Name of meeting: Health and Adult Social Care Scrutiny Panel

Date: 10th March, 2022

Title of report: Population Health Management

Key Decision - Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	N/A
Key Decision - Is it in the Council's Forward Plan (key decisions and private reports)?	N/A
The Decision - Is it eligible for call in by Scrutiny?	
Date signed off by Strategic Director & name **Is it also signed off by the Service Director for Finance?** **Is it also signed off by the Service Director for Legal Governance and Commissioning?**	**Rachel Spencer-Henshall – 24 February 2022** **N/A** **N/A**
Cabinet member portfolio	**Cllr Musarrat Khan**

Electoral wards affected: All

Ward councillors consulted: N/A

Public or private: Public

Has GDPR been considered? Yes. The report does not include any personal data that identifies an individual.

1. Summary

Public Health Improvement has been requested to provide Health and Adult Social Care Scrutiny Panel with an update around Population Health Management.

What is Population Health?

Population Health is a long-term, system wide 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

What is Population Health Management?

Defining Population Health Management is challenging. It can feel like Population Health Management is a concept which has limited connections to reality and can feel incredibly technical or nebulous. It is important to begin by defining what Population Health Management is so that it can be understood and applied in a range of services, organisations and partnerships.

PHM is one of many approaches to improve population health using data driven planning and delivery of proactive care in order to achieve maximum impact. It includes segmentation (splitting the population into different groups), stratification and impactabilty 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 variations in outcomes. This is broken down further below:

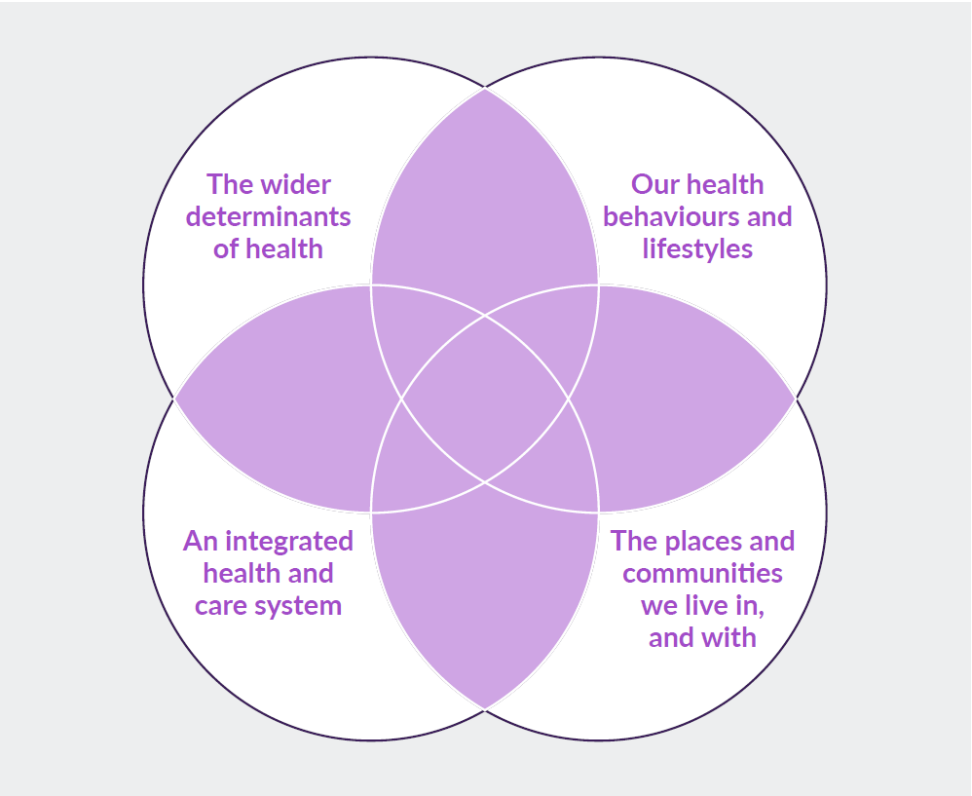
- Population health is one the core strategic aims for Integrated Care Systems; to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population, with a specific focus on the wider determinants of health (things like housing, employment, education).

