Health and Wellbeing Board

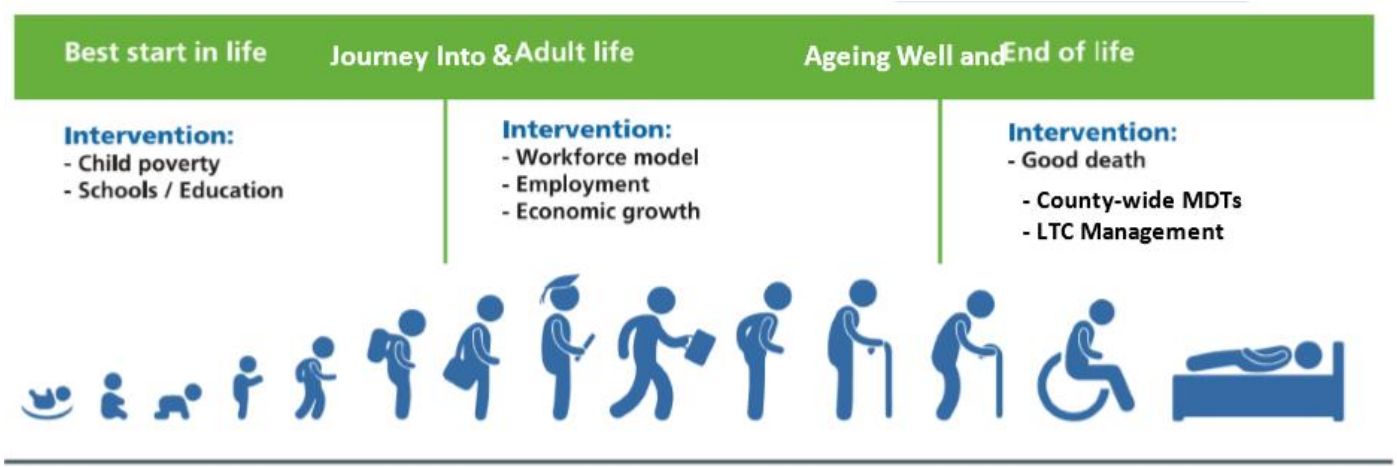
Population Health Management

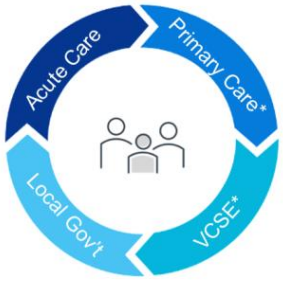
12 November 2020

What is Population Health Management?

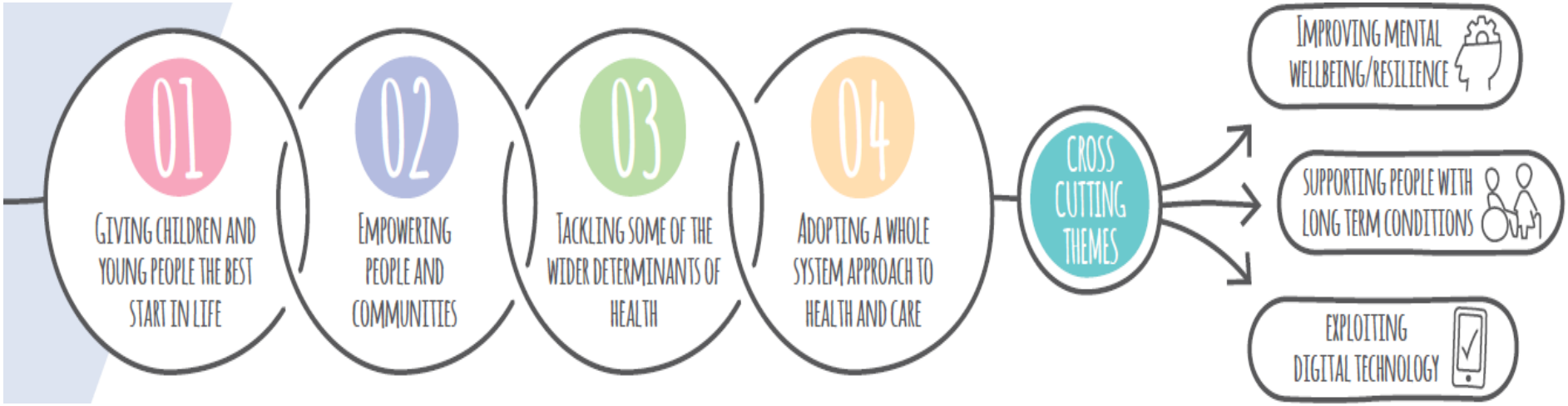
Data driven planning and delivery of proactive interventions to achieve maximum impact

