Joined Up Care
Derbyshire

INTEGRATED CARE PARTNERSHIP **ITEM 09**

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Stay Well Update - Role and function of the Population Health Management Steering Group and next focus for the Stay Well Sprint

Purpose

1.1 To provide the Integrated Care Partnership (ICP) with an update on progress made on the Stay Well Key Area of Focus (KAOF) of the Integrated Care Strategy since the last meeting of the ICP.

1.2 To bring to the attention of the ICP issues relating to the role and function of the Population Health Management (PHM) Steering Group.

1.3 To outline, and seek approval, for the proposed focus for the next Stay Well sprint and intent to carry out a ‘pre-sprint’ phase.

Recommendations

2.1 To note this update on the Stay Well KAOF.

2.2 To note that the PHM Steering Group is unable in its current format to adequately take forward both PHM and Stay Well programmes.

NHS The Derbyshire VCSE sector Alliance Derby City Council DERBYSHIRE County Council

2.3 To consider the development of a system-level PHM function is developed under a senior responsible officer (SRO) and that the PHM steering group becomes the Stay Well KAOF Delivery Group.

2.4 To agree that Stay Well begins a pre-sprint phase on adult obesity with a view to take forward a Sprint at a future date.

Reasons

3.1 To ensure that the ICP is fully briefed and supportive of the next steps for Stay Well.

3.2 To ensure that the ICP is aware that the PHM Steering Group, due to its focus on Stay Well, is not driving forward and embedding a system approach to PHM.

Supporting information

4.1 The following sets out the original role and purpose of the Population Health Management (PHM) Steering Group, changes made to support the scope and implementation of the Stay Well Key Area of Focus (KAOF). It also summarises reflections and lessons learnt from Stay Well work completed to-date and makes the case for the next Stay Well priority area of work.

Original role and function of the PHM Steering Group

4.2 The Population Health Management[1,2] (PHM) Steering Group was established during the Joined-Up Care Derbyshire (JUCD) system's participation in NHS England's (NHSE) Population Health Management Delivery Programme (delivered by Optum UK) in Autumn 2022. The purpose of the PHM Steering Group was to bring together key representatives from across the JUCD Integrated Care System (ICS) to coordinate the development of the overarching direction of travel for PHM in Derby and Derbyshire, catalysing system-level action to address population health priorities, particularly to:

- Develop policies and governance procedures for PHM.
- Oversee and provide operational support to the development of the Derby and Derbyshire roadmap and objectives.
- Identify up and coming PHM priorities, future opportunities and challenges, and prioritising potential PHM projects.
- Take decisions in relation to programme development and implementation and where necessary seek approval from relevant Boards.
- Discuss and agree practical actions about how barriers and challenges might be overcome, including escalation to other Boards or groups.
- Provide a space for information sharing across the ICS in relation to PHM.
- Influence and support transformation within the Derby and Derbyshire Integrated Care System that the PHM methodology will guide.
- Enable connection and alignment between system, place and neighbourhood in relation to PHM.
- Link with other system-wide groups to influence, share knowledge and shape PHM programme outcomes and outputs.
- Enable the Senior Responsible Officer or group members to update on key issues.

[1] https://www.england.nhs.uk/long-read/population-health-management/
[2] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/population-health-approach

4.3 The original approach to this work involved significant external support and resource from Optum UK. Learning from this programme of work identified several critical components and / or challenges to implementing system-level PHM effectively, including:

1. Data sharing
2. Capacity / capability – at this point we had a single fixed term role to transact this work
3. Shared focus between partners on a small (achievable) number of priority areas.

4.4 In early 2023, as part of the ICP strategy development, the Stay Well Key Area of Focus (KAOF) was agreed, following input from the PHM Steering Group, to "improve prevention and early intervention of the three main clinical causes of ill health and early death in the JUCD population - circulatory disease, respiratory disease, and cancer". The PHM Steering Group effectively took on development and leadership of the Stay Well KAOF and has achieved positive progress over the past 18 months.

4.5 As a result of supporting the development and leadership of the Stay Well KAOF, the membership of the PHM Steering Group has evolved (in organisations and expertise represented) and now includes representatives from Chesterfield Royal Hospital (CRH), University Hospitals of Derby and Burton (UHDB), the Integrated Care Board (ICB), Derbyshire Healthcare Foundation Trust (DHFT), the voluntary community and social enterprise (VCSE) sector, Derbyshire Community Health Services (DCHS), North of England Commissioning Support Unit (NECSU). The group has focused on implementing the Stay Well KAOF using a PHM approach.