- Population Health Management is a way of working to help frontline teams understand current health and care needs and predict what local people will need in the future.

- This means we can tailor better care and support for individuals, design more joined-up and sustainable health and care services and make better use of public resources.

- Population Health Management uses historical and current data to understand what factors are driving poor outcomes in different population groups. Local health and care services can then design new proactive models of care which will improve health and wellbeing today as well as in future years' time.

This can be demonstrated using the framework below:



- **The Wider Determinants of Health –** for example; work, income, housing, transport, education
- **Our health behaviours and lifestyles –** for example; tobacco, diet, alcohol, physical activity
- **The places and communities we live in and with –** for example; social norms, social relationships, physical environment
- **An integrated health and care system –** for example**;** person centred, integrated services and pathways, improved communication and co-ordination

Examples of Population Health Management in Kirklees

There are examples of Population Health Management being used both before and during the Pandemic. These are at various stages of development and highlight the range and complexity of PHM.

The Wider Determinants of Health

Breast, Cervical and Bowel Screening Pilot. This was a partnership between Public Health, Kirklees Homes and Neighbourhoods, Wellness Service, Community Plus and Pennine Bowel Screening. Using local data which identified the geographical areas of Kirklees which had low screening uptake, colleagues were able to work in partnership in order to engage with council tenants using a health coaching approach. Homes and Neighbourhoods staff received bespoke training from Public Health and Wellness colleagues in order to improve knowledge and understanding and to enable them to have appropriate conversations with residents. This demonstrates the potential of using PHM as a tool – using place-based intelligence combined with community development approaches.

Our health behaviours and lifestyles

Health Checks. As part of the local authority's focus on reducing health inequalities, Public Health and Communities colleagues worked in collaboration in order to improve access to Health Checks via the Wellness Service. Local data was used to target population groups who were (a) more likely to have poorer health and (b) be less likely to access Health Checks. The scheme aims to work with people living in deprived areas of Kirklees, people from Black, Asian and minority ethnic backgrounds and people with mental health conditions, all of which are groups that research has shown are at a greater risk of poorer health outcomes. In order to improve access, Health Checks are being delivered in local community spaces and venues.

The places and communities we live in and with

Covid 19 Community Response. The partnership response to Covid 19 is an excellent example of the benefits of working in partnership in order to access, analyse and interpret data at scale and at pace. It also highlights the importance of community level place-based working. Public Health Intelligence were able to provide data which indicated specific population groups who were more likely to be infected with Covid-19, more at risk of death or serious health impacts and less likely to have the vaccine. A range of responses were put in place as a result of this data. This has included; Community Response Hubs, Covid Response Officers, Community Champions and pop up Vaccination clinics.

An integrated health and care system

Public Health Intelligence provided each Primary Care Network with Intelligence packs in 2019. The purpose of these packs was to bring together data at a PCN level in order to highlight inequalities and inform priorities for each PCN place. There was a range of data included within the packs, covering PCN demographics, disease prevalence and health conditions, mortality rates and life expectancy, health-related behaviours, emotional wellbeing, and hospital admissions.

What needs to happen next?

As explored above, in many ways, Population Health Management is already happening in specific areas and workstreams across Kirklees. It is important to note that it is not our wish to develop a separate PHM workstream but to integrate, influence and add value to work which is already happening across Kirklees. Despite the ongoing PHM approaches which are already happening across Kirklees, there are a number of areas which require input and development.

