Population Health Management (PHM)

South East London is a diverse place, made up of lots of different neighbourhoods, communities and cultures with varied health needs and different preferences for accessing and receiving care. What works for people in Sidcup does not necessarily work for people in Streatham. Health and Wellbeing Plans and Joint Strategic Needs Assessment provide insight into the variability of need that exists across our ICS.

Population Health Management (PHM) is a way of working that further supports us to ensure the care we delivery is tailored to the needs of our diverse population, supported by a data-driven methodology. PHM enables us to generate and use population specific data to influence care planning, resource allocation and delivery of care, shifting our way of planning and delivering health and care from a reactive approach to a proactive approach and improving our ability to predict, prepare for and manage the health of our populations at all levels. It is as much about evidence as it is about cultural change and ways of working. It requires a system-wide change away from care being structured around organisations to care being structured around populations. As part of this shift, PHM can increase our focus on the wider determinants of health, through the strengthening of relationships across our local care partnerships.

Our vision is to build our population health management capacity and capability as an ICS across all partners, programmes and places to enable care to be tailored for individuals with early support and prevention, resulting in improved outcomes and a reduction in health inequalities for our population.

- PHM is an enabler for change, and is not something which can or should be taken forward in isolation. We believe that developing a systematic approach to embedding PHM as a way of working across all partners, places and programmes will bring significant opportunities for our patients in South East London.
- We are not starting from scratch. There is a rich history of using population data to drive the development of solutions and interventions, such as use of public health intelligence within Local Care Partnerships.

Within South East London this will be supported through a **PHM Framework** which sets out how we will develop our PHM capability and capacity across 4 key domains:

- **Population segmentation and unified outcome measures**, enable us to use a single language as a system to underpin our understanding of our population and what we are trying to achieve
- **Big data**, which links data from across our system and drives bespoke, accessible and user-friendly analytics for individual practitioners, teams, places and systems
- **Alignment of incentives**, ensuring investment and capacity is aligned to population segments and outcomes, with effective sharing of risk and reward across partners
- **Cultural change**, partnership working and integration driven through organisationally-agnostic system leadership with ownership and accountability for delivering integrated care. This will be supported by a reflective understanding of current ways of working and how these either support or act as barriers to the delivery of effective, population-based care.

Our **key priorities** over the next two years will be to:

- To develop a **core understanding of population health management** across the ICB, Local Care Partnerships, providers of health and care services as well as front line clinicians and practitioners.
- To **build population health management capacity and capability** across our partners, places and programmes
- To support the delivery of **tailored, person-centred care** where teams are able to use a data driven approach to pro-actively manage individuals and focus on prevention.