Agreed methodology and initial scope

4.6 In approaching the three main clinical causes of ill health and early death, the PHM Steering Group believed that focusing on the key drivers/ risk factors - the full driver diagram can be seen in Appendix 1 - of circulatory disease, respiratory disease and cancer would offer the greatest opportunity for impact. It was recognised that this would simultaneously provide action on our system-agreed Turning the Curve population outcome indicators. A sprint[3] approach towards the drivers was agreed with the ICP and other key system groups including the Integrated Place Executive (IPE), GP Provider Collaborative and the Provider Collaborative Leadership Board.

4.7 The first Sprint focussed on smoking cessation due to the known impact on population health and health inequalities, as well as the system-wide impact on services across JUCD. The output from the first Sprint was reported to the February 2024 ICP. It also identified the need for the System to progress work to establish clarity as to the required and appropriate data sharing arrangements to facilitate the transaction of PHM activity. This update highlighted the potential benefits of a Section 251 agreement for this purpose, and the need to undertake a gap analysis as the initial priority, in order for JUCD to progress to ensure the use of a data driven PHM approach in JUCD whilst ensuring information governance requirements are met.

[3] A sprint is a time-bound approach to project management involving the focus on a specific set of tasks or objectives.

Reflections and revised scope for the PHM Steering Group

4.8 The PHM Steering Group has begun to discuss its remit given mission creep from a focus on PHM to support the Stay Well KAOF and whether, going forward, it should focus its effort on the delivery of Stay Well (applying PHM methodology to do so), on PHM more broadly, or on both. A subset of the PHM Steering Group has subsequently been engaged to consider the role of the group.

4.9 Reflecting on the experience of the first Sprint, the importance of both programmes (PHM more broadly, as well as Stay Well specifically), as well as their significant scale and scope, is recognised.

4.10 The PHM Steering Group, in its current form, cannot adequately deliver successfully on both programmes of work, so would need to amend its membership, structure and governance arrangements if it continued with a dual focus.

Implications for the PHM function for the system going forwards

4.11 Developing and embedding an effective approach to PHM requires data, integrated data and an effective infrastructure of tools and systems to enable meaningful analysis and visualisation. The PHM Steering Group therefore recognises that a successful and embedded approach and infrastructure for PHM requires the professional input of the Strategic Intelligence Group and Digital infrastructure

4.12 The Strategic Intelligence Group is also about to take stock and consider its role, purpose and how it functions within the wider Joined Up Care Derbyshire System and the Data and Digital Strategy is also currently being refreshed. If feels timely therefore, to consider these groups / issues in the round.

4.13 As above, we know from early experience that whilst data and associated infrastructure is fundamental to successful PHM, this is only one component. There are other critical components including:

- Workforce capacity and capability
- Effective and appropriate information governance
- Change management - structural and cultural
- Experience and insight (public, patient and professional) to support both understanding of populations and issues and in designing and implementing interventions
- Research and evidence - understanding latest best practice and knowledge of ‘what works’
- Implementing service improvement and new interventions
- Evaluating success - understanding the effectiveness and impact of interventions using appropriate evaluation techniques and performance management arrangements.

4.14 Developing and embedding an effective approach to PHM is a significant change management programme that requires a clear strategy and delivery plan with associated resource and infrastructure.

4.15 As the current arrangements are unsuitable, the ICP is asked to consider the establishment of a system level function under a SRO, who has a dedicated capacity and is supported to coordinate and deliver against the data and evidence-based agenda of PHM. The current PHM steering group would then become the Stay Well KAOF Delivery Group, recognising that as there is currently no dedicated resource or funding allocated to this preventative agenda, it is reasonable only to ask the group members to drive forward the Stay Well agenda, not in addition, a system PHM function.

