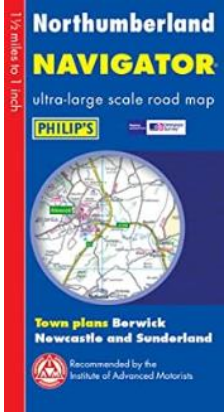

Health Improvement for Northumberland
a road map

Population Health Management building blocks

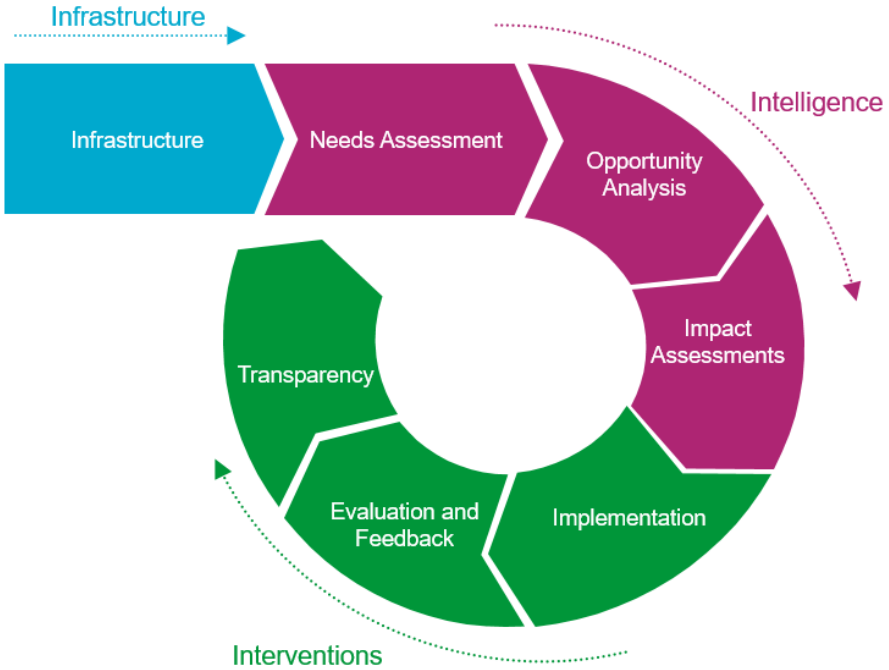


1) Infrastructure

Leadership across the system
Information Governance
Shared datasets
Common language
Defined population

2) Intelligence

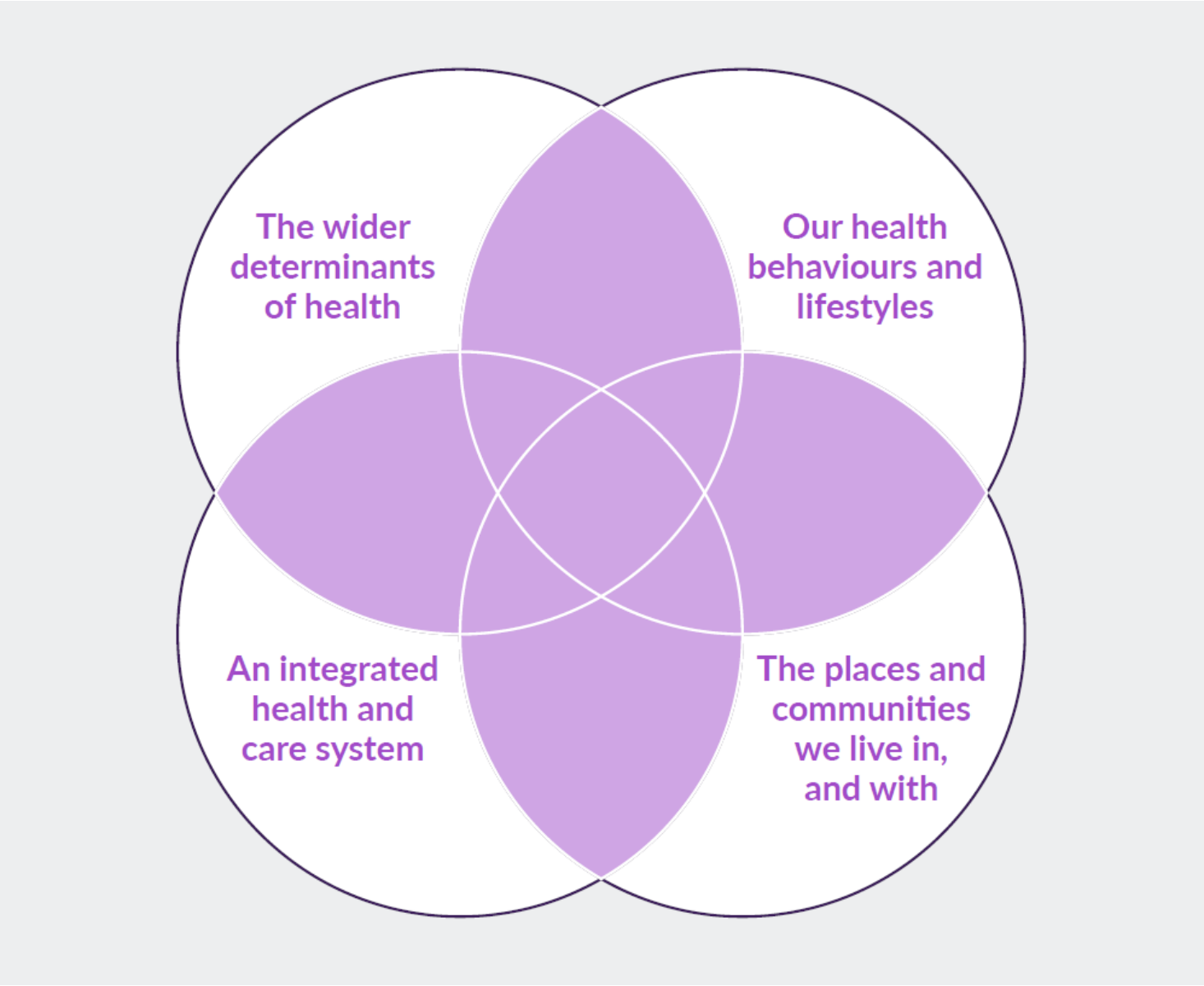
Identify inequalities & Vulnerability
Social and Clinical Evidence
Cohort Selection/Stratification
Prioritisation and Modelling
Community Engagement