- Change our interventions and care model design and delivery to achieve demonstrably better outcomes and experience for selected cohorts of people
- Advance the systems PHM infrastructure and build sustainable capability across PCNs, place and system based teams





It also delivers <u>OUR</u> H&WBB Strategy



Benefits of a PHM Approach

Puts **population health** and the **importance of the social determinants** at the forefront of planning and delivery– "more than medicine"

Facilitated cross system workshops for all levels - builds relationships and trust and develops real partnership working

Gives **purpose and power to PCNs** and builds broader multi-disciplinary teams and improves the experience of providing care.

Data driven interventions - creating linked data, generating predictive insight. Identifying gaps in care, health inequalities and prevention opportunities for individuals, teams, systems.

Developing leadership in PHM - specialist and expert coaching to support the development of PHM capabilities amongst leaders at all tiers

Enables teams to use roles, skills and technology to best effect – new and current – in the design of the care model / intervention.

Action learning set focussed and supported subject matter workstreams to upskill local teams. Interventions owned at the appropriate level.

Embedding quality improvement methodology to **enable sustainable change** to be spread at scale and pace within a system

Catalyst for PCNs, places and systems in their transformation journey. Gives people actionable insight to affect real and rapid change

PHM requires a system wide approach

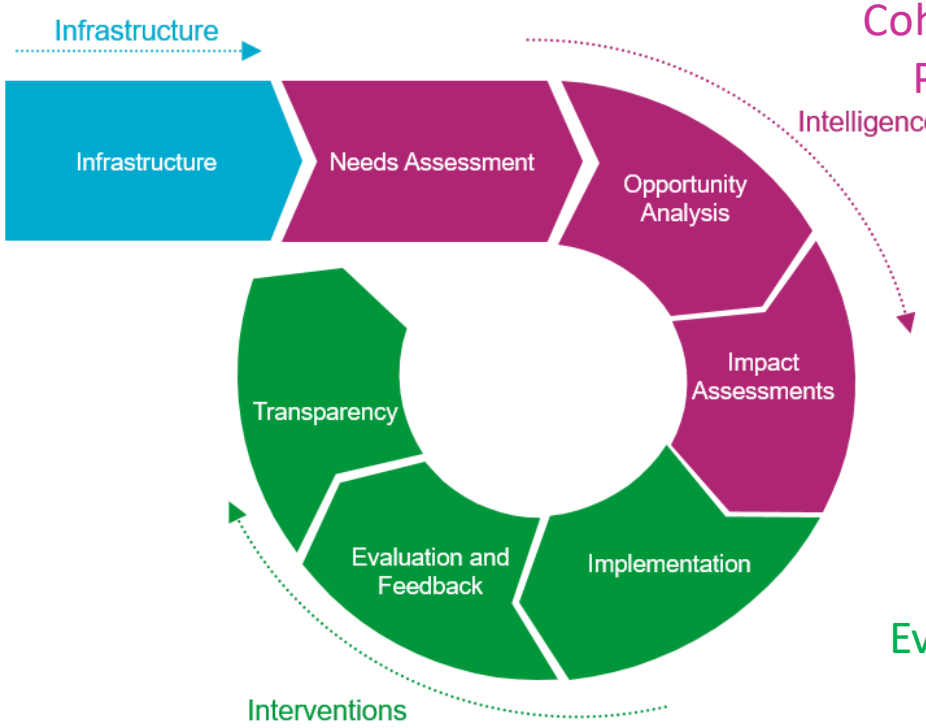
- It is **outcome focused**, driven by need not by existing services
- Considers the whole **life course** from address the wider determinants of health to early intervention, **primary, secondary and tertiary disease prevention**
- Factors much wider than health and care services long impact on health outcomes. **Wider determinants** must be taken into account in PHM
- In order to improve outcomes, distribution of health across a population needs to be considered. Understanding and addressing **inequalities in health** has a positive impact on outcomes overall

Source: Kings Fund after Dahlgren and Whitehead (1993)

PHM Building Blocks for Success

1) Infrastructure

Leadership
Information Governance
Shared datasets
Common language
Defined population



2) Intelligence

Identify inequalities & Vulnerability
Social and Clinical Evidence
Cohort Selection/Stratification
Prioritisation and Modelling
Community Engagement

