NHS

Thames Valley Strategic Clinical Networks and Clinical Senate

Population Health

Population health in Integrated Care Systems

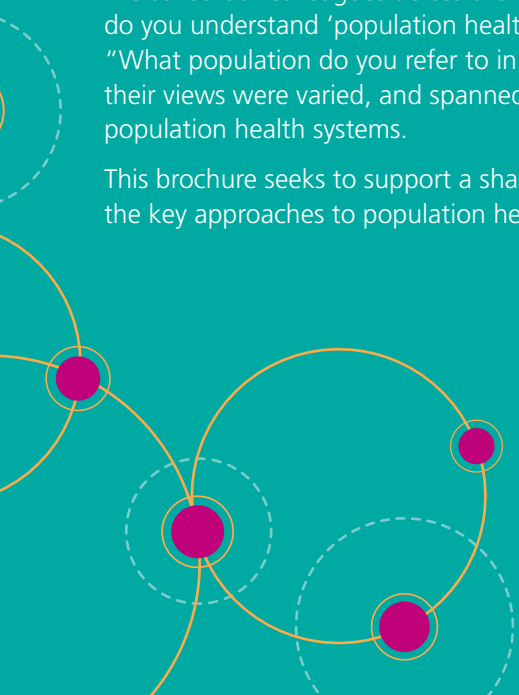
"Integrated Care Systems are groups of organisations...that can...deploy (or partner with third party experts) rigorous and validated population health management capabilities that improve prevention, enhance patient activation and support self-management for long-term conditions, manage avoidable demand, and reduce unwarranted variation..."

Next Steps on the NHS Five Year Forward View

'Population health' has emerged as a widely used phrase in relation to the NHS Integrated Care Systems (ICS) and Sustainability and Transformation Partnerships (STPs). A commonly agreed definition is currently being developed by NHS England in collaboration with Public Health England.

We asked our colleagues across the Thames Valley "What do you understand 'population health' to mean?" and "What population do you refer to in your course of work?"; their views were varied, and spanned the broad spectrum of population health systems.

This brochure seeks to support a shared understanding of the key approaches to population health.



Managing the health and wellbeing of the population, defined by geographical boundaries (See p. 4)

Using data to understand the needs of the population, stratifying groups and tailoring services accordingly (See p. 6)

Tailoring our services to meet the needs of my individual patients (See p. 8)

The Case for Change

Under increasingly challenging circumstances, it is now more necessary than ever to better understand the wider factors that can have an impact on our health, such as education, housing and employment.

Building place-based systems of care provides an opportunity for NHS organisations, patients, the public and voluntary and community sectors to work together to improve the health and wellbeing for all.

The number of people aged **85+** is due to **increase** by **128%** by **2035**

Fragmented services

Increasing cross-sector financial and workforce **pressures**

Rising healthcare inequalities

The **population** is set to **increase** by **13%** by **2035**

Increasing number of adults and children living with **long term conditions**

Place-based population health

A place-based approach aims to improve the health and wellbeing of the entire population as defined by its geographical boundaries.

This can also be referred to as the 'macro' level perspective.

