



NAPC | National Association
of Primary Care



Primary care home: population health management



#primarycarehome

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Foreword

Taking a population health management approach to health and care is integral to the primary care home (PCH) model, but it can be challenging to know where to start and which approaches to take.

Here we provide a practical guide to developing population health management with examples from home and abroad, the different approaches to understanding your population, how to engage and work with stakeholders, and how to co-design new models of care.

We introduce the NAPC's population health management approach, which has been developed by our experts.

There are PCH sites that are already taking a population health management approach, and a variety of methods are being used. These are illustrated in this guide, along with case studies.

The adoption of a whole population health management approach underpins all four core characteristics of the PCH model, and ultimately helps to deliver the quadruple aims of healthcare – to improve the health and wellbeing of patients, the quality of care for patients and communities, the overall use of local health and care resources, and staff satisfaction.

We have not attempted to provide a complete guide to population health – but instead to give you enough information to help you embark on your population health management journey. We also signpost to a range of resources that are available to support you.

Further information can be found on the PCH workspace on the futureNHS collaborative platform, or by contacting us directly.



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1. Introduction

The primary care home model is underpinned by four key characteristics including a focus on improvement in population health outcomes. This marks a shift from improving health and care processes to a more proactive approach to managing the health and wellbeing of a population.

The four key characteristics that make up a primary care home:

- A combined focus on personalisation of care with improvements in population health outcomes.
- An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care.
- Aligned clinical and financial drivers.
- Provision of care to a defined, registered population of between 30,000 and 50,000.

Population health can be defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group.¹

Population health management is a proactive approach to managing the health and well-being of a population. It aims to incorporate the total care needs, costs and outcomes of the population.

The approach involves segmenting the population into groups of people with similar characteristics. It then involves using a process called 'risk stratification' to understand how likely they are to develop more complex health needs. Some groups may need more intensive support, whereas care for others will focus on prevention rather than illness. Services are designed around holistic needs and targeted to the relevant groups and the individuals within them.

Population health management is a proactive approach to managing the health and well-being of a population.

1. Kindig D, Stoddart G. What is population health? *Am J Public Health*. 2003;93(3):380-3.

The approach seeks to understand the health and well-being of a local population by stepping back and considering the needs of different groups of people and organising services around them. It is a move away from demand-led, reactive health and care provision to a more proactive, tailored and holistic approach to care.

Wider determinants of health

Population health management is based on the now firmly established view that the health of communities is heavily influenced by a wide range of factors including where people live and work, social and economic factors – like education and employment – and lifestyles such as what people eat and how much exercise they do.

While health services play an important part in determining people's health, it is only part of the story.² Population health management includes understanding the impact of the wider determinants of health. It requires health and care organisations to work together to provide a complete care community and share accountability for the health of their populations.

The health of communities is heavily influenced by a wide range of factors including where people live and work, social and economic factors.

Population health and primary care

The case for primary care taking on a more proactive role in population health is clear cut. People use primary care more than any other part of the health and care system, giving the sector unique access to information on the health of a population and the ability to have a positive impact.

The size of PCHs means that changing the emphasis to a population health approach is achievable.

Population health management is a logical extension to the strong generalist tradition within general practice. GPs and primary care staff are embedded in the community and well-placed to make the most of their knowledge of patients and the factors affecting their health.³

The PCH model can unlock the potential of population health because it already has multidisciplinary teams providing services to registered group of patients – a relatively stable group of patients who live in a defined geographical area. The size of PCHs (30,000 – 50,000 registered patients) means that changing the emphasis to a population health approach is achievable.

2. One study (McGinnis, 2002) claimed that health interventions are only responsible for up to 15 per cent of health outcomes, while a further 40 per cent are determined by lifestyle and the remaining 45 per cent by social and environmental factors. More information is available at www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinantshhealth.laitner

3. Thorby R (2013). *Reclaiming a population health perspective*. Research report. Nuffield Trust. pp.8-9

The shift in focus from illness to wellness

Health promotion, disease prevention and health literacy are vital components of population health management. Students who are healthy and fit come to school ready to learn, employees who are free from mental and physical conditions take fewer sick days, are more productive, and help strengthen the economy, and older adults who remain physically and mentally active are more likely to live independently.⁴ Without education and employment, people are often ill-equipped to make healthy choices.

Moving the mindset from considering disability and sickness, to ideas of ability and wellness will benefit patients and the community.

Holistic care needs

Population health management also involves a personalised and multidisciplinary approach to care that focuses on the patient as a whole. For example, frail older people with complex health needs will need a high degree of continuity of care with a holistic approach. They are likely to have physical, mental health and social needs which will be best served by a multidisciplinary team.

