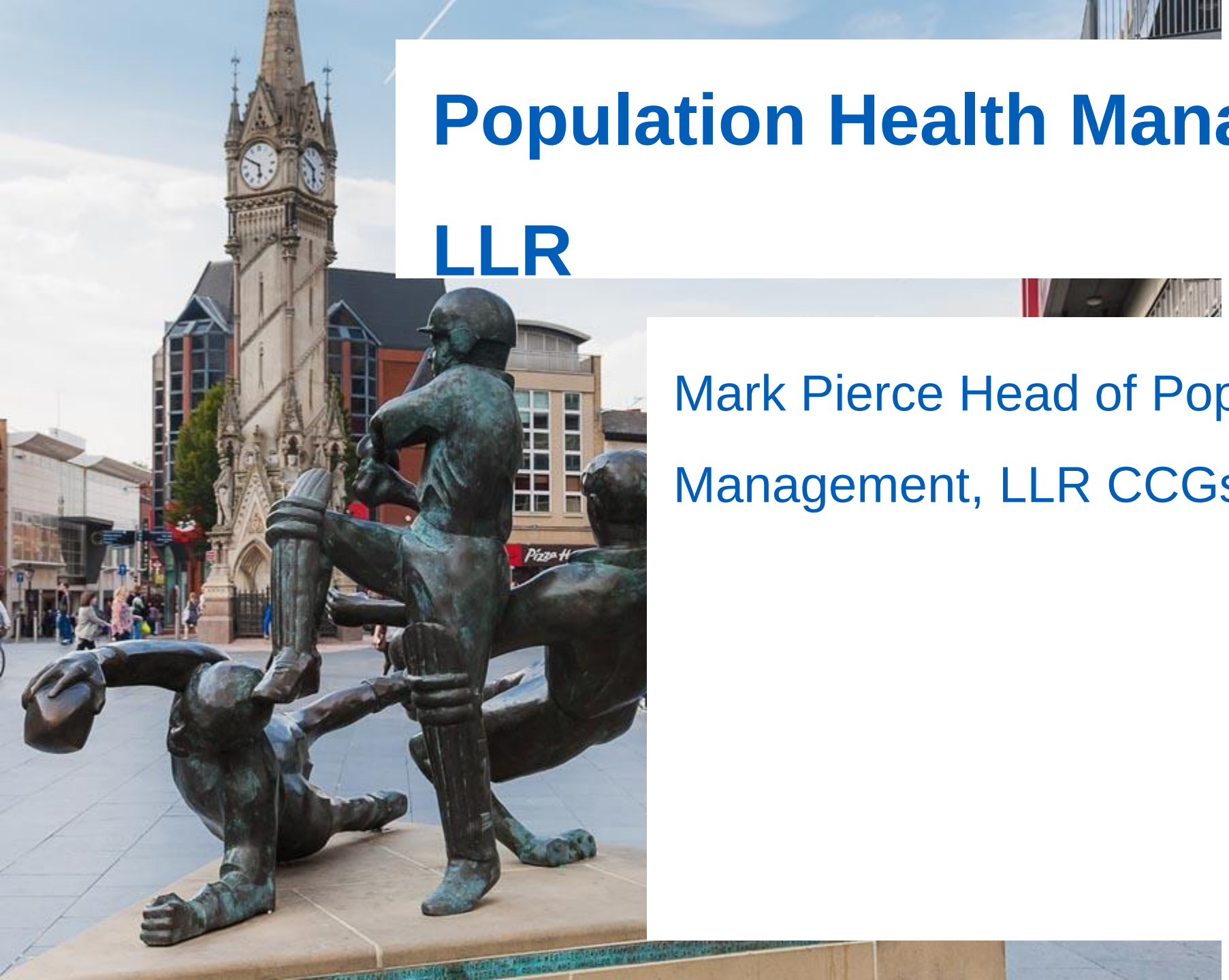


Population Health Management in LLR

Mark Pierce Head of Population Health Management, LLR CCGs

PHM - definition

- ‘Population health’ is used to convey a way of conceiving health that includes the whole range of determinants of health and wellbeing – many of which, such as town planning or education, are quite separate from health services.
- Referring to ‘population health’ rather than the more traditional phrase ‘public health’ also helps avoid any perception that this is only the responsibility of public health professionals. Population health is about creating a collective sense of responsibility across many organisations and individuals, in addition to public health specialists.

