Leicester City South

Primary Care Network

A population health management approach to addressing health inequalities using social prescribing

What was our approach to Population Health Management?

- We worked with ICB, MLCSU shared data as well as clinician led insights within our PCN population.
- Using this data supported us to identify themes across our PCN and inform the development of interventions tailored to local at-risk population cohorts, aiming for improved outcomes with reduced unwarranted variation between cohorts.
- We identified a cohort of patients who were not engaging with general practice services for their health needs and often presenting in crisis to out of hours services, the Emergency services or Police.
- Some of these patients had repeated attendances by the police or to ED which led to significant health consequences.
- They were often not responding to the usual methods of engagement.
- The 3 Conversations approach has helped support patients who have not been engaging with their health needs, have mental health issues and been highlighted within Public Protection Notifications (PPNS) from the police.

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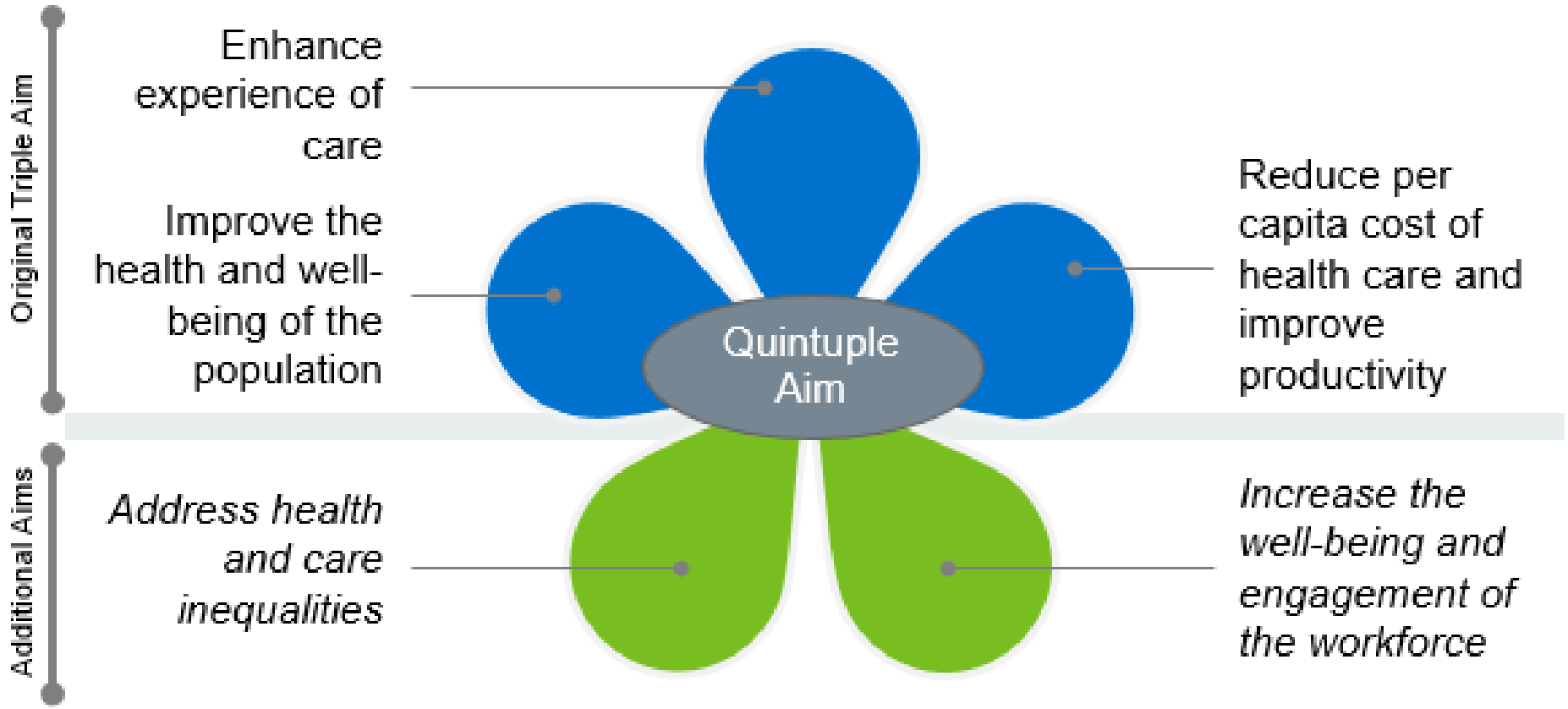
NHS

- **The Population Health Management (PHM) cycle/approach – taking collective action to improve health**

Fundamental to success is an emphasis on building relationships and trust, working in collaboration with system partners and true co-production with local communities.

There are five overall aims of Population Health Management



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The cohort

The patient is registered at Saffron Health, Sturdee Road or The Hedges Medical Centre

GP practices in the Saffron & Eyres Monsell Area

Individuals over 18

Have had a Public Protection Notice (PPN) in the last 6 months

Experience mental health difficulties even if not officially diagnosed

Not responded to GP invites of support.

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The 3 Conversations Approach:

1 Conversation 1 : Listen & Connect

Listen hard. Understand what really matters. Connect to resources and supports that help someone get on with their chosen life, independently.

