York Population Health Hub Newsletter

Issue 1
April 2022

Introduction

Welcome to the first edition of the York Population Health Hub newsletter!

This is your regular update on all things population health, data and evidence within the health and care system in York. We hope you find it interesting and stimulating to read – whether numbers are your thing or not!

Recently a number of partners (see below for who's involved) have started working together in a closer way in York, and the PHH was born – a small but perfectly formed piece of collaboration aimed at turning the information we hold on our population into data, turning data into decisions, and turning decisions into better delivery.

The Population Health Hub aims to brings data analysis and public health closer to real live projects, and to that end we have three main areas of work:

Enabling

(training, developing capacity)

Supporting the York health and care system to use population health data, and PHM as a tool

Analysing

(delivering the JSNA)

Improving the JSNA, making it useful and used

Doing

(tangible, "real work")

Leading tangible PHM projects which show the benefit of this approach

This newsletter aims to highlight some of our work, but also to get you interested, involved and thinking about how data and insight on population health could help improve health and wellbeing in whatever bit of the system you find yourself – council, third sector, NHS and beyond.

Happy reading, and feel free to get in touch with us!

Stat of the daya - 9124 people in York live in the bottom 20% most deprived areas in England

Peter Roderick, Public Health Consultant

Newsletter Content

Population Health Management 'in action'

City of York Council and Nimbuscare worked together to identify patients on a COPD, asthma or bonchiectasis register in York, in order to target home insulation support (Home Upgrade Grant) to those most likely to benefit from warmer homes.

Updates from the JSNA

Welcome to the first edition of the Population Health Hub newsletter. Circulated quarterly, we hope this newsletter will inform you of the work that is being undertaken by representatives of different health groups in this vibrant and diverse City.

What is the JSNA?

The purpose of the Joint-strategic needs assessment (JSNA) is to provide a concise narrative of health outcomes and factors that influence health and wellbeing in York.

As well as helping us write the Joint Health and Wellbeing Strategy for York, it can be used for:

accessing high quality information about the health and wellbeing of York residents

understanding better the factors that influence health in York

informing bids for charitable or project funding or strategy or policy documents

identifying areas where there are gaps in the data and knowledge

Current JSNAs in progress:

- SEND Phase Two- **Assessing the needs of young people with special educational needs.**
- Early Years Health Needs Assessment- **A look at the health or infants and children in the first 1001 days or life.**
- Pharmaceutical Needs Assessment - **a joint collaboration with North Yorkshire County Council assessing the provision of pharmacy services in the City of York and North Yorkshire.**
- A Health Needs Assessment reviewing the health needs and services to York's gypsy and traveller communities (starting mid-April)

www.healthyork.org is the JSNA's dedicated website. It includes all published JSNAs as well as data split relevant to the different stages of life (Early Years, Living & Growing Well, Ageing Well, Mental Health, and Place.) The website is updated frequently in line with new data and captures those areas where York is doing well, what needs to be improved, and specific challenges.

Heather Baker, Public Health Improvement Officer

Reporting on Covid-19

Throughout the pandemic, the City of York Council has published information on Covid-19 via a weekly release of data (with an accompanying narrative) on the York Open Data Platform. This has been highly valuable in our outbreak management and response, driving decisions on a daily basis.

The data set has covered a number of areas including :

- incidence rates of the disease
- measuring how it is spread, by instance through age groups, ethnicity or geographical area
- measuring the severe illness and those vulnerable to COVID, eg people in hospitals, schools and care homes
- understanding deaths from the disease, and how the disease is effecting

mortality rates beyond direct infection (for instance through wider impacts of COVID

- our response - for instance measuring our test and trace capacity and activity, how successful we've been at containing the disease, and how the vaccination programme is doing at reaching all parts of the York population.

MIKE WIMMER, SENIOR BUSINESS INTELLIGENCE OFFICER- City of York Council

Stat of the day - York achieved the highest contact tracing completion rates in Yorkshire and Humber, regularly seeing over 90% of our contacts traced across the last year!

