BLMK
Integrated Care System

NHS

Our Population Health Management Strategy for Bedfordshire, Luton and Milton Keynes (BLMK)

What is Population Health Management (PHM)?

It's a way for local health and care partnerships to use data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources.

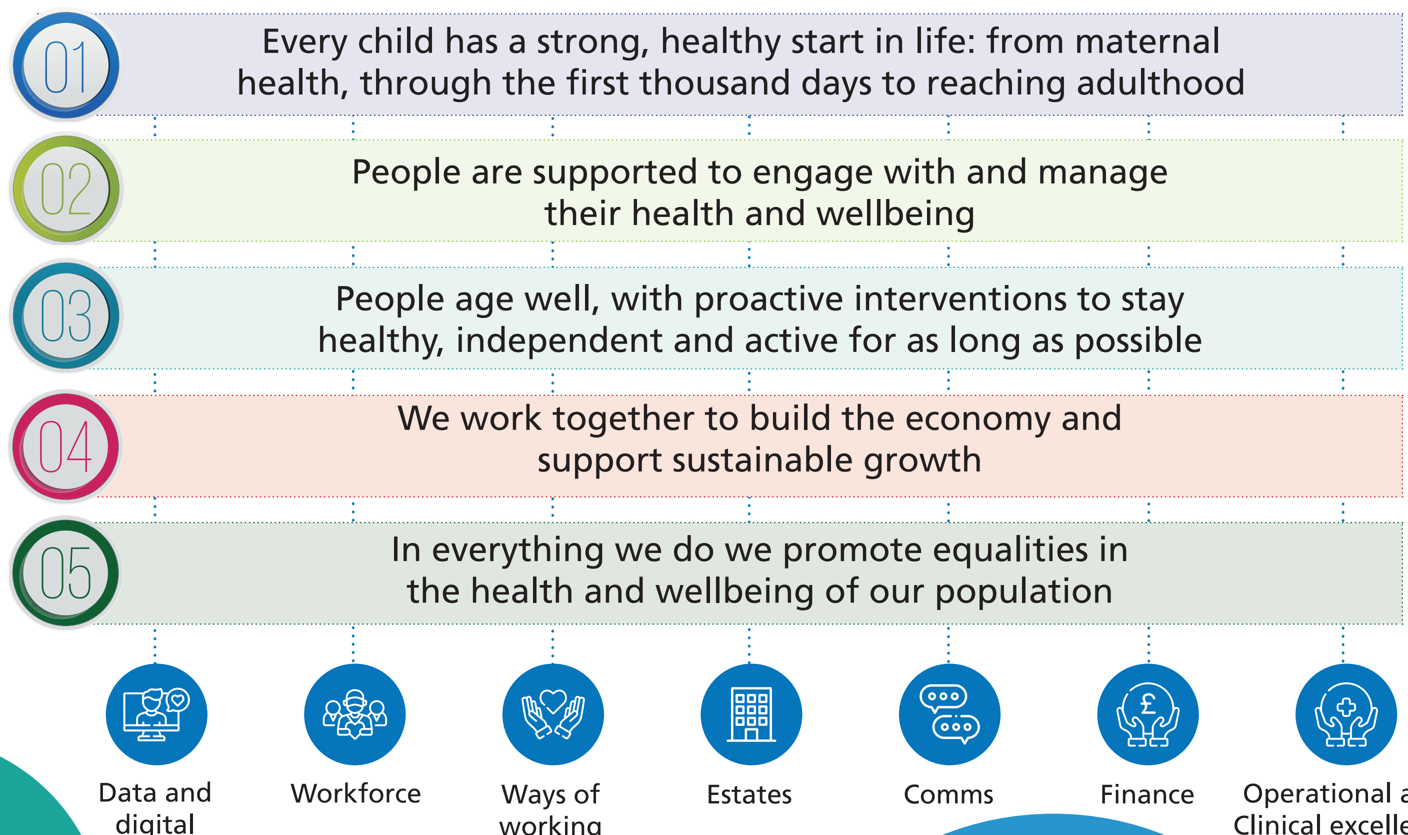
Population Health Management places the individual at the centre of their care and asks how the whole system can work better together to meet their individual needs to stay healthy, make informed choices and be supported by joined-up, integrated care when necessary.

Our vision

Across Bedfordshire, Luton and Milton Keynes (BLMK), we want to work together with health and social care partners, the voluntary sector and local communities to provide joined-up support for local people and help them to stay well by sharing data and expertise. This will enable us to take informed choices and make best use of our resources, to provide a healthier, happier and fairer place to live and work.

Our strategic priorities

We have identified the following five strategic priorities which will underpin and define our vision for change and priorities for our population. There are also seven "enablers" or groups that will support the delivery of these priorities.



Why do we need to do this?