2 Conversation 2 : Work intensively with people in crisis

What needs to change urgently to help someone regain control of their life? Put these into an emergency plan and, with colleagues, stick like glue to help make the most importan things happen.

3 Conversation 3 : Build a good life

For some people, support in building a good life will be required.

What does 'a good life' look like? What resources, connections and support will enable the person to live that chosen life? How do these need to be organized?

3Cs: Conversation one

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- Connections are made with individuals from SystmOne via GP Surgeries (Saffron Health, The Hedges and Sturdee Practice)
- Due to non-engagement, we created an initial contact letter and appointment letters to improve engagement into the service. We developed Accurx SMS templates to contact. We also resorted to door knocking to connect with individuals
- There was no timescale to work with a person.
- A meaningful conversation takes place, listening and connecting to the person, focusing on their strengths, interests and to determine what is important to the person.
- The conversation is recorded in a conversation1 templated entry on SystmOne which codes the different aspects of what is important to the patient, who should be involved in their care and how they wish to be supported
- Checking Leicester City Council Adult Social Care (ASC) Liquid Logic System (LAS) for notes and other workers connected to the individual to avoid duplication; manage timely communication and have a holistic approach
- Local team huddle meetings once a week to discuss strengths, progress updates, risks, and ending involvement.
- Huddle meeting (MDT) with neighbourhood team once weekly for shared advice and shared decision making around risks.
- Increased support was offered during a period of crisis, rather than connecting to crisis team and closing – this is a conversation2.
- Overall aim of working in this method was to prevent people requiring a Conversation3 (longer term commissioning services).

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Challenges

The time between a patient receiving a PPN and the information being shared by the police to the practices varied due to resource. Never managed to address the governance issue with police.

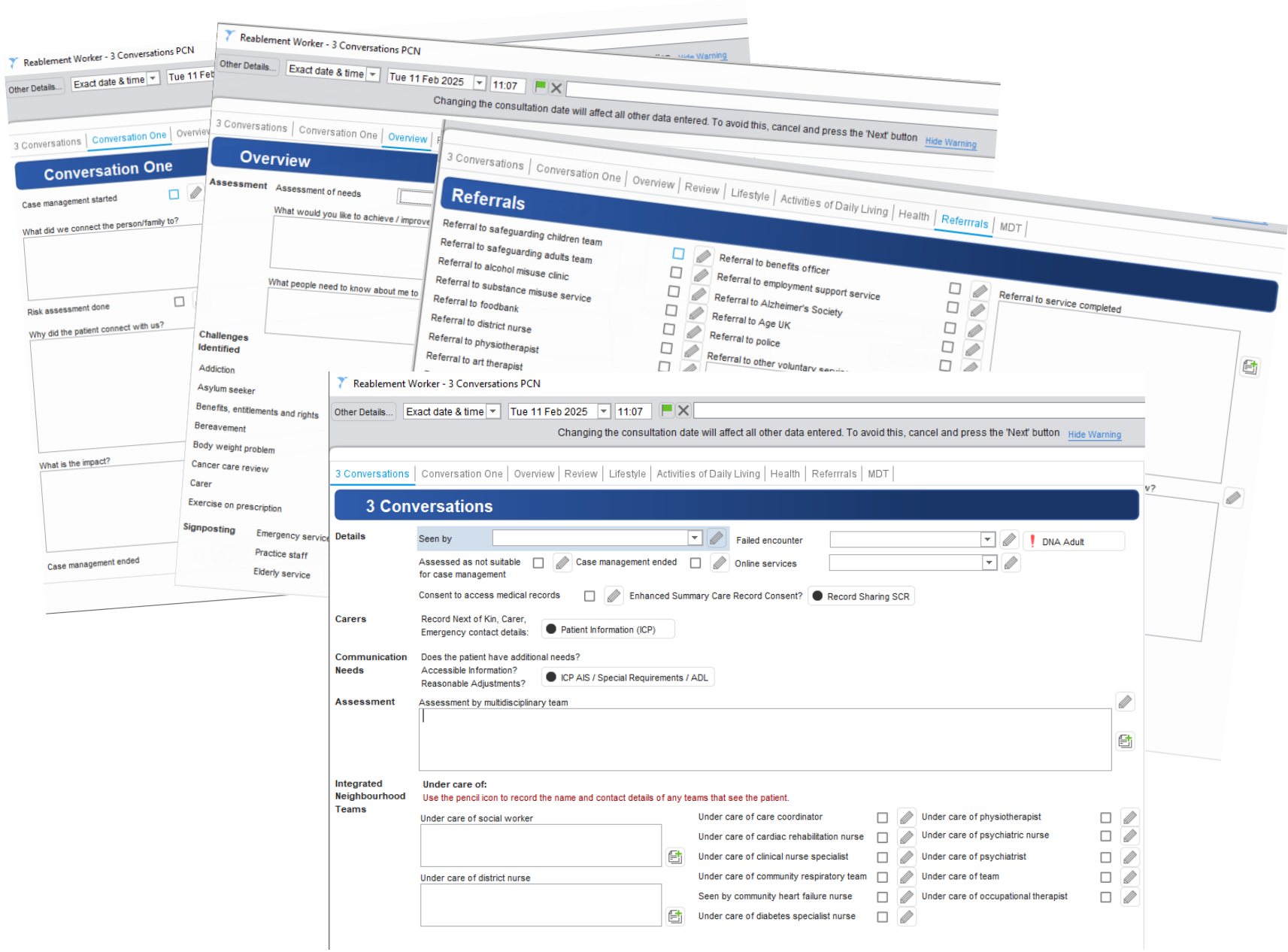
Record keeping on multiple systems. Using the patient record and governance and safeguarding involved in what was shared on the patient record. Moved to sharing patient information on record.

