

Population Health Fellowship 20/21 projects

Fellows describe their projects

Madeleine Crow

NHS Vale of York Clinical Commissioning Group

I carried out a health equity audit of Selby District, which highlighted areas of health inequality to target. I have started some projects centred on this. One is the disproportionately high smoking rates in one GP practice and one area within that. I have identified some cohorts with high smoking rates, including the local Polish population, and designed some interventions targeted specifically at them.

Another area of need is frailty. Many areas have a higher-than-average number of aging populations (for England). There is also high incidence and death from cardiovascular disease. I am part of a group on a Population Health Management Programme to design a programme for Selby Town. The cohort we have decided to focus on are those with mild to moderate frailty and hypertension. We are in the process of designing a targeted and individualised intervention programme in a bid to improve health outcomes.

Yeyenta Osasu

Sheffield City Council

I led on a medicine's delivery service on behalf of the Director of Public Health to ensure vulnerable people could continue to get their prescriptions during lockdown. During this time, I worked with NHS Sheffield CCG Medicines Optimisation Team, a public health consultant and the Local Pharmacy Committee.

I led a team to deliver the service and engaged with new colleagues in a practical and collaborative manner as I navigated healthcare systems and multi-organisation boundaries.

I established a large group of volunteers, developed training around safe practice for handling and delivering medicines, and coordinated linking volunteers to community pharmacies and individuals needing support. I subsequently worked with the local voluntary sector and the council to transfer these volunteers to a central volunteering platform.

My second project involved working closely with the Move More team to develop and distribute a resource to older people across Sheffield. The resource is a printed booklet called [Active at](#)

Population Health Fellowship 2020/21

[Home](#). Following printing, we collaborated with the Local Pharmacy Committee and the CCG to facilitate delivery of the booklet to every community pharmacy in Sheffield so that copies could be included in medicine bags for people who were shielding. I conducted a small evaluation of this project, led the and co-authored the report.

Alice Lee

Knowsley Local Authority, Knowsley Public Health Team

My project is to work alongside Primary Care Networks in Knowsley to assess MMR vaccine uptake and implement changes to improve uptake numbers.

Kelly Holehouse

Blackburn with Darwen Council

I am involved in the implementation and delivery of an Active Lifestyle Hub across Pennine Lancashire. This project aims to maximise existing resources and create a single point of equal access to all wellbeing/physical activity services for those residents of East Lancashire who are living with one or more long-term health condition.

East Lancashire leisure providers, (through a Sport England local delivery pilot, 'Together an Active Future'), will get the chance to test a different referral channel into community active lifestyle services. It is aligned to the wider, integrated prevention-at-scale approach of local Primary Care Networks and Integrated Care Systems. This project also gives us the chance to collaborate with the University of Lancaster, who has been tasked to evaluate the process that underpins the re-design and implementation of a population health approach.

The fellowship has also provided an opportunity to develop links within the North West regional public health network with reference to work being done relating to COVID-19 and Post-COVID syndrome.

Leena Patel

National Association of Primary Care

During my fellowship year I am working alongside the National Association of Primary Care. Through educational and developmental programmes, we support organisations with population health management.

Broadly speaking, my project focuses on the different methods and models and that can be used to improve the health and wellbeing of communities.

Collaborating with other organisations and public health advisors, I am supporting an innovative population health outreach initiative. This is based on an international model which has resulted

Population Health Fellowship 2020/21

in improvements in immunisation, screening and management of illness. This work has the potential to identify unmet needs in a proactive and holistic manner. My role in supporting the implementation of potential pilots and sharing the learning from this model, will contribute evidence of how to incorporate population health into primary care.

Sian Magee

Hertfordshire and West Essex STP

I am working with Hertfordshire County Council and writing a joint strategic needs assessment on food poverty. I am working with charities, public sector organisations, a university, and members of the public to develop an understanding of food poverty, including services available to those experiencing food poverty, at a county level. It is hoped that this work will go on to inform future policy.

I am also working with local CCGs to increase awareness of HIV indicator conditions among clinicians. We are working to add an alert on the primary care patient record systems to encourage clinicians to offer an HIV test to patients who present with conditions that might be indicative of HIV diagnosis. We hope this work will reduce late diagnosis of HIV.

Cecilia Peters

Nottingham City Council

My project is primarily a health equity audit. I will be looking at the uptake of childhood vaccinations and its inequalities. It will begin with an analysis of childhood vaccination data, to identify low uptake by geographical area and/or population cohorts. Once this has been done, I will liaise with key stakeholders to address these inequalities. I will also look at the literature which is already available and strategies that have worked in the past.

David McDonald

Nottinghamshire Healthcare NHS Foundation Trust

I plan to complete a health needs assessment of the speech language and communication needs (SLCNs) of children and young people in Nottingham. SLCNs include conditions such as stammering, Language Disorder and autism. To my knowledge, this is the first health needs assessment of SLCNs in the UK.

The aims of the project are to improve understanding of local need and service provision, to identify any gaps or unmet need, and to make recommendations about how the population's needs could be better met. We hope the output of the project will be useful for other areas, not just in Nottingham.

Population Health Fellowship 2020/21

Laura Bridle

Lewisham Council and Lewisham Clinical Commissioning Group on behalf of Lewisham Health and Care Partners (LHCP).

