

**OXFORDSHIRE HEALTH & WELLBEING BOARD – 15 NOVEMBER 2018**

**Current and Future Opportunities for Prevention.**

The draft Joint Health and Wellbeing Strategy (JHWS) proposes as one of its top priorities the need to shift to prevention and grasp the opportunities of healthy place-shaping.

There are currently a number of significant developments taking forward joint work on prevention across the County which will help to make this priority a reality.

This paper provides a brief overview and summary for the HAWB of three current opportunities.

These are:

1. Joining up preventative activity organisation by organisation.
2. Healthy place-shaping
3. Population Health management

They will be discussed in turn, setting out current progress and next steps.

**1. Joining up preventative activity organisation by organisation**

This approach began 9 months ago, with collaboration between the Clinical Commissioning Group (CCG) and County Council to shift the focus of services towards prevention and by building on the work of the Health Improvement Board where a major contribution from District Councils drives the agenda. Much of this work is also reflected in planning at the Buckinghamshire, Oxfordshire and Berkshire (BOB) level.

Work to date has included

- i. A systematic Population Health Management Approach which included
  - Reviewing the health of the whole population as reported in the JSNA
  - analysing needs in detail to identify priority actions to improve life expectancy and reduce health inequalities
  - segmenting the population according to need and stratifying risk for the various segments of the population that had been identified.
  - defining the target outcomes for this population
  - identifying services/initiatives unique to each population group/locality, based on evidence of good practice.
- ii. Development of an approach to prevention which can be adopted across the health and care system and which enables all partners to recognise and develop their contribution. This is now being rolled out, starting with links between the CCG and Public Health and addressing wider determinants of health through

joined up work with District Councils. An outline of this approach is summarised below.

**a. Aim**

To set out an approach for preventing ill health, improving health, addressing inequalities and promoting wellbeing which is agreed by all partners. This includes

- ambitious high-level outcomes for the population
- a response to issues highlighted in the Joint Strategic Needs Assessment and identified health inequalities
- recognition of the wider determinants of health and how the work of each organisation, including District Councils, contributes to the overall outcomes
- recognition of the importance of partners, patients and public working together to improve population health outcomes
- building on existing prevention services, their outcomes and remaining gaps
- helping to tackle long term 'system issues and pressures' such as pressure on urgent care services, through prevention.

**b. Key objectives**

**Living well and independent for longer – “Prevent, Reduce Delay”**

Prevention can mean different things to different people. Defining what we mean is important to allow all partners to be aligned:

- Primary prevention – preventing illness and keeping people healthy (**PREVENT**)
- Secondary prevention – reducing impact of the illness by early detection and preventing recurrence (**REDUCE** need for treatment)
- Tertiary prevention – soften the impact of an ongoing illness and keep people independent for longer (**DELAY** need for care)

**Tackling Inequalities**

- Inequalities in outcome by targeting the people who have worse outcomes
- Inequalities of access, by ensuring people know about the right services and can use them

**Maintaining the financial sustainability of the health and care systems**

As demand increases on NHS and local government, more preventative measures are needed to reduce the overall burden of disease in the population and maintain the financial sustainability of the health and care systems. However, rather than trying to look for immediate cost-savings, focussing on preventive activity and new models of delivery could achieve long-term gains (Chief Economist at Public Health England).

**c. The Case for Change – Summary**

- The top 3 causes of premature death in the UK - ischaemic heart disease, stroke and cancer – are largely avoidable by addressing the lifestyle factors

smoking, unhealthy diet and obesity, physical inactivity and harmful use of alcohol (Living Well for Longer 2014).

- Mental health problems represent the largest single cause of disability in the UK. People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England (Mental Health Five Year Forward View).
- It is recognised that our physical and mental health are influenced by a range of factors: our individual lifestyle factors, our homes, jobs, education, the communities we live in and the environment around us.
- Influencing individual behaviours by using information and education has been shown to be only partially effective. Instead, Marteau (Lancet 2018) highlights **the need to change environments to nudge people to change behaviour**. This has been reflected in recent NICE guidance (March 2018) and the impact of the environment to promote physical activity.

Given the range of influences on our health and wellbeing, we need a cross-organisational approach in order to address these multiple factors.