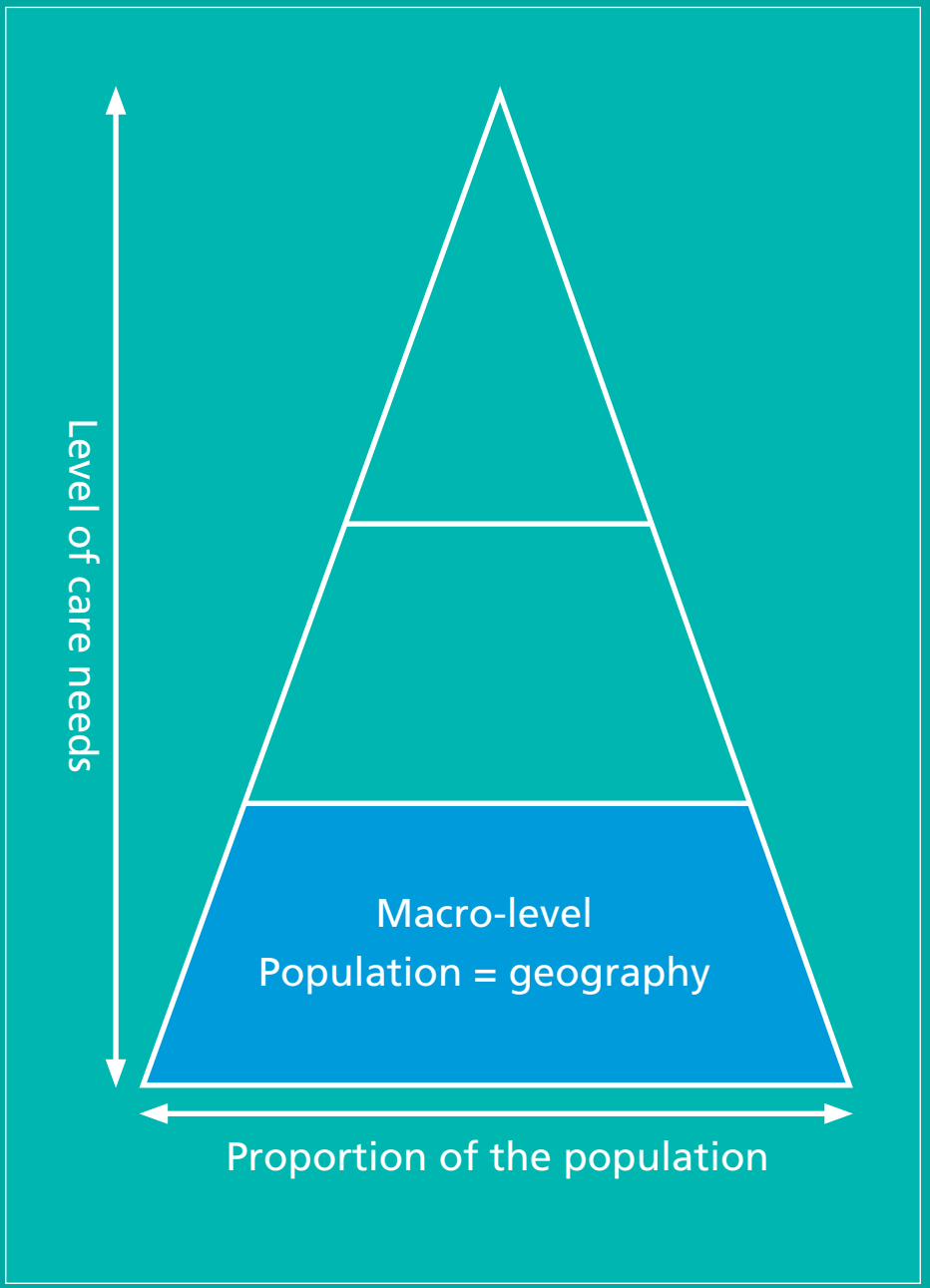
This approach requires:

- Meaningful engagement with local communities and their organisations to understand what matters most to them about their health and wellbeing.
- The collection and use of data and information to better understand the overall health needs across populations.
- Strong place-based leadership, community engagement and policies which enable and support healthy environments.

Activities at this level will be large-scale and amongst a relatively healthy population.

They may be focused, for example, upon the promotion of healthy behaviours in the built environment.

The 'Bicester Healthy Town, Healthy Lives' programme is an example of how this can be put into practice.



A place-based approach

The objectives for the Bicester Healthy Town, Healthy Lives programme are to:

- Increase the number of children and adults who are physically active and a healthy weight.
- Reduce the number of people who feel socially isolated or lonely, in order to improve their mental wellbeing.

These objectives were developed through meaningful engagement with the communities of Bicester.

Working in close collaboration with the community and its organisations, the programme is focusing on the three areas below to meet these objectives:

Bicester
Healthy town, healthy lives

1. Using the built environment to act as a 'nudge' for residents to be active, for example:

'Bicester's Blue Line'

Marked routes that are safe, accessible and free to all, developed with community engagement.

There has been a 56% increase in people walking the Health Routes since their installation, a daily average of 971 people.

2. Delivering health and care services that are focused on prevention and care closer to home.

People with long term conditions such as diabetes are being supported to manage their health with the help of digital technologies.

Skype for Business is enabling GPs to have remote consultations with secondary care consultants, to improve local management of the diabetes population.