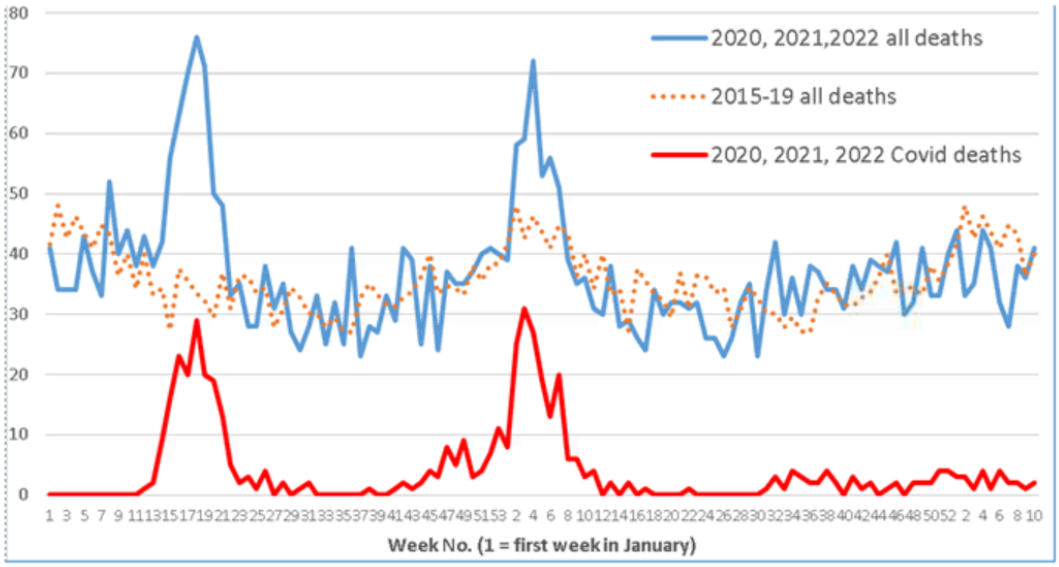
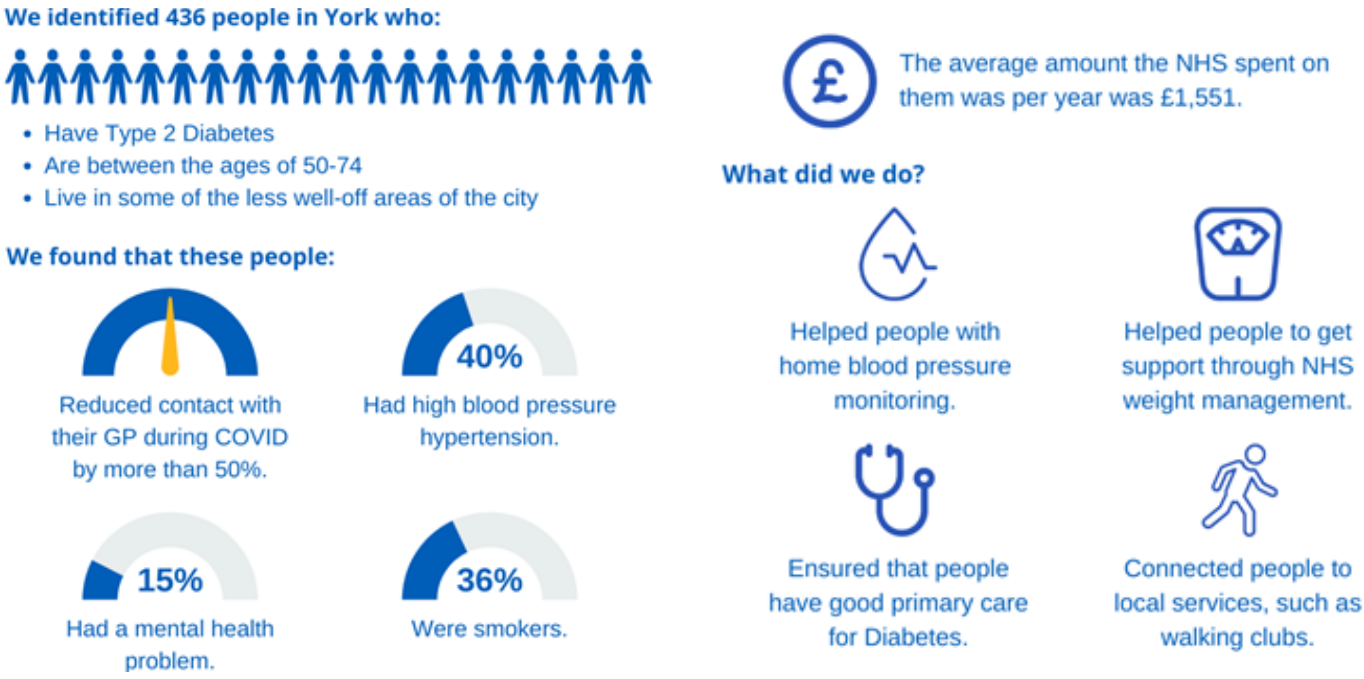