PHM - definition

- Confusingly, the phrase ‘population health management’ is also widely used, with a specific meaning that is narrower in focus than population health. Population health management refers to ways of bringing together health-related data to identify a specific population that health services may then prioritise. For example, data may be used to identify groups of people who are frequent users of accident and emergency departments. This way of using data is also sometimes called ‘population segmentation’.

PHM - definition

- 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.

Kings Fund: A vision for population health, page 18

PCNs and PHM

“Primary care networks will be expected to think about the wider health of their population, taking a proactive approach to managing population health and, from 2020/21, assessing the needs of their local population to identify people who would benefit from targeted, proactive support. ”

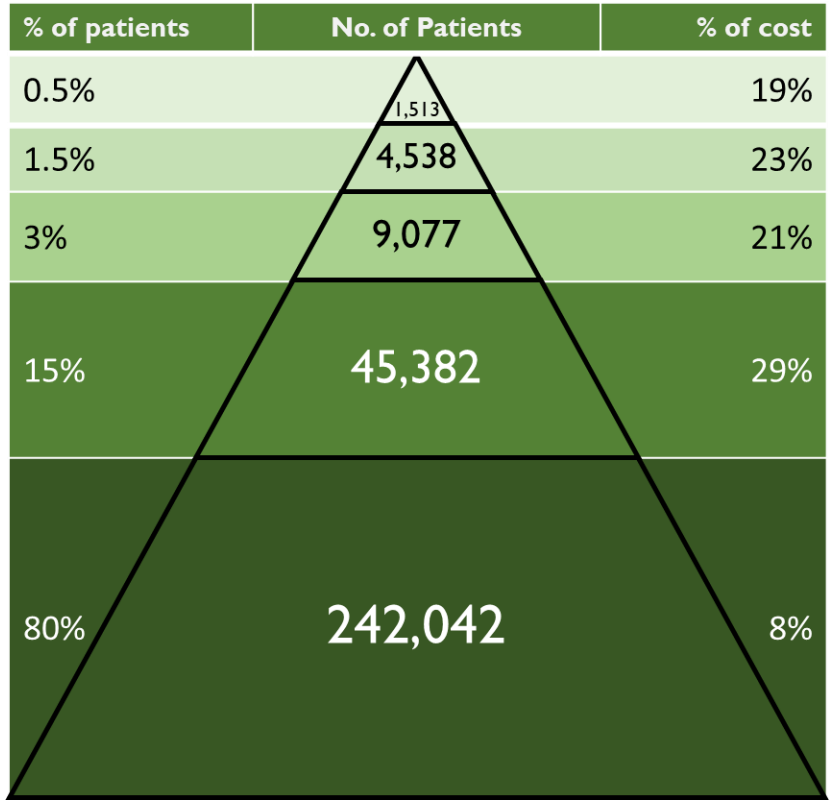
Kings Fund 2019

The following slides show that it is multi-morbidity (not age) which is the biggest driver of Acute care use

