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Tackling Health Inequalities Through Population Health Management

Resource and Reflective Guide

2023

Resources to Support Your Leadership in Tackling Health Inequalities Through Population Health Management

Enhance Coaching and Consultancy
Helping Individuals & Organisations to Grow

Produced in Collaboration with Faculty Members:-

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Contents

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Introduction

Purpose

The purpose of this guide is to offer you a range of useful resources and tools which may help you in your exploration of Population Health Management (PHM). Often as leaders it is hard to know where to start. When working in complex systems, we use the systems working framework of Myron's Maxims as a useful framework to guide our thinking. The key thing here is to not worry too much about a perfect programme or process, but to start somewhere!

We are a small consortium of independent providers of leadership coaching and development who have been commissioned by the NHS Leadership Academy to deliver a series of two masterclasses to help Care, PCN and ICS Leaders in tackling some of the health and workforce inequalities at regional, local and national levels. This resource guide sits alongside the three masterclasses, one per masterclass. This guide accompanies **Masterclass 1 : Tackling Health Inequalities Through Population Health Management**

We know there is a wide range of fantastic resources available to support you to deliver population health management at scale, and we are not trying to replicate this, rather to collate and signpost you towards these resources.

We hope you find these masterclasses and resources helpful in your leadership roles. Improving population health takes time, effort and perseverance to have impact in terms of scope and scale. We wish you all the best in your work to improve outcomes and reduce inequalities.

Myron's Maxims

1. People own what they create
2. Real change takes place in real work
3. The people that do the work do the change
4. Start anywhere but follow it everywhere
5. Keep connecting the system to itself
6. The process we use to get to the future determines the future we get

Myron Rogers – Heart of the Art

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Why PHM in Tackling Health Inequalities

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Why Population Health Management

Population Health Management (PHM) is about the health and wellbeing of whole populations. Populations can be place based or based on characteristics such as race, socio-economic status or disability. NHSE state ‘PHM is the critical building block for integrated care systems and enables local health and care partners to deliver a core offer for local people which ensures care is tailored to their personal needs and delivered as close to home as possible.

PHM enables systems and local teams to understand and look for the best solutions to people’s needs – not just medically but also socially – including the wider determinants of people’s health’ .

The key is to use data to be proactive in the offer, rather than waiting for the toll of ill health to come through the door.

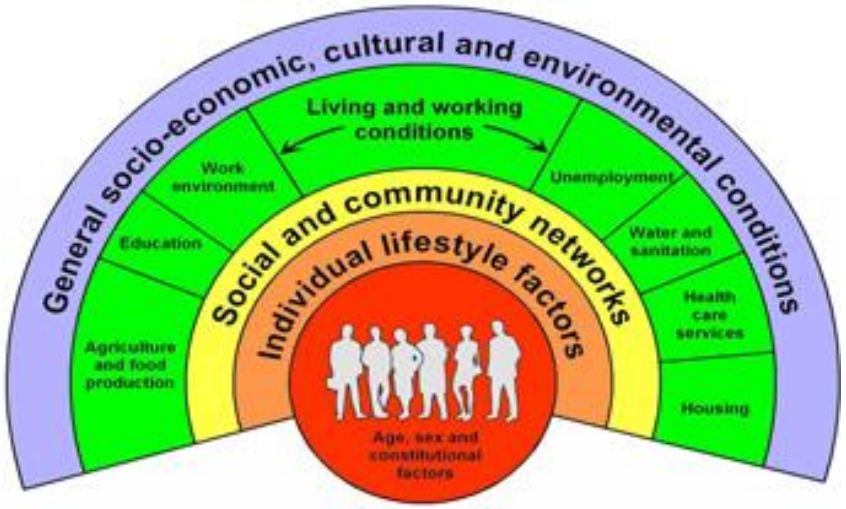
Whether you are leading an Integrated Care System (ICS) , an experienced social worker or social care manager, or a new Health care assistant, this quick video will help to orientate you to what we are going to be doing together. This video highlights the holistic nature of health and wellbeing and the fact to address health inequalities we need to work together.

https://www.youtube.com/watch?v=mz4FFE2y8PM&t=6s

In the next few pages, we will share some models of population health management and share further resources for you to read or view to help you enhance your understanding and confidence in applying population health management approaches. We would particular signpost you to the ‘Flatpack’ at the end of this section of the guide.

What is Population Health Management?

Health as you will know, is affected by both health and care service provision, and by a large number of other factors. These are shown in the infographic below, originally developed in 1991 by Göran Dahlgren and Margaret Whitehead. An individual lives within a wider context of influences on their health and wellbeing: these are variously termed ‘upstream’, ‘social determinants’, ‘wider determinants’, and/ or the ‘causes of the causes’ of health. In order to truly support people to stay well, we need to look beyond the health care system and individual lifestyle factors and consider the broader factors.



This ten minute video is a bit more academic, but explains nicely how health systems work from a leading academic Robert Yates at Chatham House.
https://www.youtube.com/watch?v=yIS2h__uezE

You might also like to look through these Concepts and definitions in Population Health from Pathways for Health.

