NHS
Kent and Medway

Population Health Management Development Update

1. Purpose

The purpose of the paper is to provide a final report on the population health management (PHM) development programme following the final System level Action Learning Set (ALS) which took place on 1 Mar 2022.

The report also includes a summary of the agreed priority areas that will inform the development of the health inequalities strategic plan which were agreed by the K&M Joint Health and Well Being Board (JHWBB) in Dec 2021 and the Partnership Board in February 2022, a brief update on the K&M Health Equality Partnership Programme (HEPP), and key changes within the Prevention Programme relating to the Turning the Tide Oversight Board and the BAME Strategy Board.

2. PHM programme summary

The start date of the Wave 3 programme commenced as planned in week beginning 19 Jul 2021. The last system ALS was scheduled to take place on 14 Dec 2021 but had to be rescheduled to 1 Mar 2022 due to COVID operational pressures.

There were 4 levels of ALSs delivered as part of the programme; System, Health and Care Partnership (HCPs) which included finance & contracting, Neighbourhoods and analytics.

A combined total of 52 virtual ALSs took place over an 8-month period (extended from 6 months due to Covid pressures) with over 224 colleagues meeting regularly from across health, social care, local authority, public health, local councils and voluntary sector to further the aims of population health management across Kent and Medway.

At the start of the programme linked data (primary care, acute, mental health and community) was generated for 215,000 people across Kent and Medway to provide insights at the start of our programme for our five neighbourhoods, with linked data for 956,000 people being generated for our two HCPs.

Whilst starting with five Neighbourhoods, the programme completed with four as one PCN withdrew. Work is continuing in that neighbourhood over a longer period and without PCN support. In the remaining four Neighbourhoods 552 people were identified who would benefit from proactive, local interventions from the insights from the linked data.

With the two Health and Care Partnerships (HCPs) around 2,700 people were identified from the insight linked data to begin to consider better ways to integrate their care.

Across all cohorts of people identified –

- Five included a focus on **obesity**
- Four included a focus on people with **diabetes** or at risk of diabetes which has strong links to obesity.
- Four included a focus on people with **mental health conditions and wellbeing**, including depression and anxiety
- Three focussed on **areas of highest deprivation** where all of the above are more prevalent.

Other selection criteria included people with three or more co-morbidities, asthma, hypertension, people who are housebound or are smokers. One HCP cohort was focussed exclusively on children and young people (0-19 years). Appendix 1 contains an extract from the case studies from each HCP and Neighbourhood and provides cohort and numbers selected for each.

2.1 System level action learning sets

The fifth and final system ALS on 1 Mar 2022 bought together 110 colleagues from across the entire programme who committed their time to hearing about the successes and celebrating the journey during the 22-week Programme. Neighbourhoods, HCPs, and analytics colleagues shared their experiences, and the initial plans for spreading the PHM approach in K&M after the Programme ends were shared.

Headline outcomes from the programme as reflected from the final system ALS are:

- A cornerstone of delivery is the work within each HCP and Neighbourhood to improve outcomes for the K&M population using a collaborative and targeted approach for those in high-risk cohorts such as diabetes, mental health and deprivation in East Kent HCP; putting in place an approach that will start to deliver real change now and in the future.
- It has supported us in developing innovative and collaborative ways of working that more constructively allows organisations, patients and other critical groups to challenge and enable the development of cross system solutions. The power of collaboration was a critical learning point of the programme and will underpin work going forwards.
- It has enabled us to start proactively talking to people about their needs and what they might need to support themselves, rather than what our own assumptions are on what they might need.
- It has proven that data is essential, but knowledge, experience and insights into the data is just as essential. This will be built into our future ways of working.
- A key outcome has been a more mature and co-ordinated approach to data and analytical intelligence; creating one set of co-ordinated data from multiple providers to support and drive change.
- Allying local expertise and knowledge to the new ways of working with information using a PHM approach allows us to develop clearer priorities and targets interventions to optimum effect.
- It has enabled us to develop a real shared commitment to start to change the way we work, giving us collective ‘thinking time’ across all levels of our system - being

able to take a step back and reflect. In essence supporting all parties to be able to work together to a maximum impact.

