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 strategies:

- A Population Health Management Strategy, and
- A Norfolk and Waveney Health Inequalities Strategy to deliver the "Core20PLUS5" approach

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 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, Chronic conditions – Cancer (including earlier diagnosis), Cardiovascular and Respiratory. We will be aspiring to a reduction in the differences in outcomes we currently experience in terms of accessing services and improvements in the health care processes for the Core20PLUS5 populations. 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 strategies to support prevention: A Population Health Management (PHM) Strategy, and a Norfolk and Waveney Health Inequalities (HI) Strategy to deliver the "Core20PLUS5" approach

What are we going to do?
We are going to develop two strategies. The strategies will ensure we are clear on our priorities for targeting resources and that we are working on agreed priorities for PHM and HI together. There is good work happening in pockets across the system, which needs to be co-ordinated so we set out a clear plan of what we are going to tackle first, how we will do it and why.

Develop 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 will include our plans for how we will be using data, how we will be developing our ICS-wide intelligence function and a single analytical platform to carry out relevant analysis to support our local decision making and planning and how we will evaluate our programme.
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.

Develop a strategy for reducing health inequalities, aiming to deliver "equitable access, excellent experience and optimal outcomes" for all people and communities living in Norfolk and Waveney. This strategy will include how we plan to implement the "Core20PLUS5" national health inequality improvement framework which identifies population groups and clinical areas which require accelerated improvement.

We will also be seeking to increase uptake of vaccinations and cancer screening where there is low uptake in patient groups and communities. We will be seeking to minimise the health inequalities as a result of the impact of Covid-19. We will also include the wider factors that impact on health and well-being such as housing and the environment we live in.

How are we going to do it?
By using joined up data to proactively identify prevention opportunities and groups of people who would benefit most from targeted health and care interventions.

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

This approach will be 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?

No additional funding is required to develop the strategies, but further 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 2023 – Sep 2023

- Mapping of existing work, gap analysis, and development of strategic priorities that are evidence based.

Year 1 Oct 2023 – March 2024

- Two strategies published by March 202

Year 2 April 2024 – Sep 2024

- Action plan developed for each strategy with SMART objectives, milestones and trajectories.

Year 2 Oct 2024 – March 2025

- Delivery of the action plan, reflection and review, reporting and re-set for year 3 based on year 2 outcomes.

Year 3 April 2025 – March 2026

- Strategy refresh/update if required, and continued delivery

Year 4 April 2026 – March 2027

- Continued focus on extending our PHM approach and reducing HI based on the data, re-set of clear objectives, milestones and trajectories

Year 5 April 2027 – March 2028

- Reflection and continued focus on using PHM to drive improvement across the system and inform where we focus our effort, and a continued targeted focus on reducing HI

How will we know we are achieving our objective?
Publication of a system wide Population Health Management strategy, and a Health Inequalities Strategy setting out our ambitions to reduce health inequalities over the next 5 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. In 2023/24 a total of £555k will be received, of which it is suggested £203k should be used for maternity. We are expecting this funding to be made available every year, though this is yet to be formally confirmed by NHS England.

The Tobacco Dependency Clinical Programme Board will lead on agreeing how tobacco support (including maternity) should be rolled out over the next five years and the estimated cost, based on learning from areas where support has already gone live. If it is identified that the national funding will not be enough, a formal request will be made for additional investment from NHS and local authority partners.

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023

- Gather learning from existing services and agree a new plan.
- Equality and equity plan published.
- Deliver a Population Health Management pilot project, addressing smoking during pregnancy working with midwives at Queen Elizabeth Hospital (QEH).
- Pilot a Smoking in Pregnancy incentive scheme with Norfolk Public Health.

Year 1 Oct 2023 – March 2024

- Recruit more maternity tobacco advisors and roll out support at QEH and Norfolk and Norwich University Hospital in line with the new plan.

Year 2 April 2024 – Sep 2024

- Roll out longer term plan, in line with the evaluation of year one.

