Improving lives **together**
Norfolk and Waveney Integrated Care System

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Population Health Management Strategy (2024-2029)

Introduction

The health and care needs of people in Norfolk and Waveney are changing. People are living longer, and our population is ageing faster than other areas. More people are living with two or more long term health conditions. There are also health inequalities across different parts of Norfolk and Waveney, and some specific groups of people.

Our health and care system needs to adapt to respond to these challenges.

Population Health Management (PHM) is a way of working, delivering care in a proactive rather than reactive way. Using local knowledge and linked-up data, we can accurately target support, care, and services to those who need it or will benefit from it the most. In this way we can focus on preventing ill-health and addressing health inequalities and make the biggest impact on improving health outcomes.

Norfolk and Waveney Integrated Care System already has a successful track record of using PHM approaches with the Protect NoW Programme, linking data and information, and working in partnership to deliver targeted, proactive, and integrated care. We want to build on this success.

This strategy sets out our vision for PHM in Norfolk and Waveney for the next 5 years, our working principles and data-driven priorities for action and how we will deliver them, to improve health and reduce health inequalities for our residents.

Glossary

Health inequalities: "unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them". (1)

Intervention: "a health intervention is an act performed for, with or on behalf of a person or population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions". (2)

Maturity Matrix: the NHS England Population Health Management Maturity Matrix allows systems to assess their progress on the journey of development for building PHM capability. (3)

Place: place-based partnerships bring together the NHS, local councils and voluntary organisations, residents, people who access services, carers, and families. These partnerships lead design and delivery of integrated services in their local area. In Norfolk and Waveney five Place Boards bring together colleagues from health and social care to integrate services with a focus on effective operational delivery and improving people's care. (4)

Population health: "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 within and across a defined local, regional, or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies". (5)

Population health management: a way of working, using joined up local data and information to better understand the health and care needs of our local people and proactively put in place new and improved models of care to deliver improvements in health and well-being and reduce health inequalities.

Prevention: "A shared and demonstrable commitment to a preventative approach, which focuses on promoting good health and wellbeing for all citizens". (7)

Primary Care Networks (PCNs): GP practices are working together with community, mental health, social care, pharmacy, hospital, and voluntary services in groups known as PCNs. They bring together health partners to enable more personalised and coordinated health and social care services for people closer to home. (8)

Public health: The science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society. (9)

Risk stratification/Health risk screening: Risk stratification, also known as health risk screening, involves identifying a target group with poorer health outcomes, identifying individuals within that group and use of a selection tool to undertake further assessment of each individual's modifiable risk and provide an appropriate intervention. (10)

Unwarranted variation: "differences that cannot be explained by illness, medical need, or the dictates of evidence-based medicine". (11)

Wider determinants of health: "Wider determinants are a diverse range of social, economic, and environmental factors which impact on people's health. They're also known as social determinants". (12)

The Vision

Deliver proactive, targeted care and support to help people and communities live healthier lives.

Population Health Management is an enabler

Population Health Management (PHM) is an approach that can be used by everyone across the Integrated Care System (ICS) striving to improve health for all(13). It supports and enables the delivery of proactive, personalised, and preventative healthcare for every community and actively helps to reduce health inequalities (Figure 1).

Figure 1 - PHM is an enabler

It can be summarised by the terms Know, Connect, Prevent (Figure 1).

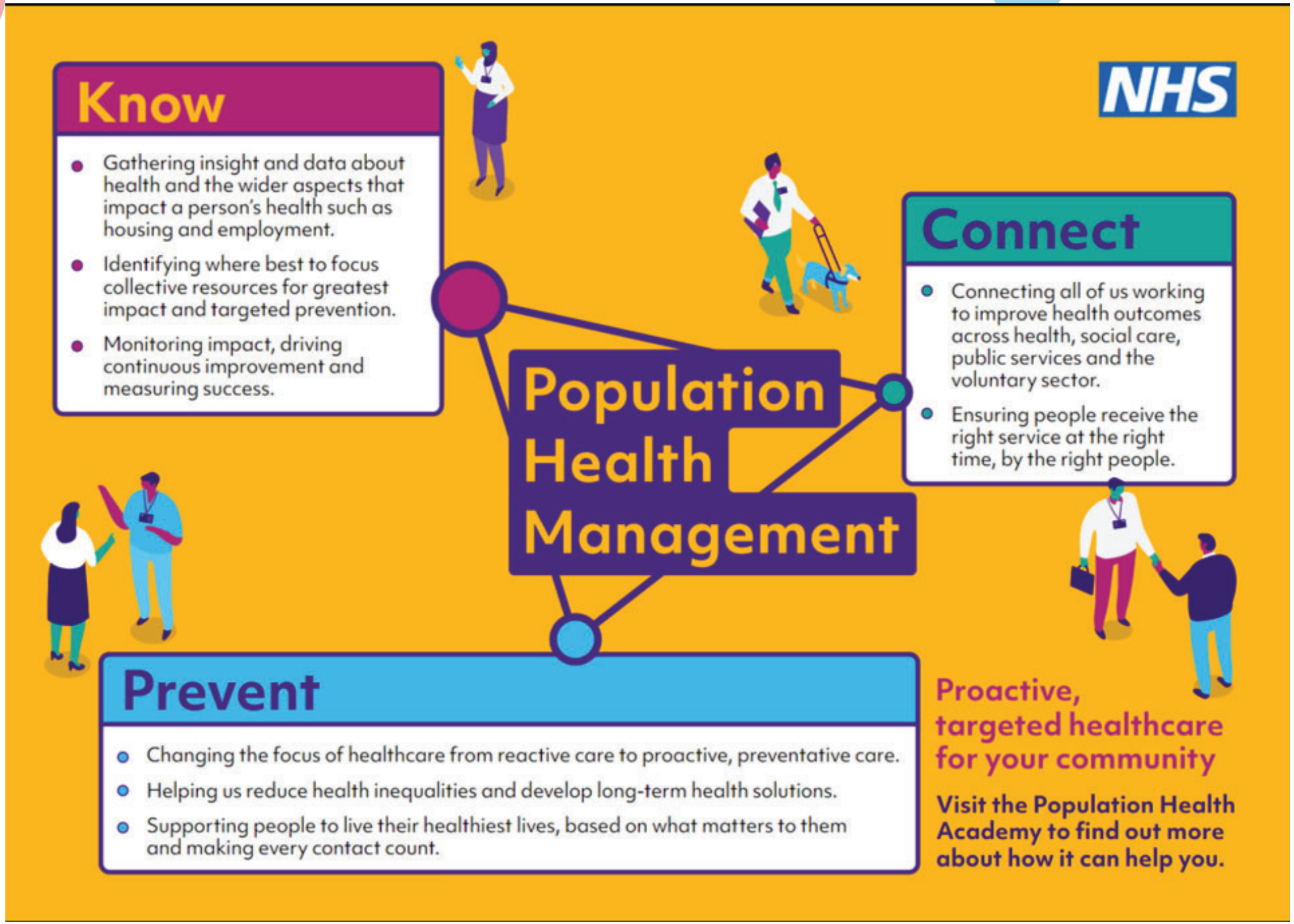


Figure 2 - Know, Connect, Prevent framework (13)

PHM will support the system to achieve its priorities

PHM supports the overarching ICS mission to help the people of Norfolk and Waveney to live longer, healthier, and happier lives, and is an enabler for all the other ICS strategies.