#### **d. Action Plans and Proposals**

This work is everyone's business and a joint responsibility. It will be undertaken by

- The public – taking responsibility for their own health as far as that is possible.
- All partner organisations Oxfordshire, through their own organisational plans and policies
- The HWB as set out in the Joint HWB Strategy and in delivering their own priorities
- Each sub-group of the HWB
  - The Children's Trust, through the Children's Plan
  - Health Improvement Board, through their priorities and working groups which include all District Councils as well as the County Council and NHS.
  - Joint Management Groups who will deliver the Older People Strategy, the Adults Strategy for those with Care and Support Needs, the Carers' Strategy
- The Integrated Service Delivery Board as they continue to develop condition based pathways and the Integrated System.
- Other partnerships could also become involved, using their influence to tackle the wider determinants of health, including
  - the Safer Oxfordshire Partnership who tackle determinants of health such as crime and community safety

#### **Next steps.**

The approach to prevention has already been developing in collaborative work between the CCG and Public Health and is to be embedded within the Joint HAWB

Strategy – for example it already features in the newly agreed priorities for the Health Improvement Board.

The next steps in rolling out this approach include

- Discussion with the Health Improvement Board regarding County, Districts and CCG going further on prevention by addressing the wider determinants of health.
- The launch of our new Sports Partnership – Active Oxfordshire – and an ambitious partnership approach to reducing physical inactivity
- Challenging all organisations in the system to demonstrate how they are embedding “Prevent, Reduce Delay” in their work
- Ensuring the sub-groups of the HAWB also embed this approach in all new and revised strategies linked to the JHWS and enabling the HAWB to monitor delivery.

## 2. Healthy place-shaping

Healthy place-shaping is practical mechanism for creating healthier communities through unified planning. It begins with the lessons learned from Oxfordshire’s two Healthy New Towns pilots and applies those concepts to other developments and wider geographies.

The Director of Public Health Annual report – also on this agenda- provides more detail about this approach to prevention in chapter two.

The Health Improvement Board has received presentations on the topic and is in support of this approach.

Healthy place-shaping can be defined as an approach to planning as follows:

***‘Healthy place-shaping is a collaborative process which aims to create sustainable, well designed communities where healthy behaviours are the norm and which provide a sense of belonging, a sense of identity and a sense of community.***

***It is also a means of shaping local services, infrastructure and the economy through the application of knowledge about what creates good health, improves productivity and benefits the economy, thus providing efficiencies for the tax-payer.’***

Healthy place-shaping is based on 3 concepts:

1. Shaping the built environment, green spaces and infrastructure to improve health and wellbeing.
2. Working with local people and local organisations, schools etc to engage them in planning places, facilities and services through ‘community activation’.
3. Re-shaping health, wellbeing and care services in the broadest sense to achieve health benefits, including health services, social care, leisure and recreation services, community centres etc.

Crucially, healthy place-shaping is not just about new developments; it applies to any geographical area experiencing significant change or growth so that all residents have the opportunity to benefit in terms of health and wellbeing.

*Thus, healthy place-shaping is an **approach** to planning healthy communities which can be applied in many ways at many levels. In Oxfordshire it may be applied at 3 geographical levels:*

*1) Level 1. Town/village/ new development level.*

Healthy place-shaping applied to all new and existing developments within Districts and City so as to create healthy communities in the broadest sense. This draws directly on application of the learning from the Healthy New Towns approach. This is fundamental as a concept and underpins the two approaches below.

*2) Level 2. Locality level.*

This applies to the re-design and transformation of services in localities covering larger populations (approximately 100,000-150,000). This approach considers how the services of many organisations (including NHS, Local Authority and voluntary sector organisations) and their built assets interlock to benefit the health and wellbeing of local residents.

*3) Level 3. County level and beyond.*

This applies the approach to health and wellbeing issues affecting larger strategic infrastructure plans. It covers for example travel and transport planning, workforce planning, the development of the local economy and productivity issues. These factors are intertwined with the health and wellbeing of local residents and the development of future health and care services.

**Next steps include:**

Discussions with County Chief Executives (District, City, and County Local Authority Chief Executives, Local Enterprise Partnership, OCCG and Thames Valley Police Chief Executives and Chief Officers) about the best way to take this initiative forward. These discussions due to take place throughout November 2018, following which time the Board will be updated again.