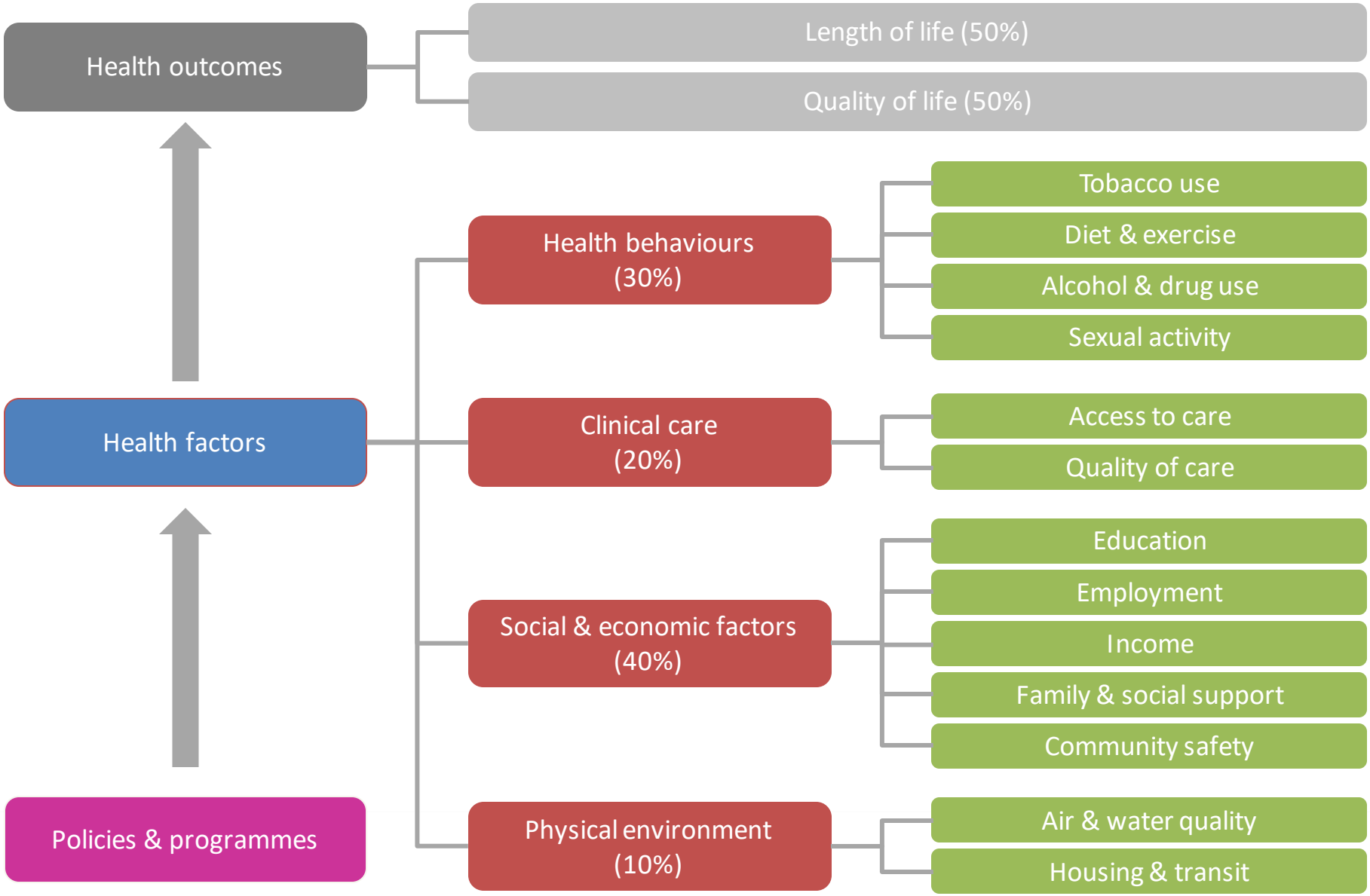
3) Interventions

Multi-agency response
Evidence based interventions
Address inequalities
Proactive care
Continuous Improvement

PHM Infrastructure

All the essential elements for success

PHM Helps to understand wider determinants



Source: County Health Rankings model, UWPI

Goal: What we will achieve

- Common understanding and Ownership of PHM across our Health and Care system
- Evidence based interventions tailored for our population which reduce inequalities
- Prioritisation of proactive / preventative care models
- High quality optimised services
- Sustainable transformational change

Action - How are we going to achieve?

