Population Health Management

Understanding how integrated care systems are using population health management to improve health and wellbeing

Our health and care needs are changing, people are living longer in poorer health, with conditions like asthma, diabetes, heart disease and dementia while our behaviours are increasing our risk of preventable disease.

Population Health Management (PHM) is a new approach which helps us understand people's health and care needs and how they are likely to change in the future. It aims to improve physical and mental health outcomes, reduce health inequalities and help us live our extra years in better health.

PHM is how we use historical and current data about people's health and how they are using health and care services to design new proactive models of care which will improve health and wellbeing today as well as in 20 years' time.

It involves the crucial role of communities and local people, the NHS and other public services including councils, schools, housing associations and social services working together to join up services for people by sharing information, resources and goals. This lets us tailor services to the needs of people in each area, improve people's health, prevent illnesses, and make better use of public resources.

Identifying and supporting people with poor housing and poor health in Blackpool

Poor housing is a key contributor to poor health. Adults and children who live in cold, damp housing may be more likely to develop respiratory problems over the next 20 years because their lungs are affected by the mould spores in their home.

In Blackpool, staff knew patients living in houses of multiple occupancy - where multiple tenants live in a single residence - traditionally experienced poorer health and were higher users of healthcare services. However, pinpointing patients who GPs and their social prescribing teams should proactively support is difficult because NHS data is not joined up with council data on housing.

By jointly analysing this data and finding 'at risk patients', local primary care networks designed new anticipatory care models which helped social link workers and well-being practitioners connect with the right groups in the community and address the adverse influences on their lives – completing housing application forms, finding them employment, nutritional advice and social groups.

Using data to identify frailty in Leeds

Advances in health care have helped people in England live longer than ever before. As a result, the number of older people in England is growing significantly and this rate of growth is projected to speed up over the next 20 years. Early identification and targeted support can help older people living with frailty to stay well and live independently for as long as possible.

In Leeds local teams adopted a proactive population health management approach to select a sub-cohort of people living with frailty who were predicted to be most at risk of a deterioration in health and could therefore benefit most from proactive interventions. They used their knowledge of local needs to test and build on the initial insights from the data.

People are living ten years longer than they did when the NHS began in 1948.

Dementia, mobility and nutrition issues were all additional factors which compounded this risk which the teams looked to address through new anticipatory care models. They introduced a proactive assessment and triage service for these patients and then a range of personalised interventions including referrals to group 'live well' consultations, individual medical consultations in clinic and home visits led by an occupational therapist.

Seeing the link between physical and mental health in Bournemouth (Dorset)

Many people living with type two diabetes also have other health conditions. These other conditions can make it more difficult for individuals to manage their diabetes. In Bournemouth, they used the data they had to identify people with diabetes who also had other conditions that put them at risk. In particular, those who also showed signs of depression and anxiety.

Between 2015 and 2035, the numbers of older people with four or more diseases will double.

They phoned these patients and assessed who would be suitable for a longer 30-minute face-to-face consultation. These consultations focussed on helping these individuals plan their care and how they could be supported to manage their diabetes. In particular, highlighting the links between physical and mental health and providing guidance on how their mental health could affect their ability to manage their physical health. By making these links clearer, patients in Bournemouth have reported having a greater understanding of the links between their mental health and their diabetes.

Targeted support for communities with poorer outcomes in Berkshire West

Reducing health inequalities means giving everyone the same opportunities to lead a healthy life, no matter where they live or who they are. The wider determinants of health have a significant impact on our lives because just 20% of a person's health outcomes are attributed to the ability to access good quality health care.

In Berkshire West, PHM data analysis of people with Type 2 diabetes pinpointed poorer outcomes for some patients in South Reading in the Nepalese community who had a poorer uptake of the standard NHS diabetes education offer.

The impact of social and economic inequalities costs the NHS £4.8billion

Working with the Nepalese community, a programme has now been created which provides group consultations and education, delivered in Nepalese, for patients who had struggled with the service in English. A specialist nurse, who is Nepalese and understands some of the cultural variants within that community, delivers the programme.

The local health and care professionals were able to work with those patients to identify and design what they needed to help them take control of their health.