3. Enabling local people to live healthy lives with support from community groups, families, schools and employers.

Organisations are working together to improve the health and wellbeing of Bicester.

40% of schools in Bicester have signed up to the lunchtime daily mile walk.

Group-based population health

The group-based approach aims to support improvement of the health and wellbeing of particular groups of individuals within geographical boundaries, who have certain health needs or risk of becoming unwell.

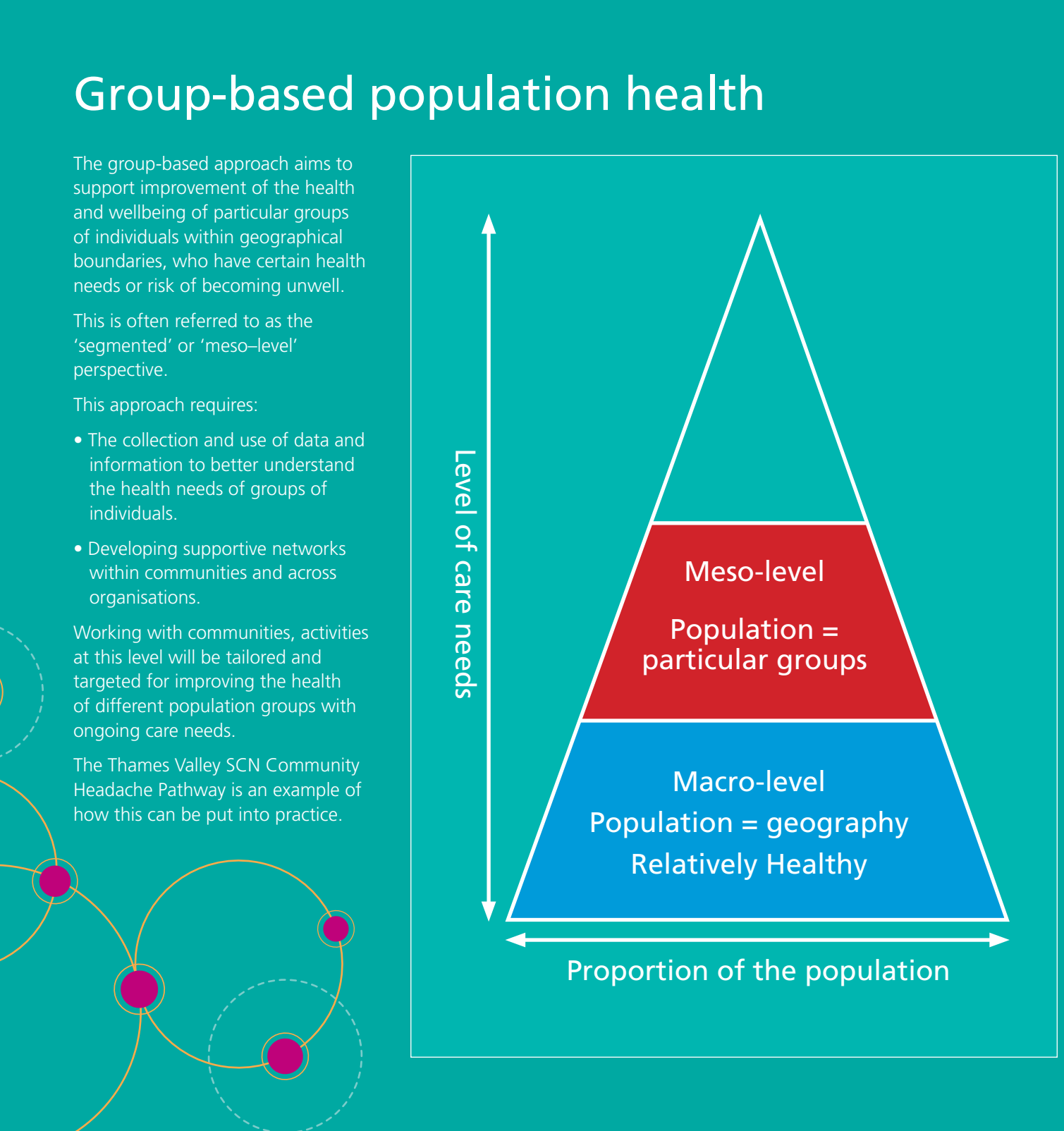
This is often referred to as the 'segmented' or 'meso–level' perspective.

