South East London Integrated Care System

NHS South East London

Embedding Population Health Management within SEL

Agenda

Over the next c. 30 minutes we will aim to cover:

- What PHM is and why it matters for neighbourhood working
- The role of PHM in supporting proactive and preventative care within neighbourhoods
- Our vision for PHM across SEL
- How PHM is applied in practice within:
  - Primary care
  - An acute / Integrator Host organisation

We will then move into a **question-and-answer** session so do have questions ready!

What do we mean by ‘PHM’?
Not just data and analytics!

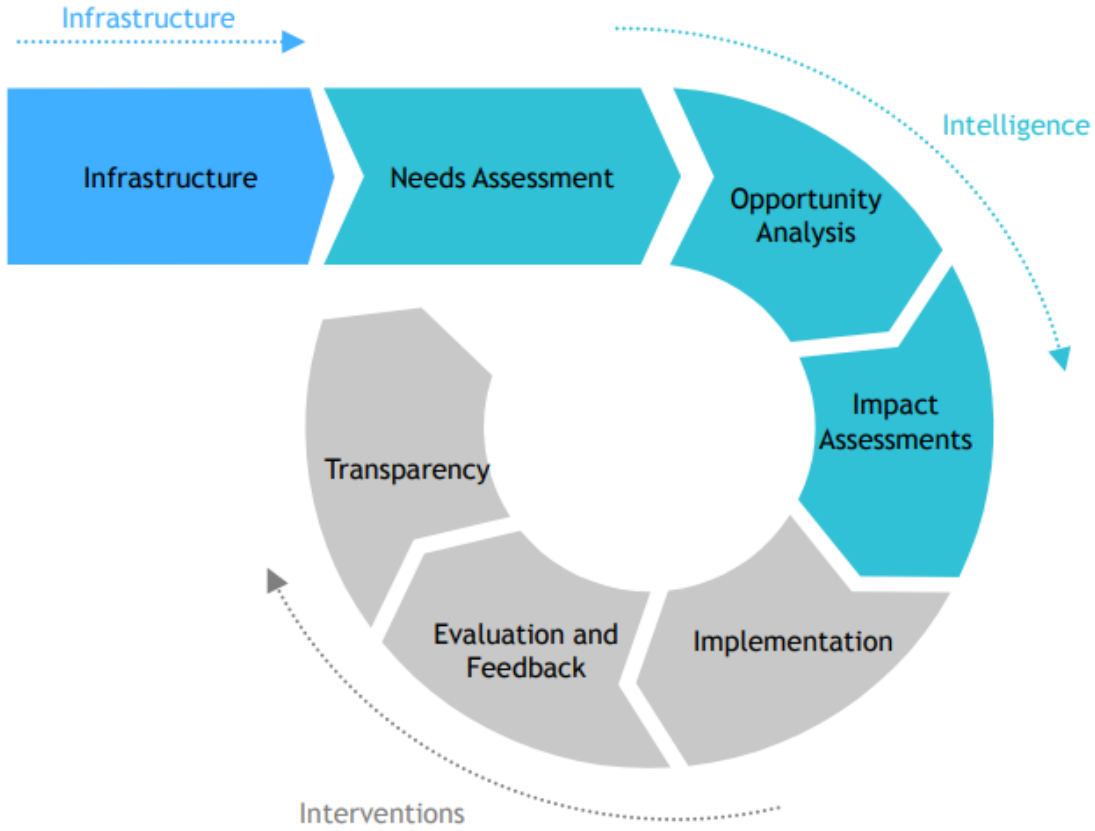
Population Health Management improves population health by **data driven planning and delivery of health and care services to achieve maximum impact**.

It includes:

- Population segmentation
- Risk stratification
- Impact modelling
- Applying insight to design interventions

It is an enabler – one ‘tool in our toolkit’

PHM as an enabler of the continuous learning cycle (NHS England)[1]



[1] NHS England 'Population Health Management Flatpack'

PHM is a core enabler of pro-active neighbourhood-based care

- Allows us to identify the right people for pro-active and preventative care
- Underpins our approach to INTs
- A holistic perspective (if we get the data right!)
- Allows us to focus resources and helps address health inequalities
- Where it is being used (e.g., LGT), it's already making a difference
- But this is a journey
  - We have pockets of best practice and excellence…
  - … but know we can go much further over time.