Practice engagement: practices did not have the time to process and refer the correct patients to the team. This was addressed by providing additional support through a flow chart and MDT

Patient lack of engagement: 2 letters created, door knock and hand delivering them in attempt to make contact. On average it has taken 6 attempts to engage.

3Cs:Conversation one

Recording of Information



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201 patients identified; 172 have been supported

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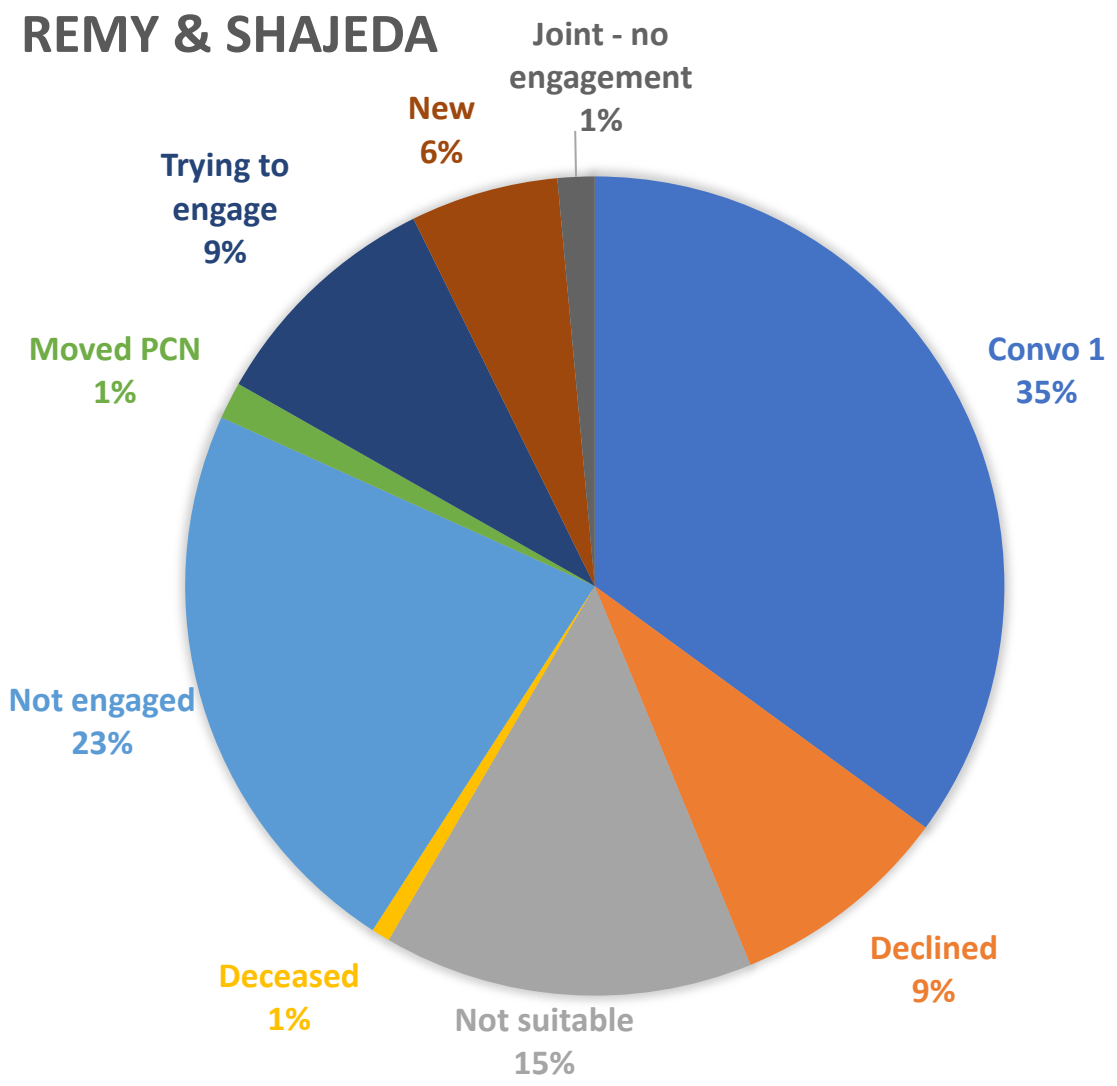