The 4 Portfolios Model

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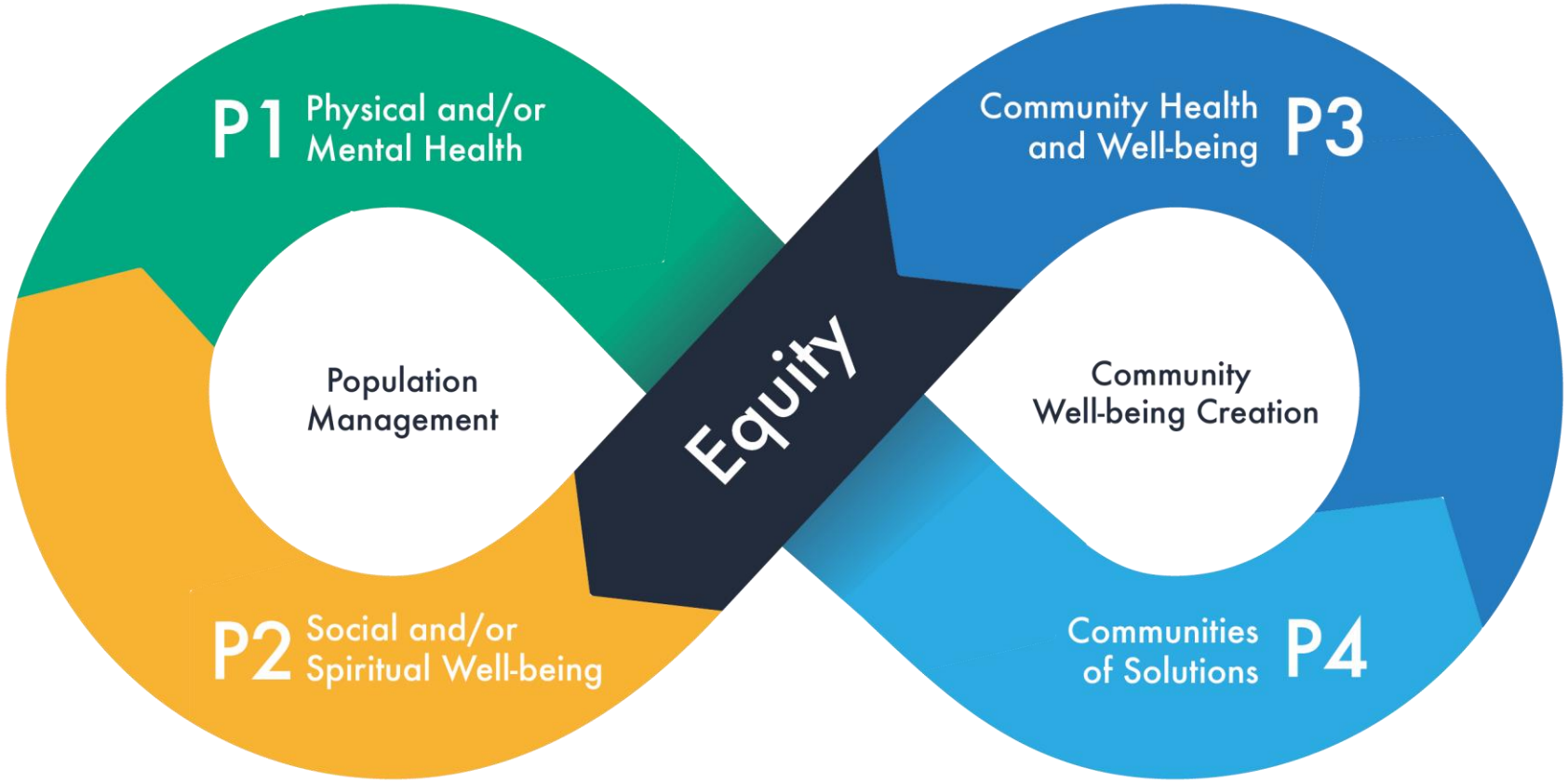

The four portfolios model is a useful and simple way of considering the interconnection between individual health and communities. The image gives an overview and we go on to talk about each of the four portfolios in more detail.

4 Portfolios

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Portfolio 1: Physical and/or Mental Health, health care organizations are focused on improving the physical and/or mental health of individuals within a defined population for whom those organizations feel directly responsible (e.g., patients and/or employees). Optimising clinical care and treatment: ranges from risk stratification to behavioural health integration to performance improvement. Building community partnerships: Identify opportunities to leverage community-based programs and assets to improve health and wellbeing for patients and the community as a whole. Focus on interventions to address health conditions that are common in the community.

Portfolio 2: Social and/or Spiritual Well-Being, health care organizations consistently screen for and address the social and spiritual drivers of health and well-being for a defined population (e.g., patients and/or employees). Social drivers encompass socioeconomic factors, such as food, housing, education, transportation, and income, as well as social connectedness. Spiritual drivers include factors that contribute to a sense of purpose, meaning, self-worth, hope, and resilience.

Portfolio 3: Community Health and Well-Being, health care organizations work together with community partners to improve specific health and well-being outcomes for a place-based population, for instance, improving asthma care among school children. The area of focus for collaboration is deemed a priority both for the health care organization and the community.

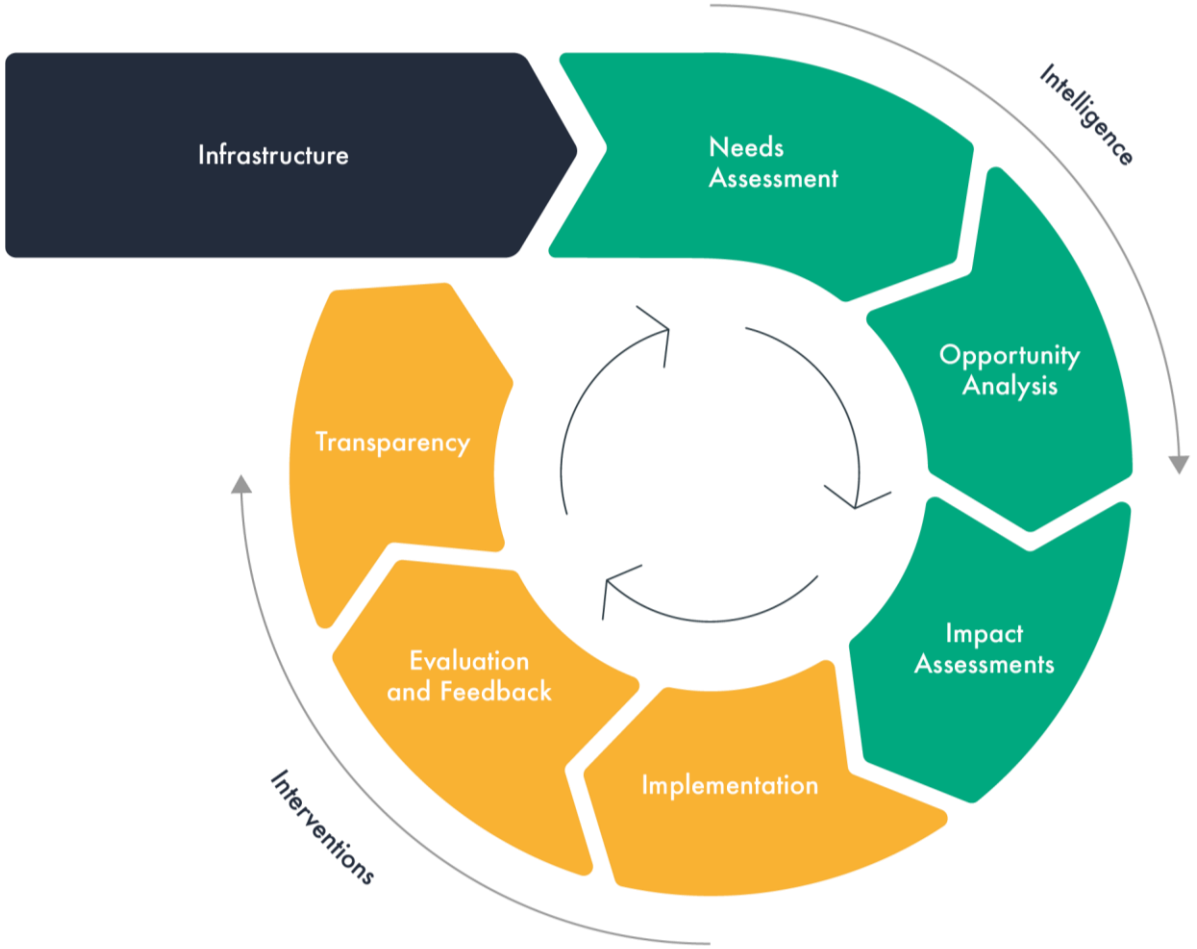
Portfolio 4: Community of Solutions, health care organizations actively engage in contributing to the long-term, overall well-being of the community as part of their mission and responsibility.

