LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Derek Ward, Director of Public Health, Lincolnshire County Council & John Turner, Chief Executive, NHS Lincolnshire Clinical Commissioning Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**9 March 2021**
Subject:	**Implementing a Population Health Management Approach in Lincolnshire**

Summary:
This paper is provided for information, and it updates on progress towards implementing a Population Health Management (PHM) approach in Lincolnshire

Actions Required:
To review the content of the report which provides background to the programme, governance arrangements, progress to date and workstreams over the coming months.

1. Background

1.1 Context

Health and care services are under unprecedented, unsustainable demand. With systems currently designed to treat, manage and care for those who become ill, pressures can only be addressed through prevention and intervention in the causes of ill-health, alongside improvements in effectiveness and efficiency of care pathways. There is a need to move to a system designed to enhance population health and tackle inequalities, optimising health over an individual's life span and across populations and generations.

Population Health Management (PHM) allows us to do this. It requires a shift in culture, alongside new processes, systems and intelligence. It also requires joint working, outside of health and care, for example with economic partners, district councils, communities, businesses, the voluntary sector and all those who influence the wider determinants of health. Tackling wider determinants and health inequalities, using epidemiology to inform decisions on need, supply and demand, quality, effectiveness and efficiency is the basis

of public health practice, and it is important that this area of expertise is engaged in the implementation of PHM across health and care systems.

Bringing the right people together to talk about their population, informed by intelligence, can only be achieved with the necessary infrastructure of data, systems and governance, but it will only be successful if the right culture is in place. As a result PHM needs to be embedded in all ICS plans at the core and a defined strategy to deliver PHM is a prerequisite for systems applying to become an ICS.

1.2 Benefits

At the programme level, PHM:

- Supports the development and use of appropriate, effective, transformative treatment and intervention.
- Facilitates individual and population prevention, and better targeting.
- Provides the intelligence to design new models of care to target the right conditions and risks, in the right way, at the right time.
- Evaluates pathways and services, to support effective joint commissioning, decommissioning and transformation.
- Drives major system change.
- Improves health outcomes and makes best use of collective resources.

At the individual level, PHM:

- Enables personalised care for those whose needs are not met by existing care models, for example due to issues of accessibility related to transport, financial exclusion, digital exclusion, work or caring responsibilities.
- Measures what matters to patients and considers individual desired outcomes when planning interventions.
- Allows identification of rising risk individuals for the provision of personalised support before the condition or incident presents, for example in falls prevention.
- Tackles issues of health inequality and service inequity to ensure that those most in need can access the prevention and treatment support that they need.

1.3 Enabling PHM Implementation

In areas that have successfully implemented PHM, engagement with the right stakeholders to build a robust infrastructure and to take the necessary actions has been important. During implementation this helps to identify the needs, systems, data and information assurance arrangements that exist, and those that are required. Early adopters and sector specialists such as the Kings Fund have identified the importance of Local Authority Public Health in the PHM agenda. Shared devolved budgets have also been important, allowing finance to be secured and ring-fenced, and the most appropriate, effective development, procurement and delivery routes to be accessed. We continue to work with a number of early adopters to support PHM development in Lincolnshire by sharing knowledge, frameworks and resources developed on their own implementation journeys.

The stages involved in full implementation include:

Leadership-Stakeholders:

- Identify key stakeholders and decision makers from across the system (eg representatives from public health, PCNs, CCG, providers (including 3rd sector), including commissioners, clinical leads & intelligence leads)
- Identify Support Organisations (eg for Lincolnshire, the Midlands Decision Support Unit)
- Form a PHM Board
- Create a shared drive, visions, goals and language
- Define a small scale project based on one geographic area and project focus as proof of concept

Information Assurance:

- Identify organisations which need to share data
- Create an IA Framework by identifying the legal basis and developing an overarching IA agreement and& privacy notice
- Establish relationships with the local Data Services for Commissioners Regional Offices (DSCRO) to navigate IA concerns, and engage with NHSD.