Figure 3 - PHM can support the delivery of ICS strategies

Existing strategies available here:
https://improvinglivesnw.org.uk/~documents/route%3A/download/691/

Our Population Health Management working principles

We held three engagement workshops on development of this strategy, our principles and how we can work together to implement PHM. We have engaged on the strategy at a wide range of ICS and Integrated Care Board (ICB) forums. We also undertook a significant review of the existing literature and relevant local and national strategies. The outputs of these workshops and this review helped us develop the following working principles:

- **Move from reactive to proactive care:**
  - Focus on prevention, using a targeted approach and managing long-term conditions.
- **Data-driven:**
  - Using linked-data from many sources to identify reversible risk and opportunities to implement evidence-based interventions to reduce unwarranted variation.
- **Focus on health inequalities:**
  - In access, quality, and outcomes, encompassing the wider determinants of health.
- **At scale and scalable:**
  - Transitioning successful pilot projects into business as usual, for evaluation, monitoring, encouraging innovation and sharing good practice widely.
- **People-focused:**
  - Involve people, communities and Voluntary, Community & Social Enterprise (VCSE) stakeholders in partnership.

Our initial priorities

To put those working principles into action, we used the following framework to identify our initial system level priorities, presented Figure 4.

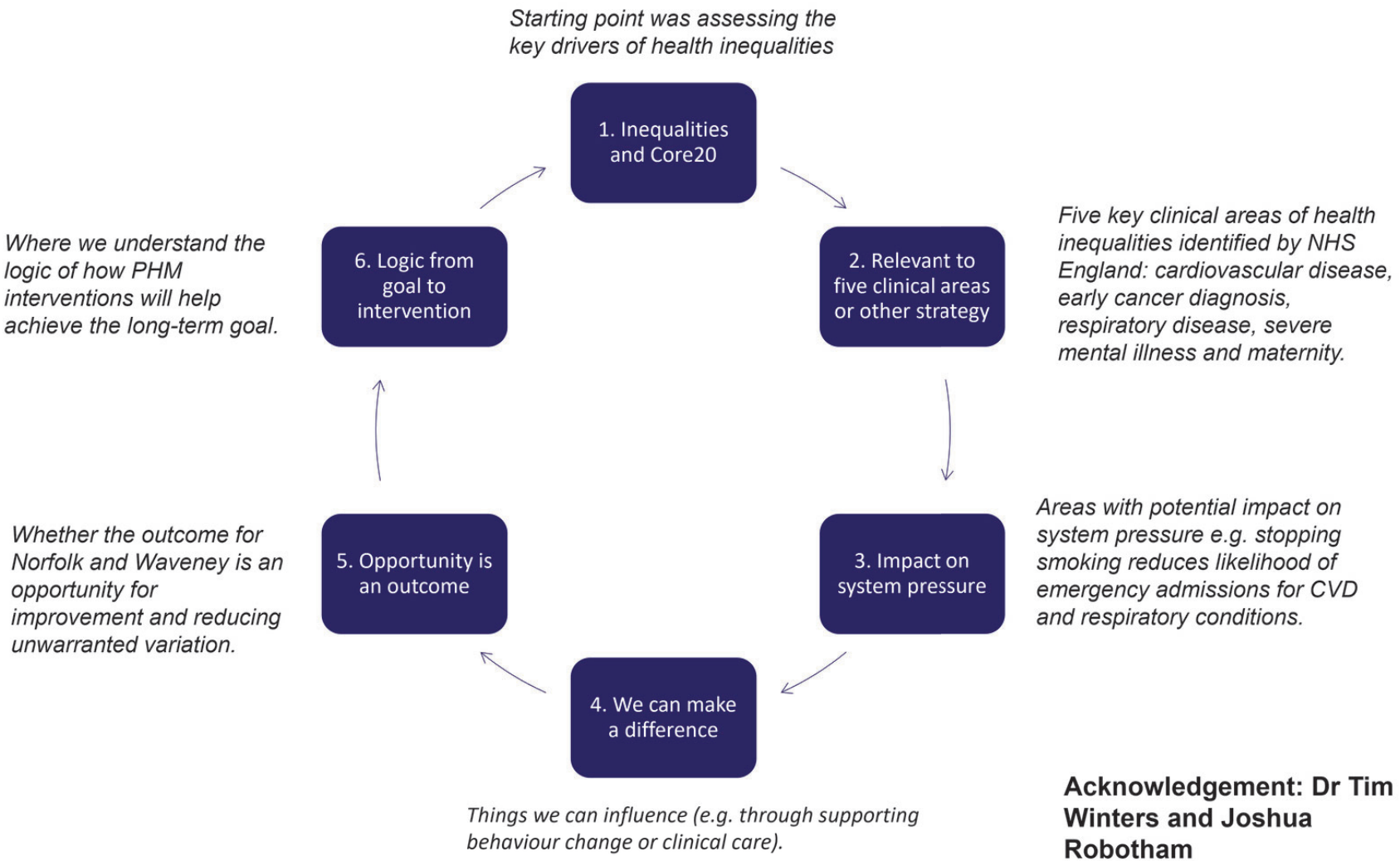
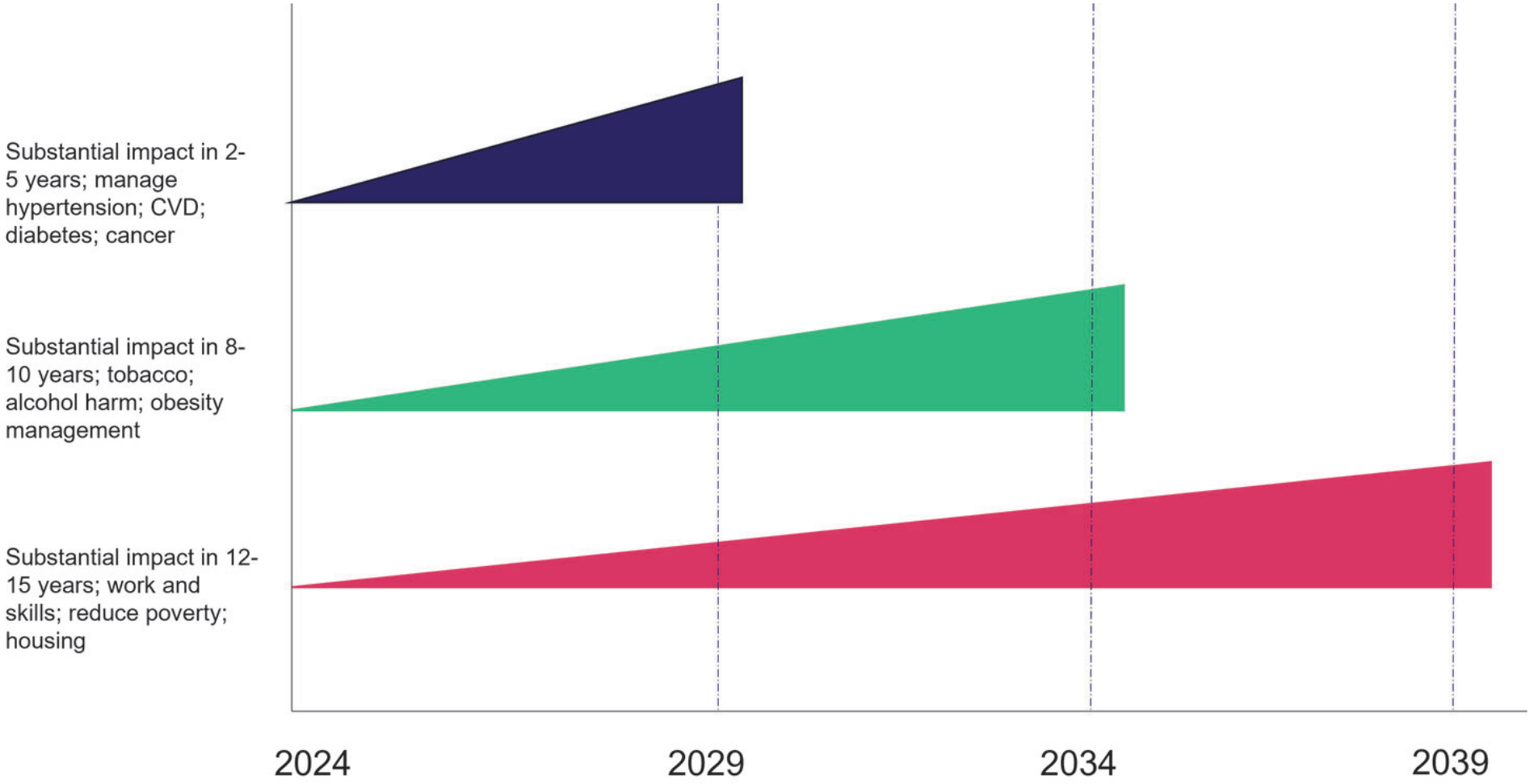