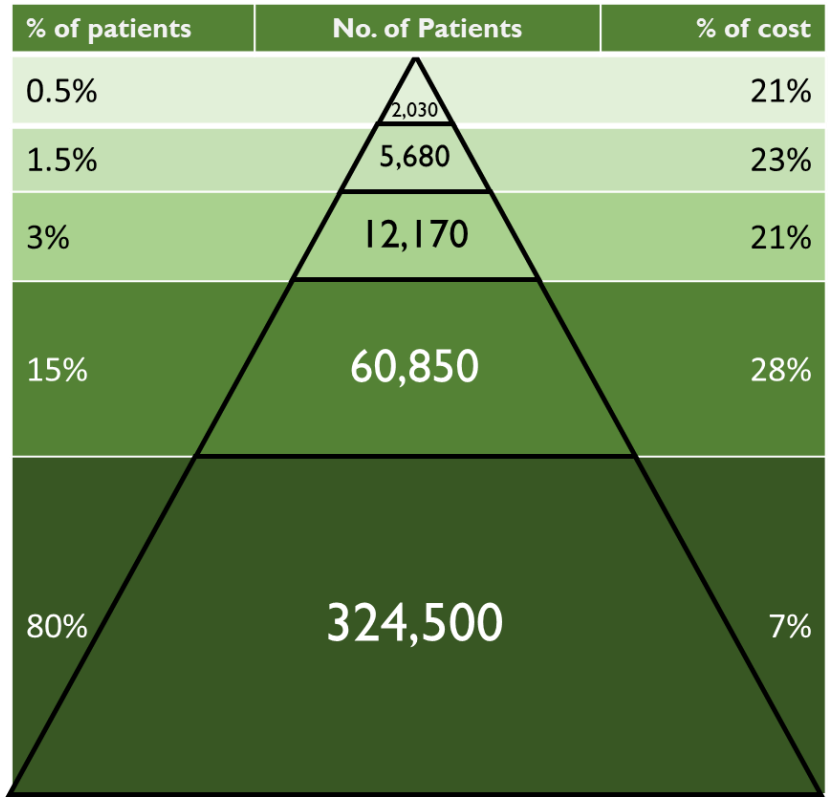
- In fact, there will be a high degree over lap between those whom the NHS might label multi-morbid (having a number of chronic health issues all at the same time – including mental ill-health) and those people who have a high probability of needing the support of statutory and non-statutory services in a community.
- Multiple health issues can lead to disability, inability/difficulty in staying in work/education social isolation, need for support with ADLs
- A person-centred approach requires close cooperation between Local Govt, the NHS and other public sector orgs and communities.