PHM is an Iterative Process

PHM is a learning cycle; its is important to return to intelligence once interventions are implemented

The following ‘Flatpack’ produced in partnership some years ago still provides very relevant information and support to help you think about how you adopt a PHM approach to your work.

Population Health Management Flatpack PDF



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Understanding PHM Data in Tackling Health Inequalities

Using Data as Intelligence

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There are a number of core capabilities required to undertake PHM well. One is intelligence or the use of data to allow us to prioritise action.

We need to firstly decide why we want data; What is the purpose? What problem are we trying to solve.? We then need to identify sources of data at different levels. This could be individual community of system or ICS level.

There is so much data available it can be confusing. We would encourage you to think carefully about what data will help in terms of linking to your objectives.

We now share a number of sources of data that might be useful for you as you embark on taking a PHM approach.

Inequality Assessment Datasets for England

Sometimes it is useful to start with national data and understand the trends over time.

THE HEALTH INEQUALITIES DASHBOARD USES THE NATIONAL PUBLIC HEALTH OUTCOMES FRAMEWORK (PHOF)

The type of data you might want to access at this national level includes:-

- Overarching indicators (life expectancy and healthy life expectancy)
- Wider determinants of health
- Health improvement
- Health protection
- Healthcare and premature mortality

This data is easy to access and may help in identifying priorities. Data is divided into four categories, shown here. By clicking on the tab, you can drill down and access the more detailed data

Wider Determinants

Health Improvement

Health Protection

Healthcare and Premature Mortality

The data can be accessed here
[Public Health Outcomes Framework - OHID (phe.org.uk)]

Regional Datasets for England

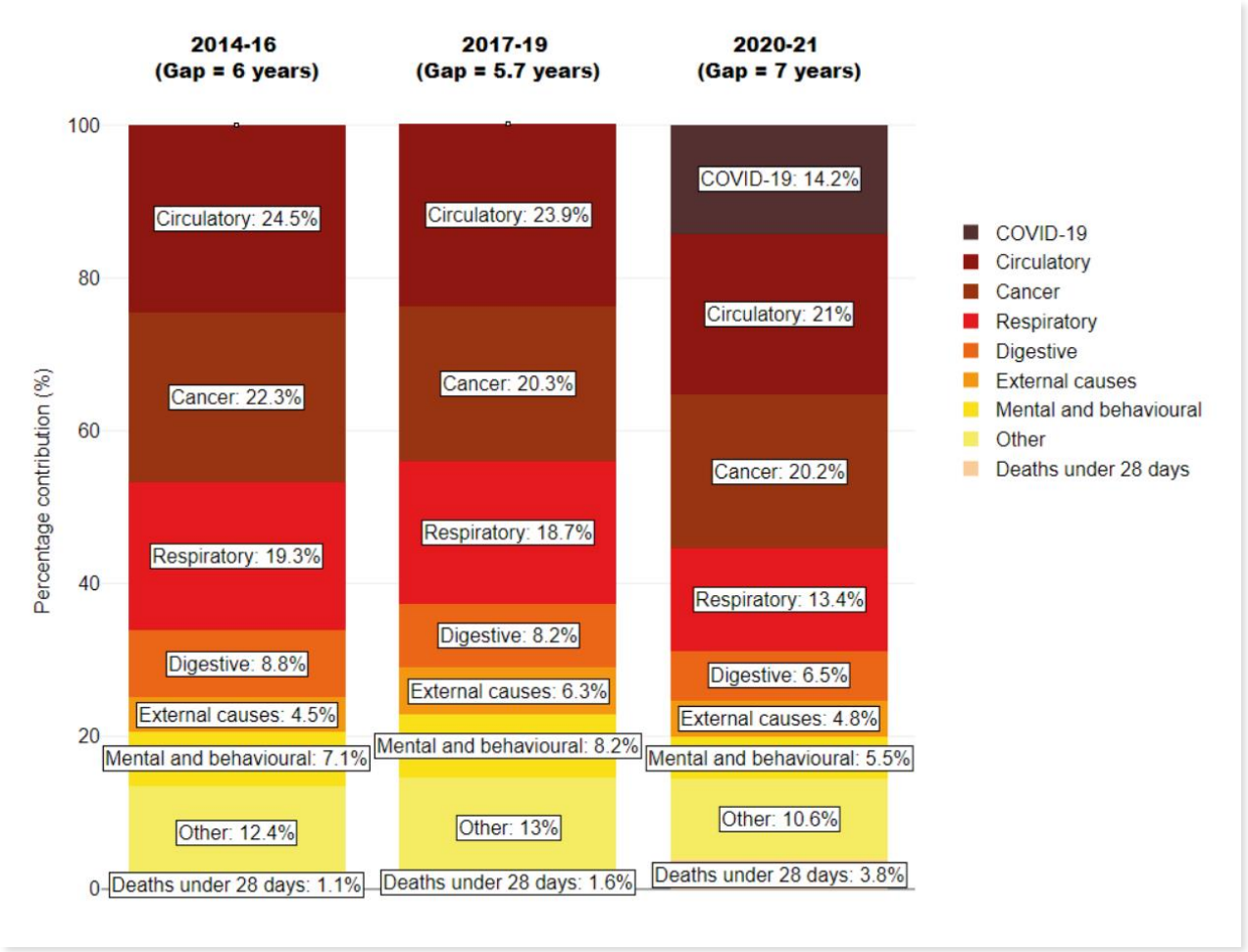
Sometimes it may be more appropriate to look at regional data. There are a number of datasets which can be accessed at NHS Regional or Local Authority (LA) Level. There is also specific data in significant areas such as Covid -19.