We are proposing a number of next steps to take over the next year. These include:

1. **Collaboration and relationships**

Build on existing relationships and partnerships across the system in order to:
(a) Develop a common understanding of what PHM is and how it can support the reduction of inequalities
(b) Understand what is happening already
(c) Identify where PHM approaches can add value
(d) Upskill partners from across the system to access, understand and use local data.

2. **Focus on reduction of inequalities via prevention and health improvement**

At the heart of PHM is the need to reduce inequalities via prevention and health improvement. It is therefore important to work alongside systems and services which contribute towards prevention and health improvement. This includes the voluntary sector, primary care and health improvement services.

3. Working with not doing to - Community stories and lived experience

Population Health Management is not just about quantitative data. It is also about working with communities in order to understand lived experience and to enable systems and services to ensure that what they provide and how they develop relationships meets the needs of specific population groups. Covid-19 response has shown us the importance and value of 'working with and not doing to'. As part of our approach to PHM as well as our broader approach inequalities it is vital to integrate community stories and lived experience into our approaches.

4. Understanding Population Health Management at Place

Linked to the above point, it is vital to understand PHM approaches as a place-based level. There are many recognised 'places' within Kirklees – from LSOA (Lower-layer Super Output Area) level through to wards, place partnerships and Primary Care Networks. The local authority will work in partnership with health and third sector colleagues as well as other partners (e.g business, fire service, police) in order to develop how we share and use data across our various place boundaries.

5. Connecting to West Yorkshire Integrated Care Partnership and the Kirklees Health and Care Partnership

The ongoing development of this local and regional work will provide opportunities to promote integration and partnership working with the NHS, social care, public health and other bodies in the planning, commissioning and delivery of services to improve the wellbeing of the whole population of Kirklees.

6. Review of progress

Officers propose that whilst it is not our wish to develop a separate PHM workstream it is still important to put in place methods in order to review progress over the next 12 months. It is suggested that we use the following to structure this; Collaboration and Relationships, Ensuring PHM approaches have a focus on reduction of inequalities via prevention and health improvement, Community Stories and Lived Experience, Understanding Population Health Management at Place and building on the connections to West Yorkshire Integrated Care Partnership and the Kirklees Health and Care Partnership.

2. Information required to take a decision

Detailed in this report.

3. Implications for the Council

3.1 Working with People

Population Health Management is not just about quantitative data. It is also about working with communities and partners in order to understand lived experience and to enable systems and services to ensure that what they provide and how they develop relationships meets the needs of specific population groups. As part of our approach to PHM as well as our broader approach to tackling inequalities it is vital to integrate community stories and lived experience into our approaches.

3.2 Working with Partners

It is vital to build on existing relationships and partnerships across the system in order to (a) develop a common understanding of what PHM is and how it can support the reduction of inequalities (b) understand what is happening already and (c) identify where PHM approaches can add value (d) Upskill partners from across the system to access, understand and use local data.

3.3 Place Based Working

It is vital to understand PHM approaches at a place-based level. There are many recognised 'places' within Kirklees – from LSOA level through to wards, place partnerships and Primary Care Networks. The local authority would like to work in partnership with health and third sector colleagues in order to develop how we share and use data across our various place boundaries.

3.4 Climate Change and Air Quality

Population Health Management can be used as a tool for a range of different purposes and population groups, which could include Climate Change and Air Quality.

3.5 Improving outcomes for children

Population Health Management can be used as a tool for a range of different purposes and population groups, which could include improving outcomes for children.

3.6 Other (e.g. Legal/Financial or Human Resources)

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4 Consultees and their opinions

N/A

5 Next steps and timelines

These are outlined in Section 1 over the next 12-month period.

6 Officer recommendations and reasons

Officer recommendation is to action the above next steps over the course of the next 12 months.

7 Cabinet Portfolio Holder's recommendations

N/A

8 Contact officer: Emily-Parry Harries and Lucy Wearmouth

9 Background Papers and History of Decisions

N/A

10 Service Director responsible: Emily Parry-Harries