### **3. Population Health Management**

The Oxfordshire approach to population health management has recently been approved by the Integrated Services Delivery Board. The paper explaining and summarising this approach to prevention and its implementation is attached at Annex 1

#### **Summary**

These initiatives, taken together, represent a marked step forward in the development of services designed to promote good health and prevent ill health in Oxfordshire or to delay its development. Taken together, they help to respond to this priority area for action as proposed in the draft Joint Health and Wellbeing Strategy.

#### **Recommendations**

The Health and Wellbeing Board are asked to discuss and note these initiatives.

## Annex 1: Population Health Management in Oxfordshire.

### Oxfordshire Health and Social Care System

#### Population Health Management (PHM) in Oxfordshire

This paper sets out Oxfordshire's Population Health Management programme following approval at the Integrated Services Delivery Board and the conclusion of the scoping phase of work. It represents a consensus of views and opinions of chief executives and senior officers from the whole spectrum of health and social care organisations.

The paper covers the following 6 topics:

- An explanation of what Population Health Management is
- The conclusions of the scoping phase of work
- A description of the features of the programme for Oxfordshire
- A model for Population Health Management for the Oxfordshire system
- A description of governance arrangements and lead roles
- A programme of work for the remainder of 2018/19

#### 1. What is Population Health Management?

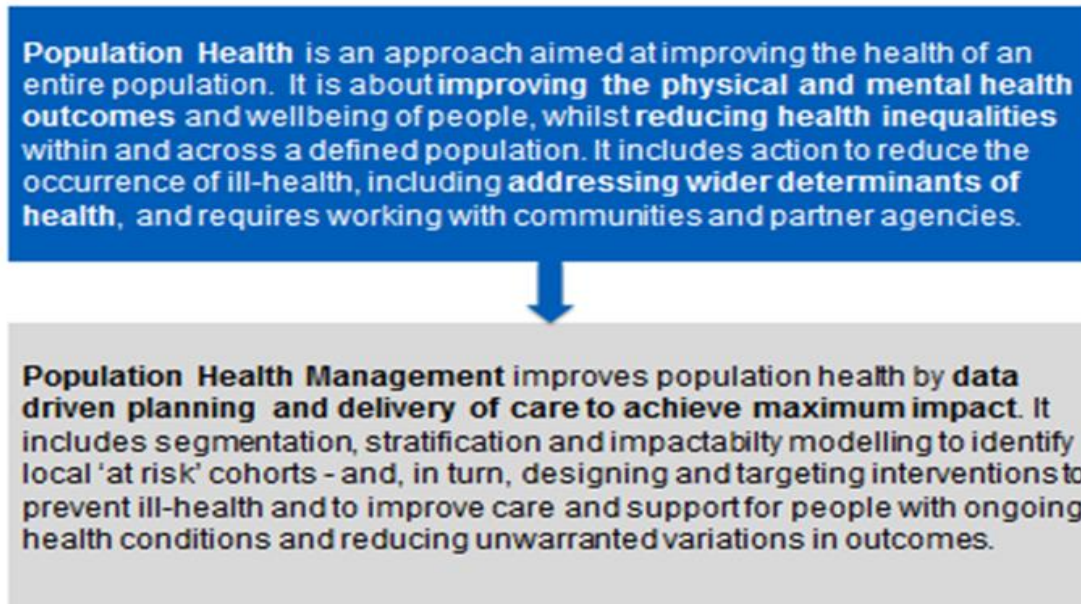
Population health management is an **approach** to service delivery and service planning which emphasises:

- Improving the health of defined groups (ie populations) through systematic, proactive prevention and disease management
- Seeking the risk factors which lead to ill health, and identifying populations affected, through careful analysis of data, and clearly defining the desired outcomes before designing the service.
- Redesigning services in the present and strategies for the future to reduce those risk factors which can be changed (ie *proactively managing* people's health rather *reacting* to their ill-health)

As an approach it can therefore be applied to any service for any defined group of people and can encompass for example; people living in a geographical area e.g. a locality; people with particular disease e.g. diabetes or multiple diseases or social care needs; people with a particular characteristic e.g. poverty or social disadvantage; people who make use of a particular service e.g. those who attend A and E.

