Ambition 1: Population Health Management (PHM), Reducing Inequalities and Supporting Prevention

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"The aim is to enable all people to stay healthy by predicting and planning for health and care needs before they happen, and ideally preventing them if we can. By working together with partners across the NHS and other public services in Norfolk and Waveney we can make an even bigger difference to many of the factors that affect our health and improve the health outcomes for our population."

Our objectives

a) Development and delivery of two strategic pieces of work:

- A Norfolk and Waveney Health Inequalities Strategic Framework for Action; and
- A Population Health Management Strategy

Plus the delivery of three specific **Prevention** work programmes designed to tackle:

b) Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people

c) Early Cancer Diagnosis – Targeted Lung Health Check Programme

d) Cardiovascular disease (CVD) Prevention

What would you like to see in our five-year plan for health and care services?

What matters most to you?
Recent JFP consultation feedback: "There should be more emphasis on prevention rather than cure." "Preventative Screening needs to be prioritised too". "Focusing on early intervention and prevention by broadening opportunities for roles such as social prescribing, community connectors, champions and health workers - providing holistic support to divert demand and in doing so, building capacity in our communities". "Preventative proactive healthcare in the community through Making Every Contact Count. Education in relation to self-care and responsibility for health".

Why we chose these objectives
We will be aspiring to a reduction in the differences in outcomes we currently experience. We have identified initial Population Health Management priorities at a system level to address health inequalities and meet the Core20PLUS5 priorities, which will have the greatest impact and where we know there are opportunities to improve. These are smoking, especially smoking in Pregnancy, Serious Mental Illness, Cardiovascular disease, diabetes and respiratory, early cancer diagnosis and children and young people. We will also be seeking to prioritise prevention activities, particularly relating to smoking, alcohol, diet and physical activity and uptake of cancer screening and immunisations.

Objective 1a Development and delivery of two strategic pieces of work to support prevention: A Norfolk and Waveney Health Inequalities (HI) Strategic Framework for Action and a Population Health Management (PHM) Strategy

What are we going to do?
Last year, we developed a Health inequalities strategic framework for action and a population health management strategy. This year we will deliver against these two strategic pieces of work. These will ensure we are clear on our priorities for targeting resources and that we are working on agreed priorities for Health Inequalities and PHM together, across the Integrated Care System. The action we have planned to reduce Health Inequalities is in the form of an overarching framework for Norfolk and Waveney, and PHM is a way of working or enabler that will support the delivery of all our plans in Norfolk and Waveney, not just Health Inequalities.

Deliver a Health Inequalities strategic framework for Action, as a first step towards a whole system approach to reducing inequalities. The framework is focussed around three key building blocks and work to create a strong foundation in the form of conditions for success. These include wider factors that impact on health and well-being such as housing and the environment we live in, lifestyle and healthcare.

Deliver a Population Health Management strategy, to proactively use joined up data and to put in place targeted support to deliver improvements in health and wellbeing. The strategy identifies five initial PHM priorities and includes plans for how we will be using data, building a PHM cycle of improvement into our work. Our approach to delivering the improvement will be at both system and at place / neighbourhood level.

This proactive approach will be focussed on prevention, reducing inequalities and improving the quality of care. It will also be driven by our knowledge of local communities, and by partners working together to identify new things that can really help to improve health.

How are we going to do it?
By working together and getting behind the priorities that have been collectively agreed by system partners and our local communities for Health Inequalities and PHM. We will be using joined up data to proactively identify prevention opportunities and groups of people who would benefit most from targeted health and care interventions.

We have a data hub in place to allow access to joined up data and the interpretation of that data and insight to support local teams to identify their own priorities.

This approach is driven by the needs of local communities, and interventions designed to support them. This may also involve working across the ICS to plan new services or models of care in an integrated way across the ICS. Therefore, we need to have participation in the development process by the range of partners and stakeholders.

How are we going to afford to do this?
Resources may be needed to support ongoing projects, on an invest to save basis – each project to be considered on its own merits and evaluated. Some national funding is allocated to the ICS to support the delivery of the Core 20 plus 5 priorities.

What are the key dates for delivery?