Examples are :-

- COVID-19 Health Inequalities Monitoring for England tool (CHIME), NHS and local gov footprints
- The Segment Tool - at England, region and LA levels – can compare the gap with either the England average or the most and least deprived quintiles (20%)

Segment Tool (phe.gov.uk)

The diagram shown here gives an example of the type of data available regionally. This shows the breakdown of the life expectancy gap between the most and least deprived quintiles of East Midlands by cause of death, 2014 to 2016 to 2020 to 2021 for females. We can see from this the gap has widened more recently. Could this be due to the inequalities we have seen in Covid deaths? Data doesn't always give us the answers, but often it guides our further inquiry.



Understanding Need, Demand and Supply

What is a need?

In order to undertake PHM effectively, we also need to consider needs and wants. Need sounds like a simple concept, but it is actually complex and contextual. What is needed or wanted by one person may not be a priority for another. We explore need in more detail.

- Normative need is need which is identified according to a norm (or set standard); such norms are generally set by experts. Benefit levels, for example, or standards of unfitness in houses, have to be determined according to some criterion. Core NHS contracts and mandated NICE guidance cover normative needs.

BRADSHAW'S 4 KINDS OF NEED

- Comparative need concerns problems which emerge by comparison with others who are not in need. One of the most common uses of this approach has been the comparison of social problems in different areas in order to determine which areas are most deprived – e.g. seeking to provide greater access to a specific service for a target population.
- Felt need is need which people feel - that is, need from the perspective of the people who have it which may or may not be expressed
- Expressed need is the need which they say they have – the service provider may agree or disagree (e.g. Individual Funding Requests or IFRs)

What are the Different Types of Population Health Assessment?

- **Health needs assessment (HNA)** – start with the population, identify key issues to aid prioritisation, development of health programmes, and commissioning of services; Steps in HNA, Cycle, JSNA is an example of this.
- **Healthcare/ Health & care care needs assessment (HCNA)** – starts with defined population at risk of receiving an intervention and attempts to quantify the number
who might benefit and the magnitude of the benefit
- **Health impact assessment (HIA)** – starts with policy or programme and tries to identify and weigh the health benefits and disbenefits – a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population and the distribution of those effects within the population
- **Equity Impact Assessment (EIA) starts w policy or programme and tries to identify and weigh the equity benefits and disbenefits** – a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on inequality in a population and the distribution of those effects on inequality within the population
- **Health Equity Audit (HEA)** – starts with a defined subpopulation and seeks to identify health inequalities and inequities of service provision – needs 2 cycles else a HE Profile (HEP)
- **Other** – health economic evaluation (HEE), environmental impact assessment (EnvIA), health technology assessment (HTA)

Understanding Need, Demand and Supply

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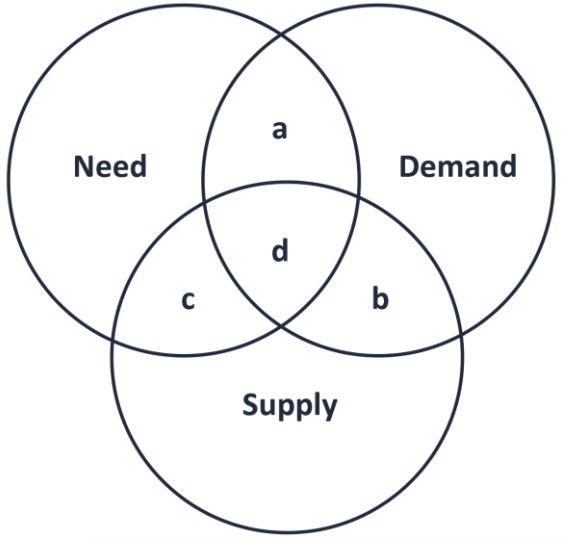
Demand = requests for service provision which may or may not be based on need.

- Supply= what is provided which may not be equal for all e.g. different practices may have a specialist GP or nurse on site, different waiting times for the same service, different customs and practice e.g. different surgical equipment or procedures used in different centres, different access to universal services due to staff shortages in certain areas
- We know if we create capacity, it is used: all too often a built bed is a filled bed.



a. **Unmet need:** need is felt and expressed as demand but not identified as a normative need by the health service.
b. **Inappropriate supply:** need is not felt, but nevertheless is expressed as a demand and identified as a normative need.
c. **Supplied Need:** need is felt and not expressed as demand, but is recognized by the service as a normative need
d. **Normative Need:** need is felt, expressed as demand and supplied as a normative need

source: Tobi 2016

Understanding Need, Demand and Supply (cont)

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What might we want to review?

There are a number of data sets you can access to help you understand the normative need of the population. You also need to consider how you consult and engage with your communities to understand the expressed or felt need.

- **Population estimates based on census or population registers**
- **Birth and abortion notifications**
- **Mortality records – death registrations, coroners records, medical examiner's records** – cause, variation by person, place and time
- **Health and care service data** – access, supply, use, activity, costs (hospital discharge data, prescribing, ambulatory services, primary care data), diagnoses, interventions, procedures, outcome measures - all in different settings primary, community, secondary, tertiary, social care
- **Health outcomes frameworks e.g. Public Health Outcomes Framework**
- **Behavioural risk data** e.g. self reported smoking status or physiological measures such as blood glucose recorded in primary care
- **Social care data** – adults, children
- **Morbidity measures** – infectious diseases notifications, cancer registers
- **Impairment, disability and handicap** – from surveys and from local 'blue badges', 'sight loss registrations'
- **Data from other agencies** – housing and living conditions, social care, environment, education eg qualifications, free school meals, employment, access to green space, air quality, crime statistics
- **Community services eg** childhood height and weight in reception, Vaccination and screening data
- **Health economic data** – costs of interventions, distribution of activity, costs at marginal and average levels

If you are unsure what data will hep or how to access it find out who the public health analysts are in your area. There are always people in the system who will help to guide you and signpost you to resources.