Population health management in action

There are many examples from home and abroad of health systems using population health management to improve care.



4. Benjamin, RM. *The National Prevention Strategy: Shifting the nation's healthcare system.* *Public Health Rep.* 2011;126(6):774–776.

The US-based Kaiser Permanente health provider uses data from its shared electronic patient records to understand its members' health needs and the health outcomes of groups of people. This enables them to target care to individuals and population groups with similar characteristics. Kaiser Permanente offers a wide range of multidisciplinary services to help patients manage their illness and maintain their independence.⁵ For example, their heart disease approach focuses on preventive interventions such as smoking cessation, exercise promotion and other lifestyle changes to reduce the risk of heart disease across populations. This led to a 26% reduction in heart disease mortality in Northern California between 1995 and 2004.

Many PCHs have started work on population health management. Newport Pagnell PCH gathered data from the local clinical commissioning group (CCG), local council, schools, youth clubs, older people's clubs and health and social care providers to understand their local community's needs and risks. The PCH segmented the population and identified three groups – in each, people shared similar characteristics. The groups were:

1. those aged 11 and over with mental health needs
2. the working age population with mental health needs
3. frail older people.

Each group was further divided according to their risk of needing more intensive care. They were then able to design and target services for the smaller groups (for more information see page 11 and the case study on page 26).

Lewes Health Hub PCH used frailty index scores from data provided by their local commissioning support unit (CSU) and analysed chronic disease information from the practices' own records to improve their understanding of their local community's needs. They used the data to segment the population into three different groups:

1. the generally well
2. people with chronic conditions
3. those with complex needs.

They then set up project development teams, consisting of doctors, nurses and receptionists, who spent half a day a week for six weeks working on specific initiatives designed to improve services, aligning them more closely to the needs of each patient group (see case study on page 28).

Both PCHs used the NAPC's population health management approach. More information can be found in the following chapters.

5. Alderwick H, Ham C, Buck D. (2015). *Population health systems: Going beyond integrated care*. London: The King's Fund.
www.kingsfund.org.uk/publications/population-health-systems

2. Developing your population health approach

The PCH population health management approach has three levels of personalisation - the community, a group of people with similar needs and the person.

The approach starts with people's needs, not the needs of organisations, professionals or services. It's about the holistic needs of people, not their medical conditions.

There are different ways in which a community's needs are met. A PCH's population – with up to 50,000 people – cannot be understood as a whole, as the needs of people are so different. Neither can we carry out population health management one person at a time. However, groups do share similar needs which enables a PCH to design services around them.

There are three steps to the population health management approach:

1. **Know** your population's health needs
2. **Engage** with your population
3. **Manage** your population

This section of the guide covers the different ways in which you can get to know your population and their needs.

The NAPC's population management framework

The NAPC has developed a framework to help PCHs segment their population into manageable groups and design personalised services around them. It is made up of two tools – a matrix and cube. Through a segmented approach, the entire PCH population can be covered over time.

The PCH matrix tracks two dimensions:

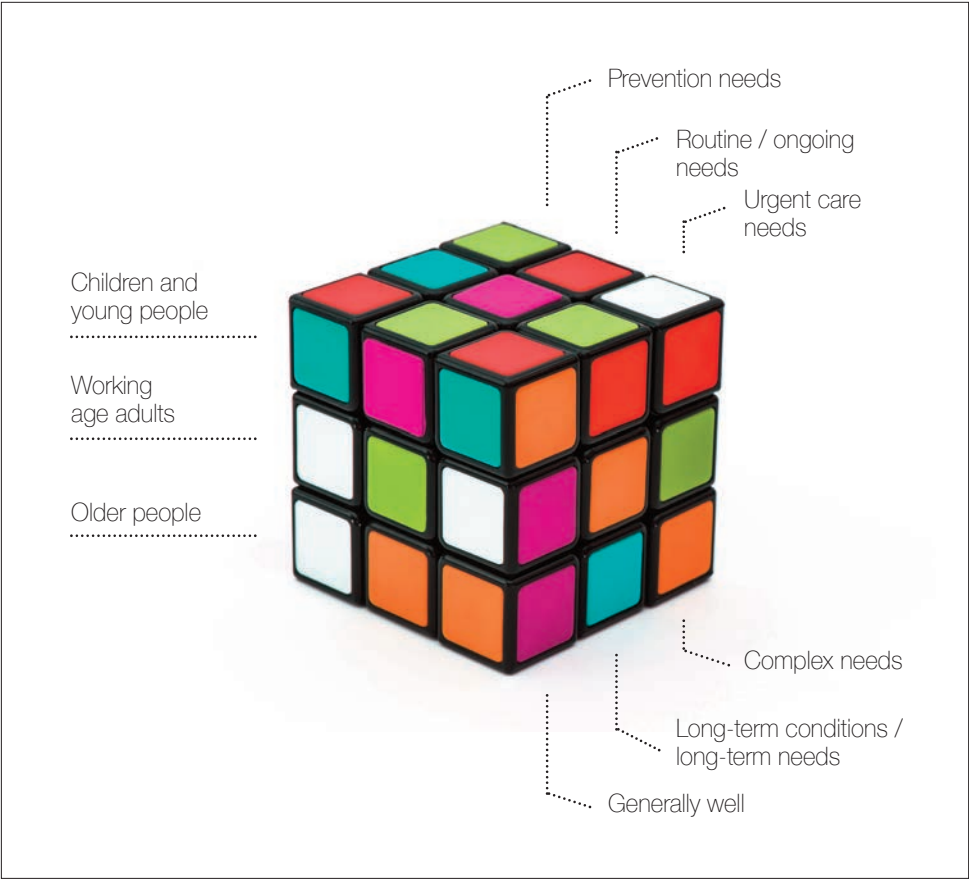
- **Stage of life/age** – children and young people, working age adults and older people.
- **Holistic health and care needs** – those currently well, people with long-term conditions (LTCs), and those with complex health needs.