- The likely demand for health and social care services in the future will become increasingly challenging for NHS and local authority budgets
- We need to address the wider determinants of health (including things like education, housing and work, which can affect people's health)
- We need to tackle health inequalities (unfair and avoidable differences in the health of different groups of people)
- Different health and care organisations need to work together as effectively and as efficiently as possible
- We need to follow the guidance in the NHS Long Term Plan and the Government's Green Paper on preventing illness

Our local population

BLMK shares many of the same challenges as other areas of the UK.

Our local population could increase by nearly **90%** by **2050**

We are also predicting higher than average growth in the number of adults aged **65 and over**

As more older people tend to have long-term, and sometimes multiple, health conditions, this is a big challenge for health and social care.

The number of people aged 85 and over is projected to double by **2035**

We are also expecting a higher than average growth in the number of children and young people aged between **10-19** years old.

There are large differences in how long people live across BLMK depending on where they live. For example, in Bedford Borough, men living in the least deprived areas are expected to live 10 years longer than men living in the most deprived areas.

The benefits of this work

We want to:

- improve the health and wellbeing of local people by putting patient needs at the heart of our decision-making
- reduce health and care inequalities
- reduce costs and improve value for local people
- deliver care tailored to the needs of individuals and improve individual experiences of care
- increase engagement with our health and care staff to improve their wellbeing
- focus on patient outcomes regardless of organisational boundaries.

By linking data, different organisations will be able to have a shared understanding of the challenges and problems faced by their residents, and be better able to work together to improve the delivery of care and address other issues that impact on people's health.

How we will deliver

To take this work forward, we have set up a BLMK Population Health Programme (PHM) Collaborative. Its role is to advise where best to invest, co-ordinate and support population health initiatives across the Integrated Care System (ICS) in Bedfordshire, Luton and Milton Keynes.
It will also ensure that all work is aligned with the ICS strategic objectives and that the PHM approach is considered across all areas of BLMK.

The Collaborative will provide regular updates to the Integrated Care System (ICS) Partnership Board, which sets the overall strategic direction for the ICS.

We will have four workstreams:

1) **Implementation** of the most appropriate services based on need and adapting current services to make them more relevant and useful to local people; monitoring and evaluation of outcomes
2) **Infrastructure** including shared and effective leadership, co-ordinated data analysis resources and an agreed information governance
3) **Intelligence** gathered from data to help us to understand population needs and to support the planning and delivery of services
4) **Incentives** through development of new financial and contracting systems to promote collaborative outcomes and enable workforce development.

Delivery will take place through the local Care Alliance (health and care providers working together) and at Place (Borough Council) and Neighbourhood (Community/Primary Care Network) levels.

Other aspects of this work will be co-ordinated by the Integrated Care System (ICS) across Bedfordshire, Luton and Milton Keynes. The ICS is a partnership of different organisations that meets health and care needs, co-ordinates services and plans how to improve population health and reduce inequalities.

Health and local authority boundaries in BLMK lend themselves well to BLMK-wide care and where possible, the local co-ordination of care. In BLMK, we have:

- **1** Integrated Care System
- **4** Borough Councils
- Care Alliance
- **23** Primary Care Networks

Population Health Management (PHM) requires working with communities and partner organisations. It's vital that the leadership team driving this forward at every level includes representatives from all parts of the system. The following groups will be involved in this work:

- Local authority services, including social care and public health
- NHS commissioners and providers, including primary care
- Data and technology, business analytics and information governance
- Charities, the voluntary sector, patient and community groups

We will continue to develop links and draw upon support available from regional and national networks such as the PHM regional and national Communities of Practice, Academic Health Science Networks (AHSNs) and NHS England's regional and national PHM teams.

What we have achieved so far

- Cross-system leadership for PHM with an agreed vision for how this works in BLMK
- ICS-wide arrangements to enable data sharing and linkage across different areas
- Identified resource to support groups of GP practices working together (Primary Care Networks or PCNs) to use a PHM approach
- Accessible data (e.g. dashboards) available to front-line staff

What we will deliver

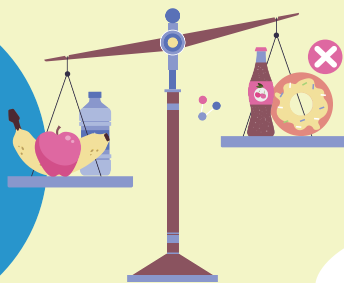
- Increase access to data and analysis for clinical staff to better understand the current and future population health needs
- More proactive personalised health and care plans for people with long term conditions
- Greater focus on areas where our health and care providers can deliver better health, care and wellbeing for people
- Clear working arrangements between PCNs and voluntary and community organisations, with joined-up support for specific patient groups
- Develop our workforce and create new roles across the ICS to support people differently
- Develop a Shared Health and Care Record which enables patient data to be joined up and enables teams to better focus on the health needs of the population
- Adopt PHM approaches that shift the focus from organisations to the needs of the population in order to make the best use of our resources, improve people's experience of health and care services and their health outcomes