SEL Neighbourhood Maturity Matrix: Integrator Principles

Facilitate population health management (PHM) by promoting the sharing and effective use of data and real-time information across organisations, enabling holistic care for residents and improving population health outcomes. Integrators will need to support ICB work to ensure the provision of real-time population health data, drawing down on regional and place capacity and skills, to enable INTs to target interventions proactively and preventatively addressing health inequalities and needs.

What might our approach look like?
What do we need to agree?

Addressing our near-term needs: How can we make best use of available tools (e.g., Ardens) to support our immediate priorities?

Getting the data in place *(Data architecture, 'Layer one')*

- We have agreed a solution by which:
  - The ICB will continue to hold pseudonymised data
  - A GSTT Secure Data Environment will be expanded to become a system asset holding Patient Identifiable Data
- We will want to continue to build our linked (or linkeable) data sets; we will need to prioritise based on use cases

System-wide shared data architecture and common tools / approaches

Running analytics on the data *(Analytics and Data Science, 'Layer two')*

- We have a small set of 'do once for SEL' functions for which ICB funding has been agreed (e.g., setting shared definitions for system-wide priority cohorts)
- The ICB will continue to hold analytics resource to support strategic commissioning and planning
- The Integrators (including their Host organisations) are working through how local analytics will be delivered, recognising the need for local insight and delivery
- This resource will need to work together through a 'network approach' to share best practice and avoid duplication

Ensuring the analytics drives change *(Implementation support, 'Layer three')*

- We need to embed PHM into our 'toolkit' so that it supports pro-active care.
- This will be a long-term shift in how we operate, and we are only starting to explore questions such as:
  - How can we make insights more readily available to front-line staff (as Ardens does for GPs today)?
  - What opportunities and support do our staff need?

Local analytics and delivery to support commissioning, planning and direct care

South East London Integrated Care System

NHS South East London

Applying PHM in Primary Care

Dr Prashanth Sathiagnanam

Data Analytics in Primary Care

Data analytics is not just about putting information into a system and waiting for insights to appear.

It is fundamentally about solving problems.

Before choosing a dataset, building a dashboard, or running an analysis, the most important step is to clearly understand the problem you are trying to solve.

A good problem-solving approach helps decide:

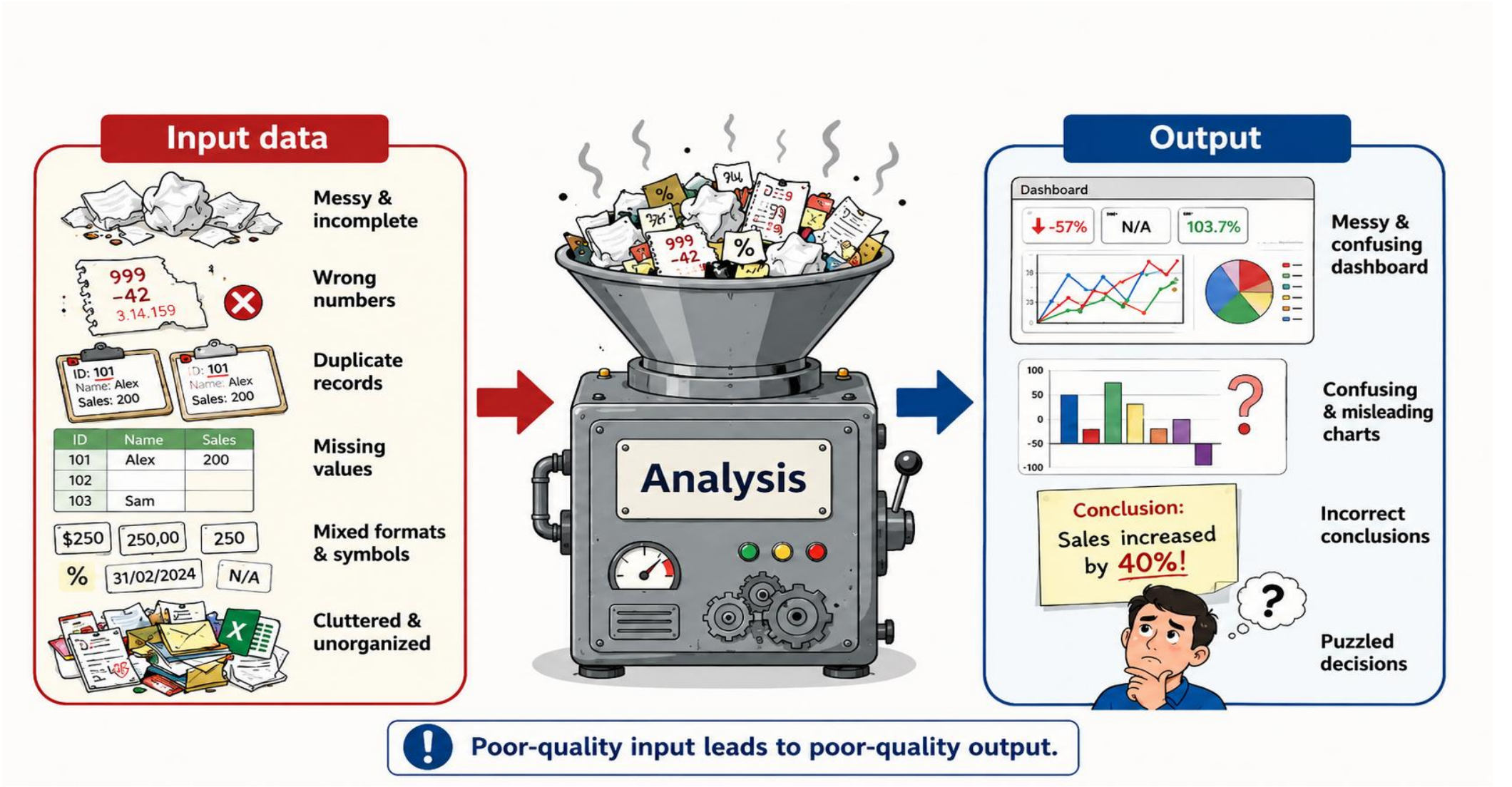
- what **information needs** to be included
- how the **data should be cleaned, grouped, or transformed**
- how the **findings will be used in practice**
- what **action** should follow from the analysis

This is especially important in population health management, where data should help us identify **needs, target interventions, reduce inequalities, and improve outcomes for residents**.

South East London Integrated Care System

Data Quality

NHS South East London



Importance of Coding

Estimated Number of Potentially Undiagnosed or Miscoded Cases

CONDITION	ESTIMATED CASES
COPD	~ 7,700
Asthma	~ 6,100
Diabetes	~ 31,000
Atrial Fibrillation	~ 25,800
Coronary Heart Disease (CHD)	~ 3,500
Heart Failure	~ 8,900
Hypertension	~ 218,000
CVA/TIA	~ 8,600
Dementia	~ 5,800
Severe Mental Illness (SMI)	~ 9,200

324,000 potentially uncoded conditions across SEL

Project Scope and Methods

Objectives

Evaluate - the current state of data usage and need in primary care.

Explore - how analytical tools are being used or underused.

Identify - gaps and barriers to data-driven decision-making.

Align - future developments with regional priorities, including the formation of Integrated Neighbourhood Teams.

Method

- A borough-wide survey of 72 practices and networks
- Two ICB-wide workshops
- Stakeholder engagement across all six SEL boroughs