- This is a new way of working and has been a launch platform to help us change the way we work including understanding where we have gaps and where we need to develop our own expertise, approach and capability in PHM. We recognise that there are still things we need to improve for this approach to be as successful as possible, however, the critical elements is HCPs and Neighbourhoods are being supported to best deliver change for patients.
- It should be emphasised that a critical element of PHM focus, and success has been the involvement of a whole wide spectrum of parties from social care, local authorities, voluntary and community sectors, libraries, parish councils, education etc as well as across the NHS. PHM has reached across boundaries to identify and deliver real change.

It is also worth noting some of the challenges raised:

- Financial mechanisms can be a barrier where preventative and proactive care initiatives may not always result in cash-releasing savings in the short term and where associated spend is within providers' fixed costs. This can make upfront investment to support new interventions challenging. We will need to work together to address these barriers so that we are able to work more freely across organisational boundaries.
- Linked datasets need to be available much more widely. The linked data used for the 22-week programme was a one-off snapshot, whilst a linked data set (primary care, acute, mental health and community) will be available from April 22 this cannot be accessed without wider engagement including with the public on using this for secondary uses such at PHM.
- Co-production will need to be built into the programme going forward as this was identified as gap; A co-production framework is already in development which will be incorporated into the next phase.
- There was not sufficient focus on planning for evaluation with the Neighbourhoods including the resources to support the neighbourhoods to do this, where needed.
- Our analytical experts felt that they would benefit from more bespoke training where analysts could spend more time analysing 'real' data (with expert support), and more support was required if analysts' roles need to change to support PHM going forward.

2.2 HCPs (Place) and Neighbourhoods and analytics action learning sets

Case Studies for the HCPs and Neighbourhoods that completed the programme have been developed. These provide details on the priority cohorts selected, the agreed interventions and the rationale for the interventions, the approach to partnership working, short, medium to long term outcomes and results so far alongside their own lessons learned. For the HCPs this also includes a focus on the integrated finance and contracted as part of the programme. Please see Appendix 1 for an extract from the case studies from each HCP and Neighbourhood on the interventions developed for each cohort.

These case studies are a key output of the programme and will be developed into material and media that can be shared much wider to spread the learning. These will be shaped to share with two types of audience: system colleagues including those who may not have been involved in the initial programme, and a public audience.

From the final HCP ALS reflections include:

- The strength of collaboration has shone through – taking a complex issue and all working towards a common vision to improve the health and wellbeing of a community.
- The approach has been like 'crowd sourcing' solutions to design an intervention. A much wider range of people have been involved and you can see the potential of the model to be transformational.
- It has been a very positive experience to develop a mutual understanding of the overall contribution and priorities of partners. The Voluntary and Community Sector have a major role to play and the aim is achievable as part of a wider team.

2.3 PCN ALS

The final Neighbourhood ALS took place in Nov 21 where progress on interventions was reviewed, and there was a focus on evaluation and measuring success.

Some the quotes received as part of the feedback from the Neighbourhoods which were also reflected in the feedback at the final System ALS are below:

- *"I have been overwhelmed by the support and care I have received from the practice team. I feel better informed and my carer now understands my condition too"*– Patient A.
- *"Honoured to have the patient voice included, and heard"* – Patient Council
- *"Felt valued and treated as an equal. Found this way of working interesting, and was able to contribute"* – One You Kent
- *"This is an excellent example of collaborative work, where each stakeholder was treated as an equal. It is a good opportunity that needs to be grasped"* – A PCN Working Group
- *"Together everyone achieves more and allows us to find the common opportunity amongst the chaos."* – PCN Clinical Director
- *"It is refreshing to see the mutual interest, contribution and collaborative as opposed to adversarial, way of working. We all had a shared purpose for the health of the local population, without bureaucracy."* – PCN Clinical Director.
- *"There is a lot to be said for being able to speak directly with GPs, public health and wider teams with information in my capacity as intelligence manager. The integrated working, targeted intervention design has helped with the practical cohesion between data and day-to-day experiences*." – Public Health Intelligence.

2.4 Analytics ALS

The aim of the analytical ALS was to develop an understanding of the types of analytics that can be used to answer key population health questions at every level of the system, and support transfer of these skills locally.

The ALSs have focussed on specialist statistical software to analyse datasets, tools to better understand the patient journey, tools and techniques to support robust evaluation of interventions, and an opportunity to provide feedback on experience and support that system analysts might need to effectively support PHM in the future.

Participants highlighted that they appreciated the breadth of partner organisations involved in the programme, developing their knowledge and skills, and using new tools and techniques. They felt that they could benefit from more bespoke training where analysts could spend more time analysing 'real' data (with expert support). Participants also felt that more leadership support was required if analysts' roles need to change to support PHM going forward.