Systems:

- Identify and evaluate existing key systems and understand gaps
- Identify a preferred model for delivery and management of a joined IT platform and data warehouse which may include new development or procurement activity
- Develop common information and coding standards and shared, or fully interoperable, IT systems to support the real-time exchange of information throughout a person's health journey, for example including referral requests, delivered care and outcomes, social care assessments and discharge summaries
- Identify tools to support the analysis, interpretation and visualisation of intelligence

Intelligence:

- Identify key data resources from across the ICS, carry out data mapping and identify gaps in data resources and potential solution to fill these
- Data security- Identify how and when pseudonymised and identifiable approaches will be used, by whom and for what purposes
- Create data flows
- Develop a model for intelligence delivery and identify those who will carry out analysis, synthesis, interpretation and provision of intelligence, for example acting as an intelligence or decision making hub
- Create an analytics community- bringing together a wide range of analysts that begin to share learning and network, and identify training needs
- Develop an intelligence driven PHM model and metrics for modelling (both qualitative and quantitative) and to support impact measurement at population, clinical and patient level and in the short, medium and longer-term
- Mobilise and develop a culture of using intelligence to inform decisions on resource prioritisation, system planning and direct care, for example undertaking business intelligence workshops jointly with clinicians and analysts

Resources:

- Management, Leadership and governance
- Stakeholder Leads
- Communications and Engagement
- Intelligence and analytics
- Systems and support

- Information assurance
- Change management
- Personalised care leads and strategists
- A combined, devolved budget
- Identify relevant funding streams and secure funding

Risk management:

- Data protection impact assessment & Ethics assessment
- Equality impact assessment
- Financial impact assessment

1.4 Governance

Engagement of the right stakeholders in key decisions and direction throughout the programme is essential in building a robust infrastructure and making the cultural changes required. Stakeholders will evolve through implementation and into 'business as usual' operation, with initial engagement required from organisations across the ICS. As the programme moves to 'business as usual' operation, and begins to deliver new approaches to prevention, intervention, and treatment pathways, wider stakeholders must be engaged including, for example, district councils, economic partners, clinicians and the third sector. Decisions must be evidence-informed, in line with population health intelligence and public health practice.

