Population Health Management Wave 3 Development Programme

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

19/05/2021

Population Health Management

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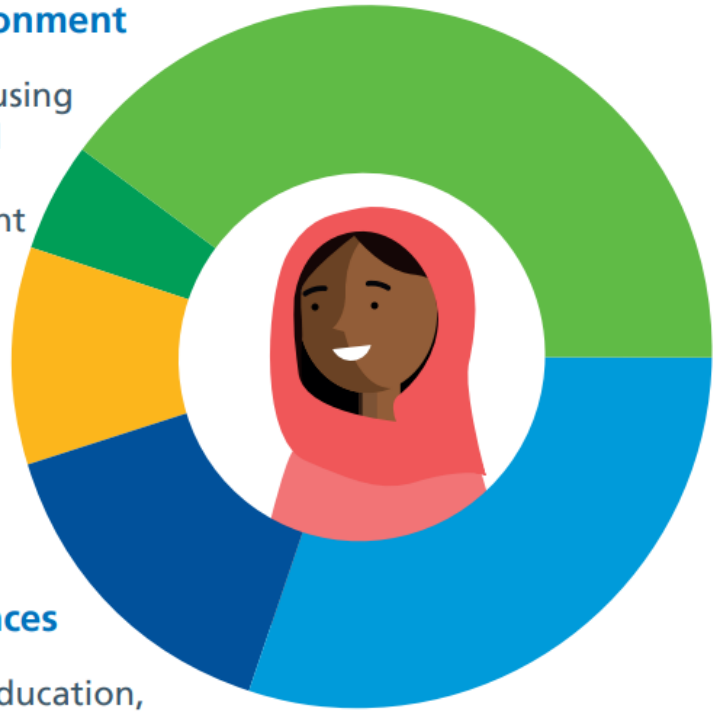
Which factors impact your health?



Our environment
5% housing quality and our built environment

Our behaviours
40% smoking, diet, alcohol use, poor sexual health

Healthcare
10% being able to access good quality care

Genetics
30% your genes can directly cause or increase your risk of developing a wide range of medical conditions

Social and economic circumstances
15% education, employment, income, family/ social support, community, safety

Our health and care needs are changing: we are living longer with more multiple long-term conditions like asthma, diabetes and heart disease and the health inequality gap still needs reducing.

Population Health Management (PHM) will help us understand and predict our future health and care needs, reducing health inequalities and making better use of resources, tailoring care better for individuals and sustaining health and social care services.

It is how we use data insights to improve health and wellbeing today and also in 20 years' time. This could be by stopping people becoming unwell or, where this isn't possible, improving the way the system supports them.

What is Population Health Management?

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Population Health…

… is an approach aimed at **improving the health of an entire population.**

It is about **improving the physical and mental health outcomes** and wellbeing of people, whilst **reducing health inequalities** within and across a defined population. It includes action to reduce the occurrence of ill-health, including **addressing wider determinants of health**, and requires working with communities and partner agencies.

Population Health Management…

…improves population health by **data driven planning and delivery of proactive care to achieve maximum impact**.

It includes segmentation, stratification and impactability modelling to identify local 'at risk' cohorts and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.

Population Health Management is about:

- **Reducing health inequalities** by taking action
- Using data-driven insights and evidence of best practice to inform **targeted interventions to improve the health & wellbeing of specific populations & cohorts**
- **The wider determinants of health,** not just health & care
- **Making informed judgements**, not just relying on the analytics
- **Prioritising the use of collective resources to have the best impact**
- **Acting together** – the NHS, local authorities, public services, the VCS, communities, activists & local people. **Creating partnerships of equals**
- **Achieving practical tangible improvements for people & communities**

Population Health Management in the current context

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The last 12 months have highlighted the disproportionate impact COVID-19, like so many other health conditions, has had on different communities as well as wider inequalities. But it also catalysed the use of **joined up data, predictive analytics and partnership working in developing proactive holistic models of care to support our most vulnerable groups.**

Now more than ever, the Cambridgeshire & Peterborough system needs to **focus on tackling unwarranted variation, reducing harm and health inequalities**. This effort must start with data and insight into the needs of our population and be followed by swift and supported action by integrated teams to design proactive preventative care models and restore services for those who need them most.