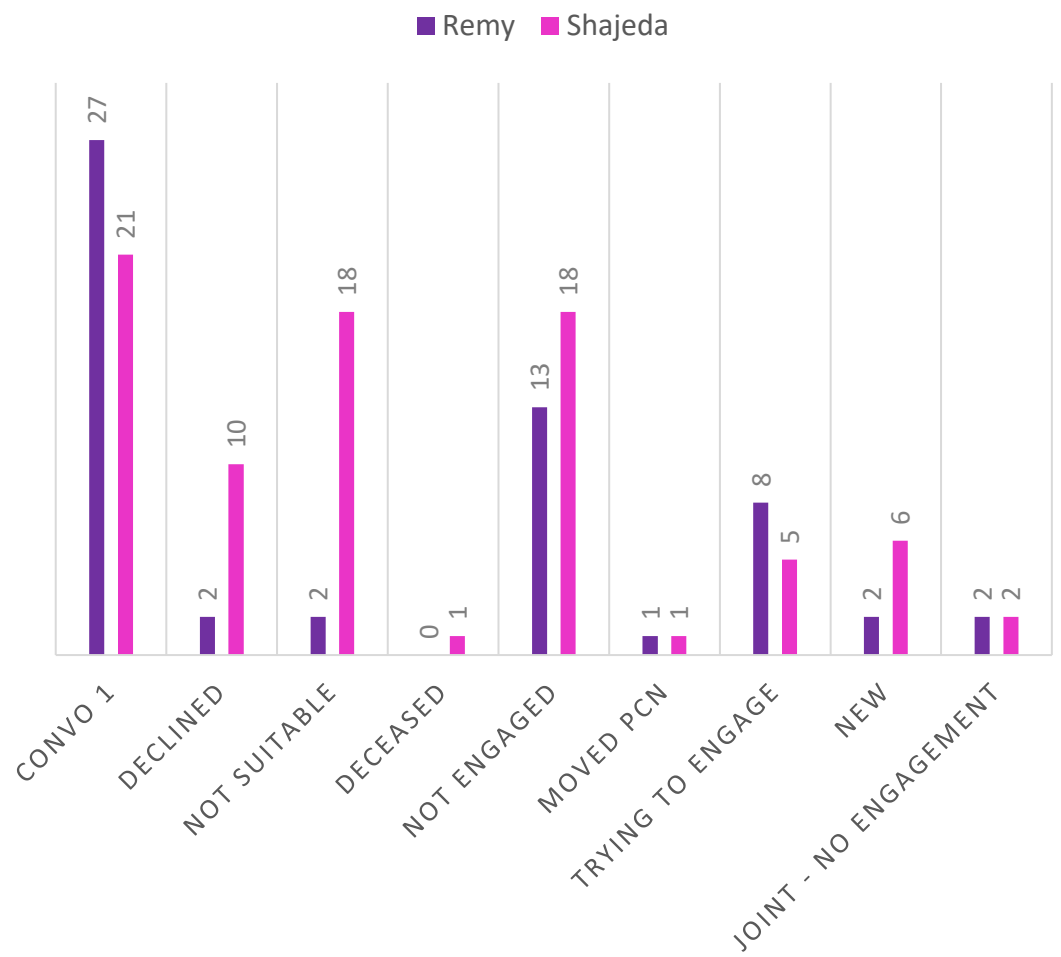

The Themes
(13 months data)

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Accessing other services themes – PCN connections	
Service	Total
GP appointments	48
Housing	15
PIP	12
Local Mental Health Neighbourhood Cafes	10
Medication	9
Bereavement Hub - Loros	9
Relationships – family / friends support network rebuild	8
Benefits	7
Cherry Tree counselling referrals	6
LWA / Freeva / ADAM project	6
Domestic Abuse / Violence	6
Food vouchers	6
Active Lifestyle referral	5
ADHD assessments	5
Resources so carer can get respite	4
Housing repair issues	4
GCSE's / A Levels	4
Police interactions / issues	4
MHP	4
Homeless	3
ASB issues	3
Debt issues	3
Dentist	3
CPN	3
Household support fund	2
Autism assessments	2
Telephone friendship services	2
Quit smoking	2
Francis Dixon Lodge	2
Occupational Therapy assessment	1
Care assessment	1

Accessing other services themes – drop-in connections]	
Service	Total
DWP early start referral	4
VitaMinds referral	4
Local Mental Health Neighbourhood cafes	2
Food pantry / vouchers	2
Joy	2
STAR referral	1
Help through hardship	1
Helping hands – debt / housing	1
GP appointment	1
GP advice	1
National energy action referral	1
Crisis number sheet	1
Leicester City number sheet	1

Total connections	Conversation 1	Finance / Debt / Budget	Substance misuse	Accessing community / reducing isolation	Emotional health & wellbeing / therapies	Education / Work / Volunteering	Accessing other services
Total	56	26	5	23	29	15	49

Connections from PCN	Conversation 1	Finance / Debt / Budget	Substance misuse	Accessing community / reducing isolation	Emotional health & wellbeing / therapies	Education / Work / Volunteering	Accessing other services
Total	48	21	5	20	24	13	42

Connections from Pork Pie drop-in	Conversation 1	Finance / Debt / Budget	Substance misuse	Accessing community / reducing isolation	Emotional health & wellbeing / therapies	Education / Work / Volunteering	Accessing other services
Total	6	4	0	1	3	0	5