This approach requires:

- The collection and use of data and information to better understand the health needs of groups of individuals.
- Developing supportive networks within communities and across organisations.

Working with communities, activities at this level will be tailored and targeted for improving the health of different population groups with ongoing care needs.

The Thames Valley SCN Community Headache Pathway is an example of how this can be put into practice.



Thames Valley Strategic Clinical Networks

The Thames Valley Strategic Clinical Networks (TVSCN) are an example of how organisations, in collaboration with patients and the public, can work together to improve the health and wellbeing of groups of individuals with specific health needs, in place-based systems of care.

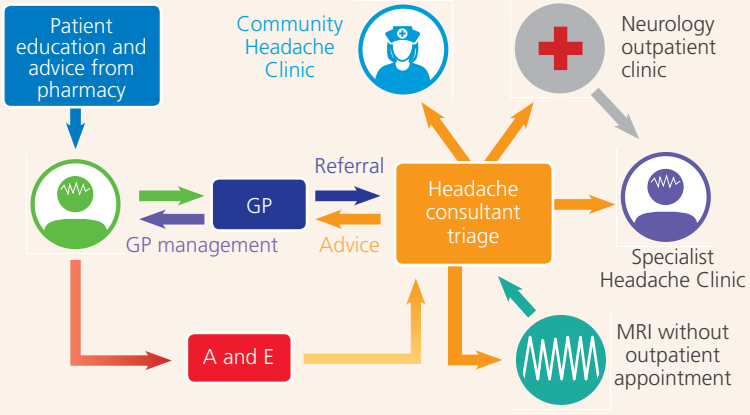
The key priorities of the TVSCN are: cancer, mental health, maternity, and long term conditions such as diabetes.

Improving care for patients with headache

It was identified that **1/3 patients** with headache were being referred to hospital and that **66%** of those could be managed more appropriately within the community.

This would enable the remaining **34%** of rare headaches to be treated faster in secondary care outpatient clinics.

Headache Pathway



A Community Headache Pathway was developed to improve the diagnosis of headaches.

A community headache clinic has been set up to provide ongoing support and advice to patients with headache disorders such as migraines. A patient support network will be based in the community clinic.

The TVSCN developed a support pack for commissioners so that this positive work may be replicated elsewhere.

Personalised care

The personalised approach aims to support the improvement of the health and wellbeing of individuals within defined geographical boundaries.