The national definition from NHS England defines PHM in 2 steps. First it describes a generic approach to population health, and then goes further to describe PHM as the *active management* of a population's health by using data to identify those at risk of ill health for whom redesigned services will bring a benefit.

NHS England's definition of 'population health' and 'population health management' is:



In terms of the technical language used, '**segmentation**' means selecting specific groups of people with common characteristics. '**Stratification**' means dividing that group up according to their level of risk and '**impactability**' means the likelihood that the people in different risk groups will be able to benefit.

**So, as an example in terms of urgent care**, the *segment* might be people over 65 attending A and E. The *risk factors* might be analysed and *stratified* according to underlying chronic diseases which led to the admission, and the *impactability* is the likelihood that different diseases or combinations of diseases could be prevented from needing A and E attendance if current services were modified or new services put in place.

**As an example in terms of planning for a locality**, a *segment* might be a specific ethnic group living in a particular town. *Risk stratification* might be done by looking at their age and gender profile, levels of education and socio-economic profile alongside the clinical evidence of disease in that population, the current incidence of disease and their use of services compared with other groups. *Impactability* might be estimated through public engagement, survey, consultation and looking at the evidence-base and best-practice elsewhere so that improved services could be planned.

PHM isn't a new idea, but systematically applying it to whole populations and to system priorities at scale as a significant driver for change *is* new.

## 2. Conclusions of Phase 1 of this approach – the scoping phase (June-September 2018)

To make this programme work in practical management terms requires 3 key elements:

1. **A shift of culture** in clinicians, managers, health and care front line professionals and strategic commissioners to think in terms of proactive prevention alongside reactive treatment.
2. **The ability to use data** to seek out those most at risk of disease and who are amenable to prevention
3. **Having the capacity and capability to re-shape services** for individuals and populations in the light of this information looking both at today's and tomorrow's services. Ultimately this approach should be "designed into" services from the start.

Some of the data involved requires very sophisticated analysis and some does not. We have sufficient data to make a start now, using what is available. More sophisticated methods of data analysis are now emerging via the work of a subgroup of the Oxfordshire Digital Strategy Group, and further improvements are expected during the next 12 months.

There is strong support amongst colleagues from across the system for taking such an approach and ***creating the right culture is seen by colleagues as the most vital step if we are to find 'upstream' solutions.*** We are already 'data rich' but are sometimes 'intelligence poor', and we spend huge effort in managing and designing services. If we shift the culture so that we ask better questions, we will get better results.

We propose to do this by working progressively with colleagues to establish a firm centre and then gradually work 'out', sharing learning and experience on the way, progressively involving more clinicians and managers.

We can also benefit from Oxfordshire's access to academic rigour and research data as the programme progresses.

The model assumes close 'system working' between partners and the engagement of all Local Authorities.

There is already good practice in place in Oxfordshire which takes a similar approach. The challenge is to create a culture in which such practice can be achieved systematically at scale for the benefit of all. Examples raised in discussion so far include:

Example	Description
General practice and The Federations	Many of the approaches to chronic disease management and frailty are similar to this approach and could be further enhanced by it.
NHS Health Checks	Men in manual socio-economic groups are at risk and generally don't attend for standard health checks, therefore the health check is delivered at



	football matches.
Bicester and Barton Healthy New Towns work	Ongoing work on the risk of falls in Barton and the risk of diabetes in Bicester as well as an asset-based population approach.
Care Programme Approach	Tailoring care to individual needs in the community when delivering mental health care.
Community Safety Practitioner in A and E	Frequent A and E attenders with alcohol issues are followed up and a care and support package is agreed.
Troubled families	This programme seeks out risk factors in families and intervenes so as to prevent deterioration in family members.
National Child Measurement Programme	Measures overweight and obesity in school age children and intervenes via standard messages to parents.

Lessons can also be learned from 1<sup>st</sup> wave ICSs and some of that learning can be used to assist us now.

This proposal has been shared in outline with NHSE's regional lead for PHM (Jackie Chin) who has commented favourably on the approach. We are in touch with the approaches of regional neighbours through NHSE networks and other professional networks.