Key Insights: Evaluating and Addressing the SEL Primary Care Data Needs

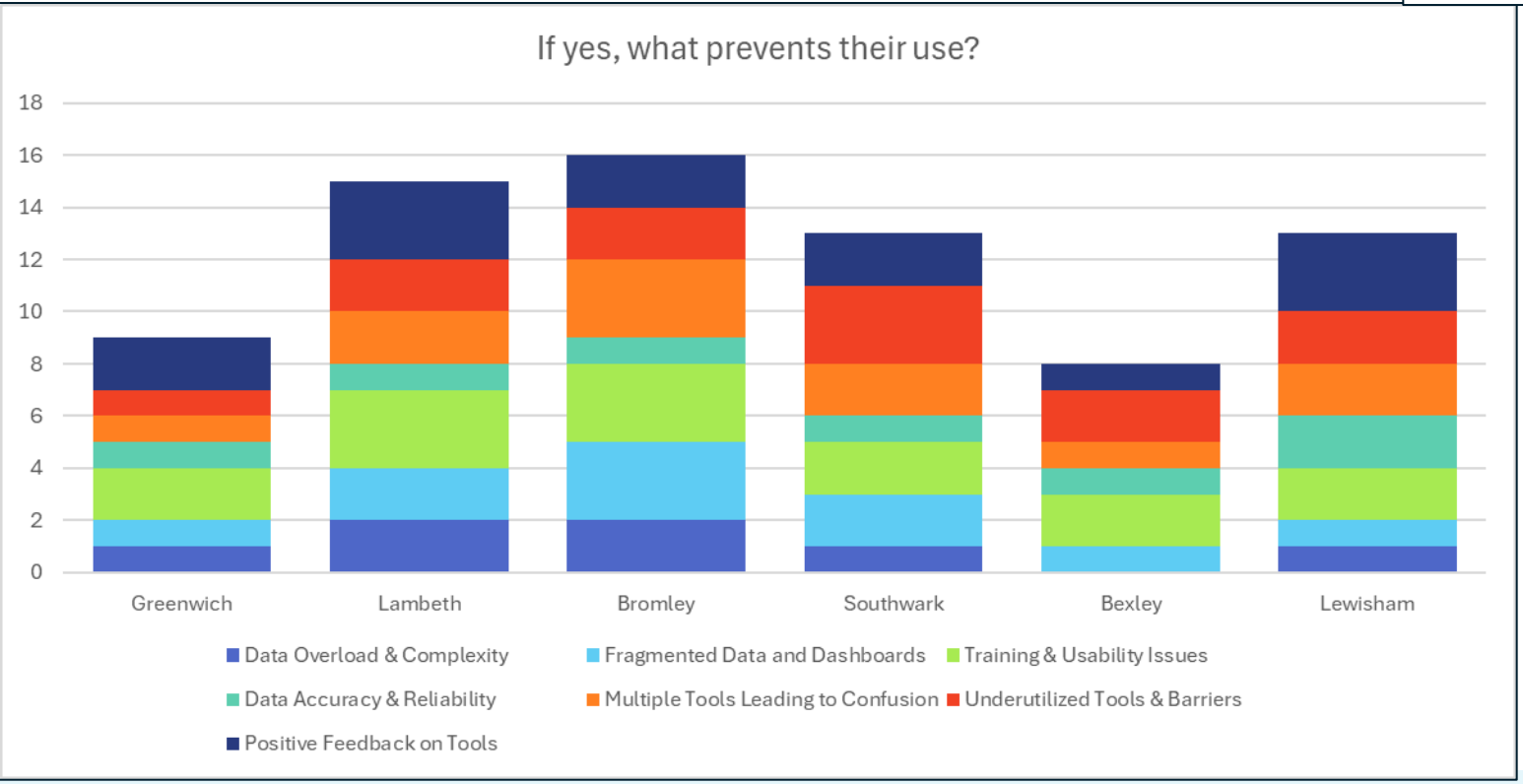
This review was grounded in the need to respond to the primary care data requirements

- That data is **abundant, but fragmented**.
- That **tools are available, but not always usable**.
- That strategy is developed, but **not always aligned** with real-world operational needs.