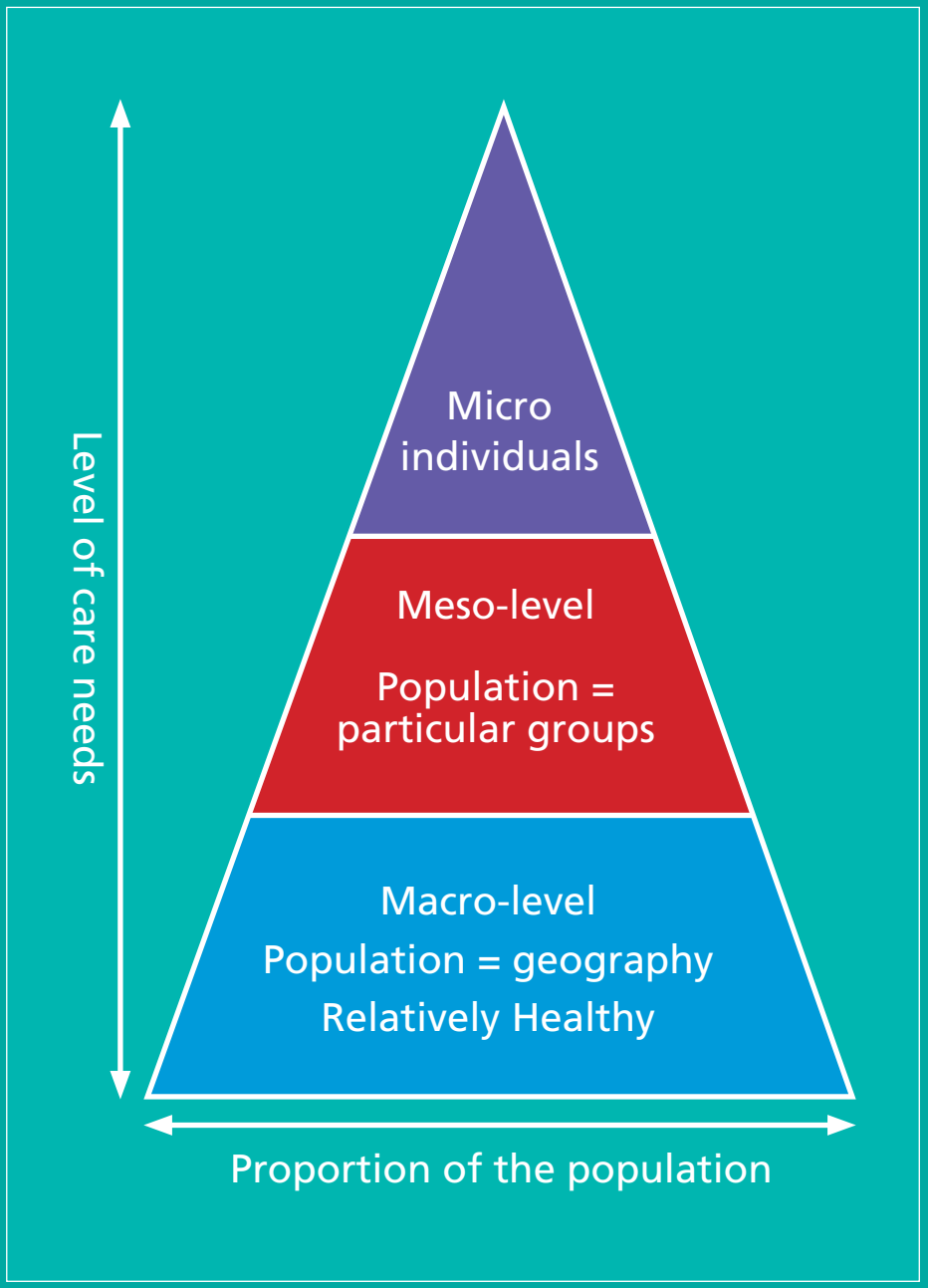
This can also be referred to as the 'micro-level' perspective.

This approach requires the close working between organisations and individuals to:

- understand the outcomes and services that matter to them
- work with patients to develop a wide range of services to support them to manage their health; within
- a geographically defined area.

Interventions at this level will be tailored in collaboration with patients who have the highest care needs, to improve their health and wellbeing.

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"



Personalised Care and Support Planning

"Personalised care planning is a collaborative process used in chronic condition management in which patients and clinicians identify and discuss problems caused by or related to the patient's condition, and develop a plan for tackling these. In essence it is a conversation, or series of conversations, in which they jointly agree goals and actions for managing the patient's condition."

The TVSCN long term conditions network continually supports the person-centred approach to care, ensuring that it is also embedded within other programmes of work such as cancer, dementia, and end of life.