Year 1 April 2024 – Sep 2024

- Action plans developed with SMART objectives, milestones and trajectories

Year 1 Oct 2024 – March 2025

- Implementation of the action plans, reflection and review, establish reporting and refresh for next year based on outcomes.

Year 2 April 2025 – March 2026

- Updated as required, and continue with delivery plans and monitoring of achievement against objectives, milestones and trajectories.

Year 3 April 2026 – March 2027

- Continued focus on reducing Health Inequalities based on the data and insights in respect of outcomes and population experiences, extending our PHM approach and a re-set of objectives, milestones and trajectories

Year 4 April 2027 – March 2028

- A continued and targeted focus on reducing Health Inequalities and reflection and continued focus on using PHM to drive improvement across the system and inform where we focus our effort.

Year 5 April 2028 – March 2029

- Review and refresh both strategic documents for the future, with refreshed objectives and trajectories.

How will we know we are achieving our objective?

Publication of action plans to reduce health inequalities and develop our PHM approach over the next 5-10 years and the improvement we expect to see.

Develop a programme of evaluation based on the best available data and insight to measure progress.

Objective 1b Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people.

What are we going to do?
Stopping smoking is a preventative approach to improving health for all, especially in pregnancy.

We will develop and provide specialist support that gives all pregnant women across Norfolk and Waveney the best help and advice to stop smoking at a time when they are likely to be motivated to quit, in line with the NHS Long Term Plan commitments.

Our vision reflects the nationally recommended model for stop smoking services for pregnant women and this will be provided through the development of a new midwifery led NHS-based service. Each hospital trust will have stop smoking advisers who will offer support based on what research tells us works best.

How are we going to do it?

- The NHS will work together with local authorities, service users and others through our Tobacco Dependency Clinical Programme Board, Tobacco Control Alliances and the Health Improvement Transformation Group to plan how we can best make use of our shared resources and how support should be rolled out.

- We will focus on health inequalities ensuring that we understand access by population subgroups (such as age, ethnicity and deprivation) to ensure equity of access.

- We will work with the VCSE around wider issues like income, cost of living and mental wellbeing that could be linked to smoking choices.

How are we going to afford to do this?
National NHS funding has been provided to help us roll out NHS tobacco support in Norfolk and Waveney. We are expecting this funding to be made available every year, though this is yet to be formally confirmed by NHS England.

We are also working closely with local authority Public Health teams who are providing significant support to help with the delivery of NHS smoking in pregnancy services, including help with staff training, access to Nicotine Replacement Therapy and vapes, quit support for partners and other people living with service users, and the provision of incentive schemes.

What are the key dates for delivery?

Year 1 April 2024 – Sep 2024

- Ensure service is embedded and established and that the care offered is effective and meets the needs of the population
- Build on hearing the service users' voice - develop information resources for service users in line with results of the Maternity and Neonatal Voice Partnerships survey and the Community Voices smoking project, which has gathered learning from local people about things that help or hinder them from stopping smoking.
- Ensure information is being collected and reported to key stakeholders about how well the service is performing and to help make continuous improvement.

Year 1 Oct 2024 – March 2025

- Roll out smoking in pregnancy incentive scheme in line with learning from any previous pilots and in alignment of further announcements from the Department of Health and Social Care.
- Explore with Public Health opportunities for providing free vapes to service users through the national 'Swap to Stop' scheme and to promote smokefree homes by working with partners and family members

Year 2 April 2025 – Sep 2026

- Ensure service user voice informs a review of how the services are working
- Working with Public Health and other partners, review longer-term support available in the community after the baby is born.
- Work with local authority and VCSE through partnerships at local community level to ensure good access to wider community support e.g. social prescribers and peer support groups
- Explore opportunities for the use of technology to improve the support to pregnant smokers and their wider families.

Year 3 April 2026 – March 2027

- Explore opportunities to enhance joined up working e.g. between tobacco advisers, antenatal teams and mental health support for women with perinatal mental health conditions.

Years 4 and 5 April 2027 – March 2029

- This objective will be retired at the end of Year 3 as the maternity tobacco dependency service becomes fully established and will continue to be delivered as 'business as usual' and monitored along with other core maternity care, using the Maternity and Neonatal Safety Improvement Programme to ensure we continue to improve.