2.5 PHM roadmap development

The system must design its own approach to spread the learning and build on PHM capabilities within and across partner organisations after the 22 weeks. The PHM roadmap, which is our local plan, is a key deliverable which will set out K&M key priorities with clear actions and timescales going forward. The views and feedback from across all the ALSs within the 22-week programme has been informing the roadmap development.

The PHM roadmap has two core elements:

- **PHM spread and sustain - indicative timeline for next phase roll out is May 2022 -** To demonstrate the systems commitment to spread the learning from the programme systems will need to develop a local approach to spread and sustain the PHM approach.

- **PHM capabilities plan by end of April 2022 –** to develop an agreed set of system PHM development programme objectives through identifying gaps in PHM capabilities (infrastructure, intelligence, intervention and incentives) and developing clear actions to improve each. This will also include scaling of successful interventions.

2.5.1 PHM Phase 2 plan

A set of key principles for the spread and sustain plan has been co-designed with a range of stakeholder groups from across the system including members of the Population Health and Prevention group, feedback from those involved in all the ALSs (system, place, neighbourhood and analytics), outputs of the ICS Partnership Board core purpose workshop in Sep 2021, and the PHM programme teams readiness and delivery leads.

The Population Health and Prevention governance group reviewed and supported the following planning approach in Nov 2021, and was ratified by the ICS Partnership Board in Feb 2022 -

- An indicative start date for the next phase of roll out plan is May 2022. The delay is directly in relation to the availability of a linked data set which will not be available until early April with the analytics pack being ready during May.

- We should be flexible on approach however broad agreement that we need a minimum 22-week cycle to allow co-production to be built into the programme, and will allow time for key actions to be completed between each ALS.

- Five neighbourhoods will participate; 4 ‘PCN buddies’ (who shadowed the lead PCNs in the current programme), will become the leads in the next phase. Leads

confirmed in the next phase are: Sheppey PCN (Medway and Swale), Gravesend Central (DGS), Canterbury South and Canterbury North will work together (East Kent) and Ashford Medical Partnership (East Kent). The West Kent neighbourhood will be participating in the new NHSE/I place-based development programme which is due to commence in Apr 2022.

- The initial thinking of the longer term spread and sustain plan is to deliver it in a total of 4 phases: the next Phase will have 5 neighbourhoods, with numbers increasing in the subsequent phases. This will mean that K&M will complete the spread and sustain programme by early 2024 assuming no major delays.

- A task & finish group will be established to localise and design a next phase plan for K&M and will involve those that participated in the 22-week programme. A real benefit of designing and delivering a K&M approach will be to develop PHM knowledge and skills within our own workforce; this will be key to embedding PHM capabilities for the future roll.

- DGS and West Kent HCPs are participating in the new NHSE/I place based development programme which has an expected start date for this programme of March and April respectively 2022. This programme has four modules focused on place development, with one module specifically focussed on PHM interventions. The learning will be an integral element of the K&M spread and sustain plan and roadmap with the learning feeding into to the Population Health and Prevention Group, and the into the next phase of the programme.

To support the next phase the following key enablers were also agreed:

- Resources will be required to support a roll out plan. The Optum team provided facilitation, clinical and analytical support to the 22-week programme which will leave gaps in resource for K&M next phase plans. Commitment and alignment of resources including from an external resource such as Optum is essential; system and place leads have started to define the balance of effort across system and place programmes including PHM to better align resources and clarify gaps.

- Place and Neighbourhood ALS need to be driven and delivered locally. Key elements should be pulled from the system level such as principles & understanding of PHM approach, programme planning, linked data & analytical support, scaling interventions, inspirational examples etc. This forms part of the work in the above bullet point which has already started.

- Place and Neighbourhood priorities need to be aligned in the future. In the current programme PCNs were able to use the data to define their own at risk cohort of patients. However, most of the feedback received highlights the need to align priorities going forwards.

- There needs to be greater interaction between Place, Neighbourhoods and system activities including purpose and function of each ALS, and greater interaction and sharing of learning between all of the Neighbourhood ALS participating in each phase.