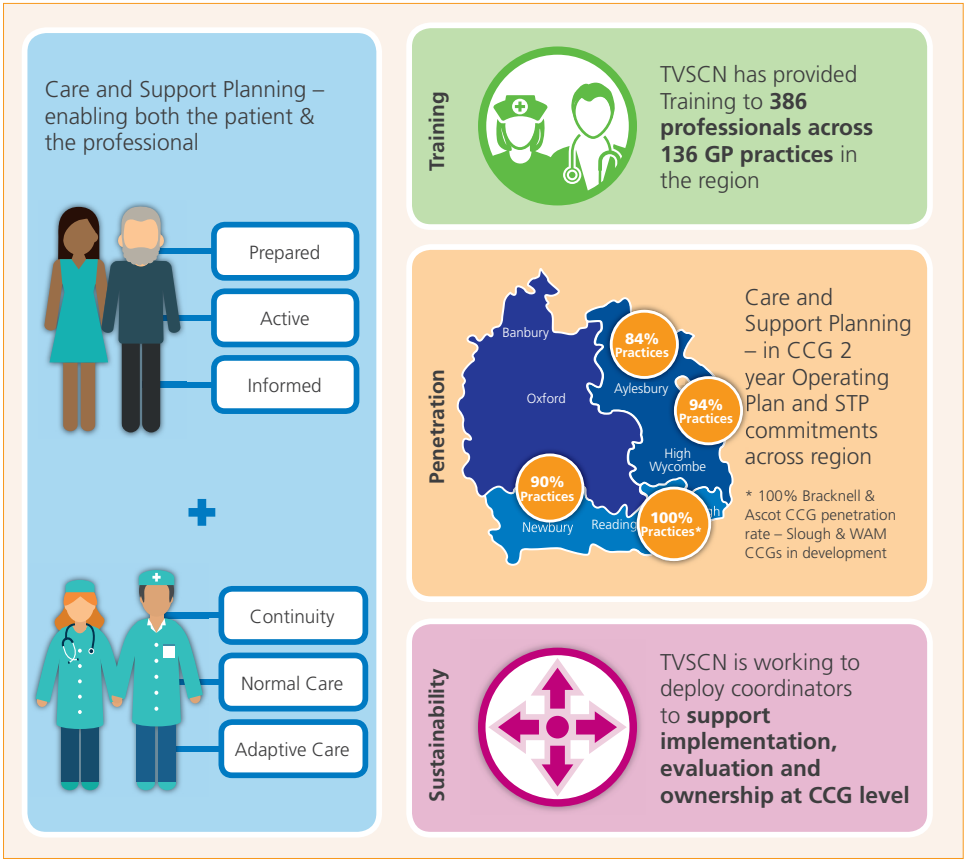
Care and Support Planning (CSP) enables people with long term conditions to:

- Self-manage their conditions.
- Communicate their treatment preferences.
- Be guided and supported by clinicians in their decision making.

TVSCN has supported the implementation of Care and Support Planning, including:

- Delivery of training in CSP.
- Appointment of CSP facilitators across all four Clinical Commissioning Groups.

Implementing Care and Support Planning



Elements of population health management

	Macro-level (whole system, large scale)	Meso-level (stratified population groups)	Micro-level (individual/healthcare delivery)
Population	Defined by geographical population.	Segments of the population, defined by need and health risk eg groups that are frequent users of heath and care services.	Within the population served eg GP registers, A&E attendees.
Aim	To improve people's health across the whole of the population they serve, as well as targeting specific interventions on the most deprived groups.	To tailor services and evidence-based interventions to specific groups according to need and health risk.	To deliver a varied range of interventions to individuals, depending on their focus.
Integration	Integrated care across a full spectrum of services to the whole population served.	Providers together, or with commissioners delivering integrated care for a particular group of people with the same disease or conditions eg care for older people, mental health, disease management programmes and managed clinical networks.	Providers together, or with commissioners delivering integrated care for individual service users and their carers through care coordination, care planning and other approaches.
Enablers	• Population-level data to understand needs across populations and track health outcomes. • Community involvement in managing their health and designing local services. • Involvement of a range of partners and services to deliver improvements in population health. • Joint Strategic Needs Assessments.	• Population segmentation and risk stratification through data analytics. • Targeted strategies for improving the health of different population segments. • Developing 'systems within systems', services and stakeholders to focus on different aspects of population health.	• Integrated health records to coordinate people's care services. • Scaled-up primary care systems that provide access to a wide range of services and coordinate effectively with other services. • Close working across organisations and systems to offer a wide range of interventions to improve people's health. • Close working with individuals to understand the outcomes and services that matter to them, as well as supporting individuals to manage their own health.
Example	• Population awareness programmes, such as: reducing salt intake (blood pressure), smoking cessation. • Bicester Healthy Town, Healthy Lives programme.	• Population screening programmes. • Clinical networks – long term conditions, cancer. • Care of older people.	• Care and support planning, shared decision making. • Virtual clinics and telehealth. • Personal health budgets. • Patient accessible electronic medical records.