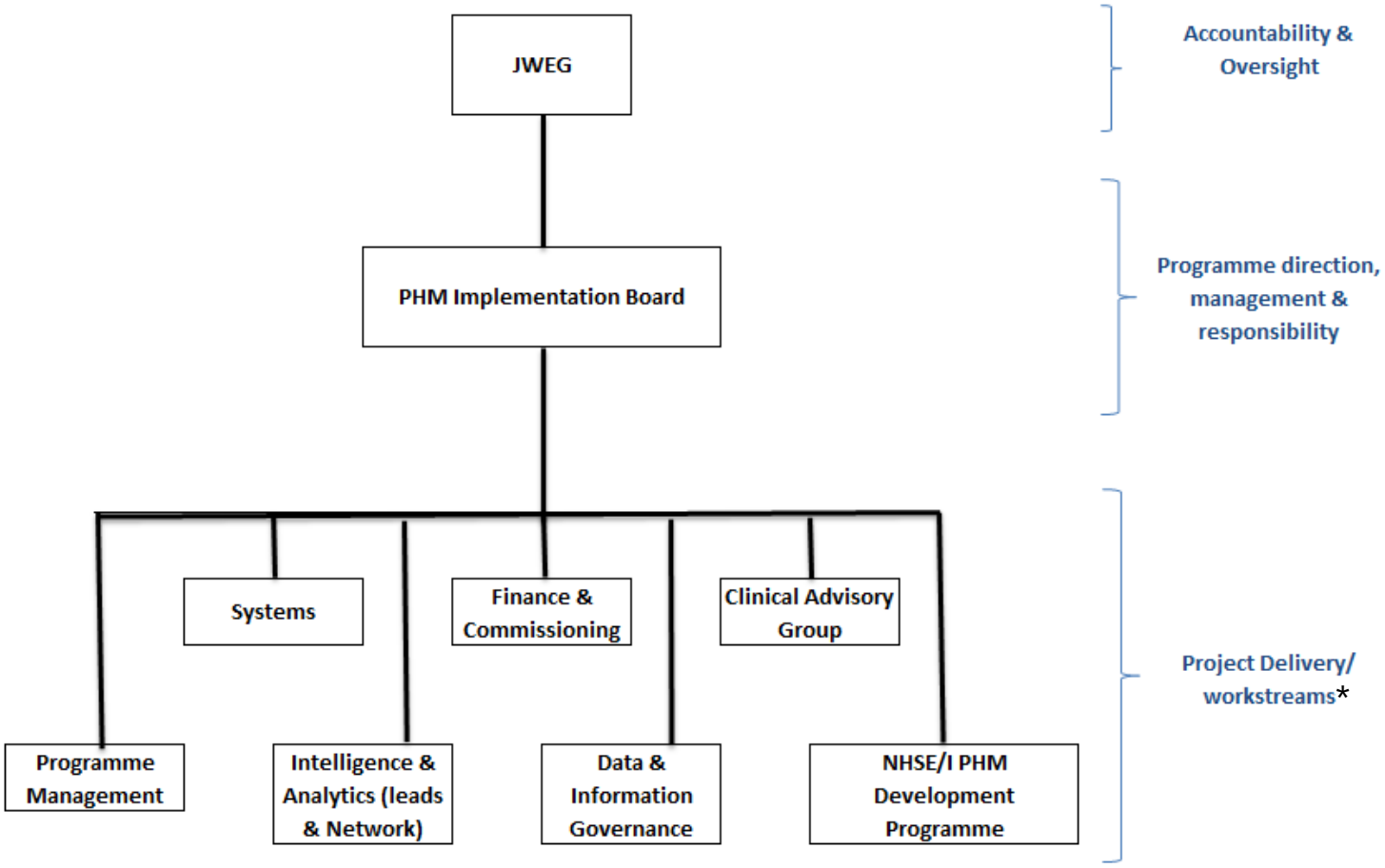
Lincolnshire's Joint Working Executive Group (JWEG) will provide accountability and oversight of PHM implementation at the current time, and Lincolnshire's Director of Public Health will be the lead officer for the programme. This will help to align PHM with the Long Term Plan (LTP) of the ICS and its programmes on health inequalities and personalisation, with public health evidence and practice.

The governance structure for implementation will be made up of project delivery working groups which report to a PHM Implementation board of ICS stakeholders, reporting periodically to JWEG. Project delivery working groups will evolve as required during implementation, often taking a 'task and finish' approach, however an example of potential groups is included in the figure 1, below. PHM Implementation Board core membership has been agreed as follows:

Senior Responsible Officer (Chair), Director of Public Health, Lincolnshire County Council	Derek Ward
Lincolnshire County Council Lead	Katy Thomas
Lincolnshire CCG & Finance lead	Matt Gaunt
ICS PHM lead	Vic Townshend
ICS Integrated Community Care lead	Sarah-Jane Mills
ICS Health Inequalities lead	Sandra Williamson
ICS Personalisation lead	Kirsteen Redmile
LCHS PHM lead	Sam Wilde
LPFT PHM lead	Jane Marshall
ULHT PHM lead	Mark Brassington
PCN lead	Martin Kay
Lincolnshire County Council Adult Social Care lead	Roz Cordy/Justin Hackney

The Implementation Board will also be attended by invitees from project delivery groups and deliver partners as implementation progresses, as required.

Figure 1: PHM Implementation Governance Structure:



** Example working groups, operating as required during implementation*

A number of project working groups are already in operation:

- Programme management meetings between the ICS lead, LCC lead and PHM Senior Project Officer are on-going on a fortnightly basis to coordinate all activity within the implementation programme.
- Similarly, the NHSE/I PHM Development Programme group meets fortnightly to manage all activity associated with this workstream.
- The Intelligence and Analytics Leads group is formed and soon to have its first meeting, after which it will meet regularly to coordinate our Analyst Network, PHM skills development and joint working.
- The Data and Information Governance group has also convened for the first time, concentrating initially on putting in place the IG framework required for the NHSE/I development programme to take place.