Next area of focus for Stay Well sprint

4.16 The PHM Steering Group concluded the sprint on smoking cessation in February 2024. A comprehensive evaluation was undertaken and the key learning as reported to the ICP previously was;

- A sprint approach fostered close partnership working, accelerated progress, and was refreshing to participate in
- A pre-sprint preparation period was essential to ensure the sprint, once it is commenced, has full engagement, the necessary data and a clear implementation plan including intended outcomes.
- The sprint serves to accelerate and pump-prime system-wide work on a key population health priority, not to subsequently sustain the long-term delivery beyond the bounds of the sprint.
- Consequently, an exit route to ensure the ongoing embedding of sprint work into the system architecture is essential. This increases the sustainability and momentum of the work commenced. A structured shadowing between the Sprint and the exit group is required to ensure all key information is communicated clearly and understood. The sprint exit for the smoking cessation focus was into the then recently established Tobacco Control Steering Board chaired by the Director of Public Health for Derbyshire.
- The IPE has helpfully agreed the exit route should include some or all Place Alliances, to aid ongoing delivery and impact.

4.17 Since February, engagement and consultation discussions have taken place with system partners and groups to canvas opinion on what driver should be prioritised within the next Sprint. Partners consulted with included:

- Public health teams and Directors within the two Local Authorities
- Integrated Place Executive
- Organisations represented on the PHM steering group including the ICB, DCHS, UHDB, CRH and the voluntary sector alliance.

4.18 Of the options considered, no single option achieved full consensus of all consultees.

The option which received the greatest level of support was for a sprint focus on adult obesity. The other options considered can be seen in 6.1.

Why obesity?

4.19 In Derby and Derbyshire in 2021, high Body Mass Index (BMI) was the leading risk factor for Years Lost to Disability (YLD) and in the top five risk factors for mortality after tobacco (Global Burden of Disease Study), having risen to this position over the past ten years.

4.20 The scale of the challenge, from what we know using primary care aggregate data from RAIDR - a health intelligence tool - there are c.26,000 people with a BMI of 40+ (severe obesity), and a further c.119,000 people with a BMI of 30-39 in Derby/Derbyshire (obese). Additionally, 12% of bookings with UHDB (Trust-wide, inc. Burton) maternity in 2023/24 (over 1,500 per year) had BMI over 35+ and therefore ordinarily receive consultant-led care due to increased risk[4].

4.21 Obesity is a risk factor, and a secondary risk factor, for many conditions, including those related to the Stay Well KAOF (see Appendix 2). For example, of the known overweight / obese population in JUCD, we know there is a sub-population (c.800) at elevated risk of diabetes.

4.22 In addition, the Major Conditions Strategy identified that a woman living with obesity is more than three times more likely to have a heart attack than a woman of healthy weight[5]. Obesity is a secondary risk factor for stroke, for which every five minutes someone is admitted to hospital in the UK[6], with a median length of stay of 7.3 days[7]. As such obesity is a causal factor for acute and step-down bedded care utilisation.

4.23 In 2017, it was estimated that obesity was, "…responsible for more than 30,000 deaths each year. On average, obesity deprives an individual of an extra 9 years of life, preventing many individuals from reaching retirement age. In the future, obesity could overtake tobacco smoking as the biggest cause of preventable death."[8] This report - Health matters: obesity and the food environment (2017) - estimated that the NHS spent £6.1 billion on overweight and obesity-related ill-health in 2014 to 2015[8].

4.24 There are known health inequalities present with obesity - the Nuffield Trust[9] highlight that the prevalence of obesity has consistently been greater in the most deprived children, both at age 4-5 and 10-11. The same is true for adults, for whom prevalence of overweight (including obesity), and obesity in its own right, is highest in those living in the most deprived areas (71.5% and 35.9% respectively) and lowest in those living in the least deprived areas (59.6% and 20.5% respectively)[10].

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4 https://www.nhs.uk/pregnancy/related-conditions/existing-health-conditions/overweight/

5 https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2#chapter-5-enabling-systems

6 https://www.bhf.org.uk/what-we-do/our-research/heart-statistics

7 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6297619/

8 https://www.gov.uk/government/publications/health-matters-obesity-and-the-food-environment/health-matters-obesity-and-the-food-environment--2

9 https://www.nuffieldtrust.org.uk/resource/obesity?gad_source=1&gclid=Cj0KCQjw9vqyBhCKARIsAIIcLMGuAmcNUOZF1nXIwYL-Ewb12pLGzf08T4e4sXN58YQ-_v4mbwANwaAaAsuwEALw_wcB

10 https://www.gov.uk/government/statistics/update-to-the-obesity-profile-on-fingertips/obesity-profile-short-statistical-commentary-may-2024#:~:text=Data%20on%20adult%20overweight%20and%20obesity%20prevalence,-The%20best%20indicator&text=The%202022%20to%202023%20obesity,in%20place%20at%20the%20time.