Other Sources of Data for PHM

If the national or regional data doesn't help, or to complement this, you will often find good locally collected data or other sources.
We share some possibilities below:-

DEDICATED/SPECIFIC DATA COLLECTION

- Surveys –national or local – these are often carried our by public health or by charities
- Broad health status assessments such as Quality of Life
- Self reported 'excellent to bad' scales do predict mortality and health service use
- Community/Place Needs Assessments, 'deep dive' Health Needs Assessments
- Qualitative research – local descriptive accounts of environmental or social factors, people's perceptions of health and their determinants

APPLIED USE OF DATA

- Big data – extremely large sets of complex linkable information – medical, environmental, financial, geographic, social media, portable health devices eg smartwatches, supermarket…
- Inferences from other populations eg national averages/ estimates from published literature – eg estimates of people with COPD in the ICS;
- Use of proxy data eg contacts with health services, expert opinion.

There is no shortage of data to support you in undertaking PHM. Start exploring some of the data sets we have shared and if in doubt, seek specialist advice and support

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Global Perspectives

How is Population Health Management Being Approached Globally?

Global health is about **improving health and reducing disparities** for all people worldwide

- All countries have some form of strategic approach to improving the health of the population but they vary greatly
- For some countries, PHM is a way to contain healthcare costs
- For others it is a means to improving outcomes and reducing health inequalities from an ethical perspective
- 44% of WHO member states have less than one doctor per 1,000 population
- We have much to learn from other's success. The way other countries have used systematic population approaches to address health inequalities for both infectious and lifestyle related diseases can help inform our strategies.

Africa

Africa faces a double burden of infectious and chronic diseases. While infectious diseases still account for most deaths in the African region, deaths from chronic diseases are on the rise. Recent years, have, however, seen significant achievements.

Success Stories- Addressing Health Inequalities :

Through a focused approach addressing health inequalities:-

- Across Africa as a whole, years of healthy life expectancy increased to 56 from 46 in 2000.
- Kenya has improved universal healthcare dramatically, establishing 700 new health facilities
- 87% of Children are fully vaccinated against diphtheria, tetanus and pertussis.
- In Senegal, 78% of newborns are now vaccinated against Hepatitis B
- improving access to modern methods of family planning, with 56% of women of childbearing age now having access to modern contraception methods
- curbing the spread of infectious diseases through surveillance for early warning signs of acute public health events, emergency planning and preparedness, training first responders, deploying emergency medical kits and other key equipment as well as tracking epidemiological trends. The time to control an outbreak has dropped to an average of 45 days in 2019, compared to 131 in 2017

Many of these successes have been achieved by working with communities and engaging community volunteers.

source: www.afro.who.int/about-us/making-africa-healthier

Asia

Many part of Asia are challenged by an aging population, therefore chronic and long term illness creates a challenge.

Some efforts to integrate primary care and hospital care in Asia are underway, however, overall care delivery remains fragmented and diverse, eg, in terms of medical electronic record sharing and availability, patient registries, and empowerment of primary health care providers to handle chronic illnesses.

The primary care sector requires more robust and effective initiatives targeted at specific diseases, particularly chronic conditions such as diabetes, hypertension, depression, and dementia.

This can be achieved through integrated care. Here we share a number of examples of projects to address health inequalities through a focus on integration of services, combined with a population based approach.

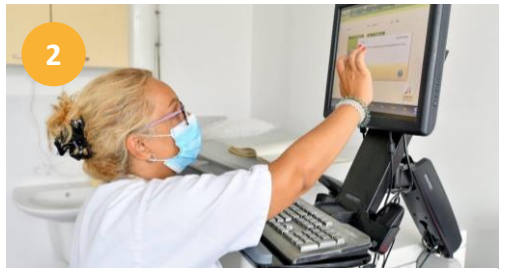
INTEGRATION ACTIVITIES BETWEEN PRIMARY CARE AND HOSPITAL CARE ACROSS ASIA

India	• Diabetes and hypertension via the mWellcare trial • Maternal and neonatal outcomes
Indonesia	• GERMANS - empowerment of primary care providers • Perinatal depression • Electronic integrated antenatal care
Japan	• Long-term care insurance provides institutional, home, and community based benefits under a case manager • Example: dementia care as detailed under 'Five-Year Plan for Promotion of Measures Against Dementia (Orange Plan)
South korea	• Large-scale databases/registries that are tied to the universal health care scheme
Malaysia	• Limited integration where primary care physicians report lack on communication with peers. Tele-primary care was launched as a potential record-keeping system; limited clinics have it
Philippines	• First Line Diabetes Care Project • Introduction of electronic medical records and enforced gatekeeping are part of the government's plan
Singapore	• Primary Care Networks initiative • Primary Care Dementia Clinic
Taiwan	• Family Practice Integrated Care Project • Integrated Health and Long-term Care Study
Thailand	• CKD trial: ESCORT based on Integrated CKD Care program
Vietnam	• The MOH'd Direction oh Healthcare Activities program is focused on the transfer of skills to lower level hospitals to support community-oriented activities • Health information systems are limited

Europe

WHO / Europe has identified 4 flagship initiatives to complement the European Programme of Work, which defines health priorities for the next 5 years.

The Pan-European Mental Health Coalition



Empower through Digital Health

The European Immunization Agenda 2030

Healthier behaviours: incorporating behavioural and cultural insights

The EU has 6 cross-country best practices on integrated care which the EU countries want to transfer nationally to improve health systems and care.
A summary can be found at :-
Integrated care - Publications Office of the EU (europa.eu)

Impact of Global Events on Health Inequalities

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If the Covid-19 pandemic has taught us anything, it is that health and health status is a truly global phenomenon. And we know inequalities are exacerbated in challenging times. Here we explore three of the Global challenges facing humankind and consider what the impact may be for health inequalities in the UK.

The three issues are :-

Covid-19

Violent Conflict

Climate Change

Impact of Socio-economic Global Trends: Covid-19

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- Covid-19 is a ‘catastrophic effect on people’s lives and livelihoods and on global efforts to realize the Sustainable Development Goals beyond dispute’.
- Years, or even decades, of development progress have been halted or reversed.
- **As of Jan 2023, more than 6.6M million people worldwide had died directly due to COVID-19**
- Global health systems were overwhelmed, and many essential health services were disrupted, posing major health threats and undermining years of progress fighting other deadly diseases.
- An additional 75 million to 95 million people will live in extreme poverty in 2022
- Billions of children significantly missed out on schooling and over 100 million more children fell below the minimum reading proficiency level and other areas of academic learning.
- Women have also been disproportionately affected by the socioeconomic fallout of the pandemic, struggling with lost jobs, increased burdens of unpaid care work and domestic violence.
- New COVID-19 variants and continued vaccine inequity, together with rising inflation, major supply-chain disruptions, policy uncertainties, and unsustainable debt in developing countries, caused the global economy to slow down again at the end of 2021.