3) Interventions

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

Population health areas



Source: Kings Fund, 2019

Direct impact of actions on health outcomes

Area	Scale of problem in relation to public health	Strength of evidence of actions	Impact on health	Speed of impact on health	Contribution to reducing inequalities
Best start in life	Highest	Highest	Highest	Longest	Highest
Healthy schools and pupils	Highest	Highest	Highest	Longer	Highest
Jobs and work	Highest	Highest	Highest	Quicker	Highest
Active and safe travel	High	High	High	Quicker	Lower
Warmer and safer homes	Highest	Highest	High	Longer	High
Access to green spaces and leisure services	High	Highest	High	Longer	Highest
Strong communities, wellbeing and resilience	Highest	High	Highest	Longer	High
Public protection	High	High	High	Quicker	High
Health and spatial planning	Highest	High	Highest	Longest	Highest

Source: Buck and Gregory (2013)

A case study in brief:

Blackpool: intervention with residents of multiple occupancy housing

PCN cohort identified through the analytics:

- Blackpool identified residents of houses of multiple occupancy, with depression and other health issues.

Locally-designed intervention:

- Holistic and proactive health assessments by health coaches in the PCN.
- Follow-up assessments of social situation by health and wellbeing workers in the council. This included assessment of particular risks to health.
- Signposting individuals to other psychosocial services – counselling, peer support and other social support.

Impact:

- Bringing together multiple stakeholders is important to make and sustain change. *"The programme brought together people who have the same purpose building a sense of camaraderie"* (GP).

Example: 'Barbara' from Blackpool

- The Blackpool team **linked up data on health and housing** to find Barbara.
- As well as suffering from depression, Barbara lived in **poor quality housing,** was **unemployed** and had recently experienced a **bereavement**. She was in rent arrears and using alcohol to help her cope.
- Barbara was assessed by a health coach in the PCN, who arranged for a **health and wellbeing worker** from the council to visit Barbara on regular basis.
- The worker identified severe **risks in the quality of Barbara's building,** and supported Barbara to call her letting agent and get housing support.
- Barbara was **referred to a local charity** to support her with her bereavement, linked up with **employment services** and **supported to build her skills and confidence**.
- **Barbara's patient activation rose from a level 2 to a level 4 during this time,** demonstrating how confidence in managing her health changed with this social support.

A case study in brief:

Pudsey, Leeds moderate frailty patient intervention

Cohort identified through the analytics:

- 80 people, aged 60-74 within moderate frailty segment, multiple Long Term Conditions (LTCs), balance and nutrition issues, not connected to the neighbourhood teams (health or social care)

Locally-designed intervention:

- Proactive outreach with telephone-based triage
- Assess areas of strength and struggle, including how they feel about ability to self manage
- Triage to one of three interventions based on level of self-care ability and need:
    1. Refer to group 'live well' consultation
    2. Individual medical consult in clinic
    3. Home visit led by an OT

Example: 'Paula' From Pudsey

'Paula' is a 63 year old woman with **moderate frailty**. She has multiple medical conditions as well as challenges associated with falls, memory and nutrition. She is not well connected into health and care. Looking at data, clinicians in the programme noticed that **nutrition data was a good predictor of risk**. This insight, together with analytics provided in the programme, identified Paula as potentially needing further attention. **Telephone triage confirmed** this and Paula was visited at home by an occupational therapist (OT). The at-home visit gave a holistic view of Paula's needs, with a focus on preventing falls, enabling better nutrition and improving Paula's ability to self-care. **Paula and the OT had a discussion about her needs and her own personal goals**. The OT identified specific opportunities to enable a healthier lifestyle for Paula at home – for example by enabling easier use of kitchen tools to help her prepare food.

Health Improvement Journey

Infrastructure
Leadership & System Team

Culture
Community Co-design

Resources
Project team "Social movement"

Intelligence
Datasets & Information governance

PHM academy
Senate & Learning arena

Intervention
Map all relevant work already underway to form coherent whole

Project work
(1) Best Start in Life
(2) Emerging Risk cohort (40-56)
(3) End of Life Case Studies

Project work
Finance & Contracting Programme Jan 2021

Ambition
scaling up

Evaluation
Learning system