2.5.2 Key risks to delivery to spread and sustain.

- **Resource commitment and alignment:** The indicative timeline will not be met if commitment and alignment of resources to support a future roll out plan are not in place. Optum has bought a wealth of experience and knowledge to all of the ALSs within this programme. Whilst a key element of this is to support systems in their journey in developing their own PHM capabilities including knowledge and skill transferring there are however, key areas in the next phase that will need resources committed. These are: subject matter expert to support production of linked data set, facilitation in ALS including use of tools and software, analyst support within in ALS sessions to share interactive analysis, and clinical coaching sessions to support the neighbourhood leaders in the next phase.

- **Production of a linked data set:** The indicative timeline will not be met where the data, infrastructure and information governance actions are not completed by early April 2022. These actions underpin the move away from the Optum contracting data (ceases Jan 2022) to the new solution. This will provide the same level of linked data to the phase 2 as provided in the initial 22-week programme.

2.5.3 PHM Roadmap development – areas of focus

Views and feedback from recent workshops and from within this programme have helped to shape the areas of focus for the PHM roadmap into the four key PHM areas as detailed below. The next steps will be to develop these into PHM programme objectives and develop clear actions to improve each - we will need to agree a phased implementation.

Infrastructure	• Delivering a **linked data set** that includes wider determinants of health such as social care, education, housing, & employment to build a better picture of our population. • Addressing some of the information governance barriers to **accessing and sharing data across partners** (safely, securely & legally). • Champion PHM as a key strategic priority including commitment of resources to support PHM **spread and sustain across all levels of the system**. • Roll out **PHM education and skills development** to a wider audience (clinical and non-clinical) to enable a shift to a new business as usual. • **Leadership commitment** through building the right culture and environment for change.
Intelligence	• Further formalise the **analytical community** to best support data use at all levels of the system. • Develop an **analytical offer to all neighbourhoods** so that data is a driver to understand local issues. • Focus on **outcomes evaluation** methods and mechanisms.

	• Improving **public awareness and understanding** of the benefits of using their data to support PHM.
Interventions	• **Embed and share the wider learning** from the programme to across all levels of the system. • Develop the **spread and sustain next phase** of PHM in K&M and build on successes of the PHM programme achievements – further **scale existing interventions.** • Build the **interaction between Neighbourhoods, Places and System** to align, learn, prioritise. • Promote **co-production and involvement of people with lived experience** in all we do. • Continue to **build collaborative forums that are wider than health –** ones that engage care, voluntary & communities. Encourage self-management and ownership of health and wellbeing. • Create **a learning environment** to maintain momentum, share case studies and learning across the wider system. • Develop mechanisms to **increase the focus on deprivation and inequalities reduction.**
Incentives	• Build on Place financial modelling to develop strategies for using **contracting as a mechanism to incentivise different outcomes.** • Continue the PHM financial led projections **(actuarial workbook progress)** to demonstrate how this can be used for future planning and incentivisation. • Configure and implement the **population segmentation and outcomes platform** developed by Outcomes Based Healthcare. • Promote **PHM methodology to help reach existing contract outcomes** and incentives.

3 Health Inequalities Strategic Plan

The aim of the strategic action plan is to identify those areas where collective, system-wide action on health inequalities is required to deliver improvement. It also aims to complement organisational and geographical health inequalities plans; system partners would be expected to continue to focus the reduction of health inequalities in the development and delivery of their services.

The health inequalities development session on 10 Jun 2021, the PHM 22-week development programme which commenced in Jul 2021, ICS Partnership Board workshop on 17 Sept 2021, and the launch of the Core20PLUS5 (a new NHS framework) on 1 Nov 2021 have all informed this plan.

A paper summarising the details behind the emerging themes and priority areas was supported at the K&M Joint Health and Well Being Board (JHWBB) on 7 Dec 2021.

The JHWBB agreed the priority areas of system wide focus should be on mental health and wellbeing and areas of highest deprivation.

They also agreed that co-production should be a key principle underpinning the action plan and local communities must be involved in its design and delivery.

The paper also summarised key points raised by system leaders at the workshops and from the PHM programme highlighting that leadership focus on health inequalities is vital:

- There is a strong sense across the system that clear, inclusive and accountable leadership is crucial if real progress is to be made on reducing health inequalities across the K&M health and care system.
- The importance of building collaborative leadership has also been stressed, including the ability for partners to be outcomes-focussed and see beyond their individual organisations to benefit our communities.
- Championing PHM is seen as a key strategic priority including commitment of resources to support PHM spread and sustain across all levels of the system.