4.25 Looking to the future, we know the prevalence of obesity is forecast to increase, such that nationally, by 2050, 60% of men, 50% of women, and 25% of children under 16 are likely to be obese[11].

4.26 Continued and unabated growth in obesity prevalence stands to impact negatively:

- on the health outcomes of the local population
- across a large number of condition pathways in JUCD.
- on the demand and cost of health and care.

Further, this forecast increase will not occur equitably across society, exacerbating current health inequalities.

4.27 With increasing obesity, in addition to increasing prevalence of diseases/conditions (such as those in Appendix 2), there is also an increased likelihood of multi-morbidity (where a person has multiple concurrent conditions, which may / may not be related to / include their obesity) and may be on multiple disease registers / waiting lists / care pathways. There is therefore a risk of increased health and social care demand (and / or longer waiting times), given multi-morbid patients tend to have a greater number of appointments and longer duration appointments (at least in primary care).

Proposed approach for the Obesity Sprint

4.28 Learning from the evaluation of the smoking cessation Stay Well sprint, the system boundaries for the purpose of the sprint would need to be agreed and articulated at the outset and in doing so, recognising contextual determinant factors that lie outside of the system boundaries, and the relationship between the two.

4.29 In terms of the process, it is proposed that a pre-sprint phase takes place initially. This would need to be data-driven (more so than the smoking sprint), including leveraging digital systems (such as the RAIDR functionality) to identify at-risk population groups, for example. It is anticipated this pre-sprint phase would require input from partners representative across the system, similar to the approach used for the smoking sprint.

4.30 Only after a robust understanding of the system landscape (including both current constraints, threats, gaps, as well as opportunities), and with system partners' agreement, would the subsequent sprint commence.

4.31 A group would need to be identified to hand actions / ownership to at the conclusion of the sprint. This will require identification of system-level senior ownership to ensure resource, accountability and delivery of action identified / commenced in the sprint. It is recommended this is supported by the Place Alliances who are well placed to support and champion action at a local level. The Obesity Alliance, with appropriate resource, could be a prime vehicle for sustained coordinated delivery against this risk factor over the longer-term.

[11] https://assets.publishing.service.gov.uk/media/5a7c7a94e5274a5255bceee6/07-1469x-tackling-obesities-future-choices-summary.pdf

4.32 In addition to the PHM Steering Group membership, representatives from the GP Provider Board, and the emergent Obesity Alliance (comprising JUCD representatives with a shared interest) have expressed support for the approach outlined above and a commitment to being involved in the process.

Public/stakeholder engagement

5.1 In determining the focus of the next Stay Well sprint, the following Partners were consulted;

- Public health teams and Directors within the two Local Authorities
- Integrated Place Executive
- Organisations represented on the PHM steering group including the ICB, DCHS, UHDB, CRH and the voluntary sector alliance.

Other options

6.1 The PHM Steering Group considered the following areas for the focus of the next Stay Well sprint.

It was acknowledged that there could likely be cross-over between the difference sprint focus areas considered (e.g., population health profiles at place level focussed on obesity, adult Severe Mental Health as a population group and their associated health priorities etc.).

Sprint focus	Rationale
Obesity	Identified as a key driver in the driver diagram. Additionally, like smoking, obesity has extended negative consequences for the patient and many areas of the JUCD system.
Core 20 (20% most deprived populations)	Identified within this Core 20 Plus 5
An identified plus group (identified population group which experiences greatest inequalities within JUCD)	To progress from the current position of an absence of system-agreed plus populations.
The provision of Population Health profile / drivers to Place groups/teams.	Provision of information to help drive action on health at a local level, informing plus populations at a local level.