Connections from SWHS drop-in	Conversation 1	Finance / Debt / Budget	Substance misuse	Accessing community / reducing isolation	Emotional health & wellbeing / therapies	Education / Work / Volunteering	Accessing other services
Total	2	1	0	2	2	2	2

MDT Huddles

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This gives us different ideas from the group, sharing information about the less well-known services in areas and allows us to work collaboratively together

Supporting each other in huddles including our own wellbeing

Having a broad range of professionals in attendance:
Dr Amit Rastogi-Clinical Director PCN,
Steph Taylor - Leicester City council Mental health team leader,
Alka Chauhan – STAR Team Leader (Housing),
Eliza Deakins – Neighbourhood Lead LPT,
Jaggs Katwa Supporting families /early Help DWP.
Kiran Chana- Social Prescriber ,
James Preston – Recovery College,
Nisha Mistry –Digital and transformation Lead.

Being able to build relationships to contact people directly

Less email communication (as we are seeing them face to face weekly so can ask any questions then)

Less form filling

Strength based conversations about specific people

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Benefits

- Single point of contact across services for patients
- Reduced attendance at ED as patients are directed into primary care.
- Reduced contact with Police as patients are supported by reablement officer
- Mental Health crisis situations averted as patients are supported during conversation one to avoid further need for support from mental health services
- Patient health has been managed as previously not engaging with support
- Social support to improve and address health inequalities
- Safeguards in place to support patients
- Preventative

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Patient Feedback

"I would like to say a massive thank you to your colleague Remy. She was very proactive when she saw me upset at the library. She helped me open up and guided me to get the help I needed. She went above and beyond. She got to the root of the problem and offered me solutions that were not overwhelming. She offered lots of advice on ways I can help myself whilst waiting for the star team to assist."

Many thanks Patient R (from Pork Pie drop in)

"Remy's been working with me for a little while now she has helped me achieve a lot of things and also helps me on the right path with organisation. I haven't been able to do any of these, without help from Remy. I'm very happy and grateful for all the help Remy has gave me."

S – Saffron Health patient

"Hello I'm E's mam , E has been out of prison nearly 3 month after doing a 3-year sentence, he was told he has appointments with mental health team , but he was let down there was no appointment, he's had no support or help from any professional since being released hence he's ended up back in prison for 28 days to sober up. I'm at my wits end with it as I'm the only one having to deal with him , so makes me poorly. Then there was this lovely lady knocked my door the day after he handed himself in but overdosed which ended up him being taken to hospital and having to have a blood transfusion, so when I went to visit him I told him about this lovely lady coming to the door asking for E wanting to listen to him & to see what support and help he needs, after telling him he said wow mum after all this time, his face said it all as he was smiling and he said mum I have a glimmer of hope. We are so very grateful that you gave us this opportunity to get a bit of help & some support, so I thank you from the bottom of my heart."

H -The Hedges patient

Patient Feedback

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"I am so grateful that you were assigned to me Remy. I was so down and suicidal...but you have made such a difference to my life in this short time that I just can't thank you enough. You have got most of my outstanding repairs done. Plus you have taken me to the doctors and I'm now waiting for appointments to finally sort my health issues out after such a long time, it's just amazing for me. I wish I had know about you many years ago. You are so patient, kind, caring and really listen to me so all I have is absolute praise for you and your company and it's so good to know that you will be calling to check how I am. I don't know how I ever managed without you."

L- Saffron Health patient

"I have had other professionals in the past but they have given up on me. Remy is the first professional that didn't give up and has given me the most help and support I have ever had, she has helped me to start to achieve my life goals and be on the path I want to be on."

J – Saffron Health patient

"Remy has helped me in more ways than I have words for. I was at a loss, lonely and didn't know where to go for the help I needed.
In the time Remy has worked with me I have gained relationships with my GP's as well as with my family and friends, I am getting help from Turning Point, I have got my benefits sorted out and I now have the keys to my own home to name just some of things Remy has helped me with.
All I can say is a massive thank you for your constant patience, care, support and kindness."

B – Saffron Health patient

"Shajeda has positive energy and always there to help."

J - Saffron Health patient

"Thank you Remy, you are a star. You are the best worker I have ever had. Thank you"

D – Saffron Health patient

A story of difference

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Reason for contact	Action taken
Patient A was connected into The Getting Help In Neighbourhood's 3 conversation team by Saffron Health Practice as she had no engagement with them, a PPN and has mental health difficulties.	• Patient A was difficult to engage at first, many phone calls, messages, 1 door knock and 1 letter, but I didn't give up and Patient A eventually agreed to meet. • Patient A was not engaged with her GP and was not on her medication the way she should have been. • Patient A never had control over her money, she never had a bank account, nor did she have any ID. Patient A was never sure if she was getting all the benefits she was entitled to as she never had control over these. • Patient A wanted to be more active and wanted to quit smoking. • Patient A has lost her support network with her adult children, other family and friends. • Patient A had suffered significant bereavement. • Patient A wanted support with her mental health, she wanted to get to the root of all her trauma. Patient A had a lot of trauma that started around the age of 3 and she was now ready to address this. • Patient A's had been homeless, sofa surfing and on the Council property list for 5 years. • Patient A wanted to join social craft clubs and social activities. • Patient A wanted to understand herself and her diagnosis better.