3.1 Health inequality strategic plan next steps

- To begin working with colleagues across the system to understand what programmes of work are already in place or in train, where there are gaps and where joint action across the system would have the greatest impact.

- Nominated senior leaders and system sponsors to attend the Health Education England commissioned health inequalities programme to support ICSs in the South East to deliver their ambitions to tackle health inequalities, delivered by the Institute of Health Equity.

4 K&M Health Equality Partnership Programme (HEPP)

The project team has been developing a local evaluation plan to measure the impact of the project which is due to be completed at the end of May 2022. An external organisation will lead the evaluation; this is the same organisation that is leading the National HEPP evaluations on behalf of NHSE/I.

The HEPP is focused on supporting those who suffer from severe mental ill-health, and is delivering two related projects. Progress since Oct 2021 is below:

- Cognitive behavioural therapy (CBT) based training for front line workers across multiple sectors: To date, 29 frontline workers have received training, and are currently receiving regular supervision sessions that is due to end in March 2022.

- Proactively identifying people with severe mental illness (SMI) and linking social prescribing to their physical health and social care planning: The team has now selected the cohort from PCNs in the pilot area and KMPT, and is currently completing health checks prior to referral to the social prescribers. This process is due to be completed by end of Mar 2022.

5 Prevention

The Turning the Tide Oversight Board is a key group driving implementation of the Turning the Tide Strategy [1] across the Kent and Medway system. The purpose of the Turning the Tide Strategy is to develop and drive a sustainable response to the inequality experienced by Black, Asian and Minority Ethnic populations both for their health and in the workforce.

It was agreed at the Turning the Tide Oversight Board on 27 October 2021 that the work of the BAME Strategy Board would be merged with the Turning the Oversight Board and the terms of reference of the group have been amended to reflect this. The group is chaired by James William, (Director Public Health – Medway Council), and vice chaired by Ms Rantimi Ayodele (Consultant Paediatric Trauma & Orthopaedic Surgeon at MTW and Chair of the Cultural and Ethnic Minorities Network). Both groups consider this to be a very positive move forward in harnessing resources across the system to the best effect.

The work plans for both groups, including the work undertaken by the Interim Equality, Diversity and Inclusion Lead are being aligned into a holistic and consistent workplan focusing on the elements of workforce and health of the population. This workplan incorporates the work related to the Kent and Medway ICS Equality, Diversity and Inclusion (EDI) Programme, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Gender Pay Gap action plans and the NHS People Plan 2020.

To help deliver the EDI Programme, a tender exercise is underway to partner with suppliers who can deliver a programme that will support us to provide staff with the knowledge and skills to understand and contribute towards creating a more inclusive organisational culture. We will work collaboratively with successful suppliers to design and deliver a blended approach to learning and development that will include a combination of drama – based learning, face to face and virtual and digital online learning.

6 Oversight of Health Inequalities, Population Health and Prevention

Currently, the Population Health and Prevention Group, established in July 2021, provides oversight and direction to deliver a shared vision for improving population health, preventing ill health, reducing health inequality, and promoting physical and mental health and wellbeing across Kent and Medway. The Group reports into both the ICS Partnership Board and Joint Health and Wellbeing Board.
From July 2022, the Inequalities, Prevention and Population Health Committee will be given this role and remit. This will be a formal committee of the Integrated Care Board (ICB) with the necessary delegated authority to act on behalf of the ICB on issues within its remit. Both Directors of Public Health will be members of the Committee.

7 Next Steps

- Linked data developed for next phase – 1 Apr 2021
- K&M task and finish group (established in Mar 2022) to lead the development of the spread and sustain plan using the approach outlined and to complete the

[1] https://www.england.nhs.uk/south-east/health-equalities/turning-the-tide/turning-the-tide-strategy/

readiness activities in preparation for Phase 2 with an expected go live during May 2022.