- **source: United Nations 2022**

In the UK

We know that whilst BAME staff make up 44% of the workforce, 72% of health and social care staff who died from Covid -19 were from BAME backgrounds. The reasons for this are complex but may include economic factors and systemic issues. We also know that in the early days, vaccine uptake in marginalised communities was low. Some of the reasons were practical, for example, with the homeless, whilst others related to vaccine hesitancy. A population health approach which involved getting out into communities and setting up walk in vaccination centres in community and faith centres increased vaccine uptake in many communities.

The BMA is in 2021 report suggested the UK response should focus on the following:-

- Reducing overall transmission of the virus
- Ensuring vaccine access for groups most vulnerable to the virus Improving financial security
- Protecting the long-term health outcomes of children living in deprivation
- Investing in a strong public mental health response

Impact of Socio-economic Global Trends:
Violent Conflict including Ukraine

- We are experiencing the highest number of violent conflicts since 1945
- Approximately 2 billion people living in conflict-affected countries by the end of 2020.
- Refugees were at the highest absolute number on record in 2021 and forced displacement has continued to occur and even grow.
- These numbers will only increase with the war in Ukraine creating one of the largest refugee crises of modern time:
- Most are women and children)
- Further 7.7 million had been displaced inside the country.
- Another 13 million were stranded in conflict areas.
- The conflict has caused food, fuel and fertilizer prices to skyrocket, disrupted supply chains and global trade, and caused distress in financial markets.
- Together with the refugee crisis, the impacts of the conflict may lead to a global food crisis and deal a significant blow to SDG progress. Those with the highest exposure to the three-dimensional food, energy and financial crisis are being hit the hardest.

source: United Nations 2022

In the UK

The UK has taken 17000 Syrian refugees and circa 70000 Ukrainian refugees. These families arrive often after arduous journeys and having survived in appalling conditions. A priority is often to provide essential primary and dental healthcare. In parts of the UK a population health management approach has been taken with specialist services established to provide primary care, but also specialist mental health support.

As well as the direct impact of displaced communities, the war in Ukraine in particular has had a major impact in terms of increasing health inequality. The cost of living crisis caused by high fuel and food prices has meant an increase in families living in poverty.
The Inequalities in Health Alliance Inequalities in Health Alliance | RCP London has found that 69% of people surveyed were worried about heating their home in the winter of 2022. This will undoubtedly impact of mortality and morbidity. We need to focus population health management approaches to address fuel poverty if we are to avoid this further increase in health inequalities.

Impact of Socio-economic Global Trends: Climate Change

- Climate change threatens the essential ingredients of good health – clean air, safe drinking water, nutritious food supply and safe shelter – and has the potential to undermine decades of progress in global health.
- Between 2030 and 2050, climate change is expected to cause approximately 250 000 additional deaths per year from malnutrition, malaria, diarrhoea and heat stress alone.
- Areas with weak health infrastructure – mostly in developing countries – will be the least able to cope without assistance to prepare and respond.
- Global emissions are set to increase by almost 14% over the current decade, which could lead to a climate catastrophe unless governments, the private sector and civil society work together to take immediate action.
- To keep the 1.5-degree goal alive, we need to capitalize on the opportunity afforded by the recovery to adopt low-carbon, resilient and inclusive development pathways that will reduce carbon emissions, conserve natural resources, transform our food systems, create better jobs and advance the transition to a greener, more inclusive and just economy.

source: United Nations 2022, WHO 2023

In the UK

As early as 2002 we were very aware of the wide ranging impact of the climate emergency on health in the UK. The 2002 Report by the Health Protection Agency was updated in 2012 and can be found here. Health Effects of Climate Change in the UK 2012 (publishing.service.gov.uk)

This report highlights the increased death rates from extreme heat, air pollution and flooding, as well as changes in pollen related illness and vector borne disease.

Climate change, justice and vulnerability | JRF In this document the Joseph Rowntree Foundation describe an increased impact of climate change for those who are 'socially vulnerable' hence the risk of a disproportionately negative impact on those who are already socially disadvantaged.

A 2021 paper by Sir James Bevan argues addressing inequality in impact of climate change needs to be a core part of the Government's ' Levelling Up agenda' Environmental inequality must not be ignored - GOV.UK (www.gov.uk)

Key Questions: Reflection

Key Questions for System Leaders to Ask – Health Needs, Stakeholders & Staying Strategic

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- What do we know about the health, care and wellbeing needs of our population and what don't we know? Are we spending enough on information and are we using our expert public health resource effectively?
- What do we know about key areas of health inequality such as life expectancy, quality of life and maternal outcomes?
- Can we be confident that our mental health services aren't exacerbating health inequalities?
- Who are our key stakeholders and how do we engage them; How will we know if we are engaging in a meaningful way with our stakeholders and populations? How do we know whether this is improving over time? How can we share power with our communities and populations in a meaningful way? Are we really listening? Are our 'patients/residents/communities' empowered to be customer-owners?
- What is our programme over the next 10 years? How do we make sure we stay strategic and don't get distracted by the next 'shiny' thing?
- How far ahead are we thinking?
- What could the unintended consequences be and how will we track them?

What Do We Know?

What More Do We Need to Find Out?

What are We Going to Do?

Key Questions for System Leaders to Ask – Resource Allocation

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- What is the total spend we have available to deliver our programmes of care, Can we access more, where can we align or pool budgets and services?
- What is our ethical approach to prioritisation given that the needs are likely to always be an order or magnitude greater than the funds we have to provide service? Are we seeking to provide the greatest benefit for the greatest number or a basic level of care for all? Are we having meaningful conversations about rationing with our populations? Can we really afford to level up without any levelling down? Do we have a health economist advising our Board?
- How are we spending the money we have, is it allocated to ensure every pound delivers the greatest value? Where is there waste and duplication in the system?
- If we invest in this, what will we stop investing in?
- How are we moving money upstream?
- How will we target our expenditure to reduce inequalities in our communities?

What Do We Know?

What More Do We Need to Find Out?

What are We Going to Do?

Key Questions for System Leaders to Ask – Health Inequalities

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- Could we be exacerbating health inequalities in our decision making, how robust are our equity impact assessments?
- Who are our unregistered populations? Who is not even on our radar?
- What levers do we have, and what levers could we create?
- How can we remove barriers to staff functioning effectively?
- How can we address information governance barriers to enable join up data at an individual and population level?
- Do we have any initiatives addressing fuel poverty?
- Are we considering climate impact as part of our needs assessment?
- Do we know about refugee communities that may be part of our catchement?
- What partnerships do we need to build or strengthen?