Figure 4 - Framework for identifying initial PHM priorities

Based on this framework five data-driven PHM priority areas have been identified (Figure 6).

We have considered both areas where we can have a rapid impact (illustrated in dark blue below) to drive improvements and build momentum for PHM, and work on areas with longer-term benefits (illustrated in pink below), such as the wider determinants of health, where over a longer period we can have a bigger impact (Figure 5).



Adapted from Public Health England. Reducing health inequalities: system, scale and sustainability. 2017. PHE: London. Available from: Reducing health inequalities: system, scale and sustainability (publishing.service.gov.uk)

Figure 5 - Impact in the short, medium, and long term

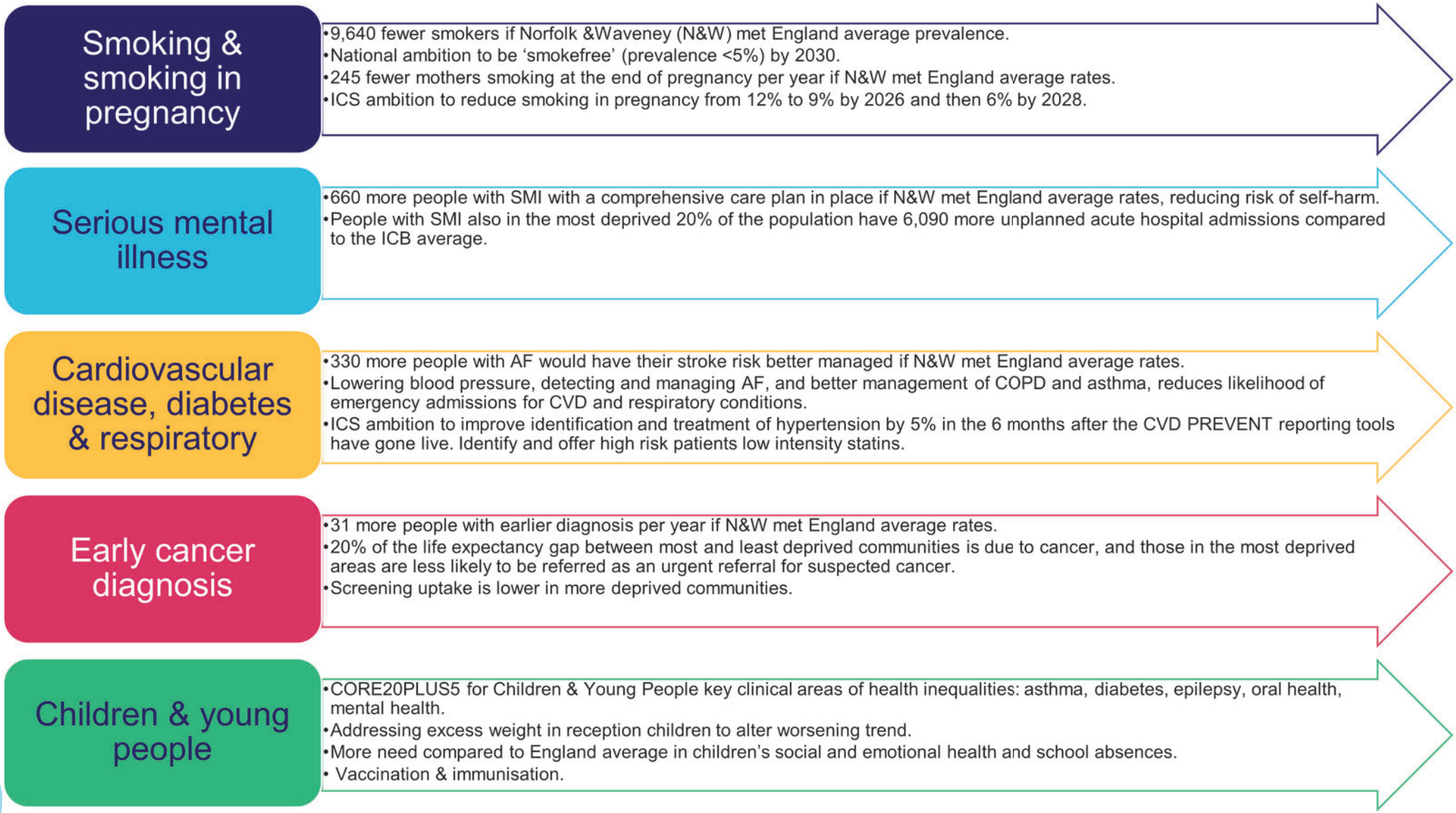


Figure 6 - Initial PHM priorities (acknowledgement Dr Tim Winters and Joshua Robotham)

Delivery - working together at different levels

There is no 'one size fits all' model of PHM, as different local populations will have different needs. How a PHM approach can work is illustrated in the PHM improvement cycle, developed by NHS England (Figure 7).

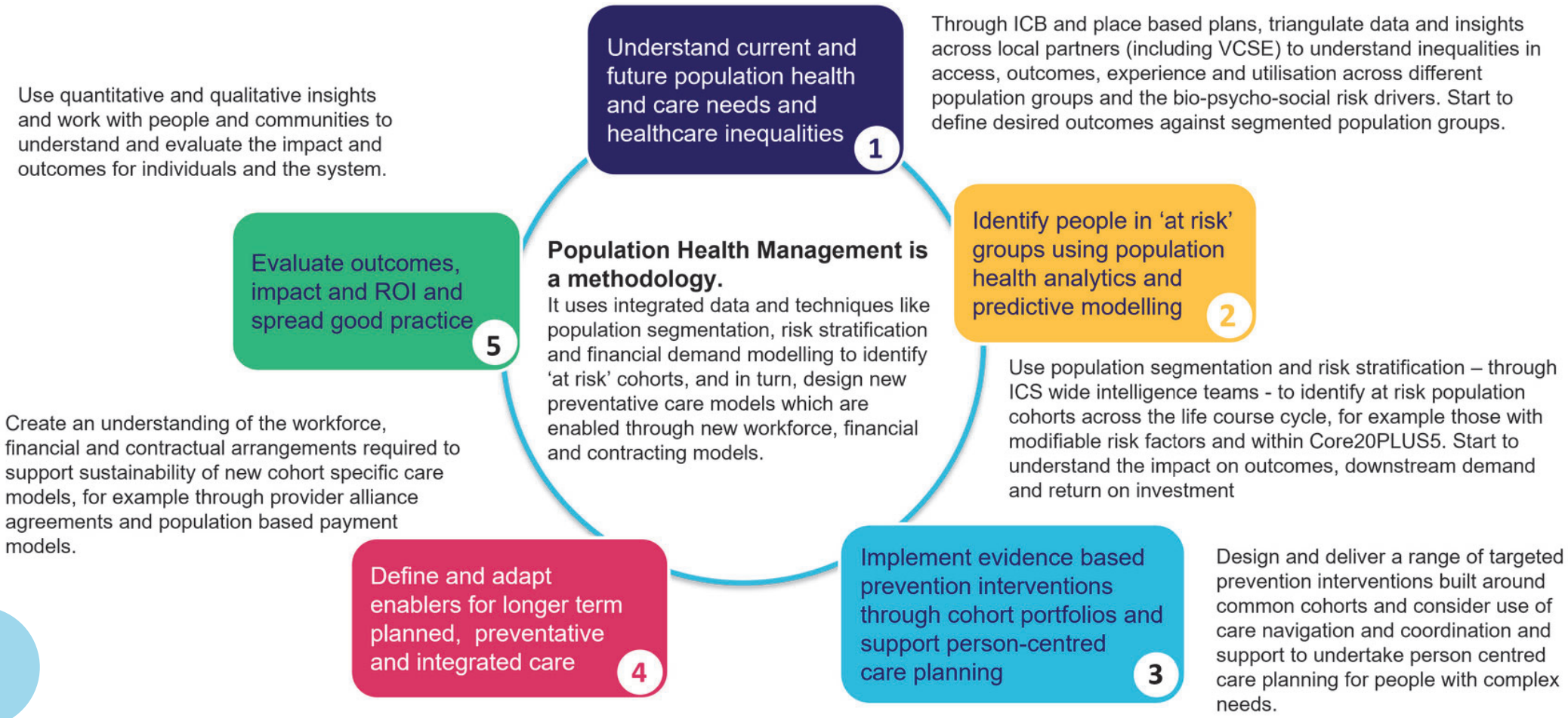


Figure 7 - PHM Improvement Cycle (3)

Building on this, our proposed approach to delivery involves working at different levels – the "core" and "wider" system, as outlined in Figure 8.