Every CCG area is approaching PHM in a slightly different way depending on local circumstances. Some are emphasising very complex data analysis for high-needs patients almost exclusively. Our proposed approach is characterised by looking at the whole system and whole population, working with a wide partnership, emphasising cultural change and being pragmatic about using existing data until developments in data systems permit more complex analysis. More complex analysis is likely to come 'onstream' in 12 months' time.

Because this approach applies PHM thinking to current system priorities, we can avoid complex governance arrangements by working alongside existing programmes of work. We propose to engage the clinicians, care staff and managers already involved in this work as they will already understand the issues and the data. In due course we can engage with the public through this route as well.

It is important to see this programme as a way of improving services on the ground and not 'data for data's sake'. The data and data systems are a tool to be used and not an end in themselves.

### **3. The proposed approach for the Oxfordshire System has the following characteristics. It:**

1. Is designed to assist with progress towards ICS status and complements the CQC action plan.
2. Works with established system priorities and helps to deliver them.

3. Includes the whole spectrum of care from prevention/ broader determinants of health through community services to specialist care. It therefore seeks to engage many organisations across health and social care, including District and City Councils, which are key to prevention and tackling the 'wider determinants of health'.
4. Concentrates on practical service change and inclusion in all strategies.
5. Changes the culture so that people 'think PHM' in service delivery and design.
6. Includes a Population Health Management approach to Social Care.
7. Is built into the thinking of the new Health and Wellbeing Board and Joint Health and Wellbeing Strategy.
8. Is built into the service transformation planned for localities, beginning with support to work in the locality around Wantage.
9. Assists with creating 'Healthy Communities', drawing on the lessons from the Healthy New Towns.
10. Adopts a 'parity of esteem' approach regarding mental and physical health issues.
11. Works alongside the development of a single platform for data sharing via the Local Health and Care Record Exemplar (lhcre) approach. This is a complex project covering many Counties which is overseen in Oxfordshire by the Oxon Digital Strategy Group which also reports to ISDB. The forthcoming addition of the 'healthEintent' module to this project will permit more complex analysis of shared records in approximately 12 months' time. We propose to start with the data we already have, including community and social care data and using the existing data warehouse, standard hospital data, primary care data, ONS data and census data. We believe this is sufficient to make a useful and practical start. This will further enhance the Joint Strategic Needs Assessment.
12. Involves input from clinicians through their work on existing system priorities (frailty and diabetes are good examples) as they already have good knowledge of services and data.
13. Creates tangible examples and local case studies to demonstrate our approach to a wider audience.
14. Meshes with Buckinghamshire's ICS approach and proposes shared learning and cross-membership with Bucks (and in due course with W Berkshire).
15. Complements and influences Population Health Management at STP/ BOB level while focussing on Oxon system priorities.

#### **4. Phase 2 Proposals (October 2018 to October 2019)**

Phase 2 proposes to meet the following objectives:

1. To test the application of PHM to 'live' priority programmes of work through engagement with system leads and clinicians.
2. To begin to create a culture in which a PHM approach is the norm.
3. To develop local experience and confidence in the approach.
4. To influence strategic service change and new models of care as they emerge.

5. To provide practical service-based advice to the PHM sub-group of the Oxon Digital Strategy Group and to support its work.
6. To continue to seek out existing local good practice and assess it for applicability at scale.
7. To develop practical examples of local application
8. To learn from new models of care being developed elsewhere and assimilate them as appropriate.
9. To further strengthen whole-system working.

The proposed system priorities we propose to scope the application of PHM approach to over the next year are:

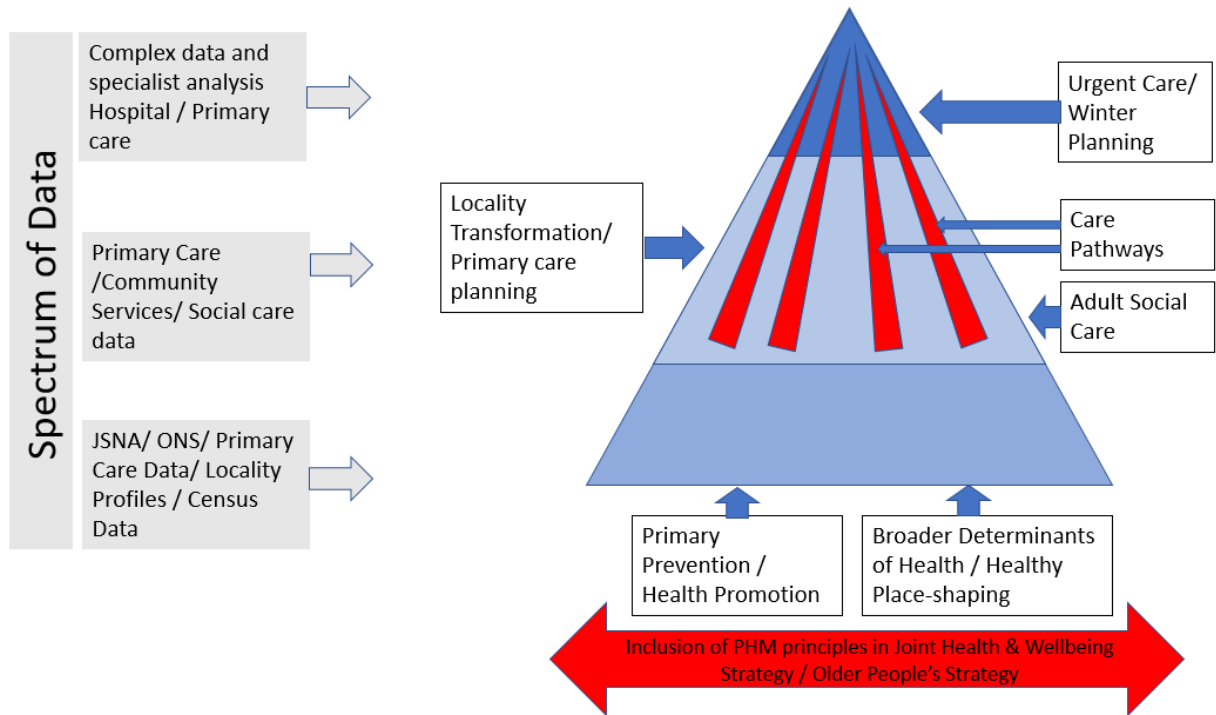
1. Transformation of services in localities, beginning with the locality around Wantage
2. Winter Planning/ Urgent Care
3. Pathways of care
4. Integrating Adult Social Care and NHS services, beginning with work to test applicability to Social Care data.
5. Wider determinants of health and 'creating healthy communities' beginning with healthy place-shaping.
6. Primary prevention services (those aiming to prevent disease before it starts)
7. Including PHM in system strategies beginning with the Older Peoples' Strategy.

This gives us a programme which is set out in the schematic below. The schematic shows a 'population risk pyramid'. The pyramid is divided into three groups for the purposes of presentation and denotes the following:

1. **The base of the pyramid:** The majority who are basically well and use services occasionally. The unit cost of treatment is low. The aim is to keep people well for longer.
2. **The middle of the pyramid:** Those who are already ill or have care needs. These are fewer, and the unit cost of care is higher. The aim is to prevent further deterioration so as to prevent people moving towards the apex of the pyramid.
3. **The apex of the pyramid.** Health and care needs are multiple and multi-morbidity is common and care use frequent. The unit cost of care is very high.

The 'spectrum of data' running alongside the pyramid is indicative of the different types of data that can be used at each level.

