

Board of Directors (in Public)

Item 3.4

Subject: Population Health Management
Date of Meeting: 26th April 2023
Presented by: Director of Strategic Partnerships
Purpose of Report: To Note

BAF Reference	Impact on BAF
BAF 9	Assurance regarding the progress of work in respect of population health management.

Level of assurance (please tick one) To be used when the content of the report provides evidence of assurance					
<input type="checkbox"/>	Acceptable assurance Controls are suitably designed, with evidence of them being consistently applied and effective in practice	x	Partial assurance Controls are still maturing – evidence shows that further action is required to improve their effectiveness	<input type="checkbox"/>	Low assurance Evidence indicates poor effectiveness of controls

1. Executive Summary

Addressing health inequalities is a key focus for the NHS and for Liverpool Heart and Chest Hospital (LHCH). The report provided, gives an overview regarding LHCH's strategic approach to tackling health inequalities, adopting a Population Health Management (PHM) approach underpinned by the national health inequality framework, CORE20PLUS5. The cardiovascular disease (CVD) prevention programme has been used to best demonstrate the Trusts strategic approach, a programme of work led by LHCH at both a local and system level across Cheshire and Merseyside.

At a system level the Trust is actively engaged in several initiatives/interventions aligned to the PHM approach including: national campaigns, local development of resources and guidelines, health promotion via the Happy Hearts website and associated social media campaigns and numerous outreach events aimed at health screening and patient engagement. The report has however focused on specific examples of locally led initiatives, specifically the development of proactive models of care, outreach and community events and staff focused events.

A set of five recommendations have been identified:

- Note the Trusts strategic approach to addressing health inequalities, using a PHM approach, underpinned by the CORE20PLUS5 framework.
- Note examples of progress to date.
- Approve next steps (section 5).
- Note and approve LHCH's progress against the 7-point action plan (appendix 1).

- PHM to continue as part of the strategy/community agenda with updates shared as part of Cardiac Board/Strategic updates.

The Executive team are asked to note and approve the contents and recommendations presented herein.

2. Background

PHM is an approach to healthcare delivery, focusing on improving overall health of a defined population, rather than solely treating individual patients when they become ill. In the context of the NHS, PHM aims to improve health outcomes, enhance quality of life, and reduce healthcare costs by addressing the root causes of illness and disease.

PHM recognises that individual health is influenced by a complex interplay of biological, social, economic, and environmental factors, and seeks to address these factors in a comprehensive way. PHM programmes typically involve a combination of clinical and non-clinical interventions including:

- health promotion
- disease prevention
- health screening
- disease management
- patient engagement

The overall aim being to improve health outcomes for the entire population.

A key component of PHM is that of preventive measures, including public health campaigns, health screenings, and education programs that aim to raise awareness about healthy lifestyles and encourage individuals to adopt positive behaviour changes. Examples of PHM programmes include those that target specific populations, such as older adults or those with a high risk of developing chronic conditions, to provide targeted health education and preventive services.

PHM is increasingly being recognised as a critical component of healthcare delivery. The NHS Long Term Plan, which outlines the priorities for the NHS over the next decade, recognises the importance of PHM in improving health outcomes, reducing healthcare costs, and addressing health inequalities. The plan calls for a more integrated, patient-centred approach to healthcare delivery, with greater focus on preventive measures and disease management.

3. Trust Strategic Approach

CORE20PLUS5 framework is a national NHS England and NHS Improvement approach¹ to support targeted action in healthcare inequalities improvement, defining a target population cohort – the 'CORE20PLUS' – and identifies '5' key clinical areas requiring accelerated improvement.

The 'CORE' being the most deprived 20% of the national population, identified by the national Index of Multiple Deprivation (IMD). To note, 62% of the Liverpool population are from the most deprived national quintile.