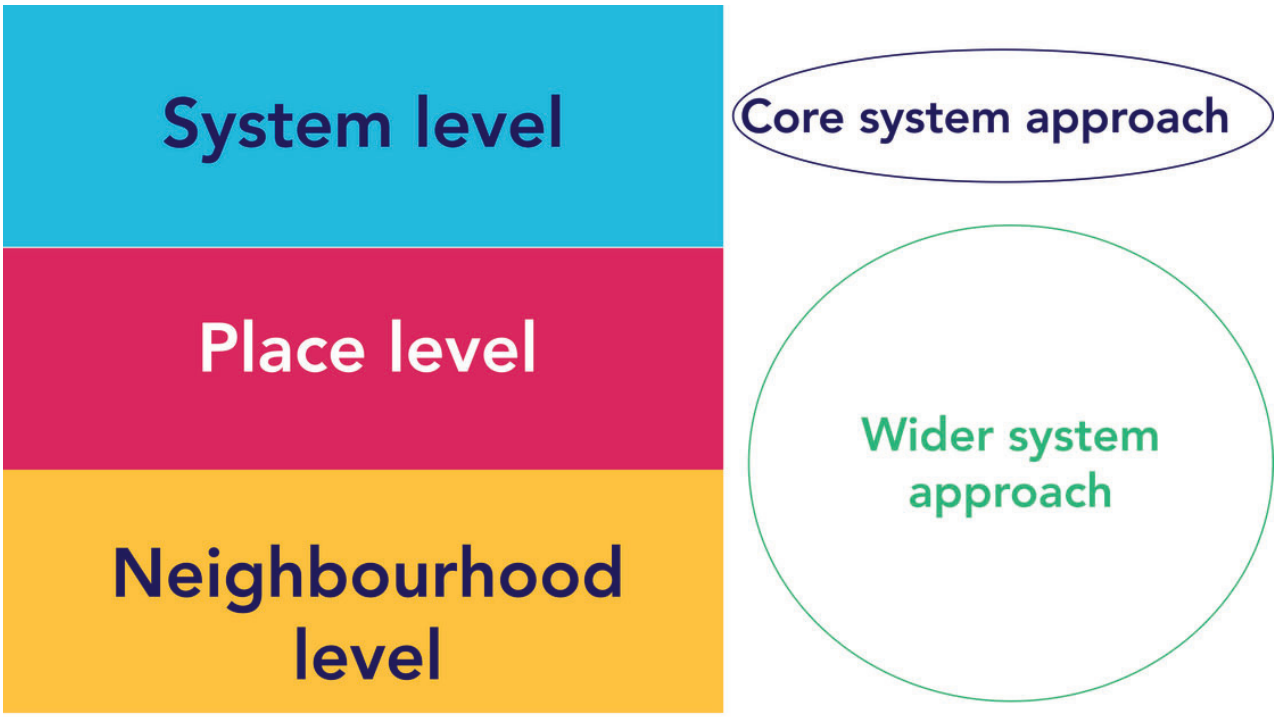


Figure 8 - Core and wider system approaches to delivery

Core system approach

The core system approach will involve:

- Development of system wide programmes based on identified system priorities, using strategic analysis.
- Prioritisation of interventions to make the biggest impact.
- Close working between Programme Leads and the ICB PHM team.
- Utilising Protect NoW Virtual Support Team (call handler team).
- Embedding evaluation and monitoring of the programme.
- System level support from Business Intelligence (BI), Patient and Engagement and Information Governance (IG) teams.
- The Clinical Steering Group, the PHM Oversight Group and reporting to the Population Health and Inequalities Board.

Case study: "ABC" (Atrial Fibrillation, Blood Pressure, Cholesterol) Cardiovascular Disease Programme

A core system PHM approach is being taken in Norfolk and Waveney to improve outcomes for people with Cardiovascular Disease (CVD). CVD has been identified as a priority opportunity for improvement, and key areas of focus identified are Atrial fibrillation, Blood pressure and Cholesterol (ABC). The "ABC" project involves a universal offer to GP practices of access to CVD Prevent indicators which link directly with practice data, that they can use to identify their at-risk patients. There will also be a tiered offer involving our Protect NoW Virtual Support Team (call handler team) to contact high risk patients living in areas of deprivation and direct them to appropriate support, including signposting to clinical care and lifestyle support, to improve CVD outcomes and reduce health inequalities.

Acknowledgement: Joe Crowe

Case study: Digital Weight Management Programme

The evidence-based NHS England Digital Weight Management Programme (DWMP) supports adults living with obesity and a diagnosis of diabetes, hypertension, or both to manage their weight and improve their health. Improving uptake of this national preventative programme was identified as a key opportunity to proactively improve health for this group of people in Norfolk and Waveney.

Eligible patients were identified using primary care data and contacted by letter, text message and/or motivational interviewing phone calls by the Protect NoW Virtual Support Team. Eligible patients were also able to sign up via a website landing page. At the time of writing over 32,000 eligible patients had been contacted and over 4,000 agreed to a referral, which was then made by their GP practice. Patients not able to access a digital programme were signposted to Local Authority Tier 2 services. Norfolk and Waveney went from 22% of system target uptake to 164% and at the time of writing was the number one referring system in the country. As of December 2023, 93% of referrals met eligibility criteria and the proportion of patients from the most deprived areas of Norfolk and Waveney taking up referrals was high relative to their representation in the general population. Patients accessing the programme receive tiered support to manage their weight and improve their health.

The project was led by the ICB Planned Care and Cancer Team working with the PHM team and wider partners including GP practices, NHS England and Local Authority Tier 2 Weight Management Services.

Acknowledgement: Jo Maule, February 2024

Wider system approach

The wider system offer will involve:

- Supporting PHM as a way of working for everyone.
- Giving teams the support they need to deliver their own local projects, based on the needs of their local populations.
- Workforce development and training, including upskilling place teams and PCN leads.
- Support for data access and interpretation.
- Advice for identification of evidence-based interventions.
- Advice on evaluation.
- Sharing of ideas and best practice.

Case study: Great Yarmouth & Waveney Warm Homes Programme

The Warm Homes project in Great Yarmouth and Waveney enables a targeted PHM approach to identify clinically and socially vulnerable residents that may be eligible for welfare and financial support including the Household Support Fund (HSF). Its aim is to positively impact on exacerbations of chronic respiratory ill-health caused by living in cold homes and fuel poverty.