- To support DGS and West Kent in the place-based development PHM module – Mar and Apr 2022 respectively.
- To complete the K&M PHM Roadmap development for end of Apr 2022.
- To focus on developing the health inequalities strategic plan to understand what programmes are already in place for the two key priority areas and where additional joint action across the system would have the greatest impact

APPENDIX 1 – intervention extracts from case studies

Medway and Swale HCP - intervention extract from case study

Medway and Swale Place Cohort

- **Place population size: 421,033**
- **Key Place attributes: 36% of year 6 children with excess weight, 67% of adults classified as overweight or obese. Deprivation score of 39 for Medway Central PCN.**
- **Cohort size: 1980**
- **Cohort description: Children between the ages of 5-19 years, who have Obesity with either Diabetes or Asthma from the 2 highest deprivation deciles**

Intervention

- **Cohort selection:** Medway and Swale are an outlier for childhood obesity a complex health issue. The causes of excess weight gain in young people are similar to those in adults, including behaviour and genetics. Local data shows an increase in health conditions related to childhood obesity impacting on acute / community and primary care services.
- **Description of intervention/service:** A specialist member of staff that can confidently lead on a multiagency approach who will also talk to complex families, carers of children or young people about their: excess weight, discuss the underlying weight issues, psychosocial difficulties and refer to psychology and family weight management services. Children and young people with excess weight (overweight or very overweight) are more likely to be ill, be absent from school due to illness and require additional health care support than children and young people of a healthy weight.
- **Wider determinants considered:** The local JSNA evidences a clear link between PCN area's with lower average income / deprivation and vulnerability scores and childhood obesity.
- **Activities undertaken for the cohort:** Active case finding to identify target group, which could be very overweight children or weight plus comorbidity (like asthma or diabetes). Child and family member access MDT for 12 appointments over 12 months support, front loaded to build momentum. Baseline, post intervention and long term measurement of weight, body shape, activity, diet, wellbeing, blood markers, BP etc to assess effect. Mapping of service in Swale in being defined.
- **Resources required:** Funded through Better Care fund for Medway. Funding source for Swale to identified. Medway Public Health are providing support in managing the project and funding overheads within existing infrastructure.

Rationale for Intervention

- The aim will be to reduce incidents such as: demand on the social care system, school absence, unemployment, stigma, bullying, low self-esteem, high blood pressure, pre-diabetes bone and joint problems and ill health and mortality in adult life.
- Challenges: We wanted to use personal and demographic data, link it to social and wider determinants of health to improve services and offer targeted intervention for prevention. The data sets did not allow for this and we had to find local work arounds
- **No single intervention can halt the advance of the epidemic of obesity.**

"The data analysed by Optum came from primary and secondary care, and did not include community or other data. This limited the usefulness of the analyses for the problem we wish to address (childhood obesity)
The linked data that Optum worked with will not be available to us on an on-going basis, we still have many hurdles o creating a lasting linked dataset. National support for linking data is sorely needed."
David Whiting, Deputy Director of Public Health – Medway Council

East Kent HCP – intervention extract from case study

East Kent – people living in deprived areas with multimorbidity

- **Place population size:** 721,840
- **Key Place attributes:** Geographically diverse area including rural villages, market towns and coastal communities. Persistent health inequalities and significantly lower life expectancy in parts of East Kent compared to the Kent average which is strongly linked with deprivation. East Kent benefits from an active and engaged voluntary, community and social enterprise sector, seventeen primary care networks, six district councils and a county council.
- **Cohort size:** 727
- **Cohort description**: People with diabetes, depression, at least three other long-term conditions (LTCs), living in areas of deprivation

Intervention

- **Cohort selection:** Our cohort was chosen because the East Kent Health & Care Partnership had already identified diabetes, mental health and reducing health inequalities as key strategic priorities.
- **Description of intervention/service:** A collaborative approach to care that takes account of multi-morbidity (in accordance with NICE guidance), including:
  - personalised assessment
  - establishing the individual's preferences, goals, values and priorities
  - review of medicines and other treatments
  - agreeing an individualised management plan (may include non-medical interventions such as engagement with social and community activities).
- **Wider determinants considered:** Throughout the Action Learning Sets, there was a clear recognition of the critical role of the way in which socio-economic factors influenced the health and wellbeing outcomes for the selected cohort.
- **Activities undertaken for the cohort:** Task and Finish Group has developed a outline service definition document that sets out the objectives of the intervention.
- **Resources required:** Skilled workforce, upfront funding for the intervention and links to community assets and resources.