- Use of System Transformation Board 5 flagship programmes to address at system level
- Dedicated Programme Director input to each flagship
- Promote digital maturity with initial baseline assessment of Business Intelligence resource and development of appropriate data sharing agreements
- Project Management Resource to support planning and delivery of actions
- Dedicated systems workshop to develop our skills (Optum/Frimley)
- Utilisation of existing BI expertise & packages (e.g. Tableau)
- Co-design with our communities

System Transformation Board: Flagship Programmes

- Our Children & Young People
- Our Workforce
- Our Communities
- Our Connectivity
- Our Culture

Dedicated system workshops on PHM

- **OPTUM** – a series of facilitated workshops using action learning sets

- **Working:**
  - **PCN Level** - Valens PCN with 50 000 population to develop localised interventions in collaboration with local providers ***(Commenced September 2020)***
  - **Place Level** – selection of the Northumberland population to design/implement an integrated care model ***(Commenced October 2020)***
  - **Finance & Contracting** - shared understanding of expected future finance and demand pressures and the likely impact of transformation activities – focused on Northumberland. ***(Due to Commence February 2021)***

- **Frimley workshop** - Learning from a Health and Care partnership with a population of 800 000 across 3 CCGs who has successfully implemented a PHM infrastructure ***(Due to Commence 13 November 2020)***

OPTUM Place Workshop October 20- Prioritisation based on analysis during Segmentation workshop and review of bio-psycho-social risk factors

Comments from the session:

"Good relationships between the LA and the Health sector in Northumberland"

"Crucial we engage with VCS for example MIND, AGE UK etc given the focus on mental wellbeing"

"Co-design with communities, ask the how we deliver this"

Stakeholders for Action Learning Set 1 – October 2020

GPs and CDs, Community providers, Analysts, Ambulance Service, ICP and Primary Care leads, Programme managers

We used Menti to rank 4 risk factors that should be the focus

Clinical Risk: Risk of extreme COVID-19 exacerbation

Clinically Extremely Vulnerable: formerly 'Shielded' cohort

CV1. Solid organ transplant recipients

CV2. People with specific cancers

CV3. People with severe respiratory conditions

CV4. People with rare diseases

CV5. Pregnant women with significant heart disease

CV6. Age 80+

Clinical Risk: Risk of Long Term Conditions not being managed

LTC6. Hypertension

LTC7. COPD

LTC8. Cardiovascular Disease

LTC9. Atrial fibrillation

LTC10. Diabetes

LTC11. Heart failure

LTC12. Asthma

LTC13. Dementia

LTC14. Chronic liver disease

LTC15. Cancer

LTC16. Obesity

LTC17. Stroke

Psycho-social Risk: Risk of Mental Health issues exacerbating

MH17. People living with learning disabilities

MH18. People living with depression

MH19. People living with anxiety

MH20. Dementia

MH21. Drug and/or alcohol abuse

MH22. Serious mental illness

Psycho-social Risk: Risk of Social Needs driving Health Inequalities

S23. People living in deprived postcodes

S24. People from BAME backgrounds

S25. Children receiving free school meals

S26. People living in poor quality housing

S27. Unpaid carers

S28. Social vulnerability (including social isolation)

S29. Assisted bin collection

S30. Homelessness

S31. Communities with language barriers

Bio-psycho-social risk factors to prioritise

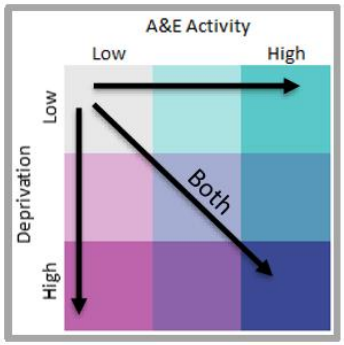
Clinical LTC	
Diabetes	12

Psycho-social – MH	
People living with depression	12
Serious mental illness	11

Psycho-social - Inequalities	
People living in deprived postcodes	19
Social vulnerability (including social isolation)	15