Financial and value for money issues

7.1 None directly arising from this report.

Legal implications

8.1 None directly arising from this report.

Climate implications

9.1 None directly arising from this report.

Socio-Economic implications

10.1 None specifically arising from this report; however, socio-economic issues relate to obesity and its impact.

Other significant implications

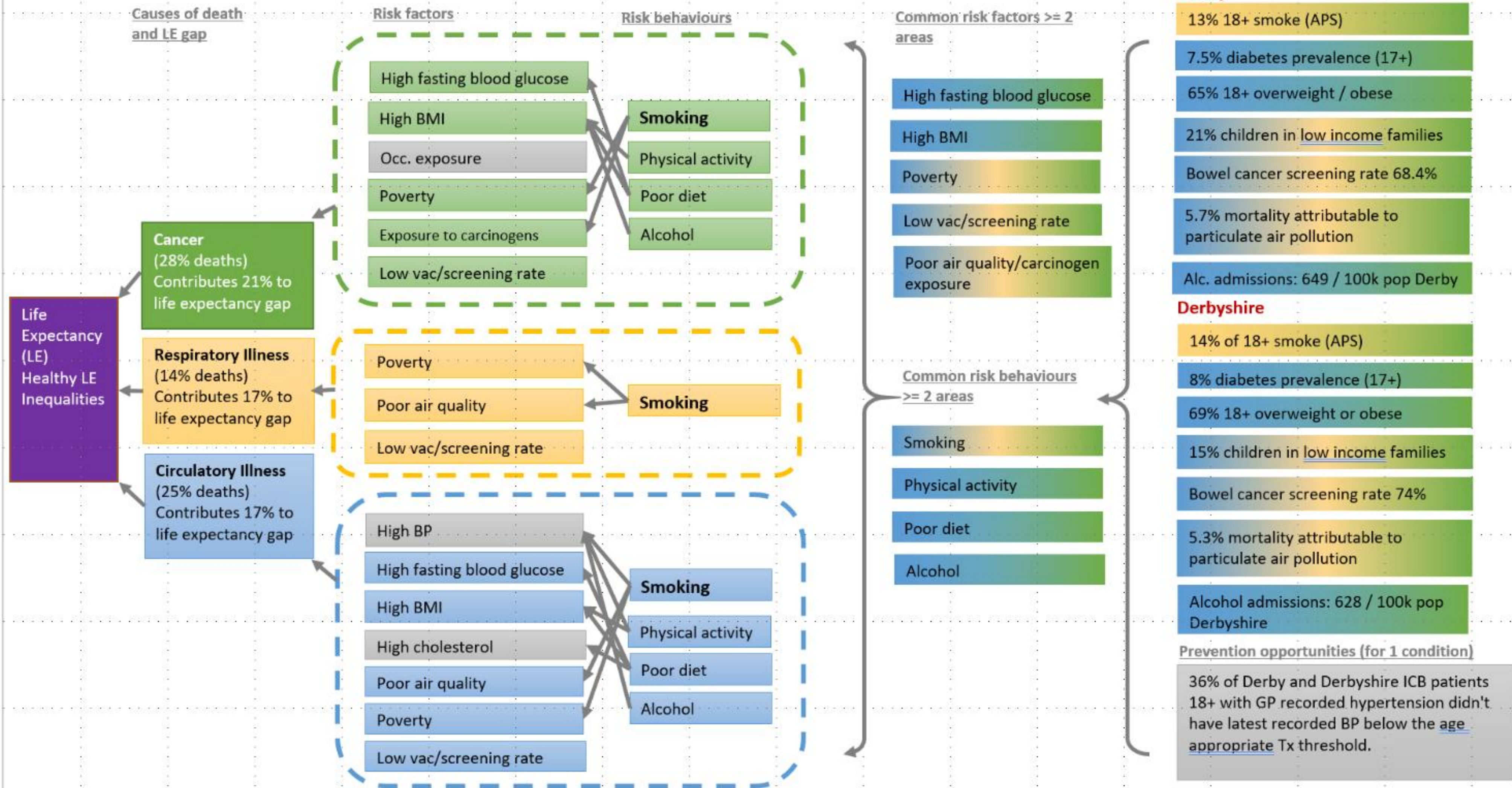
11.1 None arising.