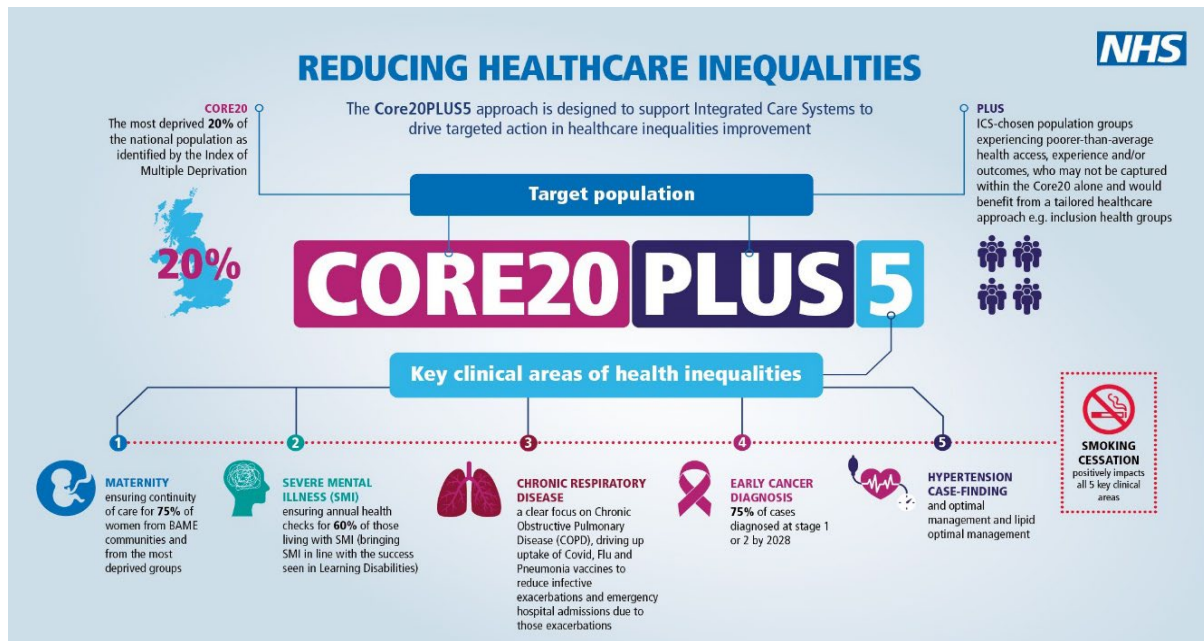
The PLUS population groups refer to ethnic minority communities, inclusion health groups, people with learning disabilities and/or autism, costal communities with pockets of deprivation hidden amongst relative affluence, individuals with multi-morbidities and protected characteristic groups, amongst others. This element of the framework has yet to be defined for C&M.

The final element sets out '5' key clinical areas of focus:

1. Maternity,
2. Severe mental illness (SMI)
3. Chronic respiratory disease
4. Early cancer diagnosis

5. Hypertension case finding/lipid optimisation

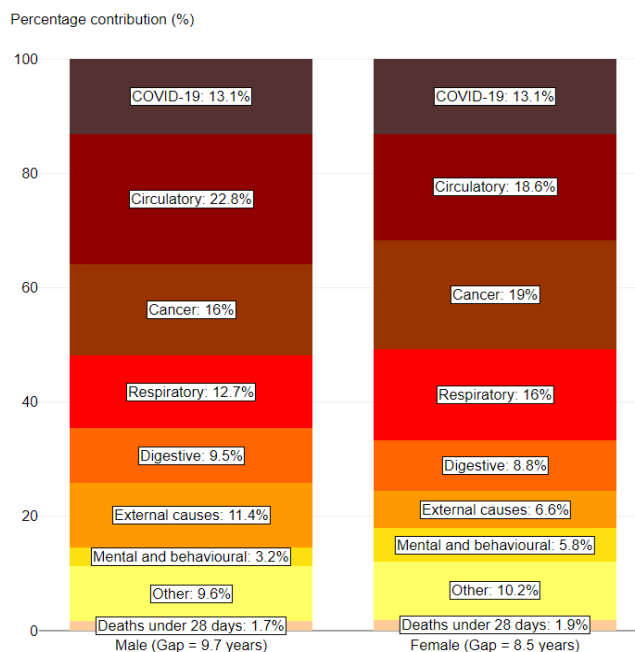
Smoking cessation is now also referenced as having a positive impact upon all 5 clinical areas.