What Do We Know?

What More Do We Need to Find Out?

What are We Going to Do?

Resources

Reducing Healthcare Inequalities: The 80% Needs Joint Working

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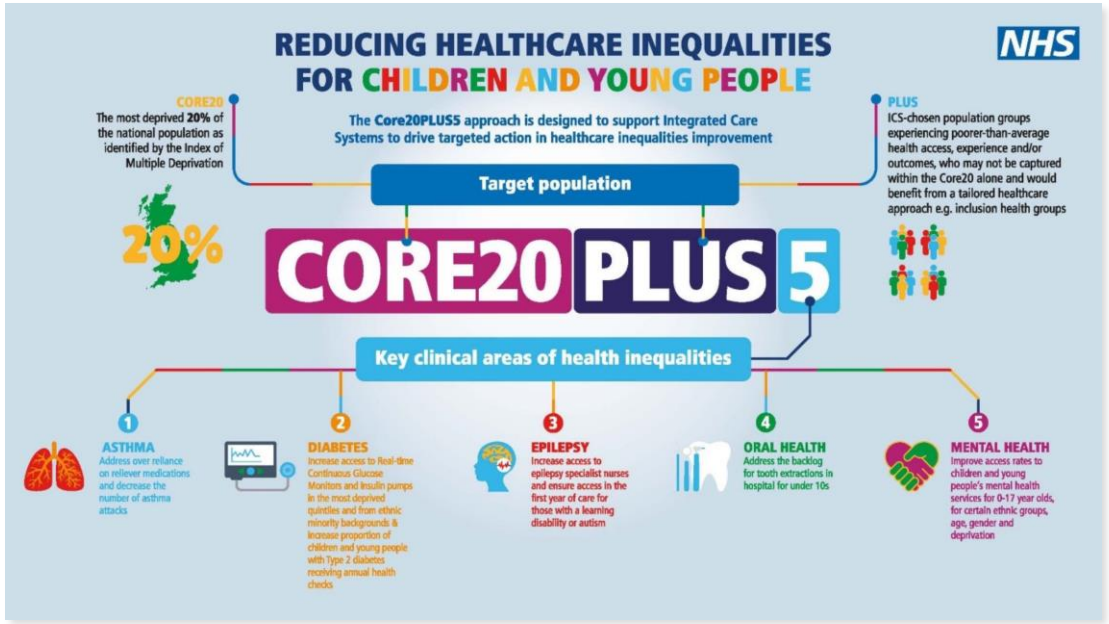
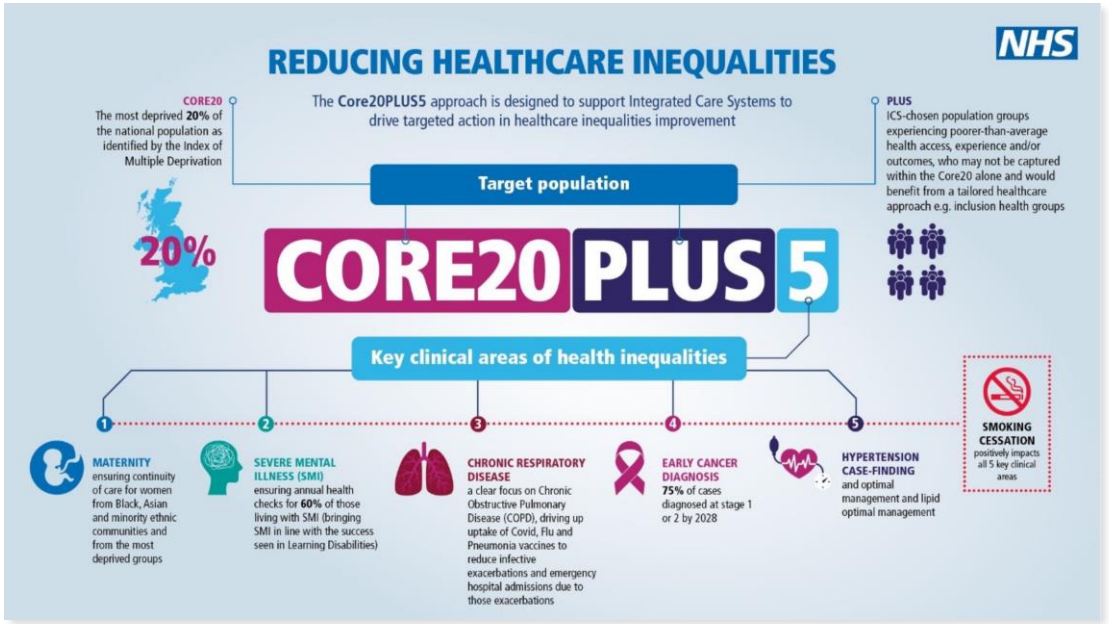
The Core20PLUS5 initiative is an integrated approach to support the reduction of health inequalities of both adults and now children and a systemic and local level. The 20 refers to the 20% most deprived communities on the Index of Multiple Deprivation (IMD). The PLUS refers specifically to under-served populations and the 5 relates to five clinical priorities. The five clinical priorities are Ashma, Diabetes, Epilepsy, Oral Health and Mental Health. We encourage you if you are not involved to find out what initiatives locally are being undertaken as part of the work on Core20PLUS5. You can find out more at [NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people]





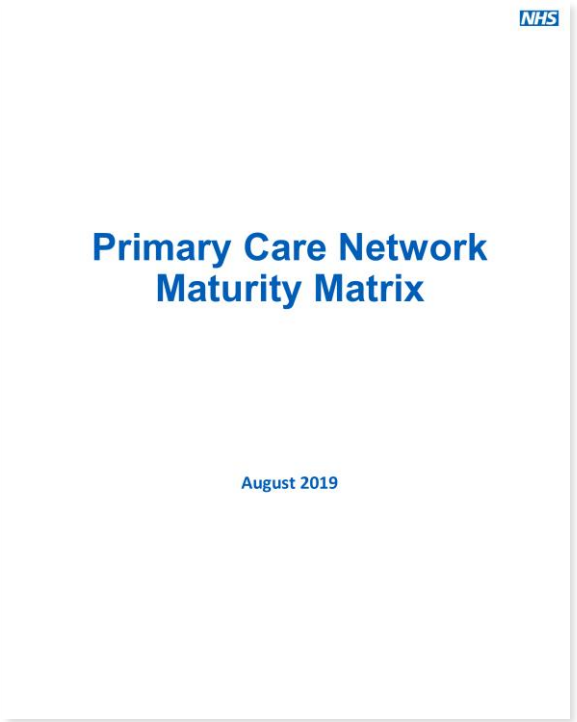
Getting Started Locally – The PHM Academy