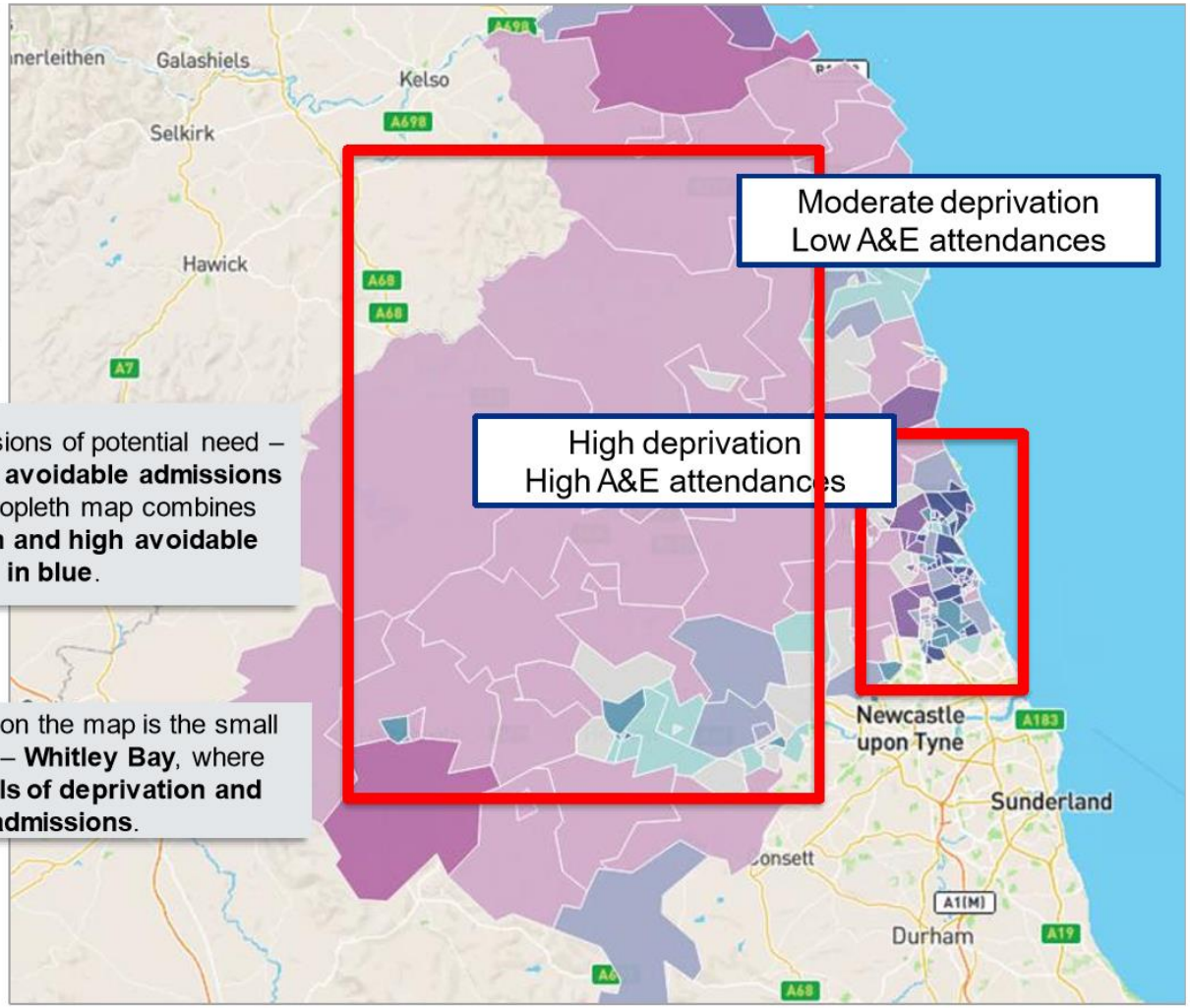
Optum Place Workshop: Oct 2020 Collective Challenge?

- Already existing Health inequalities show trends in unplanned utilisation



This map shows two dimensions of potential need – **deprivation in purple**, and **avoidable admissions in teal.** The bivariate choropleth map combines areas of **high deprivation and high avoidable admissions in blue**.

The most obvious area on the map is the small dark patch at the right – **Whitley Bay**, where there are **higher levels of deprivation and avoidable admissions**.



The Ask For Northumberland

- Shared priority actions
- Be ambitious with the outcomes we want to achieve and measure impact
- Make Northumberland the best county in the country to live in
- Lead innovation across the country in the creation of health, wealth and happiness
- Be a national centre of excellence for population health, prevention and co-design with our communities

Conclusion and Future

- Defined road map for utilisation of PHM
- Significant ‘buy in’ from the system to drive the agenda forwards through STB flagship
- Impetus to drive improvements and transformational change in our System
- Development of evidence based interventions which reduce inequalities
- Strong engagement with our communities
- Share learning across the wider system