The Trust has adopted a PHM approach, underpinned by the CORE20PLUS5 framework to support delivery of targeted interventions aimed at addressing health inequalities and improving local population health. This approach is best demonstrated through the CVD prevention programme, led by LHCH at both a local and system level across Cheshire and Merseyside.

3.1 CVD prevention

CVD is recognised as the biggest cause of premature mortality in areas of deprivation and the biggest contributor to the gap in life expectancy (rich/poor) in the Northwest of England as illustrated in the below scarf chart (2020-2021, OHID).



CVD is associated with deeply embedded inequalities, particularly in relation to deprivation, certain ethnic minority groups, other demographics e.g. working age males, and underserved or vulnerable communities e.g. those with SMI.

The Long-Term Plan sets out national ambitions for the detection, monitoring and management of three high risk conditions associated with CVD, Atrial Fibrillation (AF), high blood pressure (BP) and high Cholesterol, collectively known as the 'ABC' of CVD which play a central role in its prevention.

Deprived communities are more affected by the ABC conditions with those living in deprived areas, 30% more likely to have high BP than those living in the least deprived areas. Recent Public Health England (PHE) modelling shows that if the national ambitions for AF and BP were achieved across Cheshire and Merseyside, within 3 years, 1500 heart attacks and strokes may be prevented, collectively saving the NHS over £25m.

The CVD prevention programme, is a system level programme of work led by the CVD prevention group, reporting into Cardiac Board, a primary focus of which is the 'ABC' of CVD, with robust workstreams centred around hypertension (high BP) and lipid optimisation, aligned to the clinical areas of the CORE20PLUS5 framework.

From a Trust perspective, LHCH lead a variety of prevention focused initiatives with key areas including:

- Early cancer diagnosis – Targeted Lung Health Checks
- Hypertension case finding and lipid optimisation – CVD prevention
- Smoking cessation – pathway introduced in November 22 at LHCH

4. Progress to date

This section aims to provide an overview of specific LHCH led initiatives to demonstrate the Trusts strategic approach in action.

Extend Targeted Lung Health Check (TLHC) programme to include CVD prevention service

This is an example of an innovative place-based proactive care model, developed to target a specific cohort, those patients with an incidental finding of coronary calcification following a low dose computed tomography (LDCT) scan as part of a TLHC, predisposing them to an increased risk of heart attack and stroke. Delivery of the service will coincide with phase 3 of the TLHC programme, located in South Sefton and St Helens places in 2023/24.

Outreach events and partnership working

The strategic partnership team lead a number of outreach events across C&M, delivering CVD opportunistic health checks to the public, schools, and businesses, signposting and providing advice and raising awareness of the importance of maintaining a healthy lifestyle to prevent long term conditions. Key to their success is the adoption of a partnership approach which sees the Trust working with multiple partners; local PCN's, LFC Foundation, Citizens Advice Bureau as examples.

LHCH healthy families Heart project

An IMD approach has been adopted to support the future delivery of this project with 120 primary schools in Liverpool now mapped into IMD cohorts, lowest ranking IMD % is indicative of the most deprived areas. 11% of schools fell into a 1% IMD (most deprived) followed by 33% of schools falling into a 2-5% IMD ranking. This has informed the strategic partnership teams' delivery to support a targeted approach in which those schools in the most deprived areas will be prioritised for project delivery.

Seven key actions have been identified to strengthen and build upon the current strategic approach to addressing health inequalities (appendix 1), with progress noted against each action.