The difference	Innovator's experience
• Patient A was given the space to talk at her speed and liked the fact there was no assessment that it was just an open conversation. Patient A then felt able to open up and express how she was feeling. • Patient A had not been to the GP in years, so we attended a few appointments together and now Patient A makes and attends all her GP / CMHT appointments on her own. Patient A is now back on her medication as she should be. • Patient A did not have her own bank account and no ID to open one. We opened a basic bank account for her and now Patient A has all her own benefits into her own bank account, she now has full control over her own money. Patient A needed help and support around making sure she was receiving all the benefits she was entitled to; Patient A now receives all benefits she should. • Patient A had lost connection with all family and friends over the years, we reconnected her to this support network. Patient A now has a bus pass and is now able and does go to visit family and friends all over Leicestershire every week. • Patient A had significant bereavement last year, after many different offers of places of support. I got Patient A weekly counselling at Cherry Tree, and she is on the list for further support from Leicestershire counselling Service. • I signed Patient A up to Active Lifestyle which she attends and a Quit smoking program that she doing well with. • Patient A attends courses with Recovery College and is starting to understand herself and her diagnoses better. • Patient A attends local craft groups as well as other local social activities. • I managed to get Patient A her own ground floor flat with her own garden, which she has settled into. Patient A cannot believe she finally has a place to call home.	Working this way has given me to opportunity to get to know the person that I am connected with. It has given me the ability to tailor the support that the individual needs. It also gave me the time to ensure that referrals made to other services are connected in and are suitable for the individual.

A story of difference

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Reason for contact

- C.U was connected to the Getting Help in Neighbourhood team via her GP surgery, Sturdee Health.
- She received a PPN, as she was struggling with her mental health.
- C.U was experiencing Postnatal depression and had tried to take her own life in the past.

Action taken

- C.U struggled to access the community with her child. I connected her to Toddler group's at Pork Pie library & Eyres Monsell Community Centre.
- C.U has re engaged with her GP, after I arranged an appointment for her.
- C.U is receiving talking therapy support as she is accessing Cherry tree counselling. Additionally, gaining further support from vitaminds.
- Connected her with Home start horizon and Mammas (South Wigston), to provide her with extra support around postnatal depression.
- C.U was provided with a booklet with information about all the local venues in her area, and what they have going on, as well as the recovery college.

The difference

- Although, C.U was under the support of Perinatal team she did not feel that she was being listened to. She expressed that they would only come around to check on the baby, rather than her. Also, she stated that they never provided her with how to access organisations i.e talking therapies or groups in the area which was her wishes and wants.
- She also expressed that a lot of services would only contact her via phone call and would never come to see her face to face. She was happy that I would meet her out in the community to talk and listen as she never missed an appointment, rather than a phone call.
- From struggling to go out or accessing any groups, she know attends numerous toddler groups by herself or her even take's her friend with her. This has encouraged her to reconnect more with her network and increased her confidence.
- Not only is she gaining support for prenatal depression, but she has been given a chance to address childhood traumas through therapy.
- Overall, she is more confident within herself and has improved her relationship with her partner and friends and her wellbeing is more positive.

Innovator's experience

- Working this way, allowed me to ask what her wishes and work in a person- centred approach, and tailoring the individuals support provided.
- I was able to build a relationship after our first face to face meeting, which helped her feel more comfortable and be able to open up and confined in me.
- She also had my contact information, if she ever needed to get in touch.

A story of difference

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Reason for contact

- M.S was connected into the Getting Help in Neighbourhood via her GP, Sturdee.
- She received a PPN, regarding experiencing mental health difficulties.

Action taken

- M.S believes that she has ADHD but has never explored support around it. I arranged an appointment with the Mental health practitioner. We completed her ADHD referral form together, and she chose to go through the Right to choose path. This has a shorter waiting list for outcomes and diagnoses for ADHD.
- M.S expressed how she was supposed to be referred to Francis Dixon Lodge, as other therapies have not benefited her. When she and I have both called, they cannot see any referral on the system. Therefore, I gained the referral form and completed it with her.
- She is also accessing online courses at the recovery college, to understand herself better.

The difference

- M.S liked how our face-to-face conversation in comfortable environment (house) for her, and there was no assessment involved and she was freely allowed to speak at her own pace.
- M.S use to feel scared to leave her house or even open the door to anybody, as she has experienced a bad landlord. However, by persistently reassuring her, she opened the door and let me into her home for a first conversation.
- She expressed how distraught she would feel if she had to repeat her childhood traumas on the phone to gain a referral to Franis Dixon Lodge. Instead, she was happy that she can bypass that as I got the referral form for her.
- She has gained courage to leave her house and attend appointments at her GP surgery.
- She has also developed recent hobbies and exploring her creative sides such as decorating the house with flowers and paintings.
- M.S still continues to engage with myself and the GP surgery.