My project is a health equity project. I will be looking at Cerner data to see how many women who were diagnosed with gestational diabetes (GDM) in pregnancy are being offered the NICE recommended screening for Type II Diabetes, according to GP practice and Primary Care Network. This screening should be offered at three months and then once every year. This is using the hba1c test.

When I have the data, those GP surgeries and PCN's will be contacted to validate the data, contact the women for screening and then reassess uptake. I hope to interview women to discuss their experience and what helped or prevented them from accessing it and write a paper on this topic. Black and Asian women are at increased risk and I want to ensure this group can access screening and education/support to either prevent or at least delay Type II in later life.

I am starting to explore a possible second project looking at women who are on anti-depressants and how many continue or stop these once they become pregnant.

Mairead McErlean

North London Partners

My fellowship project with UCL Partners focuses on cardiovascular disease (CVD) prevention in NHS staff working in secondary care. The spirit of the project can be summarised as: "Population health starts with the health of the population looking after you."

The project aligns with two important national policy priorities: the NHS Long-Term Plan and the NHS People Plan. The main aim of the work is to improve the detection and subsequent management of undiagnosed and undertreated high blood pressure among staff in pilot sites at several NHS acute trusts. Different models of work will be explored including adapting existing services and/or implementing new pathways.

We intend to contribute to better understanding the burden of elevated blood pressure among NHS staff and to prevent significant numbers developing accelerated CVD. Through engagement exercises and wider collaborations, we also hope to inspire better preventative health behaviours, encouraging NHS staff to lead by example.

Sarah Milne

Royal Free Hospital Trust with Barnet Council and Barnet ICP

Recent analyses of hospital episode statistics across all Royal Free London sites linked to Indices of Multiple Deprivation (IMD), ethnicity data and discharge diagnoses suggested stark inequalities: longer hospital stay, increased non-attendance rates and 62 days breaches for

Population Health Fellowship 2020/21

cancer treatment, higher number of admissions due to long-term conditions. These were observed in those segments of the population living in the most deprived areas and with a higher proportion on Black, Asian and Minority ethnic groups (BMEs). Understanding and addressing inequalities and building equity of access is a key priority of the Royal Free Hospital Trust.

A new integrated heart failure model is being developed by the North Camden primary care network (PCN) and the Royal Free Hospital Trust to improve the heart failure journey and patient outcomes. At present there is limited information available to describe the barriers to accessing heart failure services across Camden. This project offers the chance to gather both quantitative and qualitative data and improve equity of access to care for patients with heart failure. The learning gained will be used to inform future service design for other long-term conditions and to inform working within integrated care partnerships.

Ahmad Saif

Oxford Centre for Enablement

I am working on analysing the characteristics of patients attending a 'Long-Covid' clinic to better understand this new disease and those at highest risk in order to target appropriate interventions.

I work with the local Buckinghamshire, Oxfordshire, Berkshire integrated care system in bringing together services to be able to appropriately investigate and rehabilitate patients following Covid-19. This is for them to be able to return to normal life and work. The impact of Long-Covid is only just being appreciated and the project closely aligns with the recently published NHS England guidance on this topic.

Carolyn Royse

Dorset, Hampshire and Isle of Wight - The Wessex Activation and Self-Management Programme (WASP)

The personalised care model is aimed at the whole population throughout a lifetime and targets different tiered intervention at the whole population (100%), those with long term physical and mental health conditions (30%) and those with multiple long term or highly complex conditions (5%) (NHS England).

Dorset CCG has commissioned a facilitation programme called WASP (Wessex Activation, Self-Management and Personalisation) Programme, which consists of an in-depth personalised care self-assessment tool and a 12-week QI and education programme.

My project will address the extent to which personalised care, using the WASP model, addresses the potential for inequalities to arise in health and healthcare, among people in

Population Health Fellowship 2020/21

different communities covered by the programme. Inequalities would be likely to impact adversely on health outcomes, contrary to the aims and principles of the programme.

Kate Markham

West Sussex County Council (working with the Sussex Health and Care Partnership)

I am evaluating a maternal Smoke Free Service set up in West Sussex hospital Trusts in February 2020. The national average of women smoking at the time of delivery is 10.6%. The Tobacco Control Delivery Plan 2017-2022, a report by the Tobacco Advisory Group, highlights the importance of reducing smoking in pregnancy from 10.6% to 6% or less by 2022.

Smoking in pregnancy leads to 5000 miscarriages, 300 perinatal deaths and 2,000 premature births a year. The Smoke free service involved personalised one-to-one care using expert advice and Nicotine Replacement Therapy. The programme has continued, despite some necessary changes, including telephone consultations, throughout the Covid-19 pandemic. I am analysing the data collected from this service to determine whether the campaign has been effective at reducing the number of women smoking at delivery and whether it is cost effective.

Eleanor Barnwell

During my fellowship I am placed at the Bromley by Bow Health Partnership, where I am working on two overlapping projects. The first project involves identifying patients with a mental health diagnosis and social needs, designing screening questions for these patients, and designing pathways into tailor-made social prescribing to address any issues. This work forms part of a borough-wide transformation of how community-based mental health services are designed and run. For my second project I am looking at how we record and code the social needs of patients in EMIS, an electronic patient record system widely used by general practices, and how we can capture the outcomes of interventions within this system. The expected outcome of this work is more streamlined and holistic care for patients with mental health needs.