Rationale for Intervention

- Analysis of the linked data showed wide variation in use of non-elective hospital care between people with who just had diabetes compared to those who had at least three other LTCs.
- Research evidence and NICE guidance highlight the need for personalised assessment of individual needs, goals, preferences and development of individualised management plan to improve quality of life and wellbeing

"The main thing for me has been time to understand and value the different perspectives of stakeholders and how collectively we can do something that could really help patients
- ALS participant

Dover Town PCN - intervention extract from case study

Dover Town PCN Cohort

- **PCN population size: 27,500**
- **Key PCN attributes:** There are approximately 52.8% of adults aged 18-74 yrs living with a low complexity condition(s), living in an average IMD index of 4.4
- **Cohort size: 131**
- **Cohort description**: We chose adults aged between 40-69, who are obese and diagnosed with hypertension and depression.
  - Their condition is defined as mid-complexity, and we chose this cohort to prevent future worsening of conditions/ill-health which is likely to tip them over into the high-complexity band and impact the local healthcare systems in Dover Town PCN.
  - We wanted to do this by empowering them to make healthier lifestyle choices, reduce their reliance on health and care services by co-creating targeted health and social care interventions.

Intervention

- **Description of intervention:** GP practice introduces service, passes onto One You Kent who co-create a personalised plan for health; provide support/signpost for wider determinants of health impacting health and wellbeing. Intervention includes medicines review, baseline biometrics and support via local social/voluntary organisations.
- **Rationale for intervention:** Recognition that health and wellbeing is impacted by lifestyle choices, which require community/social support and intervention; not a medicalised approach. Our intervention aims to non-medicalise health & wellbeing.
- **Wider determinants considered:** A third of the cohort live in deprived wards, and providing support for employment and peer-led self-help through local organisations e.g. libraries; allows wider determinants of health to be addressed.
- **Activities undertaken for the cohort:** Time spent to create an invite letter that can promote positive engagement. Initial assessment to establish what does the person want out of the intervention? Establish their goals for reviews at week 26 & 52. Target those initially with multiple encounters and polypharmacy.
- **Resources required:** Knowledge of local organisations, and how to share/transfer information. Time, commitment and networking to bring expertise into the group and outreach work via libraries and other local groups to reach cohort members, not captured at GP practice level.

Partnerships

Our core group consisted of representatives from the following organisations:

- Social prescribers/Link workers
- GP/PCN Pharmacist
- One You Kent (social care organisation)
- Patient Council
- ASPIRE (community health project)
- Take Off (peer-led self help groups)
- Social Enterprise Kent (Community Navigation Service)
- Kent Community Health Foundation Trust
- ICP project/analysis support

Together everyone achieves more, and allows us to find the common opportunity amongst the chaos – Dr S Chaudhuri, Clinical Director

Honoured to have the patient voice included, and heard – Carol Coleman, Patient Council

Felt valued, and treated as an equal. Found this way of working interesting, and was able to contribute – Beverley Crossland, One You Kent

Medway Central PCN – intervention extract from case study

Medway Central PCN Cohort

- **PCN population size: 60,244**
- **Key PCN attributes: The average IMD index across the cohort is 3.4, with the average age of onset of condition complexity is 36 years.**
- **Cohort size: 166**
- **Cohort description**: We have chosen a cohort aged between 20-39 years of age, who are obese and potentially pre-diabetic with a diagnosis of hypertension. We think we can prevent their onset or progression into long-term diabetes and cardiovascular disease, including increased multimorbidity. We would also like to reduce their health inequality gap, to ensure better health outcomes.

Intervention

- **Description of intervention/service:** Intervention at GP practice to focus on obese persons with potential pre-diabetes who can be referred for further intervention to prevent onset of diabetes (dietitian, group/virtual sessions, local social & exercise options). Other organisations to identify cohort who have uncontrolled hypertension, and highlight to GP practice, as well as note proximity to fast-food outlets (mapping for wider public health measures)
- **Rationale for intervention:** The intervention design was chosen to highlight the impact of fast food outlets/density within Medway, and their health on the local population. Through mapping, individuals can be educated to make healthier choices as well as prevent onset of LTCs, and impact on local healthcare resources.
- **Wider determinants considered:** Key determinants identified as education, employment, housing, social isolation/family relationships and health behaviours. Addressed by including referrals/support via job centres, childrens centres, access to personal health budgets to provide link into wider determinants of health.
- **Activities undertaken for the cohort:** Invited social care organisations e.g. job centre to place "pods"/clinics within GP practice to allow ease of access and make every contact count. Health & social care interventions provided in same space.
- **Resources required:** Time & commitment within group to drive this forward as a group, despite day-to-day work pressures. Expert knowledge regarding sharing of data across organisations, referral processes and linking in with initiatives already in place.