The Need for Health Care Varies – All Secondary Care Costs

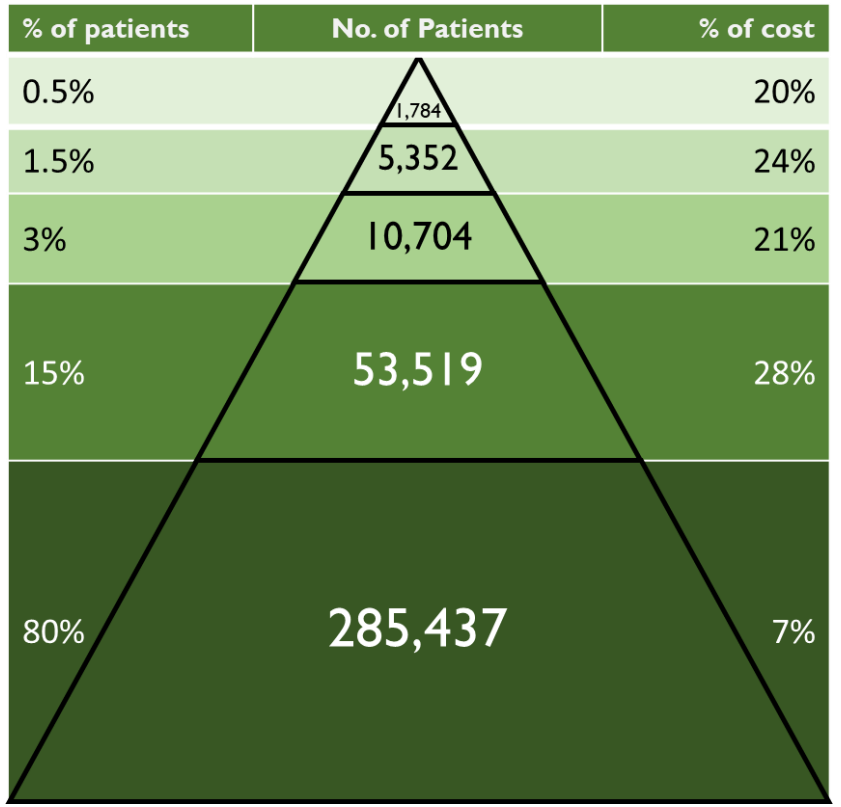
East Leics & Rutland CCG



Leics City CCG



West Leics CCG



Similar pattern across 3 CCGs: just 0.5% of the population accounts for around a fifth (c20%) of secondary costs in the previous year and around 5% of the population accounts for almost two-thirds (c66%) of all secondary care costs over a year. 80% of the population account for zero costs.

These figures relate only to secondary care costs.

Multimorbidity Drives Cost

Increasing multimorbidity is associated with higher costs and resource use:

			Mean values								
LTC Count	Number of patients	% of patients	A&E attendances	Outpatient attendances	Elective admissions	Emergency admissions	Total APC cost	Emergency admission cost	Unique presciption types	Risk of persistent high cost	Risk of emergency admission (next 12mths)
0	179,543	50%	0.2	0.4	0.0	0.0	£ 48	£ 28	0.9	1%	6%
1	78,370	22%	0.3	1.0	0.1	0.1	£ 128	£ 55	2.2	2%	11%
2	37,592	11%	0.3	1.7	0.2	0.1	£ 282	£ 94	3.7	6%	16%
3	21,661	6%	0.4	2.3	0.3	0.1	£ 466	£ 153	5.4	11%	21%
4	13,201	4%	0.4	2.9	0.4	0.2	£ 644	£ 219	6.8	17%	26%
5	8,835	2%	0.5	3.5	0.6	0.2	£ 999	£ 405	8.2	24%	32%
6	5,981	2%	0.6	4.3	0.7	0.3	£ 1,295	£ 575	9.5	30%	37%
7	3,864	1%	0.7	4.7	0.9	0.5	£ 1,727	£ 822	10.5	38%	44%
8+	7,749	2%	1.4	6.2	1.1	1.1	£ 3,576	£ 2,417	13.2	54%	59%
Total	356,796	100%	0.3	1.2	0.1	0.1	£ 277	£ 135	2.7	0.1	0.1