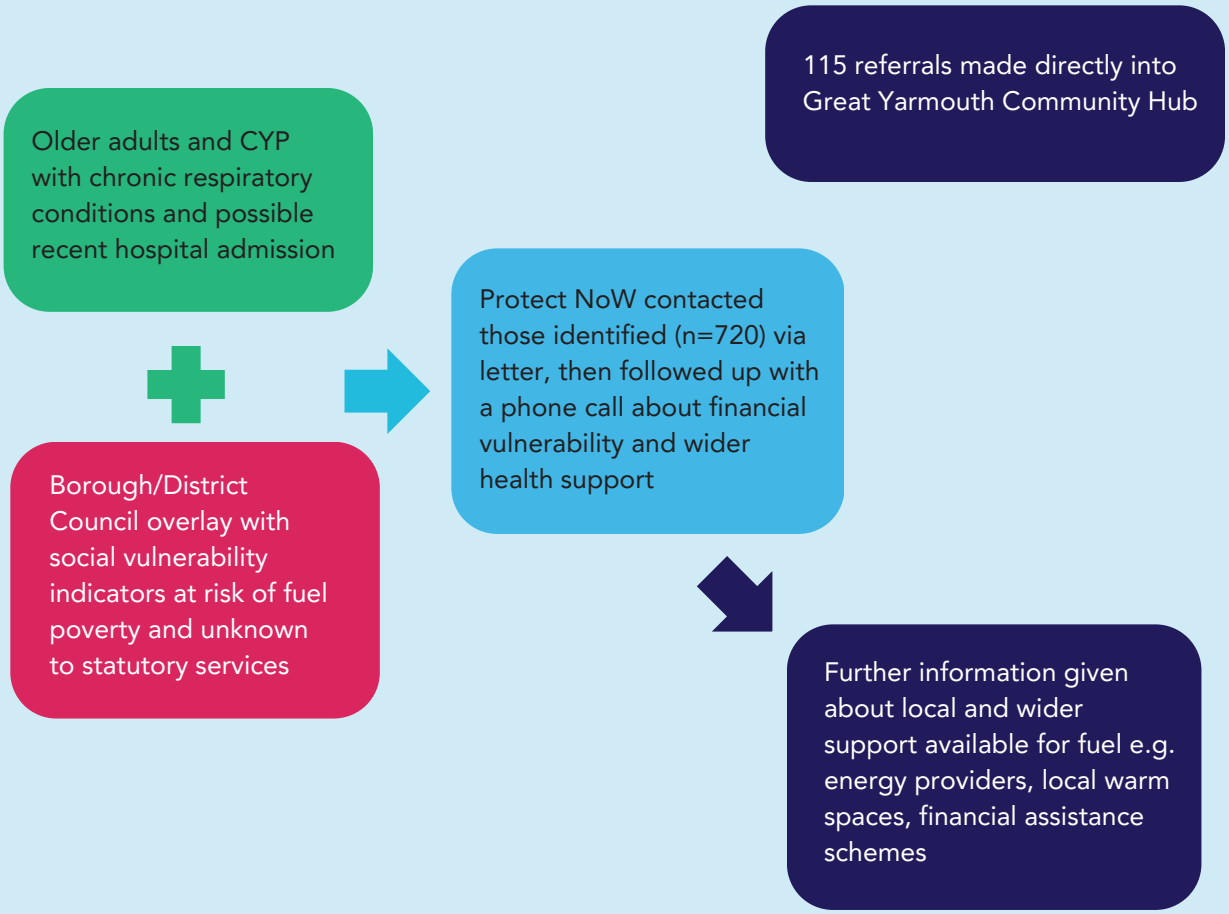
The project demonstrates the benefits of linking health and local authority (Great Yarmouth Borough Council and East Suffolk Council) data sets to identify specific vulnerable households to receive non-clinical support to improve their health. Working in partnership, NHS & Local Authority partners first trialled this approach in winter 2022/23. In winter 2023/24 the project was rolled out again and aimed to find a much bigger eligible cohort.

All households contacted had an individual with a chronic respiratory condition, aged 60+ or a child aged under 10 living in the most deprived areas of the locality (Index of Multiple Deprivation 1 & 2) and some individuals had experienced a recent hospital admission. The Protect NoW team proactively sent out letters and followed up with telephone calls. They signposted to key links on wider welfare and health support and made appropriate referrals to the respective Local Authority.

Case study continues overleaf

Case study: Great Yarmouth & Waveney Warm Homes Programme (continued)

As of February 2023, Great Yarmouth contacts have been carried out, see initial output details below. Waveney contacts will be contacted in due course with an expected cohort in the region of 300-400 people. Partners plan to undertake a collaborative review of the impact and learning from the project to ensure how we operate continues to be refined and benefits well understood, as well as scalability and sustainability considered.



Acknowledgements: Sophie Crowe and Rachel Hunt

Protect NoW Virtual Support Team (VST)

Protect NoW is the Norfolk and Waveney Integrated Care System's initiative to deliver proactive population health and care which is focussed on tackling health inequalities. The Protect NoW programme of work uses data-led, PHM approaches and comprises a growing number of distinct projects, each focused on optimising mental and/or physical health and reducing unwarranted variation (Figure 9).

Protect NoW is a dynamic collaboration between NHS organisations, Local Authorities, VCSE and independent partners working across Norfolk and Waveney.

The Protect NoW Virtual Support Team (VST) is the delivery arm for many of the programmes. The team is made up of a supervisor and five call agents, from diverse professional backgrounds and with a wide range of different skills and experience. They each have strong communication skills and are passionate about improving the lives of people in Norfolk and Waveney. The team engages with people to offer targeted support and interventions to prevent ill-health and improve health outcomes. They undertake training aligned to each project and have a strong track record of delivering PHM interventions.

COVID Vaccination Uptake

Aim: Increase vaccine uptake and gain insight into hesitancy.

Scope: To reach out to all patients considered at risk, immunosuppressed and housebound and book them in for the vaccination within various sites across N&W. (Partnership with NHSE, NCC, QEH, NNUH, JPAGET, GP Practices, PSL)

Flu Vaccination

Aim: Increase flu vaccination uptake and support to book

Scope: 3,000 most at-risk patients not vaccinated against flu in the preceding 12 months.
(Partnership with PSL & GP Practices)

Reducing avoidable admissions

Priority Patient Review
Aim: Reduce hospital admissions through primary care risk alerts relating to six biomedical markers – review, action and follow up.

Scope: 33 Practices across N&W, 12 month Pilot project.
(Partnership with PSL & GP Practices)

Diabetes prevention

Aim: Increase referrals into National Diabetes Prevention Programme to prevent / reverse type 2 diabetes and address clinical variation.

Scope: 43,000 people in N&W with pre-diabetes / HBA1c of 42 – 47 in the last 24 months. Initial cohort circa 15,000 of in areas of highest deprivation.
(Partnership with PSL, Reed Health, GP Practices)

Improving Access Psychological Therapies (IAPT)

Aim: Increase referrals to Wellbeing Service and address clinical variation.

Scope: 8,000 Patients prescribed medication for depression / anxiety but not accessing IAPT. Focus on Practices with the biggest 'gap to ambition'.
(Partnership with Wellbeing, NSFT & PSL)

Health checks

Aim: Encourage patients who are overdue their health check, to take up the offer.