How will we know we are achieving our objective?

We will begin to see our approach is working because we will begin to be able to measure a reduction in the percentage of women in Norfolk and Waveney who are smoking at time of delivery.

Data for Norfolk and Waveney from December 2022 shows that 12% of mothers were smoking at time of delivery.

We aim to see this reduce over the next two years, by March 2026, towards the regional and national average of 9% and to reduce further to 6% by the end of March 2028.

Ultimately, the national ambition, which we share for Norfolk and Waveney, is to become 'smoke-free' by 2030 – achieved when adult smoking prevalence falls to 5% or less.

Objective 1c Early Cancer Diagnosis – Targeted Lung Health Check programme

Targeted Lung Health Checks are a preventative approach to improve the health of those who may be at risk.

What are we going to do?
Deliver a TLHC Programme designed to assess a patient's risk of Lung Cancer and to identify any signs of cancer at an early stage when it is much more treatable – ultimately saving lives.

The programme is being offered to people between the ages of 55 to 74 who are current or former smokers and at greater risk of lung cancer.

We will initially prioritise patients in our most deprived, Core 20 populations. The programme will also incorporate smoking cessation support to encourage current smokers to quit as there is strong evidence that individuals who live in areas of high deprivation, with higher smoking rates, are likely to have particularly poor lung cancer outcomes.

How are we going to do it?
- As the programme is rolled out across Norfolk and Waveney, we will use a place-based local approach to support its promotion.
- Eligible individuals will be invited to a Lung Health Check appointment. At the Lung Heath Check a risk assessment will be undertaken which will identify if the patient is at a higher risk of Lung cancer. If the participant is considered to be at high risk of lung cancer, they will be referred for a Low Dose CT scan, provided as close as possible to home. If the scan results come back with signs of anything of concern, the participant will be contacted with further information and referred for further tests and treatment. Most of the time no issue is found, but if a cancer or other issue with participant's breathing or lungs is found early, treatment could be simpler and more successful.

How are we going to afford to do this?
- The TLHC programme is funded by the National Cancer Action Team, and this is expected to continue until the system achieves 100% roll out to the baseline population in March 2029. After this it is expected that the programme will become part of the recently announced National Lung cancer screening programme.

What are the key dates for delivery?

Year 1 April 2024 to March 2025
- Continue to deliver TLHC to the Great Yarmouth and Lowestoft populations.
- Commence 24-month follow-up scanning of the Great Yarmouth population from November 2024
- Develop an engagement plan working with Community Voices to improve uptake in the Great Yarmouth and Waveney area
- Finalise modelling/planning for roll out to Central Norfolk and West Norfolk. By April 2024 we will have confirmed who will be delivering TLHC to the rest of Norfolk and Waveney in 2024/25.
- Commence delivery to wider Norfolk and Waveney eligible population September 2024. The initial target will be our Core 20 areas of highest deprivation.

Year 2 April 2025 – March 2026
- We will finish delivering lung health checks to all individuals in Great Yarmouth and Waveney who are in the initial target audience for the programme.
- Continue with follow up scans for individuals at high risk of lung cancer, every 24 months until they reach the age of 75
- Subject to capacity, commence invites for patients who have reached the age of 55 and review the risk assessment of previously lower risk patients. Risk can change over time due to increased age and changes in an individual's life (e.g. start smoking again)
- Continue roll out to the remaining 'ever smoked' group across Norfolk and Waveney focusing initially on areas of higher deprivation.

Years 3, 4 and 5 April 2026 – March 2029
- Continue expansion to the remaining 'ever smoked' populations in Norfolk and Waveney, including invitation of patients who reach the age of 55, and continue with 24 month follow up scanning.
- The national target is to cover the whole eligible baseline population of approximately 136,000 individuals by the end of 2028/29.

How will we know we are achieving our objective?

Proposed % of Uptake of Lung Health Checks for 2024/25(*):

	Baseline Position	Q1	Q2	Q3	By Q4
Uptake (%) of Lung Health Checks	35% at the start of the programme	40%	40%	40%	45%

(*) the national target for 2024/5 is take-up of 53%, however the most recent uptake rate nationally is 44%, which is an increase of 3% in the previous 12 months.