NHS Leadership Academy

- Have you signed up to the PHM Academy to keep up to date with all the latest PHM information and resources. - Any staff member within a health and care system can register.
- The PHM Academy is an inspirational hub of information around PHM techniques and resources, as well as ongoing PHM work within the health and care sectors.
- Get started with PHM
- Learn about the core PHM capabilities – Infrastructure, Intelligence, Interventions and Incentives – to support maturity in line with the PHM Maturity Matrix
- Use online e-learning materials to support your PHM developmental journey, including case studies, webinars, podcasts, videos, guides and toolkits
- Read case studies from the national PHM Development Programmes
- Compare and contrast with PHM work in other countries
- Link to the central NHS PHM team for help
- Engage in peer learning by talking to other systems – sharing local best practice and asking practical questions to learn from elsewhere in the country
- Access weekly reading and remote learning for the PHM development programmes.

Getting Started Locally – The PCN Maturity Matrix and LGA support

NHS Leadership Academy



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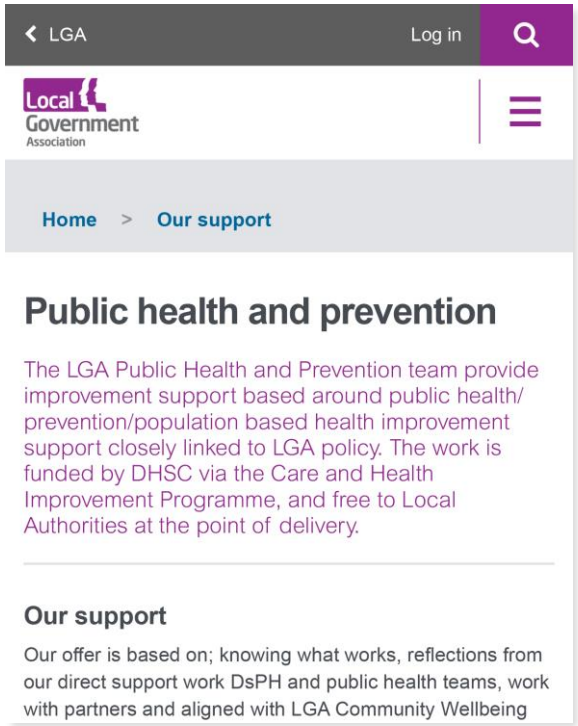

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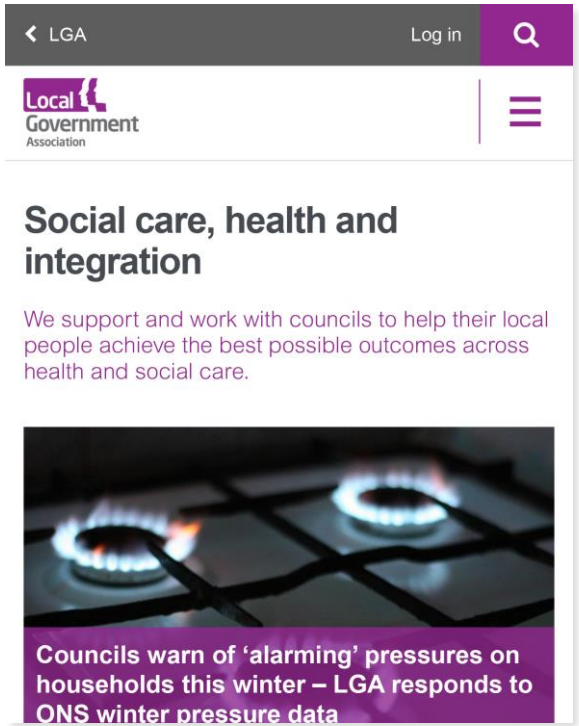

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Getting Started Locally – Reducing Health Inequalities Through Population Health Management

NHS Leadership Academy

As well as the resources mentioned elsewhere in this guide, the following offer useful information, direction and frameworks.

The Healthcare Inequalities Improvement Planning Matrix

The Healthcare Inequalities Improvement Dashboard

The Health and Wellbeing Alliance

Population health framework (nhsproviders.org)

And further resources and access to sessions can be fund:-

E-learning modules for community nurses on PHM: Community Nurses: Getting started with Population Health Management - Population Health Management Academy - Integrated Care (future.nhs.uk)

Case studies on PHM in practice, long and short reads and handy infographics: Case studies - Population Health Management Academy - Integrated Care (future.nhs.uk)

Join the lunch and learn sessions on PHM: PHM Lunch and Learn - Population Health Management Academy - Integrated Care (future.nhs.uk)

National Resources Leadership Development

As well as specific resources for public health there are excellent national programmes which you can access. The national offer includes programmes aimed at all levels of leaders in the NHS. Take a look below:-

https://www.leadershipacademy.nhs.uk/programmes

We would particularly direct you to https://www.leadershipacademy.nhs.uk/programmes/systems-leadership

In addition the following resource will allow you to access useful leadership material which may help in your journey.

https://midlands.leadershipacademy.nhs.uk/our-offers/leadership-learning-zone

Other Relevant Reviews to Guide Learning on Systemic Health Inequalities

NHS Leadership Academy

Ockenden review: summary of findings, conclusions and essential actions - GOV.UK (www.gov.uk)

Inquiry into racial injustice in maternity care - Birthrights

Who I am Matters – A report into the experiences of being in hospital for people with a learning disability and autistic people - Care Quality Commission (cqc.org.uk)

https://www.mind.org.uk/about-us/our-policy-work/equality-and-human-rights/young-black-men

What Does One Health Require of Leaders?

https://www.who.int/health-topics/one-health

One Health is a World Health Organisation (WHO) initiative which attempts to unify the approach to human and animal health with the health of the ecosystem we are part of.

'One health' means that the health of humankind , animal and the environment are interconnected and a new approach focusing on all three at once is required rather than focusing on just on human health.

Reflect on what this requires of you.

What might the key skills be around partnership, trust building, curiosity to step outside boundaries and courage to act.

What might you have to change in terms of the structures and processes we work within ?

Key Contacts

If you would like any further information or to share your thoughts, please contact the Lead Commissioners and Programme Managers

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