	Generally well / good wellbeing	Long-term conditions / social needs	Complexity of LTC(s) / social needs and / or disability
Children and young people			
Working age adults			
Older people			

The segments can then be further refined, for example into more detailed age categories, individual diseases and according to the risk of people developing more complex needs.

	Generally well / good wellbeing		Long-term conditions / social needs		Complexity of LTC(s) / social needs and / or disability	
	Low risk	High risk	Low risk	High risk	Low risk	High risk
Children and young people Neonates Children Infants Adolescents Toddlers						
Working age adults Young Middle aged Older working age						
Older people 65-80 80-90 90+						

The PCH cube includes a third area of consideration – the type of needs groups of people have at different points in their life. For example, generally well people with episodic health needs may need an effective clinical triage approach but are unlikely to need a high-level of continuity of care from a multidisciplinary team. This additional information will help PCHs plan their services and teams providing care.



In this guide, three different methods of population health management are outlined, demonstrating how different types of information can be used. The best way is to start with the information you have, and then work through the approaches outlined below, gathering information as you go and gradually building up a richer picture. The approaches should not be taken in isolation. A combined approach will give a clearer picture of local health and care needs.

A. Community engagement approach

This approach uses deep engagement with PCH staff, patients and carers, the community and the wider healthcare, social care and voluntary sector workforce to understand which population groups could be better served with more tailored health and care services. This can be done without access to any quantitative data, but informed by the experiences of all those who, together, are best placed to help shape health and care services locally.

For example, Newport Pagnell PCH developed a list of local organisations and stakeholders, including the council, schools, youth clubs and older people's clubs, as well as health and social care staff. They set up one-to-one meetings with each of them to discuss the population health management approach and their initial thoughts of the unmet needs of the local community. They also collected public health and CCG data, so that they could benchmark their area (see section B, population-level data approach).

The PCH then held a meeting to work through segmenting the local population and to co-design services. They continue to hold these meetings every three months to listen to each other's experiences and opinions, share ideas, and work together to come up with approaches that will benefit the population.

Staff are an important source of qualitative data. Group discussions can inform how they think patients' needs can be better met and highlight priorities as well as empower colleagues to propose and go on to lead solutions.