This report has been approved by the following people:

Role	Name	Date of sign-off
Legal		
Finance		
Service Director(s)		
Report sponsor	Jayne Needham, Director of Strategy, Partnerships and Population Health, Derbyshire Community Health Services NHS	07/06/2024
Other(s)		

Background papers:	None
List of appendices:	Appendix 1 - Driver Diagram Appendix 2: Condition specific implications of increased obesity prevalence

Appendix 1: Driver Diagram



Appendix 2: Condition specific implications of increased obesity prevalence

Condition specific implications are summarised in the table below:

Condition with increased prevalence due to increased overweight / obesity prevalence:	Implications (e.g., impact on services, opportunities, unmet need intelligence etc.)
Type 2 diabetes	Increased demand for diabetes management services, diabetes education services, GP presentations for diabetes care, podiatry presentations due to diabetes complications, wound care service presentations (and longer healing times for more people) Prevention opportunity: expand weight management and lifestyle intervention programs to prevent the onset of type 2 diabetes
High blood pressure	Expansion of hypertension clinics: More clinics or services focusing on monitoring and managing high blood pressure will be needed. In 2023, 30% of adults had hypertension (including 15% with untreated hypertension), though this varies by age, ranging from 9% of adults aged 16-44 to 60% of adults aged 65+[12]. In terms of current levels of unmet need, in Derby City Council area it is estimated that 9,656 people have undiagnosed high blood pressure, while in Derbyshire County Council it is 22,068 people[13]. Optimisation of hypertension treatment (including increased diagnosis and ensuring provision of and adherence to optimal treatment) has been identified as a High Impact Intervention by NHS England[14]. While increasing diagnosis will increase medication costs, over 10 years, reducing population average blood pressure by 5mmHg could save an estimated 45,000 Quality Adjusted Life Years (QALYs) and c£850m in related health and social care costs.
Heart disease	Increased demand for cardiology services, including diagnostics, treatments, rehabilitation, and surgical interventions. Opportunity for enhanced community-based prevention programs to promote heart-healthy lifestyles.
Stroke	Stroke Units and Rehabilitation: Increased capacity in stroke units and more resources for post-stroke rehabilitation. Public Awareness Campaigns: Campaigns to educate the public on stroke symptoms and prevention strategies.

[12] https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2021-part-2/adult-health-hypertension

[13] https://joinedupcarederbyshire.co.uk/news/get-your-blood-pressure-checked-and-beat-the-silent-killer-urge-nhs-and-local-communities/

[14] https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/cardiovascular-disease-high-impact-interventions/#ot-3

Metabolic Syndrome	Integrated Care Models: Development of integrated care pathways to manage metabolic syndrome, combining dietary, lifestyle, and medical interventions.
Fatty Liver Diseases	Liver Disease Clinics: Establishment or expansion of clinics dedicated to diagnosing and managing non-alcoholic fatty liver disease (NAFLD). Prevention opportunity for Public Health initiatives to reduce risk factors through public health campaigns focused on diet and physical activity.
Cancers	Increased demand for cancer screening, diagnostics, and treatment services.
Breathing Problems	More pulmonary rehabilitation programs to support patients with obesity-related respiratory issues, such as sleep apnoea.
Osteoarthritis	Increased demand for orthopaedic consultations, surgeries (e.g., joint replacements), and rehabilitation services. Enhanced pain management programs for chronic musculoskeletal pain.
Gout	Greater need for rheumatology services to manage gout and its complications.
Diseases of the Gallbladder and Pancreas	More surgeries for gallbladder removal and treatments for pancreatic conditions. Preventive opportunity to focus on dietary modifications to reduce the risk of these diseases.
Kidney disease	Increased need for nephrology services, including dialysis and transplantation programs Opportunity for secondary prevention to ensure enhanced screening programs for early detection of kidney disease.
Pregnancy Problems	Maternal Health Services: Expanded services for managing high-risk pregnancies, including more frequent monitoring and specialized care. Preconception Care: Programs focusing on weight management and health optimization before pregnancy.
Fertility Problems	Fertility Clinics: Increased demand for fertility treatments and interventions. Lifestyle Counselling: Counselling services to address weight management as a component of fertility treatment. This is in the context of an already declining birth rate.
Sexual Function Problems	Establishment of clinics specializing in sexual health and erectile dysfunction. Mental health and counselling services to address the psychological aspects of sexual dysfunction.
Mental Health Problems	Increased demand for mental health services for conditions associated with obesity, e.g. depression, anxiety, and others. Collaboration between physical and mental health services to provide holistic care.