In December 2020 NHS Cambridgeshire and Peterborough's application was accepted for the **wave 3 Population Health Management programme**. This programme will be run through a blend of NHSE/I teams, external Subject Matter Expert (SME) (Optum) and transformation partners and is intended to support and enhance local efforts and will build on local governance rather than add to an already stretched workload of frontline teams.

Every health and care system faces challenges…

- Managing the resurgence of COVID-19
- How to accelerate the integration of health and care services
- Responding to increasing morbidity, co-morbidity and hidden harm
- Restoring care and support inclusively – cancer, mental health, Long Term Conditions, electives
- Reducing widening inequalities in access and outcomes
- Contributing to developing sustainable communities

Achieving this will require:

- Understanding the needs of our population, their risk and drivers of demand
- Effective prioritisation, targeting resources on the individuals, cohorts and communities who will benefit most from interventions
- Re-designing prevention, care and support pathways to optimise outcomes and value
- Accurate segmentation to protect the most vulnerable and manage COVID-19
- Support for frontline Multi Disciplinary Teams (MDTs) to understand the data and design new models of care

Introduction to the Wave 3 Development Programme

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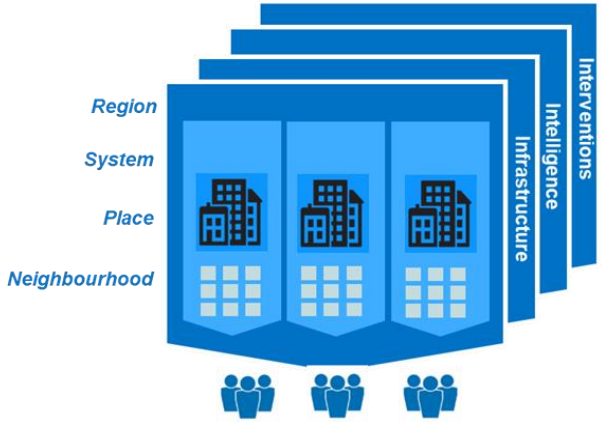
A 22 week supported action learning Programme to:

- Working with each tier of the system to **link local data**
- **Build analytics skills** across the system
- Find rising risk cohorts
- Risk stratification of elective backlogs and explore alternative models of service delivery
- Support the design and delivery of new models of care for Impactable patients
- Costed segmentation to develop **new population based blended payment models**, and **evaluate impact** of interventions.



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Advance the system's infrastructure and build sustainable capability across all tiers of the system which supports a focus on proactive population health management and tackling unwarranted risk.

Ensuring the lessons learnt throughout the programme enable system and provider participants to accelerate data, analytical infrastructure and sustainable care transformation support across the rest of the Integrated Care System, with clear roadmaps for making PHM 'business as usual' and clarity on critical support functions and enablers (including ongoing digital transformation, analytical capability, finance, commissioning & contracting, care coordination)

1

Support changes to integrated care delivery - through Primary Care Networks (PCNs), community, acute and mental health providers and public health and social care teams - to achieve demonstrably better outcomes and experience for selected population cohorts and support knowledge transfer to spread the approach to other cohorts.

PCNs with involvement from other providers and system teams designing and implementing proactive care models for key population cohorts identified through segmentation and risk stratification and measuring the net impact using local intelligence tools, including an understanding of how shared workforce and provider operating models can be adapted to sustain these changes.

Key components of the programme

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Targeted Action Learning for every tier of the system the programme brings together analysts, clinicians, providers and other professionals with place, finance and system leaders across the programme's 4 workstreams to use data to generate a sense of common purpose and priority and then develop a series of action plans and outputs using logic models and other techniques. This programme is 10% analytics and 90% behaviours
The result within **22-weeks** is tangible change on the ground that benefits individual patients and cohorts, improving their health and wellbeing and provides a sustainable way to do quality improvement within integrated care teams.