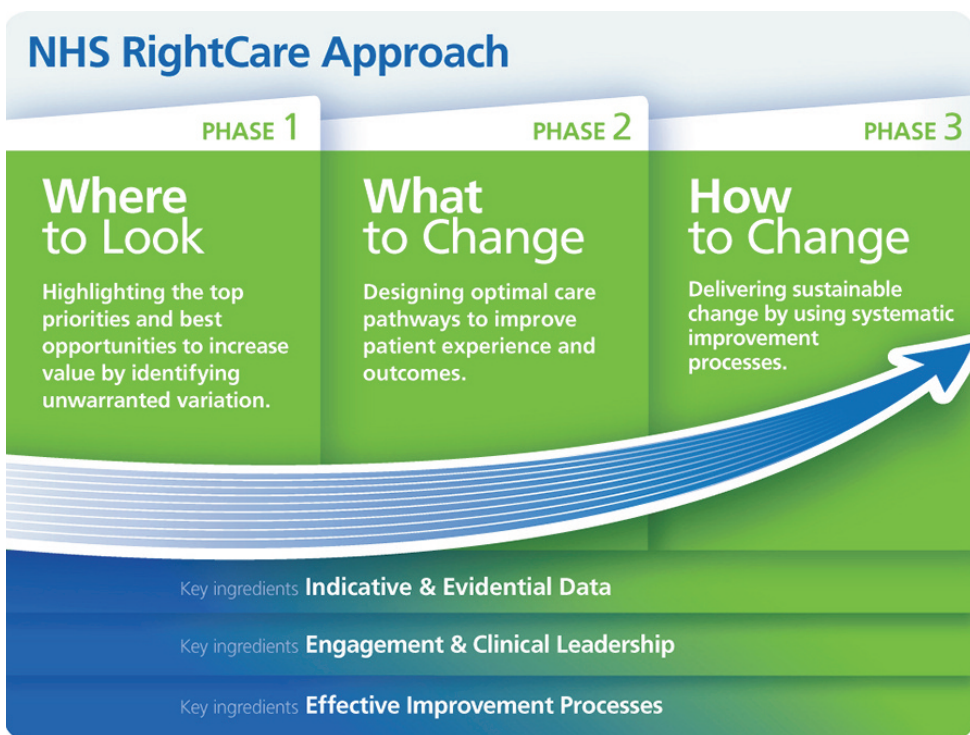
Thanet Health PCH combined the analysis of quantitative data with qualitative insight from staff in the development of their services for frail older people. Nurses from across community and primary care attended a series of events that looked at the risks and health needs of frail older people and how the skills and expertise of health and care staff across the community could be used more effectively. The engagement resulted in the development of an integrated nursing team to provide an enhanced frailty pathway and an acute response team to provide personalised care to help to reduce unnecessary hospital admissions.

B. Population-level data approach

In addition to stakeholder engagement, there is a wealth of data already available to help segment the local population and define their needs and risks. Below is a list of some key sources of information:

- **CCGs** and **local authorities** collate metrics from different sources for their own purposes, but a PCH can request information from them and they may be able to find relevant data for the PCH population. This includes population statistics, levels of deprivation, use of health and care services, and local statutory and non-statutory service provision.

- **Commissioning Support Units** (CSUs) provide information to CCGs on outcomes, patient metrics, frailty index, and patient and staff perception. A PCH can ask their CCG to request this information from their local CSU, or approach the CSU directly. For more information, go to: www.england.nhs.uk/commissioning/comm-supp/csu.
- **NHS England** and **Public Health England** are useful sources of data at a CCG or local authority level. NHS England includes data on its website on cancer waiting times, hospital admissions and bed days. See: www.england.nhs.uk/statistics/statistical-work-areas. Public Health England has data on its website on areas such as obesity, dementia and maternity care. See: www.gov.uk/guidance/phe-data-and-analysis-tools.
- **NHSRightcare** advises local health economies how to make the best use of their resources. It is a rich source of comparative information at CCG and Sustainability and Transformation Partnership (STP) level which identifies outliers compared to other similar areas in the country. Their data packs and online tools can help identify where to start when changing services and pathways at a local health economy level. See: www.england.nhs.uk/rightcare.



- **Joint Strategic Needs Assessments** (JSNAs) are the process by which local authorities and CCGs are required to assess the current and future health, care and wellbeing needs of the local community to inform local decision making. They join up social care services (education, social care and well-being) with public health and NHS services to assess the needs of a defined population.
- **Compendium of Population Health Indicators** is a collection of indicators giving a comprehensive overview of population health at a national, regional and local level. The data will help to compare the profile of the local area with other regions and national averages.

The local CCG or CSU may be able to help make sense of all the data, or an analyst with experience in this area could be hired to help. Together with the qualitative approach detailed earlier, a PCH will be able to form a good idea of priority areas. While this does not always give an indication of absolute need, it will help to gain a clearer picture of local needs.

It is important to use the PCH matrix and cube to help amalgamate the relevant population segments, create themes and decide where the focus might be.

C. Patient-level data approach

The greatest potential for personalised and targeted population health management comes from analysing patient-level data which maps patients' journeys across multiple sectors and health providers, such as primary care, community care, hospital care, mental healthcare and social care. This information can be used alongside other sources of person-level data, including deprivation, housing, and behaviours such as smoking.

This provides us with a rich set of information about every person within a PCH. The data can then be grouped using the PCH matrix, so that people are segmented into those with similar needs, for example older people with multiple complex health needs or adolescents with mental health needs. Targeted and personalised services can then be designed around these groups. These can be further divided according to risk, for example, those likely to develop more complex health needs or a complication which needs hospital admission. This provides a powerful tool to inform the design of preventive services.