For context against the national picture, Great Yarmouth and Waveney take-up is approximately 35%. We will be working with the local council and community organisations on targeted engagement strategies and wider communication to improve uptake.

Invitations and uptake will fluctuate between the quarters due to batch invitation processes and delays for some participants between invites and lung health checks. Uptake will also be impacted in Q3 when the roll out is mobilised because there will be a time lag between invitations being sent and Lung Health Checks taking place.

Objective 1d: Cardiovascular Disease (CVD) Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol

Early detection of cardiovascular disease forms a preventative approach to improving health of those at risk of developing the disease.

What are we going to do?
We will provide all Norfolk and Waveney Primary Care Networks (PCNs) with real time data on their patients who have:

1) A diagnosis of CVD; or at high risk of CVD, and

2) Risk-stratify these patients, to help Practices treat those at greatest need.

This will allow action to be taken early to prevent and reduce the negative outcomes of unmanaged CVD.

In addition, we will be running a PHM project and contacting patients identified through the above case finding tool, assisting Practices in promoting CVD Prevention, and helping to reach those patients who most need intervention.

How are we going to do it?
We will be using a national audit tool called "CVD PREVENT" to benchmark our system. The Eclipse platform will be utilised to risk-stratify and identify specific patients on practice systems. The Eclipse system has been updated to case find patients based on the same categories used in the national CVD PREVENT audits.

Our PHM Team will engage with practices identified as needing support and will contact patients to seek to get them to see their relevant health professional or point them to services that can help with lifestyle changes that promote better cardiovascular health.

Local engagement will be a key component of the CVD prevention objective. Each place has different demographics and challenges, and VCSE partners. Their engagement will be key in supporting PCNs to achieve our targets.

We will scope how Primary and Community Care services could work together to prevent CVD. Given that this objective focuses on the desire to prevent CVD before community services input is required, the greater scope will be for Primary care working with other ICS VCSE partners.

We will evaluate our findings using the audit tool and as part of our Population Health management programme evaluation. As CVD PREVENT is updated on a Quarterly basis, progress can be monitored very closely.

How are we going to afford to do this?
Funding has been secured via Health Innovation East to support the project. Further funding is available via Suffolk Public Health to promote lifestyle interventions in the GYW area. There are links with Primary Care funding and Quality Outcomes Framework funding.

What are the key dates for delivery?

Year 1 April 2024 – Sep 2024

- Delivery to commence through sharing of Eclipse monitoring tool for CVD with Primary Care. GP Practices enabled to commence real-time monitoring and risk-stratification of identified patients with a diagnosis of CVD or at higher risk of developing CVD.

Year 1 Oct 2024 – March 2025

- ICB PHM Team and Planned Care team to support GP Practices with patient contacts and signposting to support services. Year one evaluation to be undertaken.

Year 2 April 2025 – March 2026

- Metrics in CVD PREVENT domains should see Norfolk and Waveney in the top quartile for prevention and management of Atrial Fibrillation, Hypertension, and Cholesterol.

Year 3 April 2026 - March 2027

- Second evaluation and further PHM team support if required.

Year 4 April 2027 – March 2028

- Further evaluation or it may be that this objective can then be retired and moved into business as usual.

Year 5 April 2029 – March 2030

- Continued monitoring of progress and support for GP practices where need identified but this becomes business as usual.

How will we know we are achieving our objective?

In the first 6 months, we will gather all relevant baseline data and complete the creation of our patient-specific reporting tools for Primary Care. We expect to see more patients with high blood pressure identified and treated and those who would benefit treated on low intensity statins – This data will be readily available on the next quarterly CVD PREVENT Audit. We aim for a 5% improvement in each of these hypertension metrics 6 months after these reporting tools have gone live.

In the longer term we would expect to see reduction in inequalities in terms of early mortality, reduction in admissions related to CVD related events. Data will be available via CVD PREVENT and via the Model Health system for trajectory tracking. Tangible targets for reduction will follow national NHSE operational planning guidance which will be adopted once made available each year.