How we will measure our success

To demonstrate the value of adopting the PHM approach, it is vital that we measure how successful we have been in meeting our objectives. We will measure this by:

- How well we deliver on our priorities and can demonstrate improved outcomes for people
- The number of PCNs adopting a recognisable PHM approach
- Outcomes measures relating to:

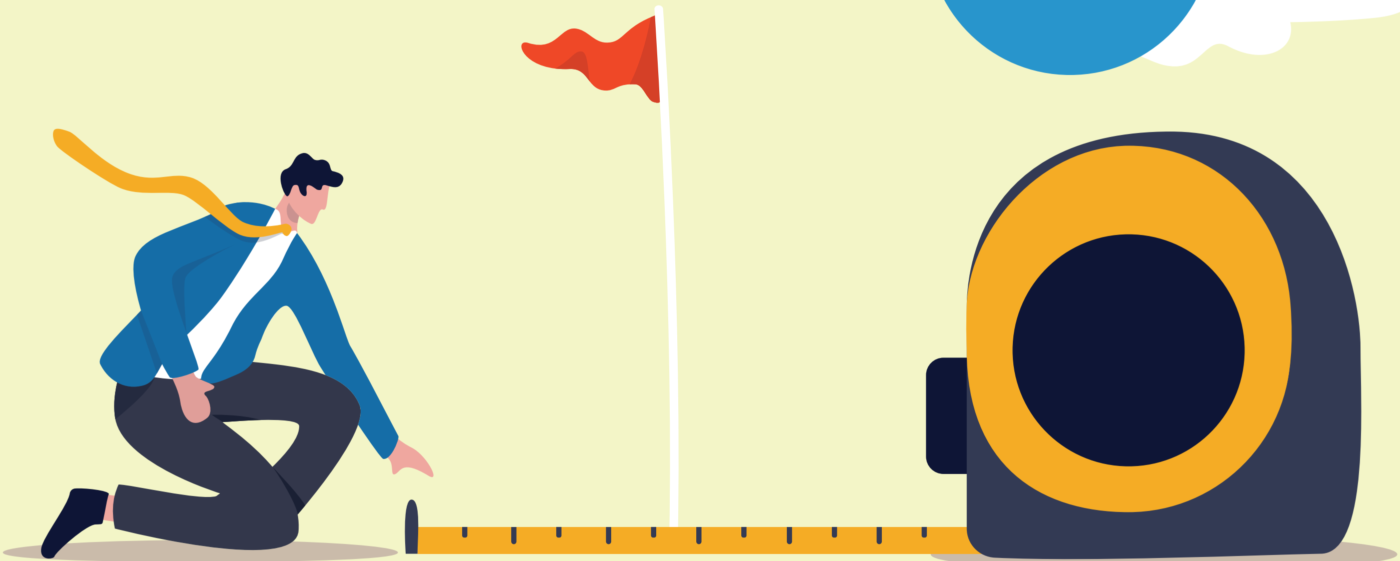
Reduction of health inequalities



Improved health and social care outcomes, working in partnership

Enhanced life expectancy and healthy life expectancy

Greater personal wellbeing



Demonstrating the success of the PHM approach

By combining their experience along with population health data, one of our Primary Care Network (PCN) teams was able to understand more about their local population and which groups of patients were more likely to be admitted to hospital due to a crisis event.

High blood pressure (hypertension) was identified as a high-risk factor for patients as it can progress to life-threatening diseases. Social vulnerability and depression were also common within this group. This new insight supported the PCN in understanding where they should focus their PHM efforts and which patients they needed to support differently.

The wider multi-disciplinary team reviewed their patient records together to gain a shared understanding of their patients' needs. This enabled the PCN to talk to these patients and agree meaningful goals and a personalised care plan. Patients received a clinical assessment but were also referred to Social Prescribing and/or the Lifestyle Hub, using a patient experience (PAM) assessment tool to further enhance and support their care plan.

An example of what this achieved is below:

Case study

Mr A is recently bereaved and has a complex medical history with multiple medications. Pain control has been challenging and he has a history of not engaging with healthcare services. Following a multi-disciplinary team assessment, Mr A was contacted by a Social Prescriber and consented to an assessment. He reported that he didn't fully understand his treatment or medications, despite regular contact with the surgery.

A Social Prescriber advised Mr A about how he could make changes to support his wellbeing. He was directed to the Citizens Advice Bureau for financial support and accepted weight loss advice and support from the Lifestyle Hub. He was also referred to the clinical pharmacist who carried out a comprehensive medication review with him. As a result of this review, Mr A has now significantly reduced the number of prescribed medications he takes. He has also accepted a referral to the Community Mental Health Team for bereavement support.