Innovator's experience

- Working this way, allowed me to ask what her wishes and work in a person- centred approach, and tailoring the individuals support provided.
- Made me understand that this individual will require a softer approach as she finds it hard to trust professionals.

A story of difference

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Reason for contact

Patient B was connected into The Getting Help In Neighbourhood's 3 conversation team by Saffron Health Practice as she had no engagement with them, a PPN and has mental health difficulties.

Action taken

- Patient B was difficult to engage at first, many phone calls, messages, 3 door knocks and 3 letters, but I didn't give up and Patient B eventually agreed to meet.
- Patient B was not engaged with her GP and was not on her medication the way she should have been.
- Patient B wanted to understand herself and her diagnosis better.
- Patient B was wanting therapy that suits her needs.
- Patient B needed advice and support around being an occasional carer for her father.
- Patient B wanted help and support with her Leicester City housing officer, Leicester City ASB officer, Leicester City repair issues.
- Patient B needed help and guidance around previous domestic violence relationships and her current relationship.
- Patient B needed support around her benefits.

The difference

- Patient B was given the space to talk at her speed and liked the fact there was no assessment that it was just an open conversation. Patient B then felt able to open up and express how she was feeling.
- Patient B has signed you and enjoyed courses via Recovery College which has helped her to understand some of her diagnoses better.
- We have contacted and had lengthy conversations with Patient B's Leicester City Council housing officer, Leicester City Council ASB officer and Leicester City Council repairs department. Patient B and her housing officer have a better relationship now, Patient B no longer has an ASB officer as the issues have been resolved and repairs on her property are underway.
- Patient B has been to see her GP and has made appointments herself since this.
- Patient B needed to resubmit her PIP claim paperwork as she was at her end date, Patient B accessed and used the social prescriber at the GP surgery to help her with this.
- Patient B needed support in how to remain calm and make phone calls. Patient B now explains herself and her needs and requests they have patience with her while she is trying to talk. Patient B will now make all calls by herself.
- Patient B has been requesting therapy since the first day we met, Patient B did try every avenue suggested to her and was turned away. But I since found an acceptance letter from Francis Dixon Lodge, have contacted them and they have said they will see her by October this year which she is pleased about.
- Patient B has used the resources given to her around care and support for her father.
- Patient B is now taking all prescribed medication as she should be.
- Patient B has accessed Freeva, knows where to reach out should she need to, and we have applied for a 'Clare's Law' on her current partner due to recent situations that have occurred.

Innovator's experience

Working this way has given me to opportunity to get to know the person that I am connected with. It has given me the ability to tailor the support that the individual needs. It also gave me the time to ensure that referrals made to other services are connected in and are suitable for the individual.

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Next steps…

To provide required support for helping those needing mental health support via the PCN Mental Health Support Worker (Adults)

Share the 3Cs approach to address health inequalities across the system. Standardisation of the data entry to be able to evaluate and track a patient's journey

To connect with community partners: Recovery College; Lamp to support this cohort of patients offering social prescribing and enable patients to manage their health.

To reinstate the neighborhood approach with the 3Cs partners to support a cohort of patients

Improve patient engagement, utilising the PCN social prescriber to embed this approach to support patients in the PCN

As a PCN focus on PNG cohort to work in supporting those patients with their long term conditions

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So, what have we achieved using the population health management approach as a PCN?

"One project was looking at a multi-comorbidity cohort identified through a PHM approach which allowed patients to share themes of what was important to them and how they would like to be supported."

Working age multi-morbid cohort (inc. mental + physical ill health)

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Engage and co-design intervention/s targeted at individuals aged 18-64 years with 5+ long-term conditions (including a mental health diagnosis) focused on two most deprived PCN areas in Leicester

Our cohort selection criteria are:

- Adults aged 18-64
- Multiple (5+) long-term conditions
- Have both mental + physical ill-health
- Living in the 2 PCNs with highest numbers (also the most deprived – inc. Hockley Farm (LC&U) & Leicester City South

Outcomes to achieve:

- ↑ understanding of lived experience and barriers to accessing health and other support services
- ↑ capacity for collaborative partnership working to address health inequalities
- ↑ uptake of proactive care and prevention services e.g. self-management, health checks, screening/immunisations etc. amongst target cohort
- ↑ sense of control / meaningful activity e.g. employment / independent living amongst target cohort
- (Long term: improved healthy life expectancy)
- ? Process / Partnership outcomes ?