Patient-level data is available from GP practices within the PCH, and can be sourced from hospitals and social services. An expert can be commissioned from the CCG or CSU to integrate the datasets from the different settings.

An example of a person-level dataset across a system of care is the Kent Integrated Dataset (KID). Kent County Council has developed a unique partnership with the county's seven CCGs to create one of the largest integrated datasets in the country, covering the health and care records of 1.5 million people. The data connects routinely collected administrative activity and

cost data from almost all NHS providers across Kent and many non-NHS organisations at person-level. The data for each person is linked using pseudonymisation (a procedure which replaces identifying information with one or more artificial identifiers or pseudonyms). The data include information on activity, cost, service/treatment received, staffing, commissioning, provider, diagnosis, demographics and location.

It may be useful to combine sources of data and risk tools to enable a better understanding of patients' needs. For example, in Thanet Health PCH, to gain a deeper understanding of the health and care needs of frail older people and design care around them, they combined insight from the KID with data from its practices using the electronic frailty index (eFI) within the EMIS clinical system. The eFI uses data that is routinely available from electronic patient record systems at GP practices to identify older people with mild, moderate and severe frailty, and who face an increased risk of hospitalisation, care home admission or mortality. The information highlighted to GPs that they needed to come together with other health and care organisations to pool resources and build an integrated service to improve care for frail elderly people and reduce demand.

Information governance considerations

It is imperative that a clear information governance (IG) approach is used when using linked datasets. A PCH needs to be clear what the legal basis is for the collection, analysis and use of patient-level data. The distinction between primary use, i.e. direct patient care, and secondary use, e.g. system design and management, must be considered. It is worth obtaining expert governance advice, but there are privacy enhancing techniques that make patient-level linked data possible.

A PCH needs to be able to re-identify patients from the linked dataset to target services to those individuals, for example:

- Targeting health promotion interventions to people identified as being at risk of a long-term condition.
- Providing health coaching services for people with long-term conditions who have poor control and may not access traditional services.
- Bringing older people with complex needs into a multidisciplinary team (MDT) led programme of care.
- Providing pharmacist-led medication reviews for people on multiple medications.



3. Designing services around your population's needs

Once you have got to know your population's health needs, the next step is to engage with them to redesign services.

Segmenting a population, as discussed in the previous section, helps understand the distinctive needs of different groups of people. This should inform the pathways and services provided. It also enables effective prioritisation, with a focus on what is most relevant and urgent for the local population.

For a population health management approach to be successful, local stakeholders (people and groups) should be involved from the start in any service re-design.

There also needs to be ongoing monitoring and measurement to ensure any changes result in improvements in health and wellbeing.

Involving local stakeholders

Engagement and communication with stakeholders will be critical to the success of a population health management approach.

Once the population health groups and their care needs have been mapped out, all the people and groups involved in delivering care to each group need to be identified. These stakeholders



could include acute, community and mental health providers, commissioners, local authorities, the third sector, the wider community, patients and carers.

It is vital that PCHs engage with the local population, explain the strategy for health improvement, and work with the community to set priorities. Stakeholder mapping will help to develop an effective engagement strategy and target the right people at the right time. There are several different ways of mapping stakeholders – see the *NAPC stakeholder engagement* guide for more information on this.

Co-designing services

Key to the success of any new model of care or service re-design is involving everyone who is impacted at the beginning.

Align services to needs

Population health management leads to a more proactive approach to promoting well-being, preventing illness and managing holistic care needs.