**Model for Phase 2 Showing Oxfordshire proposed workstreams and relevant data sources – 'The Oxfordshire Model'**



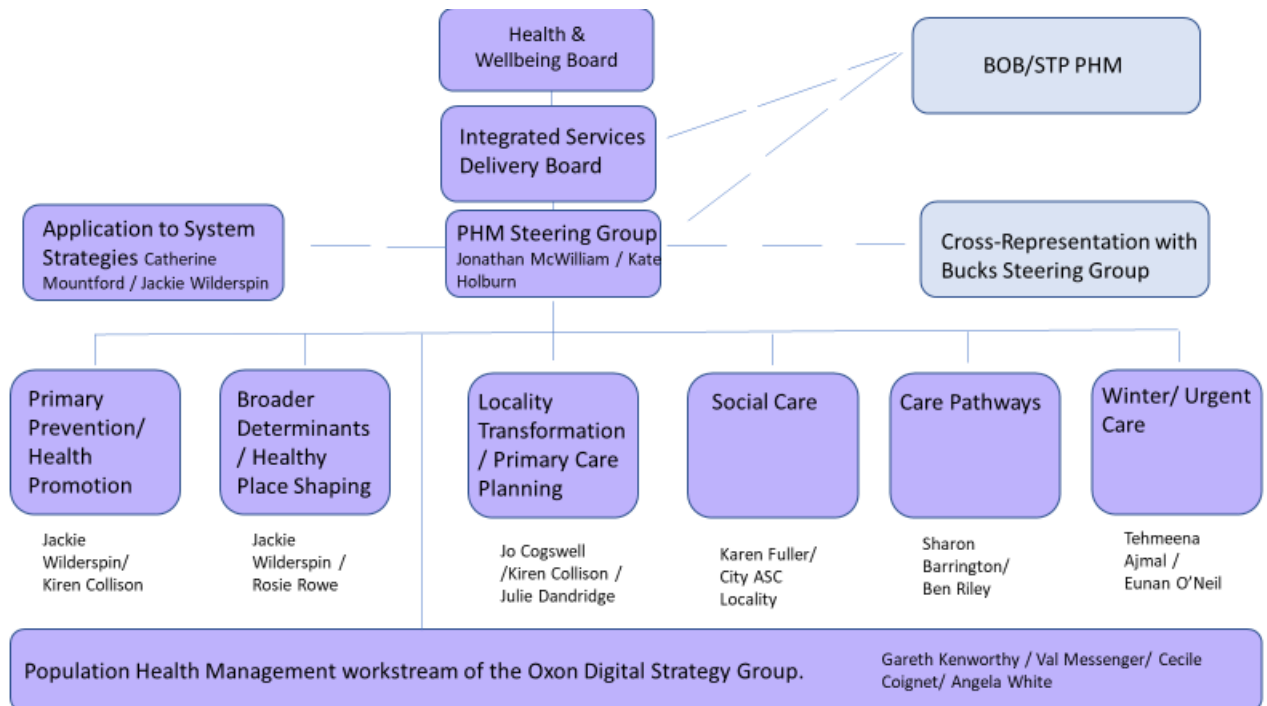
## Governance, workstreams and workstream leads for Phase 2

This gives an initial programme with the following governance, workstreams and leads. ***This enhances and works alongside system priorities and represents a coordinating mechanism rather than additional bureaucracy.*** This does not duplicate existing working groups, it enhances them and seeks to change their culture. The role of the leads is to work together in the steering group to consider how PHM applies to each lead area. This is an initial iteration and will develop over time. To avoid delay, we have already begun to explore how this will work in practice using this model.

### Governance structure, workstreams and workstream leads.

The SRO for the programme is Jonathan McWilliam until 31/10/18 and will be Val Messenger from 1/11/18.

## HWB7c(4)



### 5. Next Steps and timescale to February 2019:

1. Complete scoping discussions with clinicians and managers – 1/10/18
2. Create a framework for locality data to support work in the Wantage area and subsequent work – September - December 2018
3. Seek out remaining emerging good practice already ongoing in Oxon – December 2018
4. Explore a wider range of existing data and test for applicability– December 2108
5. Advise on the development of the 'healthEintent' module – from September 2018
6. Maintain a link with the developments in existing BOB and lhcre bid analysis– Ongoing.
7. Focus work on scoping the contribution of population health management in 3 areas: locality analysis in the Wantage area, urgent care and the older peoples' strategy - January 2019
8. Oxon programme event for a wide range of clinicians and managers following initial scoping by workstream leads with keynote speakers and local presentations Feb 2019

### 6. Resources

The proposals in this programme can be completed within existing budgets for the most part. Additional resource may be required re data analysis but this has not yet been scoped. The key resource is the time of the staff involved.

Dr Jonathan McWilliam – DPH & Oxon System SRO for Population health management  
Kate Holburn – Population Health Management Programme Lead  
18/10/18