POPULATION HEALTH MANAGEMENT AND JOINT STRATEGIC NEEDS ASSESSMENT 2022

Relevant Board Member(s)	Caroline Morison Kelly O'Neill
Organisation	Hillingdon Health and Care Partners London Borough of Hillingdon
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Papers with report	None

1. HEADLINE INFORMATION

Summary	This paper provides a high-level overview of the work in train to drive forward a population health management approach in Hillingdon, consistent with our joint health and wellbeing priorities. It also develops further our understanding of local needs through the Joint Strategic Needs Assessment and proposed further work to collect intelligence regarding disparities.
Contribution to plans and strategies	Our partnership work on population health management and needs assessment is integral to delivering the priorities in our Joint Health and Wellbeing Strategy.
Financial Cost	There are no direct financial costs arising from this report.
Ward(s) affected	All

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **notes the action in place across Hillingdon Health and Care Partners to take Population Health Management approach to improving the health and wellbeing of our population.**
2. **notes the progress in partnership working with Brunel University and public health that will develop an updated Joint Strategic Needs Assessment and further intelligence led enquiry which will provide greater insight to disparities in health and care in Hillingdon.**

3. INFORMATION

Introduction

Hillingdon Joint Health and Wellbeing Strategy 2022-25, approved by the Board at its December 2021 meeting, includes as Priority 2, to:

Tackling unfair and avoidable inequalities in health and in access to, and experiences of, services.

There is also stated commitment to use evidence and data to work to reduce disparities in the Borough.

In addition, our experience through the pandemic and across all HHCP partners, has increased our understanding of communities and enabled us to develop relationships with groups that had not always been in place before. Our activities in recruiting community champions and promotion of vaccine take up, for example, has added to our knowledge and created links that will have a legacy going forward and serve as a conduit for health messaging and exploring issues within and amongst communities.

At national level, policy drivers (including the NHS long term plan and the more recent Levelling-up white paper) point to expectation and commitment to talking health inequalities and wider disparities that exist within boroughs.

Population Health Management provides a framework and methodology to achieving these aims in Hillingdon and our work on the JSNA will update and refine our evidence base to reinforce this.

Population Health Management (PHM)

What 'population health' is – headlines:

- Population health is a whole-systems approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across a defined population – this can be a cohort defined by identity or, as we are doing as part of the NWL PHM work, 'place-based'.
- The 'approach' or 'framework' uses data, evidence and insight from local communities to see where there are the greatest inequalities. It involves identifying groups of people at risk of ill health and then working with these groups and the latest evidence to design interventions that can enable them to better health, considering the wider aspects which might influence health and evaluate them to understand the impact.
- The aim is to bring together partners / stakeholders and prioritise planning and implementation of evidence-based interventions. The approach means we strengthen partnerships across communities, local government and the NHS - a partnership approach which is committed to tackling these health and care issues.

NWL ICS has commissioned a firm named Optum to work with HHCP in support of Borough based Population Health Management activities. The start of the 4 action learning sets (ALS) was Covid-delayed but the first one took place late February. The ALS have 4 areas to explore:

1. Emergency presentations of working age men for chest pain
2. Frequent attenders – mapping of these people to look for flags for what drives this behaviour
3. Frailty and falls
4. High care users – the relationship between high care packages and health

Optum will be working with HHCP as part of a Borough 'Place' PHM challenge – there will also be a PCN place challenge too.

The Borough challenge will be a 22 week process through which we identify a problem, use data and insight to segment this to a group of people and, through joint working and engagement, we look at intervention(s) that will be targeted to that group to achieve better 'access to, experience of, benefit from' so better outcomes, which we evaluate. A point is that programme is about learning, and even if the process does not achieve the intended outcomes, we learn from it, refine and try again.

The task and finish group will decide which of the two initial challenges we want to focus on – frailty and falls, or chest pain acute presentations amongst working age men – both would benefit, and the task and finish group is to decide why we start with one, the rationale, what outcomes we want to achieve so we measure our success, and a narrative about health inequalities is key.

The next session we have requested more focused wider determinant, cohort descriptors: who is falling; where do they live; previous falls. For chest pain: characteristics of the group; their health seeking behaviours (they are men, so empirically they may access health services reactively); where do they live; what their employment is, etc.

The intention is that the PHM approach and methodology is developed in Hillingdon and amongst partners and able to the rolled out across the Borough to review and agree further issues at the PCN level over the coming years. The Optum work in Hayes is the start of that journey.

Joint Strategic Needs Assessment (JSNA)

In parallel (and linked to the PHM work) we have also developed our relationship with Brunel University and the Council's public health team to provide an accurate picture of health in the Borough and to support our insight into communities and access to and use of health and care services.

Stage 1 of the JSNA work has updated and extended the epidemiology review and is in the process of being uplifted onto the Council's website.

Stage 2 will draw conclusions from the epidemiology of the evidence and test this fully with key stakeholders through workshops and using various techniques.

Stage 3 will provide the opportunity to reach out into community groups to research more as to why certain groups may or may not be accessing services and support and how this could be improved through process such as co-design and co-production.