SYSTEM WORKSTREAM:

5 SME facilitated Action Learning Sets that **bring together all system stakeholders to develop a common understanding** and learn from international good practice

- Focus on **sharing learning across workstreams** and **collectively unblocking barriers** to scale PHM

PLACE & ICP WORKSTREAM:

- 6 Action Learning Sets with providers, Local Government and wider partners to **develop a scalable plan to restore services inclusively and address inequalities** by linking elective data with person level analysis

** 1 place funded through programme*

PCN WORKSTREAM:

- 5 Action Learning Sets with primary and secondary care partners, social care and third sector teams to **identify at risk groups and develop & deliver new holistic model of care**
- **Regular coaching** throughout the to key members of PCN MDTs

** 3-4 PCNs funded through programme depending on system footprint*

ANALYTICAL WORKSTREAM:

- 7 Action Learning Sets that bring together system analysts for **hands-on learning of PHM analytical techniques** and a facilitation to **create a sense of shared purpose** for system intelligence teams
- Local analyst community learns to directly **support MDTs designing intelligence-based care models** within the programme

Timeframes and Sequencing of Events

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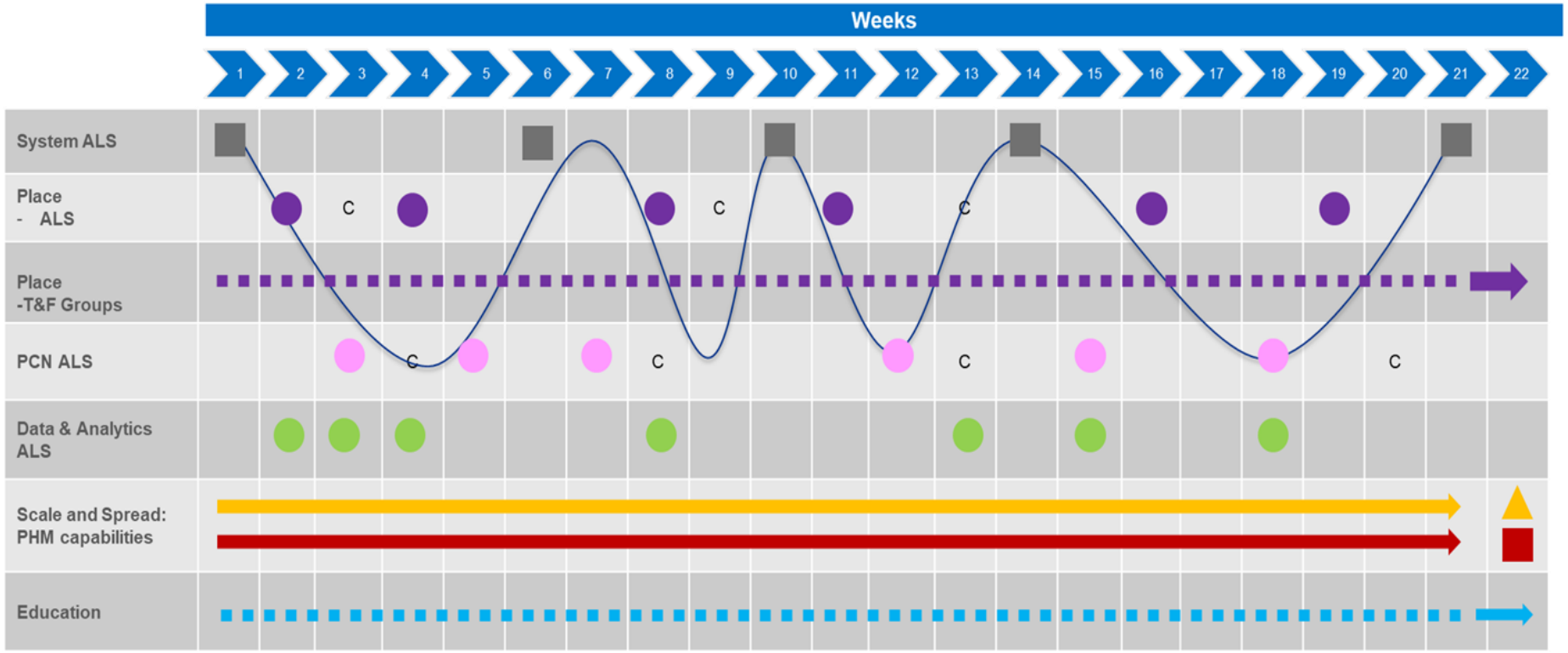
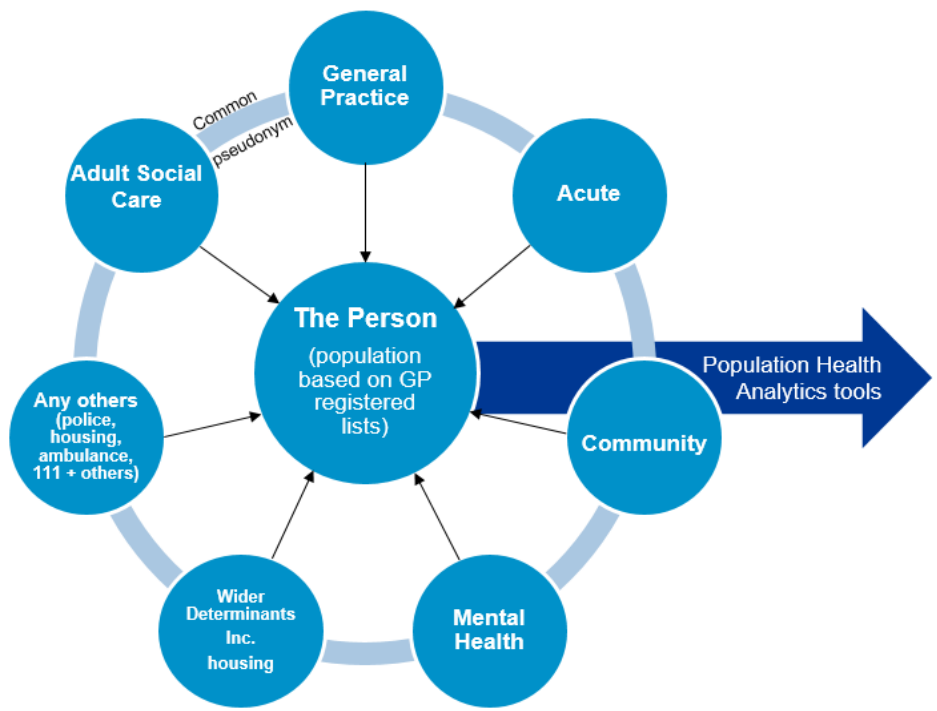
Each ‘intervention design’ workstream (for Place and PCNs) will have dedicated Action Learning Sets that bring together integrated teams to take action on chosen cohorts. Those workstreams then feed into the System Workshops to share progress and learning and ensure the programme generates a sense of collective purpose. The programme also ensures that leaders understand the lessons learned and barriers faced to change on the ground in an effort to unlock new insights about how the System itself can be an ‘unblocker’ to locally owned change and a support by scaling resources effectively.



First step

PHM starts from the creation of a linked data set. This will enable our teams to have a ‘shared source of truth’ that builds up an understanding of need and priorities for our population. Teams will see their population using data that represents ‘the whole person’, providing insights into complexity, multi-morbidity and overall bio-psycho-social need. The enhanced focus from these insights will help integrated teams to prioritise and make actionable change which benefits individuals, cohorts & communities.

Linked data set the foundation for PHM



To commence programme:

Health and care systems will be supported through the Information Governance and extraction process to create a ‘snapshot’ linked data set that at a minimum will link primary and secondary care data for the PCNs chosen to be on the programme.

Within programme to scale and sustain:

Systems will be supported to create a PHM Roadmap with a goal to further link health and care data across the entirety of the ICS that can provide near real-time access and track outcomes across time.

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