Adapted from The King's Fund, Population Health Systems, 2015 www.kingsfund.org.uk/publications/population-health-systems (last accessed 13 February 2018)

The Building Blocks of Population Health

Places as systems: it is in the interaction between these elements of the system that change can be delivered

Contact the Team

Aarti Chapman
Associate Director
aarti.chapman@nhs.net

Wendy McClure
Thames Valley Clinical Senate Manager
wendy.mcclure@nhs.net

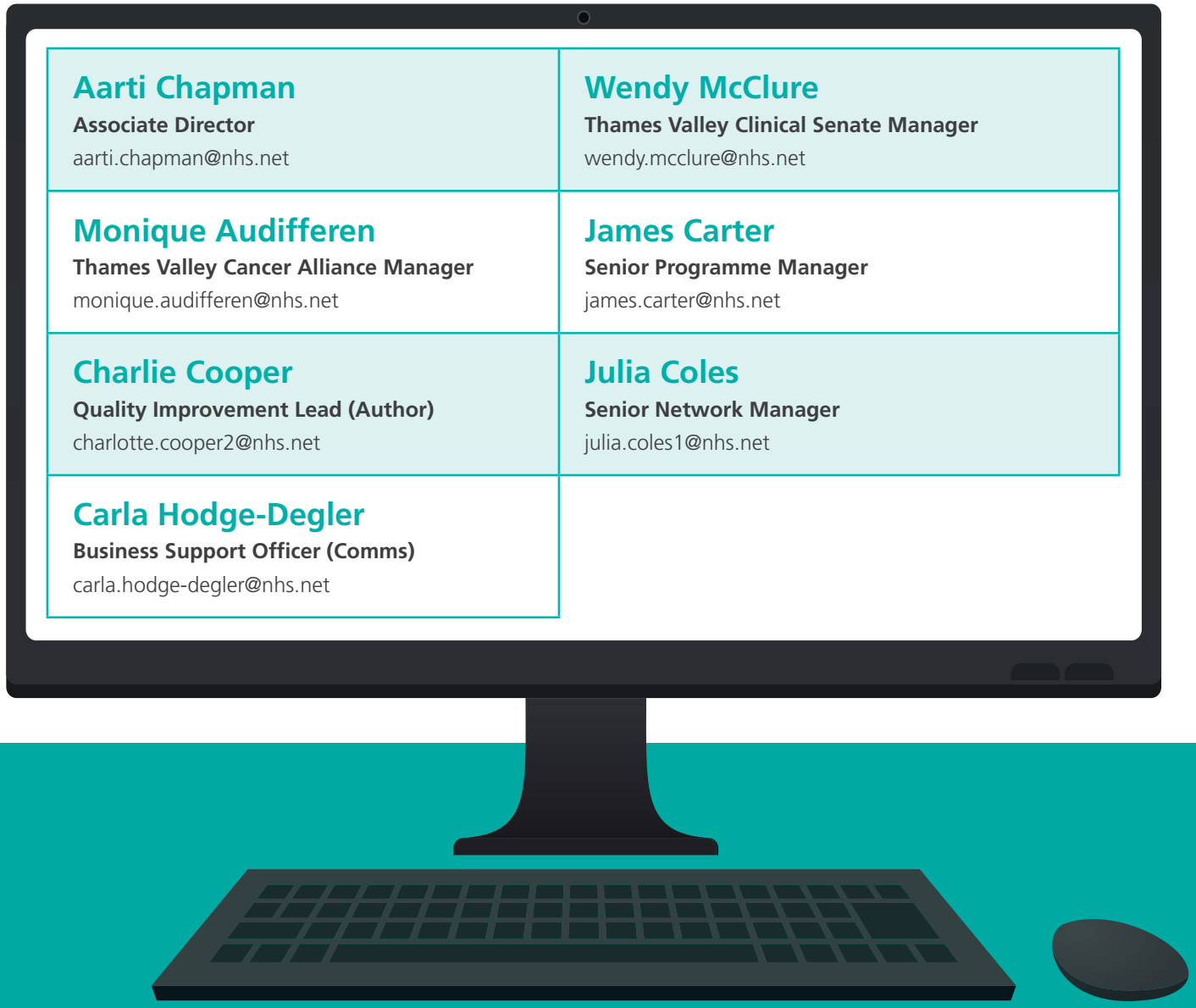
Monique Audifferen
Thames Valley Cancer Alliance Manager
monique.audifferen@nhs.net

James Carter
Senior Programme Manager
james.carter@nhs.net

Charlie Cooper
Quality Improvement Lead (Author)
charlotte.cooper2@nhs.net

Julia Coles
Senior Network Manager
julia.coles1@nhs.net

Carla Hodge-Degler
Business Support Officer (Comms)
carla.hodge-degler@nhs.net



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