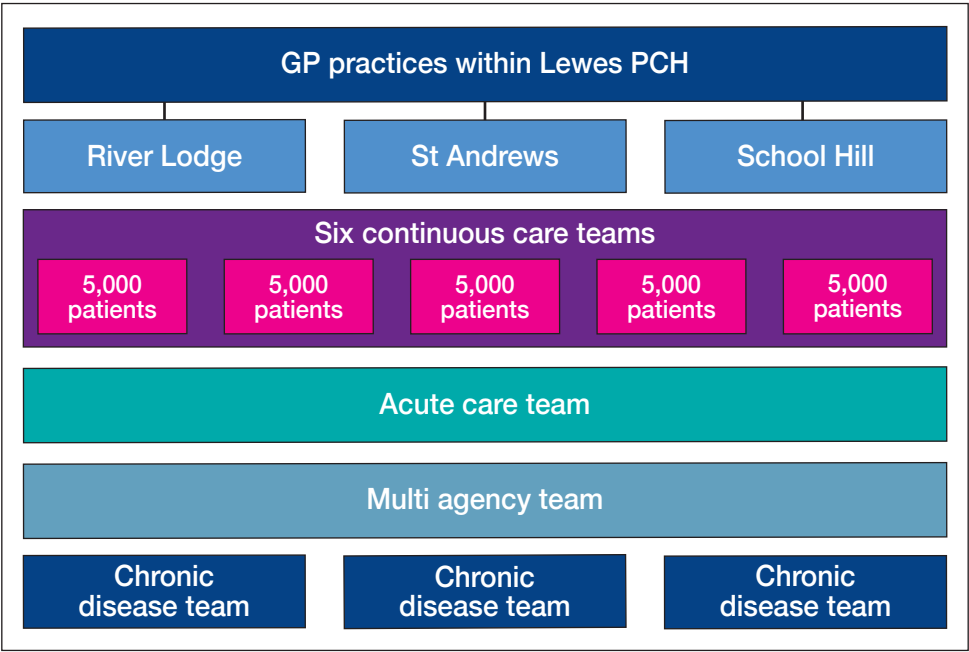
Plans can be made by gathering information on the interventions needed for sub-groups of the population, including impact and cost. The NAPC approach to re-designing services (using the matrix) is set out below.

- **People who are generally well.** Services to help maintain the physical, mental and social health of these people throughout their lives should be the focus, for example, maternity care, childcare and housing. This also involves identifying people who are currently well but at risk of developing long-term conditions. People in this group may need short-term treatment, such as care for injuries. This will require the same responsive care as the other groups need but with less of a focus on continuity of care and multidisciplinary support.
- **People with long-term conditions.** Care for people with long-term conditions includes early diagnosis, personalised care planning, support with self-management, and help with medicines management. They will have on-going as well as episodic care needs (such as operations). They will also need effective acute care, for example, when there is a sudden worsening of a long-term condition.
- **Older people with complex needs including frailty.** This group requires integrated, holistic, personalised, coordinated care. There should be a multidisciplinary team within the PCH and the team should include an expert generalist clinician such as a GP or geriatrician. This group will need very responsive urgent care that is personalised with a high degree of continuity of care.

There are many different ways of approaching re-designing services, depending on what the data analysis has revealed. For example, at Lewes PCH, outcomes from their population health management approach enabled them to radically redesign the way the practice is organised. A telephone triage system has been introduced and new teams developed who care for specific segments of the population. The teams at Lewes are outlined below.

- **The acute team** cares for patients who are generally well with new problems. It is staffed by nurses and GPs. There are plans to join forces with the local minor injuries unit and offer appointments for all patients the same day if needed, seven days a week.
- **Six continuous care teams** each have 5,000 patients who have chronic and complex problems. They are based around a micro-team of GPs.
- **The multi-agency team** cares for the most complex patients who require active case management.

The teams work collaboratively, ensuring there is communication between them.



At Newport Pagnell PCH, the team found that taking a population health approach enabled colleagues to have a better knowledge of services in the community, and they joined forces with them (see case study on page 26).

4. Workforce and leadership

The next step is to design a PCH's workforce around the population's health needs and those of the segmented groups. It is a shift in thinking from roles, to functions and teams.

This is the **manage** your population stage which involves taking a multidisciplinary approach to meet the needs of the different population groups. Staff should be involved every step of the way to ensure their commitment to the new approach to health and care.

Leadership of a population health management approach should be based on being collaborative, connecting people who need to work together, and supporting a culture of integration.⁶ PCH leaders need to focus and drive this population health culture, and train and develop colleagues in this approach.

The change from an 'institutional' healthcare culture to a population healthcare culture is illustrated below.

Institutional healthcare culture	Population healthcare culture
Focused on service provided to patients	Focused on population health, namely the health status of the whole population
Competitive	Collaborative
Quality and safety, whatever the cost	Invest only if outcome is increased with no more resources
Winning	Win-win
Give patients simplified information	Offer people using the service access to all information
Clinicians responsible for effectiveness, quality and safety	Clinicians responsible for effectiveness, quality and safety, and for the stewardship of resources

The difference in leadership with a population healthcare culture⁷

6. Chana N. 'Five ways to improve patient care and staff morale'; NHS England, Blog 2 February 2017, www.england.nhs.uk/blog/nav-chana

7. Gray, M., Chana, N., and Kanani, N. (2017). Leadership of population healthcare. *Journal of the Royal Society of Medicine*. 110 (10), 400-403, doi: 10.1177/0141076817718136.