Scope: Aged 40 – 74, significantly overdue their health check. Focus on Practices with the biggest 'gap to ambition'.
(Partnership with NCC)

Figure 9 - Some key Protect NoW Projects. Acknowledgement Catarina Hamlet - part 1, continues overleaf

Pain management

Aim: Triage and prioritise waiting patients by acuity.

Scope: Patients waiting more than 20 weeks for a first outpatient appointment in West Norfolk. (Partnership with QEH)

Cervical screening

Aim: Increase cervical screening in eligible women with no recorded cervical screening or none in last 3-5 years and gain insight into reasons for missed appointments / encourage to re-book.

Scope: 25,000 + over two years across N&W – most at risk (2,500) through smoking and lifestyle identified. (Partnership with PSL, GP Practices)

Long Covid clinic design

Aim: Gain insight from those with lived experience of Long Covid to inform design of service specification for commissioning Long Covid clinics from community provider
.
Scope: 13,500 people across N&W 12+ weeks after confirmed Covid 19 infection.
(Partnership with PSL, GP Practices)

Cataracts waiting list

Aim: To reduce back log and inequalities in the cataract's surgery waiting list at the NNUH (70+weeks).

Scope: Offer patients the surgery in commissioned providers by the CCG (legacy). (Partnership with NNUH)

Housebound vaccination

Aim: Support GP Practices Covid vaccination rollout to housebound patients.

Scope: GP Practices provided a list of patients identified in their system as Housebound, the VST contacted these patients to confirm their status and if they wanted to get the vaccine. (Partnership with GP Practices)

Cold homes

Aim: Identify vulnerable residents living with chronic respiratory conditions, who may also be eligible for financial support from the Household Support Fund, but unaware of their eligibility.

Scope: VST to call these patients and refer them to their registered Borough Council, for financial aid if needed. (Partnership with GYBC/PSL and ESBC)

Figure 9 - Some key Protect NoW Projects. Acknowledgement Catarina Hamlet - part 2

Case study: Lowestoft Healthy Hearts

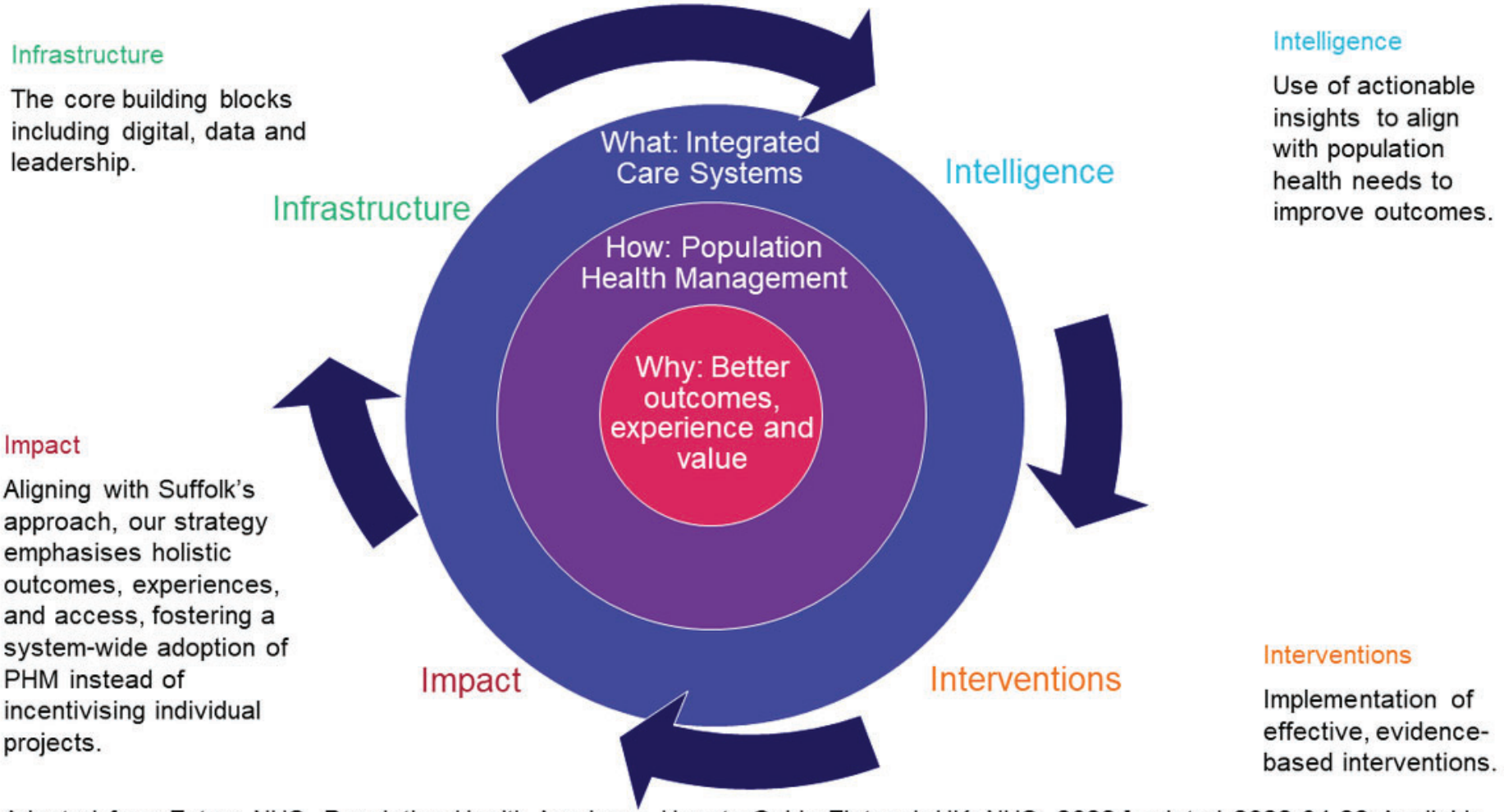
The Lowestoft Healthy Hearts programme aims to improve hypertension outcomes, using a range of interventions focused around healthy lifestyle support.

Lowestoft PCN was identified as an area with opportunities for improvements in hypertension outcomes. The focus of this project is support for lifestyle change to improve this. Trusted Communicators will help identify suitable support for at-risk patients, such as gym access or home blood pressure monitoring, offering wrap-around lifestyle support.

Acknowledgement: Joe Crowe

The capabilities which form the foundation of PHM

We have used NHS England's "Four I's", which are the four key capabilities that form the foundation of PHM, to establish where we are, where we need to be and how to get there (Figure 10).