5. Next Steps

Delivery of the following steps are a key focus to support PHM:

- Local analysis of patients accessing LHCH services to support further targeted interventions led by Associate Director of Data & Analytics.
- Utilise available ICS Intelligence Functions – CIPHA CVD dashboard now has 44 'live' metrics with a further 32 to follow, available in April 2023. Utilisation of the dashboard will continue to support the Trusts approach to improving population health, guiding intervention delivery to areas of high deprivation, underserved and vulnerable communities. This work will be led by the Strategic Partnership team.
- Continually look to improve current initiatives/interventions, strengthen existing partnerships, and look to form new working partnerships, led by the Strategic Partnership team.

6. Conclusion

A core strategic priority for LHCH is that of improving population health, tackling health inequalities through a vehicle of prevention. To support delivery of this objective the Trust has adopted a PHM approach, underpinned by a national framework, CORE20PLUS5, designed to support ICSs with a targeted approach to reducing healthcare inequalities. Good progress has been made to date however several steps have been identified that are required to strengthen and build upon existing efforts one of which includes the use of the newly developed CIPHA CVD dashboard to target those areas most in need.

7. Recommendations

The Executive team are asked to note and approve the following recommendations:

- Note the Trusts strategic approach to addressing health inequalities, using a PHM approach, underpinned by the CORE20PLUS5 framework.
- Note examples of progress to date.
- Approve next steps (section 5).
- Note and approve LHCH's progress against 7-point action plan (appendix 1).
- PHM to continue as part of the strategy/community agenda with updates shared as part of Cardiac Board/Strategic updates.

8. References

1. NHS England » Core20PLUS5 – An approach to reducing health inequalities.

Appendix 1: LHCH action plan

Action	Description	Progress	Lead	Completion date	Status
Assessment	Conduct analysis of health needs and demographic characteristics of the population served by LHCH	Work led internally on waiting list analysis. CIPHA CVD Dashboard will further support with this action.	AG/KF	Q1 2023/24	In progress
Prioritisation	Based on results of assessment, prioritise health conditions and risk factors that have the greatest impact on the population	LHCH has focused upon; early cancer diagnosis (TLHC programme), hypertension case finding (BPQI, BP@home), lipid optimisation (clinic pilot underway). TLHC/CVD prevention service pilot.	Strategic Partnership team	Q4 2023/24	In progress
Development of interventions	Design and implement evidence-based interventions to address the prioritised health conditions and risk factors	Aligned prevention interventions to CORE20PLUS5 framework applying a PHM approach – raise awareness, health promotion, disease screening	Strategic Partnership team	Q1 2023/24	In progress
Monitoring and evaluation	Establish mechanisms to monitor and evaluate the effectiveness of interventions, including regular assessments of patient outcomes and programme performance	Internal monitoring systems established to monitor and evaluate LHCH led outreach events; surveys and feedback forms, anonymised clinical findings to support trend analysis and improvements, collection of patient stories.	Strategic Partnership team	Q3 2022/23	Complete
Data integration	Ensure that data from various sources are integrated to support the management of population health	Current data sets utilised: PHE Fingertips, CVD Prevent Audit report, Internal data collection following outreach events. Commence utilisation of CIPHA CVD Dashboard in April 2023.	Strategic Partnership team	Q1 2023/24	In progress
Collaboration	Develop partnerships with community-based organisations, healthcare providers, other stakeholders to enhance the impact of population health management efforts	Robust partnership working; Local PCN's, Providers including: LUHFT, LWH, EFCiC, LFC Foundation, Champs, PHE, Liverpool Place, Philharmonic Orchestra, Knowsley Safari Park, Innovation Agency, Cardiac Clinical Network	Strategic Partnership team	Ongoing	Complete
Continuous improvement	Continuously evaluate and refine the PHM plan to ensure it remains effective and relevant to the changing health needs of the population	Strategic Partnership regular review process in conjunction with awareness of changes in national, regional, and local policies and guidance.	Strategic Partnership team	Quarterly review	In progress