There are ways to help drive a population health culture. The leaders of a collaborative culture should make sure that each sector or organisation understands and appreciates each other's value, and that they respect each other's work. It is also important to create a common language and ensure all staff and organisations understand the key terms involved in population health management, for example, 'accountability', 'engagement', 'system', 'network' and 'pathway':⁷

- **Accountability** is the relationship between persons or groups, where one is responsible to another for something important.
- **Engagement** is the work of forming communities of practice.
- A **system** is a set of activities with a common set of objectives.
- A **network** is the set of organisations and individuals that deliver the system.
- The **pathway** is the route patients travel through the system to receive care for health conditions.

For more on leading change within a PCH, see the NAPC's *Primary Care Home: population health-based workforce redesign* guide.

7. Gray, M., Chana, N., and Kanani, N. (2017). Leadership of population healthcare. *Journal of the Royal Society of Medicine*. 110 (10), 400-403, doi: 10.1177/0141076817718136.



5. Impact and monitoring

Impact of a population health management approach

Early evaluation of the PCH programme shows that the model is having a positive impact.

A report by PA Consulting – *Does the Primary Care Home make a difference?* – showed that the programme is delivering a range of benefits for patients, staff and the wider health system. Findings from an early analysis of three rapid test sites (the first tranche of PCHs) showed reductions in A&E attendances, emergency hospital admissions and GP referrals to hospital. For GP practices and other providers involved, the benefits include reduced prescribing costs and a rise in staff satisfaction and retention. Patients experienced a drop in the average waiting time to see their GPs and reduced stays in hospital.

A Nuffield Trust evaluation also shows the model has promising signs of success and, like most NHS transformation, is on a journey that is likely to take time working with partners, refining initiatives and building capacity to deliver long-term outcomes. The evaluation said that the model is a strong catalyst for collaboration between health and social care organisations, redefining relationships between GP staff and the wider primary care community.





The PCHs that have implemented a population health approach have discovered the positive impact that the approach can have, on both staff and patients.

At Lewes PCH, patients are now either seen or spoken to on the same day, which has reduced pressure on A&E and the out-of-hours service, and improved patient experience. There have been improvements in the morale of staff who, because of the engagement process, feel a sense of ownership of the new system.

At Newport Pagnell PCH, the impact on outcomes for patients has been clear, for example, a drop-in centre with a drug and alcohol service has led to some young people making a commitment to further therapy.

Monitoring

The first step to monitoring the impact of changes is to have an established baseline. This will give a reference point from which to assess the impact of any changes to the health and care of a targeted group. The data generated during the population health approach (see section 2 of this guide) should form the basis for this.

The data collection methods that were initially used should be continued to gather evidence of change and impact, as well as other approaches including feedback from patients and patient participation groups, and surveys. Progress can be continually assessed this way.

6. Conclusion

Taking a population health management approach is one of the key characteristics of the primary care home model and one that is designed to achieve optimal health outcomes for the local population.

This guide has outlined the PCH population health management framework which has three levels of personalisation – the community, a group of people with similar needs and the person.

Three steps are set out for PCHs to work through to proactively manage the health and wellbeing of their populations. There are also different approaches described on how to discover your population's health needs. It is recommended that they can be combined to give a richer understanding of the population's health requirements.

The three steps are:

- 1. Know your population's health needs.** We have outlined three methods - working with the community to understand the needs of different population groups, gathering population-level data and analysing detailed patient-level data that map journeys across sectors and providers. This is an ongoing process and there are different levels of analysis a PCH can carry out when it is ready.
- 2. Engage with your population.** It is wide engagement across the community that will ensure the success of a population health management approach. Services should be co-designed with patients and all stakeholders involved to ensure they make a positive difference to the groups you have defined. An engagement strategy should be developed and implemented.
- 3. Manage your population.** After designing services in collaboration, this is the implementation of a multidisciplinary approach to meet the needs of the different population groups. PCH leaders should work towards a culture of collaboration and retain a neighbourhood sense of belonging for patients and staff. Measuring against a defined baseline is key to success.

Initial results of the PCH population health approach have been positive with a range of benefits for patients, staff and the wider health system. Early analysis of the rapid test sites has shown improved employee satisfaction, staff reported patient satisfaction and reductions in A&E attendance and emergency hospital admissions. The model has been viewed as a catalyst for collaboration. A population health approach is intrinsic to the PCH and to delivering the desired outcomes of the model.





Case study

Newport Pagnell Medical Centre and NPMC@Willen PCH

The challenge

The primary care home – made up of two practices – has designed its PCH around a population health management approach, enabling more preventive and targeted care with its existing and wider integrated team.