Adapted from Future NHS. Population Health Academy: How to Guide Flatpack UK: NHS; 2022 [updated 2022-04-22. Available from: https://future.nhs.uk/connect.ti/populationhealth/view?objectID=131791269]

Figure 10 - PHM Capabilities

	Where we are	Where we are going
Infrastructure: the basic building blocks that must be in place	• Developing a shared understanding and vision for PHM • Developed governance structures and understanding of roles, including PHM Clinical Steering Group and PHM Oversight Group • Alignment with ICS strategies, including Health Inequalities • Promoting integration through ICS formation • "Data Hub" creation • Majority sign-up on a system level data sharing agreement • Information Governance processes in place for PHM programmes • "Community Voices" initiative providing qualitative insights • Some local and national PHM training and resources available • Baseline Maturity Matrix completed	• Move from reactive to proactive, preventative, integrated care • Working together to focus on system priorities • Support the delivery of core and system wide approaches • Further development of the "Data Hub" • Centralised data repository providing stakeholder interoperability • Person-level data aggregation and linkage across partners • 100% sign up on system level data sharing agreement • Relevant training available to those across the ICS • Continually monitor and improve upon the Maturity Matrix for PHM • Platforms to share learning and good practice across systems
Intelligence: opportunities to improve care quality, efficiency & equity	• Established & experienced PHM Team • Leadership from Clinical Advisors • PHM Projects Governance Pack developed • Initial PHM priorities identified • Utilisation of existing resources and skills within the ICS • Strong links with Public Health Team • Sharing evaluation of our PHM programmes with decision makers • Some PHM expertise available within the system	• Data-driven approach (quantitative & qualitative) • Identifying unmet need & reducing unwarranted variation • Identification of data gaps and improved data quality • Further development of a population health intelligence capabilities and locally developed strategic analysis tools • Cross-system PHM support • Reduce demand caused by failure to do something right first time • Workforce with relevant skills across the system • Stakeholders can access & interpret data to understand their population's needs • Surveillance & oversight of PHM to understand what is happening across the system and minimise overlap and duplication

We conducted a SOAR (Strengths, Opportunities, Aspirations, Results) analysis for each of the PHM capabilities (Infrastructure, Intelligence, Interventions, and Impact) in collaboration with stakeholders at our engagement events. The results for 'Impact' are integrated across the "Where we are going" column.

Figure 11 - Where we are and where we want to go - continues overleaf

	Where we are	Where we are going
Interventions: proactive interventions to prevent illness, improve health and reduce health inequalities	• Lessons learned from experiences and evaluation of N&W PHM programmes and place-led work • Track record of delivering PHM programmes in Norfolk and Waveney • Established and experienced Protect NoW call handler team • Evaluation template included within Governance Pack • Plans to create a communications and engagement strategy, including consulting our residents where appropriate • Interventions which encompass the wider determinants of health	• Improvements in population health outcomes • Reduced health inequalities (access, experience, and outcome) • Better outcomes for cohorts with protected characteristics • Move towards integrated, personalised, proactive care • Patient empowerment • Use data to target limited resource and return on investment • Improved system capacity • Working at different levels of the system & across boundaries including with the voluntary sector • Embedded evaluation to build and share what works • Effective programmes become business as usual • Build momentum for PHM by sharing best practice • Support adoption and spread of innovation

Figure 11 - Where we are and where we want to go - continued

What we will do next

We will develop an Action Plan for the delivery of this strategy between April and September 2024 as part of our commitment in the Norfolk and Waveney Joint Forward Plan. This will be led by the PHM Oversight Group and overseen by the Population Health and Inequalities Board. It will include SMART objectives, milestones and trajectories developed in collaboration with key stakeholders including Programme Leads, Business Intelligence and Information Governance colleagues. This Action Plan, subject to resources, will include:

Infrastructure: the basic building blocks that must be in place

- Completion of PHM software procurement exercise
- Collaboration with BI team to refine data and analysis requirements and to develop the "Data Hub"
- Develop a plan for training and workforce development and associated resources to support a PHM approach
- Information Governance: supporting the development of our ICB Section 251 Application for Risk Stratification and Population Health Management
- Continue to review and update our progress against the NHS England Maturity Matrix

Intelligence: opportunities to improve care quality, efficiency & equity

- Refinement of our initial PHM system priorities
- Development of a PHM team workplan based on our system priorities and focused on areas PHM can have the greatest impact
- Work with partners and share data to support broadening a PHM approach

Interventions: proactive interventions to prevent illness, improve health and reduce health inequalities

- Development of a programme of evaluation based on the best available data and insights to measure progress
- Develop to a PHM dashboard to start to monitor our progress against our priorities
- Develop a communications and engagement plan, including sharing learning

Lenses of PHM – How our stakeholders hope to apply this strategy

PHM is for everyone. These are some examples from our third engagement workshop of how stakeholders plan to apply the PHM strategy. Everyone is encouraged to advocate for a PHM approach and support implementation of this strategy across the ICS.

I will look at how I can use a PHM approach to reduce health inequalities.

I will look for opportunities to use a PHM approach to proactively care for my patients.

I will support the management of data in line with legislation.

Work with partners using a PHM approach to target system priorities so we can reduce unwarranted variation and have the biggest impact possible.

I will work with colleagues to further develop the Data Hub, so it can be used to support a PHM approach across the system.

I will support and encourage colleagues to use PHM approach in their work, using concrete examples where possible.

I will support sharing data for linkage from my organisation and delivery of interventions in PHM programmes.

Support embedding evaluation in PHM programmes, so we can scale up what works and stop what doesn't; support adoption and spread of innovation.

Summary

This strategy sets out our vision for PHM in Norfolk and Waveney for the next 5 years - to deliver proactive, targeted care and support to help people and communities live healthier lives. Using PHM approaches, everyone across the system can work together to prevent ill-health, reduce health inequalities and make the biggest impact on improving health outcomes. We will move from reactive to proactive care, be data-driven, focus on health inequalities, work at scale and be people-focussed. We have used a framework, taking health inequalities as a starting point, and considered areas we could make the biggest difference. These initial PHM system priorities are smoking and smoking in pregnancy; serious mental illness; cardiovascular disease, respiratory and diabetes; early cancer diagnosis; and children and young people. We will be building the infrastructure, intelligence and interventions to support the delivery of PHM across Norfolk and Waveney. An action plan to support this strategy will be developed with milestones and objectives.

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