Year 2 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.

Year 3 April 2025 – March 2026

- Review support provision for partners of pregnant women to support smokefree homes.
- Review the current service with service users

Year 4 April 2026 – March 2027

- Review longer-term support available in the community after the baby is born.
- Review engagement with local authority and VCSE to ensure good access to wider community support e.g., social prescribers and peer support groups.
- Explore opportunities to enhance joined up working e.g., between tobacco advisers, antenatal team and mental health for women with perinatal mental health conditions.

Year 5 April 2027 – March 2028

- Use the Maternity and Neonatal Safety Improvement Programme to ensure we continue to improve on smoking reduction in pregnancy.
- Explore opportunities for the use of technology to improve the support to pregnant smokers and their wider families.

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 three years, by March 2026, towards the regional and national average of 9% and to reduce further to 6% by the end of year 5, 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 Targeted Lung Health Check (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.

We will 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. 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.

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.
- Those eligible 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 are then 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 is contacted with further information and referred for further tests and treatment. Most of the time no issue is found, but if a cancer or an issue with a 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 currently funded by the National Cancer Action Team, pending the decision from the National Cancer Screening Committee to incorporate it into the National cancer screening programme.

What are the key dates for delivery?

- **Year 1 to March 2024**
  - Continue to deliver TLHC to the Great Yarmouth population and expand to the Lowestoft area by end of July 2023.
- **Year 2 April 2024 – March 2025**
  - Continue to deliver TLHC to the Great Yarmouth and Lowestoft populations. Finalise modelling/planning and commence roll out to Central Norfolk and West Norfolk. The initial target will be our Core 20 areas of highest deprivation.
  - Confirmation of system model July 2024
- **Year 3 April 2025 – March 2026**
  - Complete the Lung Health Checks for the initial eligible population in Great Yarmouth and Waveney and commence 24-month follow-up scanning.
  - Invite patients who have reached the age threshold to join the programme. Continue roll out to the remaining ever smoked group across Norfolk and Waveney focusing initially on areas of higher deprivation.
- **Year 4 April 2026 – March 2027**
  - Continue expansion to the remaining 'ever smoked' populations in Norfolk and Waveney, including invitation of patients who age into the programme and 24 month follow up scanning.
  - Target of expanding to cover the whole eligible population of approximately 125,000 individuals by 2028/29.

How will we know we are achieving our objective?

Proposed trajectory for 2023/24:

	Baseline Position	Q1	Q2	Q3	By Q4
Uptake (%) of Lung Health Checks	25% at the start of the programme	40%	40%	50%	50%

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
2) One of six high-risk conditions associated with CVD and are not being reviewed or treated in line with national guidance.

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

In addition, we will be implementing a PHM pilot as part of our system wide "Priority Patient Review initiative", by case finding specific patients who will benefit from low intensity statins or who have untreated hypertension.

How are we going to do it?
We will be using a national audit tool called "CVD PREVENT".

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 is identified to support the delivery of the Priority Patient Review initiative.

There are links with Primary Care funding and Quality Outcomes Framework funding.

What are the key dates for delivery?

- **Year 1 April 2023 – Sep 2023**
  - We will scope a reliable source of robust data which will be needed by our PCNs.
- **Year 1 Oct 2023 – March 2024**
  - We will commence production of local data reporting to align with the metrics that are already produced nationally via CVD PREVENT and share with PCNs.
- **Year 2 April 2024 – Sep 2024**
  - Delivery to commence through monitoring of identified patients with a diagnosis of CVD or at higher risk.
- **Year 2 Oct 2024 – March 2025**
  - Year one evaluation to be undertaken.
- **Year 3 April 2025 – March 2026**
  - Metrics in CVD PREVENT domains should see Norfolk and Waveney in the top quartile for all.
- **Year 4 April 2026 – March 2027**
  - Second evaluation
- **Year 5 April 2027 – March 2028**
  - Further evaluation.

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.