What they did

The site started with population segmentation – a process that analyses qualitative and quantitative population health data and identifies groups of people who have similar health needs and risks. The PCH met with a range of local stakeholders including the council, school, youth clubs, older people's clubs and health and social care providers to capture their views of the needs locally. It also collected public health and clinical commissioning group (CCG) data, and benchmarked the local area against the rest of Milton Keynes and England.

The PCH was then able to segment the population into three groups of people with similar characteristics – people aged 11 and over with mental health needs, the working age population with mental health needs and frail older people. Each group was further divided into three groups according to their risk of needing more intense care – those currently well with less complex health needs (focusing on wellness rather than illness), patients with long-term conditions including mental health, and patients with complex health needs requiring support from multidisciplinary teams.

The impact

From the analysis the PCH was able to understand the population health needs and design the most appropriate services for each group and the patients within. The approach has also enabled the site to have a better knowledge of, and join forces with, services in the community that align to those needs.



Initiatives for young people aged 11 and over with mental health needs include gym courses to help with confidence and social isolation, and working with youth clubs to support those with low-level anxiety and depression. The site is working with a drug and alcohol service to run drop-in sessions at the PCH's practice during the summer holidays. This has resulted in some making a commitment to further therapy.

For working age adults, the PCH has developed a primary care navigators approach with their GP personal assistant (PA) team. They have also set up health and nutrition clinics for patients at risk of developing diabetes. The local psychological therapies service is providing primary prevention and cognitive behavioural therapy (CBT) for the practices' patients. A pilot is underway for people with complex mental health needs who frequently use primary and secondary services, providing in-house care with GPs and nurses.

For frail older people, the PCH is working with a health club for patients in the less complex health needs group, and a retirement village to provide falls rehabilitation. It is also supporting local care homes to reduce unnecessary emergency admissions and working with patients admitted as an unplanned admission for respiratory and cardio problems to prevent readmission.

Lessons learnt/success factors

Having a good understanding of the other health and wellbeing projects in the area can be useful and avoids duplication of work. For example, the site became aware of a community provider project that was similar to its work with care homes and was able to pool resources and work together.





Case study

Lewes Health Hub PCH

The challenge

Three practices, which form the primary care home, successfully bid for funding from the Estates and Technology Transformation Fund (ETTF) to help develop new premises which will be built over the next two years as part of a 700-home development in Lewes. Preparations for their merger into a single practice, based in the same building, have involved looking at their different systems and processes as well as reviewing and adopting best practice. It became clear that, to improve patient care, they would need to take a population health management approach. This involves segmenting their local population – a process that analyses health data and identifies groups of people with similar health needs and risks with the aim of redesigning services tailored to the needs of each.

What they did

The practices have started this approach by segmenting their patients into three different groups – the generally well, people with chronic conditions and those with complex needs. This has been done in three ways – by questioning patients when they phone for appointments, using frailty index scores from data provided by their local commissioning support unit and analysing chronic disease information from the practices' own records.

The PCH has set up project development teams, consisting of doctors, nurses and receptionists who spend half a day a week for six weeks working on specific initiatives designed to improve services, aligning them more closely to the needs of each patient group. The teams have worked closely with patients from each of the three groups, conducting detailed interviews and recording their concerns and suggestions in a shared database. A telephone triage system has been



introduced and receptionists are having training as care navigators. Acute care teams have been established in each practice and there are plans for them to join forces at the local minor injuries unit (MIU) where they will work with hospital staff as one urgent treatment centre, treating people with urgent medical problems as well as injuries. Over the next few months, they will start offering a seven-day service from 8am to 8pm. Each practice also has a continuous care team – a small group of four or five doctors who are available from 8.30am to 6.30pm each weekday to see patients with ongoing, recurring or multiple medical problems. When patients call to book appointments, they're asked about their condition and whether it's a new or ongoing medical problem. The receptionist then refers them to the most appropriate team.

The impact

Previously patients were seen on a first come, first served basis until the practices ran out of capacity. Now each patient is either seen or spoken to on the phone on the same day and this has helped reduce pressure on A&E and the out-of-hours service. Morale has improved among staff who feel a sense of ownership of the new systems and processes. Recruitment has been difficult in the past but now doctors are keen to work for the PCH as they are impressed by the redesign of services and “whole system” approach to patient care.

Lessons learnt/success factors

Initially it was assumed that the workload of the continuous care teams would be substantially higher than that of the acute care teams but the volume of work is similar for both. Fragmented services result in more expensive, poor quality patient care.



More information

If you have any questions relating to this guide or would like more information on population health management, please contact the NAPC team either by phone on: **020 7636 7228** or by email: **napc@napc.co.uk**.

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