Partnerships

- GP practices
- Pharmacy technician
- One You Kent (social care organisation)
- Better Medway (public health)
- Kent County Council
- ICP colleagues (IG, local initiative leads)
- Social prescribers
- Analytics/project support
- Geographical mapping of fast-food outlets
- Early adopters from cohort to help with intervention revision, if needed

This way of working has shown us a local model that can achieve results. It allows us to firm up existing links, expertise and initiatives e.g. clinical variation work, rather than creating new pathways. – Dr Aly, Joint Clinical Director, Medway Central PCN

Garden City PCN Case Study – intervention extract from case study

Garden City PCN Cohort

- **PCN population size: 56,964**
- **Key PCN attributes:** The geographical spread across the PCN means that there are pockets of deprivation, with average deprivation deciles ranging from 5.1 to 7. Any intervention needs to address access to services.
- **Cohort size: 137**
- **Cohort description**: We chose a cohort of 137 people aged between 40- 60 years; who are obese, suffer from anxiety and are smokers. We feel we can promote healthier living and self agency within this group, to prevent the onset of associated long-term health conditions

Intervention

- **Description of intervention/service:** Cohort member contacted by GP practice and offered lifestyle referral to KCHFT One You Lifestyle Service, which then conducts initial assessment and goal-setting in conjunction with member. A personalized plan is created using motivational interviewing and behaviour change techniques, to address the health and wellbeing needs of the individual. Referrals are made to other organisations to support the person, where needed e.g. via social prescribing or green social prescribing programmes locally.
- **Rationale for intervention:** Intervention is designed to promote healthy living via increased self-awareness and education, promoted via non-medical routes e.g. self-help apps, social programmes and community groups.
- **Wider determinants considered:** Addressed access and availability of services by co-creating a personalised plan. and providing educational resources that can be used in member's own time. Ensuring that every contact is made to count.
- **Activities undertaken for the cohort:** Once re-identified, cohort members approached initially via letter and then 2 weeks later with a follow-up phonecall from GP practice, to allow members to reflect and encourage uptake.
- **Resources required:** Time and commitment to joint working, adapting referral processes to be able to track cohort members for outcome measures. Utilising a comprehensive directory of local services/groups (ConnectWell).

Partnerships

- GP practices & staff
- One You Kent (social care organisation)
- CCG and primary care support
- Medicines Management/Pharmacists
- Public Health/Public Health Observatory
- County Council
- Growth, Environment & Transport Directorate

It is refreshing to see the mutual interest, contribution and collaborative as opposed to adversarial, way of working. We all had a shared purpose for the health of the local population, without bureaucracy – Dr Payne, Clinical Director, Garden City PCN

Ramsgate PCN – intervention extract from case study

Ramsgate PCN Cohort

- **PCN population size: 51,132**
- **Key PCN attributes:** The PCN has an average deprivation index of 3.4, and there is a large proportion of the elderly population in the high complexity group, who are considered socially vulnerable.
- **Cohort size: 118**
- **Cohort description**: We have selected a cohort of 118 people of any age who have diabetes and are housebound; any level of complexity, across all deprivation levels. We think we can empower them and their families to become more "visible" to all health and social care organisations, establish trust and improve their quality of life .

Intervention

- **Description of intervention/service:** The GP practice is going to utilise its nurse practitioners to outreach into the housebound cohort and flag them to the other organisations to ensure their needs are explored, including updating their medical/medicine reviews.
- **Rationale for intervention:** The intervention is designed to flag up the burden of social vulnerability on the chosen cohort, and also to ensure that any carer burden is recognized and support is explored, to ensure health inequalities are not widened through this burden.
- **Wider determinants considered:** The wider determinants of health that were considered are food poverty, housing, safeguarding and isolation, including impact on family relationships and overall deprivation.
- **Activities undertaken for the cohort:** Cohort have been contacted for home visits, co-ordinated between social prescriber and nurse, completing healthchecks, providing diabetes online tool, Diabetes UK resources and other required support.
- **Resources required:** Time, commitment, co-ordination and outreach support with other stakeholders from health and social care. Local support that may be available locally via community and voluntary sectors.

Partnerships

- ANP, GP and practice staff
- Social care practitioners
- PCN Pharmacist
- Community Nurse Practitioners
- Trainee ACP/GPs
- Data Analysis expertise from CCG
- Public Health
- Voluntary sector – Diabetes UK, local voluntary services

It has been incredibly hard to incorporate the diabetic health checks while doing covid boosters, flu vaccines and the day job. I have done my best but need more time to complete these – Clinician, PCN