Figure1: National Covid-19 Statistics

Case Study: Diabetes Support Project



A cohort of 400 York patients was identified from multiple services including primary and secondary care. All were living with Type 2 Diabetes and had other risk factors potentially progressing their condition to other complications or long-term conditions. Individuals were also in the bottom 50% IMD score and demonstrated minimal engagement with Primary Care in 19/20.

A multi-disciplinary working group was established in March 2021 to explore engagement methods with identified patients and any interventions that were currently accessed clinically and in the community.
The objectives of the project are:

i. Understand more about this cohort and what gaps in care and support / barriers they might face

ii. Improve their confidence to manage their own condition and get support when needed

iii. Identify prevention opportunities (clinical, social) given their age range and deprivation score, and additional support to engage

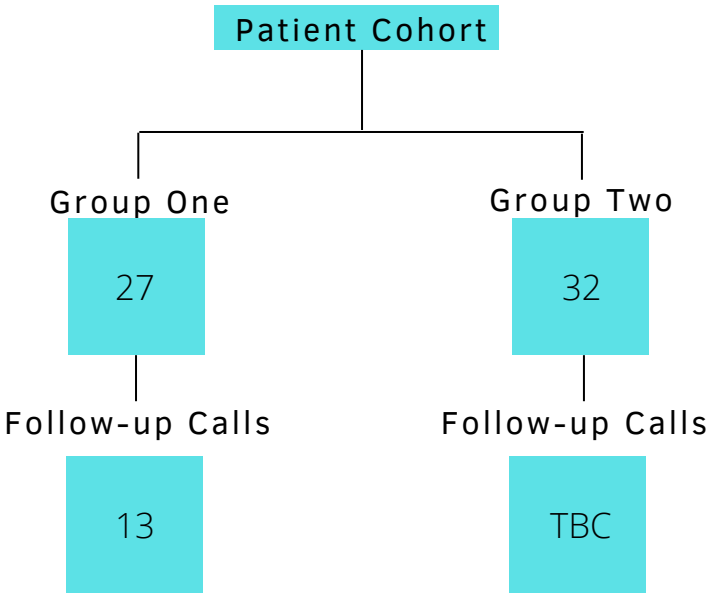
With the support of York CVS, social prescribers were the patients' key contacts. They would decide if the interventions offered met their needs or if a further intervention was required. A referral to the health trainers, mental health practitioners or practice nurses could then be made if necessary. Follow-up calls would be made at six-monthly intervals.

The anticipated outcomes for the project are an improvement in the patient's ONS – 4 wellbeing score, improvement in their Chronic Self-Efficacy scale score, where indicated appropriate referral to lifestyle change programmes and social support.

Waiting Well

Vale of York CCG commissioned a 'Waiting Well' dashboard, a data tool which
means GP practices can now see their patients who are on an elective waiting list and assess their needs and risk factors in order to help support them 'while they wait'.

Case Study: Diabetes Support Project



Weight management appeared to be high on the list of patient priorities although many were not interested in the Tier 1 weight management programme. Social prescribers were able to make some referrals to the CYC Health Trainers. Some patients have wanted to try to lose weight on their own and review this at their planned follow up.

Initial responses show that most people do attend their 9 care processes appointments to enable their GP to complete their annual diabetes review. Some have not been to their retinal screening appointment due to lack of transportation to Clifton. Some people have had difficulty booking in for blood tests and haven't been able to get to the Community Stadium for these - again due to transport issues.

The amount of time the social prescribers were able to spend talking to patients made a difference in the underlying issues they were able to uncover and signpost or refer to appropriate support. The challenge will be to maintain the obvious benefits that come from bespoke, resource intensive interactions and deliver this at scale by increasing the confidence and upskilling all those who encounter this cohort in both primary care and the community and further developing patient pathways to include targeted lifestyle support.

CHARLOTTE SHERIDAN-HUNTER, COMMISSIONING & TRANSFORMATION MANAGER- Vale of York CCG

The next issue will be published in June

With grateful thanks to all members of the Population Health Hub

Did you know?

The average life expectancy in the UK has risen almost 5% since the year 2000