Multimorbidity Drives Cost – adults

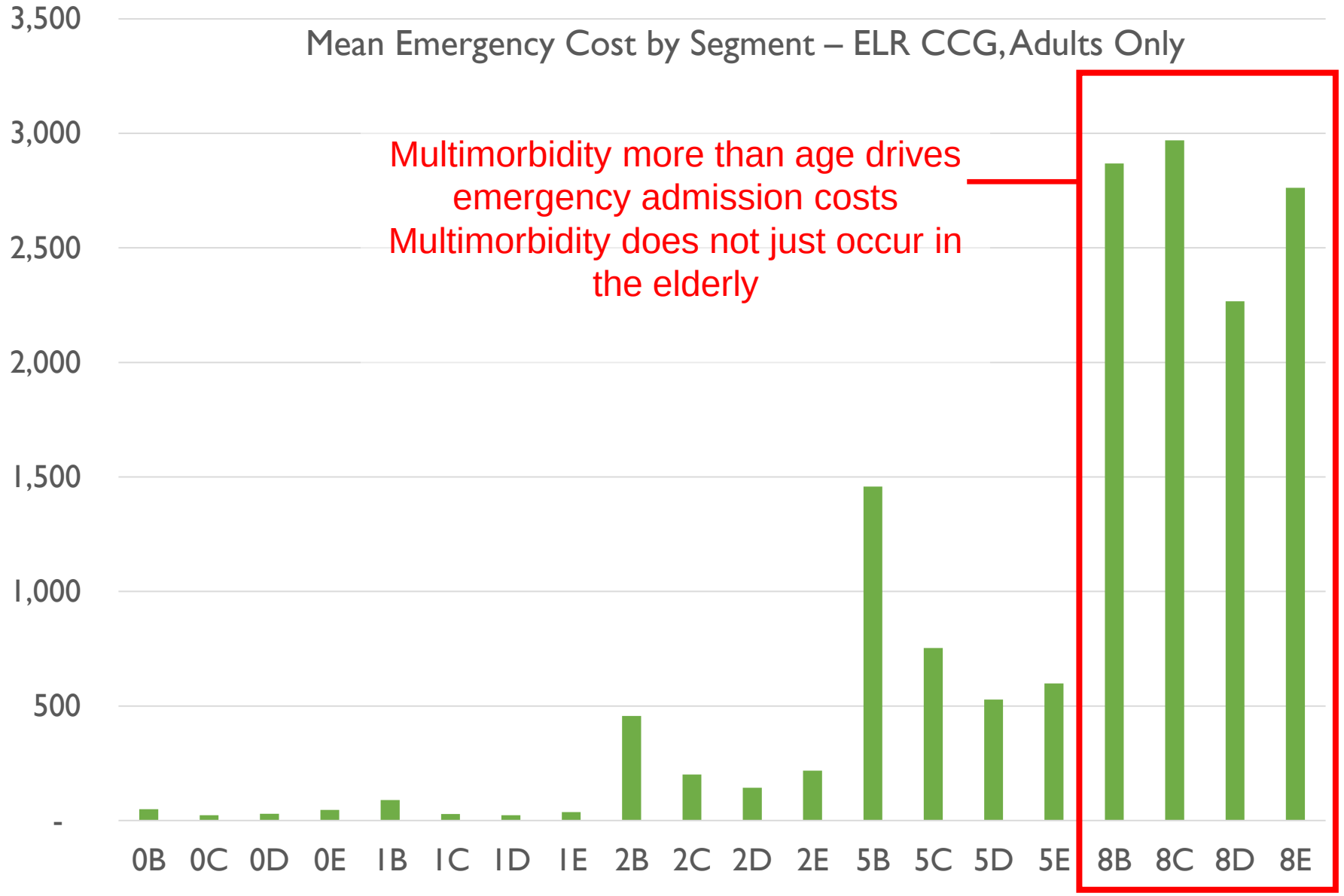
Segments created by combining age of patient and the number of chronic conditions they have:

Number denotes number of chronic conditions:

- 0 = 0
- 1 = 1
- 2 = 2 to 4
- 5 = 5 to 7
- 8 = 8 or more

Letter denotes age band:

- A = 0-17
- B = 18-44
- C = 45-64
- D = 65-79
- E = 80+



BUT!!! If we're going to be about more than fire fighting we have to collaborate on primary prevention and public health, resilience and wellbeing

- "Population health balances the intensive management of individuals in greatest need of health care, with preventative and personal health management for those at lower levels of risk." (Deloitte)
- The above makes sense only if we regard health in its widest sense and acknowledge the importance of the Wider Determinants of health in determining "health" outcomes – education, housing, clean air, access to green spaces, access to meaningful and fairly paid work, safety from discrimination, support to carers – this image is well known and sums up this idea:

The Wider Determinants of Health…

Population Health Management should be a key theme for place-led joint working…

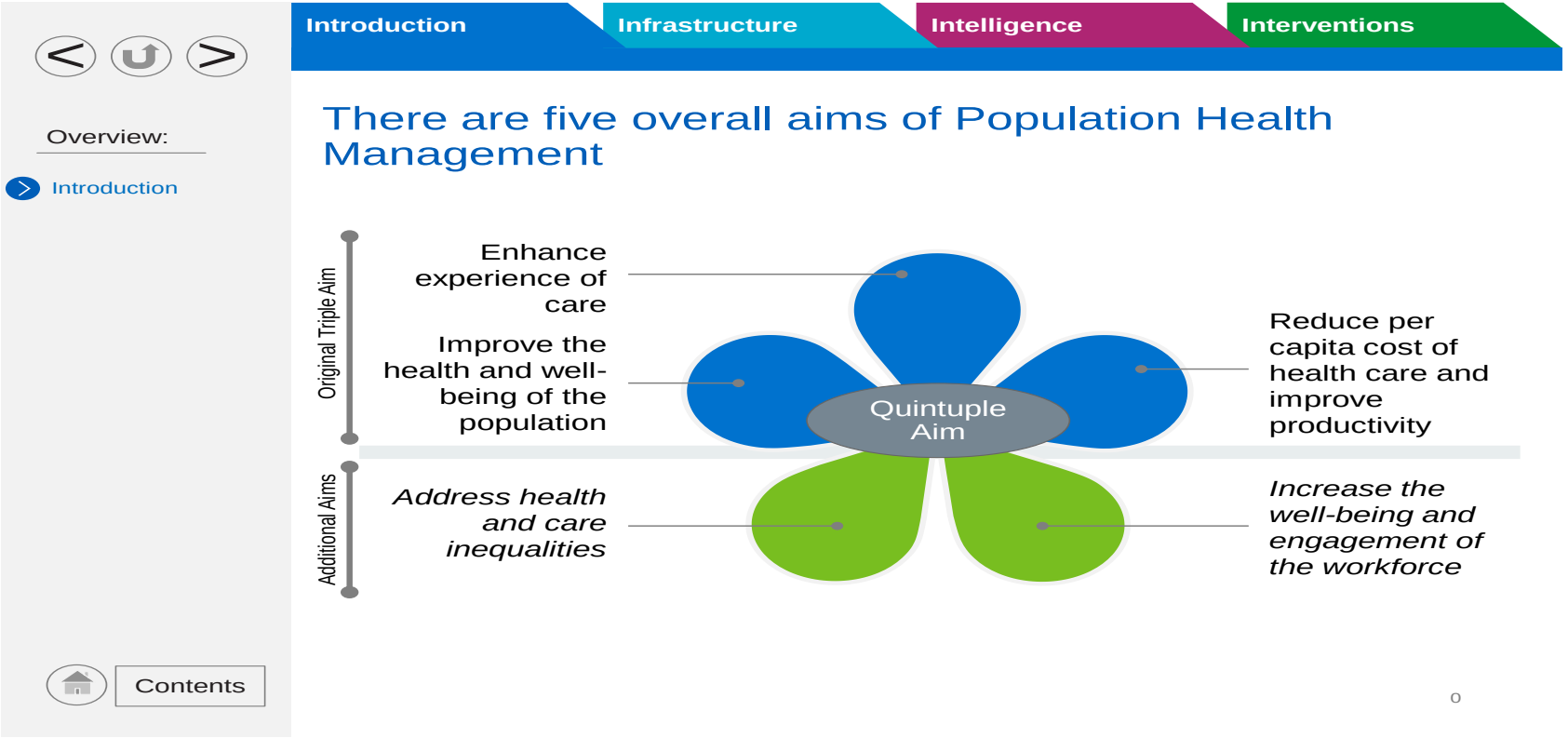
- Person-centred care
- Promoting safety
- Promoting independence
- Equality and equity
- Asset and strength-based approaches
- Community engagement and involvement
- Health and local authority collaboration
- Wellbeing
- Jobs and the economy – (inc.”Anchor Institutions” and “social value”

Joint working in PHM (cont)

- Data sharing and aggregation
- Public Health
- Health in all policies
- Housing
- Carers
- Education
- Green agenda
- Community resilience
- Transport
- And lots more …

We need one another – and our residents need us to work together with them on all of this

- How do we provide the greatest value? Is it only about cashable savings?



THANK YOU

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