Programme governance requirements and Board membership will be reviewed regularly to enable a smooth transition between implementation and business as usual PHM delivery as the programme progresses.

1.5 Current Workstreams

Work in relation to PHM is currently taking place across a number of workstreams, including with the health inequalities programme, the care portal, modelling of outcomes from cancer pathways and joint work with economic colleagues and the Joint Biosecurity

Centre on the economic impact of Covid-19 on coastal tourist resorts and small and medium sized market towns. In relation to implementation specifically, work is taking place across three broad areas:

- *NHSE/I PHM Development Programme:*

We have successfully applied to wave 3 of the NHSE/I PHM development programme. This is an externally supported action learning programme, which will take place throughout 2021, working to link local data and build analytical skills, find rising risk cohorts, risk stratify backlogs, evaluate interventions and design and deliver new models of care. Five PCNs, covering communities across coastal, rural and urban areas of the county, have initially been engaged to take part in the programme, in the form of action learning sets. Through these, they will identify a cohort of patients to work with, engage with them to deliver interventions, gather patient stories, and share pseudonimised data. Readiness work has already begun, which will deliver some aspects of PHM implementation in areas such as engagement with primary care and putting in place the required information governance frameworks. The development programme will also deliver contracting and finance intelligence for Lincolnshire as a whole and help to put in place plans for sustaining momentum and progress after the programme has ended.

Whilst fairly narrow in terms of the wider intentions of PHM delivery, the Development Programme will help to engage primary care, facilitate IG and data sharing with primary care partners and deliver some immediate change in relation to treatment pathways within the NHS.

- *Midlands Decision Support Unit:*

Since late 2019, we have been engaged with the Midlands DSU. This facilitates networking with other areas in the process of PHM development, allows us to access support in implementing PHM and training opportunities for analysts across our system and to shape the Midlands DSU work programme. We have identified analysts across the Lincolnshire system and provided access to on-going, free, training opportunities at varying levels of time requirements from staff as well as networking and peer support opportunities. The Midlands DSU have released analytical outputs that support local work, including an analytical tool for modelling local mental health service demand following the pandemic, and the recent report by The Health Foundation on the impact of COVID-19 on spending requirements, which their contributed to.

We are currently working closely with the Midlands DSU, Midlands and Lancashire CSU and other ICSs in the Midlands to support our work around partnership development, finance, skills mapping and the development of our analyst network. Work with the Midlands DSU will help us to refine our intelligence model whilst bringing together analytical skills and resources and providing opportunities for skills development.

- *Parallel Work:*

In parallel with these areas of work there are a number of workstreams that must also take place. Our final PHM delivery model, IT systems, data linkages and financial models must be developed and agreed, and IG frameworks must be established with wider partners across health and care, and outside of it. As we move from implementation to business as usual delivery we need to engage wider stakeholders who can examine the resulting evidence, talk about the population of Lincolnshire, and make evidence informed decisions. This will include health and care system partners but also district councils, the voluntary sector, economic colleagues, the Greater Lincolnshire Local Enterprise

Partnership (GLLEP) and more. This will ensure that the programme can move from addressing some short term treatment pathway change within the NHS, to truly address prevention and early intervention through tackling the wider determinants of health and working jointly.

Programme plans will be kept under review to accommodate the pressures that partners are under in responding to the Covid-19 pandemic, and activities and joint progress will take into account the ability of partners to engage at various points in the programme.

2. Conclusion

PHM implementation is a vital and on-going programme of work, which the Board will receive regular updates on, as required throughout the programme.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Group must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

The PHM Implementation programme will put in place the required PHM strategy and delivery model for Lincolnshire. This will add to the available evidence base of the JSNA, for example on pathway effectiveness for specific cohorts, service equity and health inequality, in ways that have never been possible before due to new system and data linkages. It will therefore also help the Board to deliver against the JHWS.

4. Consultation

Consultation has taken place with ICS partners via JWEG. No public consultation has been required in relation to PHM implementation itself.

5. Appendices

These are listed below and attached at the back of the report	
None.	

6. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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