mental Health

Peer support – around conditions e.g. asthma, heart conditions, groups with similar people
Motivation and **self worth**
Ownership of own health and self managing conditions
Family support
Isolation – need for activities and groups, buddy systems for groups
Lack of **support for mental health** – before going into crisis.
Lack of **support for carers**
Age UK Selby closing down – now lack of **assistance with shopping**, **befriending** etc.

3. Health Conditions (management)

Information - Lack of info provided at reviews around LTC's; dealing with diagnosis, the impact, management and education, healthy ageing. Leaflets as well as online
Pain and mobility – need support to manage
Digital/IT/technology - education of how to access information about condition etc
Continuity of care - Having to repeat yourself in appointments. Lack of joined up working between GP Practice teams and hospital teams; Multi-Disciplinary Team approach is much more effective.
Holistic support –focus on health as a whole
Ap**pointments** – waits and difficulties booking appointments, want F2F appts, feeling very rushed during phone apps, could they access other surgeries? More regular reviews
Accessibility - difficulties accessing some services/diagnostics in rural areas e.g. stroke support and phlebotomy. SWMH short hours. Could some tests e.g. blood tests be done in surgery rather than hospital?

Lessons Learned, Partnership Working and Engagement

- **A video interview summary of feedback from participants and a description of what was done well, challenges and potential improvements can be found here**: Selby Town PCN Population Health Management Programme – YouTube
- **Media release about the success of the programme, and how GP practices in Selby are changing patients' lives with a new approach to their health can be found here**: https://www.valeofyorkccg.nhs.uk/gp-practices-in-selby-are-changing-patients-lives-with-a-new-approach-to-their-health/
- **Selby Town PCN – Care Coordinators in a class of their own 'Ockham healthcare' podcast can be found here**: Podcast - Selby Town PCN - Care Coordinators in a class of their own - Ockham Healthcare

Solutions discussed:

Healthy Lifestyles:
NYCC (through Selby Leisure Centre) Tier 2 weight management offers e.g. Move it or Lose it 12 week programme.
Corporate membership, discounts and offers for e.g. carers (free memberships for carers in receipt of carers allowance)
The need for more varied social groups e.g. for men, working people,
The need for a community centre around Selby Park (accessible to all)
The use of the outside gym equipment – a 'how to' session
Ramblers and walking groups available – to start from Selby Leisure Centre

Outcomes and Next Steps

Evaluation - Short, medium and long term measures of impact:

- Improving awareness of existing community services
- Reduce/delay progression to severe frailty
- Develop links and improve MDT working
- Improve patient activation scores
- Reduction in contact in primary and secondary care e.g. out of hours
- Re- engage with those people who completed the health assessment questionnaire (and did not continue with focus groups/co designing)
- Improvements in health and wellbeing
- Reduced duplication in service offers

To consider…

Opportunity for **scalable impact and PHM capability**: plans for further engagement with similar cohorts and how to make future PHM interventions manageable and sustainable for partners.