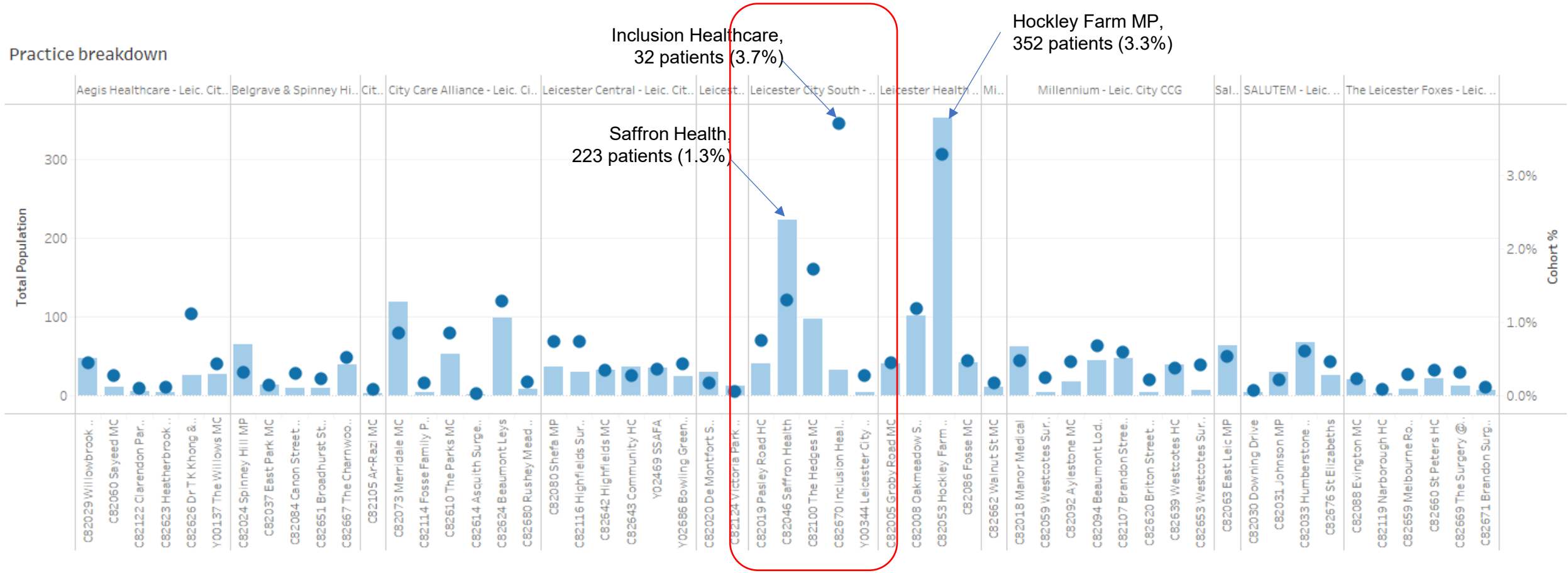
Intervention design 'principles':

- Approach based on Secondary/Level 2 prevention – keep away from a medical model
- Map existing 'assets' already working with this cohort and maximise their potential (e.g. VCSE sector, Social Prescribers, LPT, Local Area Coordinators etc.)
- Requires buy-in from all relevant partners – try to minimise need for clinical leadership/expertise beyond key decision making
- Engage and co-produce interventions with people in the population cohort (2-3 x initial focus groups + follow-up – led by local VCSE partners)

Steps taken

- Identified/risk stratify cohort with the core team
- Develop & agree engagement plan inc. resource implications
- Data collection & design intervention/s based on insight
- Use the learning to help normalise PHM approach/collaboration

- **PCN/GP chart for 18-64 years, Five or more Long term conditions including mental health, Core20 most deprived areas.**



What we did:

Using PHM data and collaborative partnership approaches we

1) Co-ordinated gathering of qualitative insights from people living in the target areas to better understand lived experience and barriers to health improvement,

2) Engaging VCSE and communities to have conversations that enable the co-design of interventions to improve outcomes – eg, working with Pink Lizard, Goldhills and Eyres Monsell Young Persons Centre.

Themes which emerged from the focus group which social prescribers and care coordinators are supporting:

Daily Living:

- Meeting physical needs
  - Physical functioning and adaptations
  - Environmental structuring
- Resilience
  - Mental wellbeing
  - Fear
  - Apathy
- Support networks
  - Social support
  - Isolation
- Interaction with health services
  - Professional support
  - Medication
  - Technology

Self- Care:

- Self- empowerment
  - Personal responsibility
  - Prioritisation of needs
  - Management strategies
  - Instinctive/routine
  - Knowledge
- Work-life health balance
  - Prioritisation and de-prioritising of own needs
- Support
  - Digital /Professional distrust
  - Professionals / Support groups
  - Friends/family/neighbours
- Resilience
  - Fear/Stigma

With thanks to Leicester City Public Health

Unmet needs and strategies the PCN could support the patients with:

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- Meeting physical needs – providing tangible support options
  - Access to assistive devices (working with the Care Navigators),
  - Supporting with adjustments and getting back into work.
- Social Support
  - Signposting to services, social groups which cater for working age adults,
  - Support for carers, reducing the burden on family and friends.
- Medication
  - Supported with non-medical options if available,
  - Explanation of reasons for medication and appropriateness – knowing how to use and discussing the monitoring and side effects.
- Access to General Practice
  - Sharing knowledge of who to see in the first instance,
  - Support available through drop-in sessions to learn the digital tools and understand the processes available.

What are we working on to address the unmet need:

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- Social Prescriber support with the multi morbidity cohort of working age,
- Using the SMR (Standardised Medication Reviews)leaflet designed to support better understanding of why they are taking medications ,
- Using the PCN care coordinators to empower patients of things they may want to discuss and why they are seeing the pharmacist to support them with their medication,
- Sharing opportunities available in the community/VCSE via SMS.

Next steps: Connect in with community pharmacy