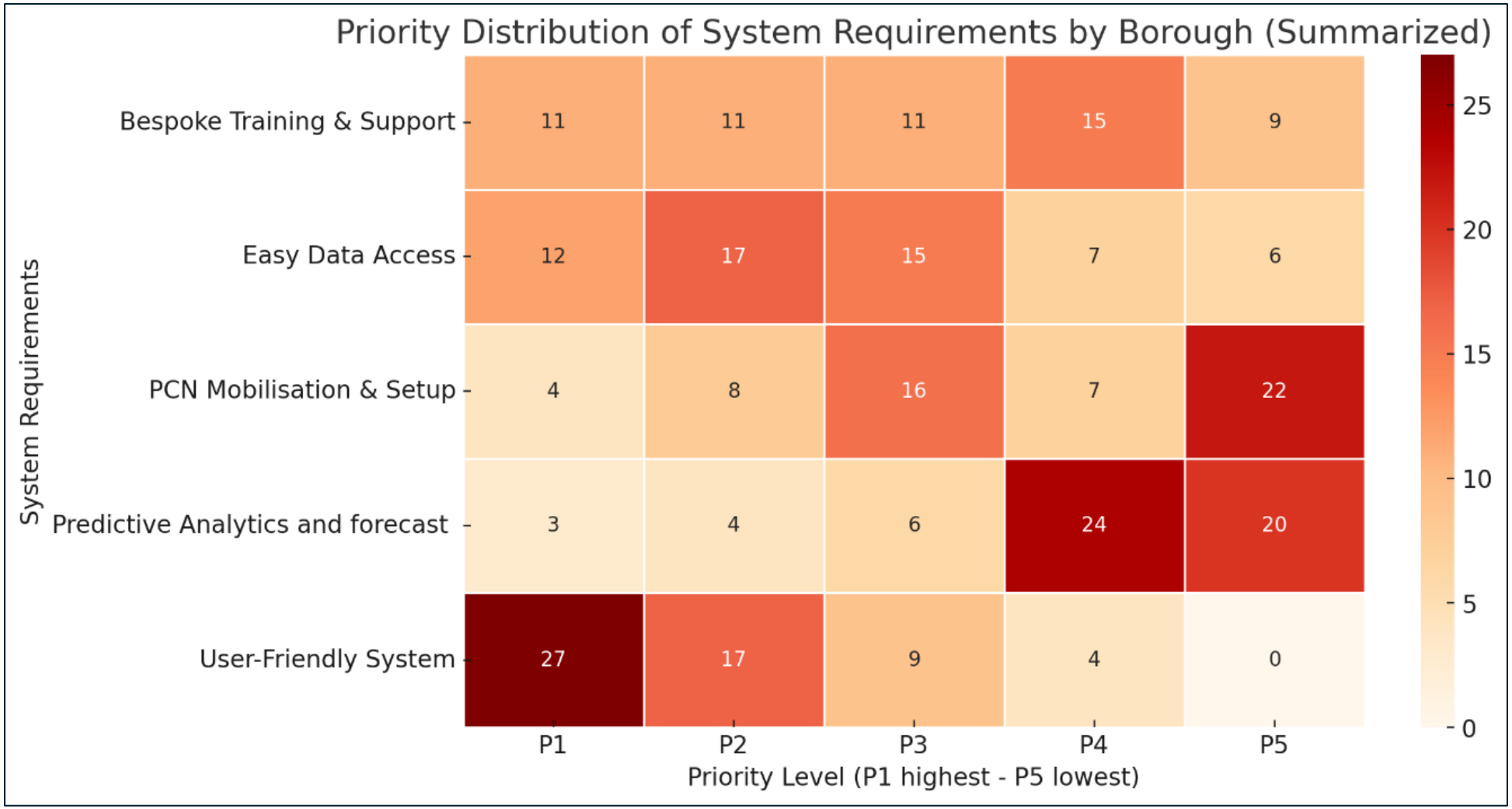
In the context of the Fuller Stocktake and the ICS ambition to scale integrated working, especially through INTs, the case for responsive, streamlined, practice-aligned data infrastructure is more urgent than ever.

Barriers to utilising Analytical Tools

17 respondents (31%) answered time for this question.



Requirements for Better System Use, Performance and Uptake



Six ways data can help us understand and solve problems

1. Making predictions

2. Categorizing things

3. Spotting something unusual

4. Identifying themes

5. Discovering connections

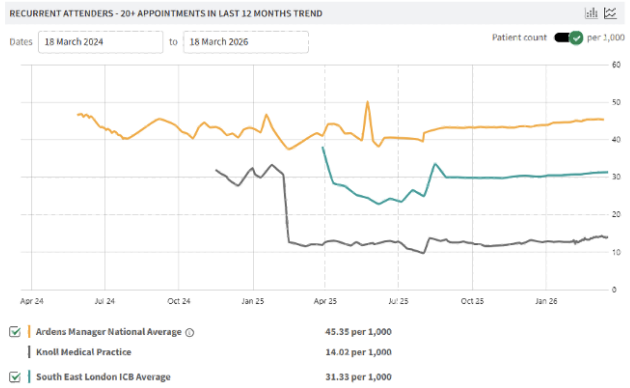
6. Finding patterns

Google, 2026

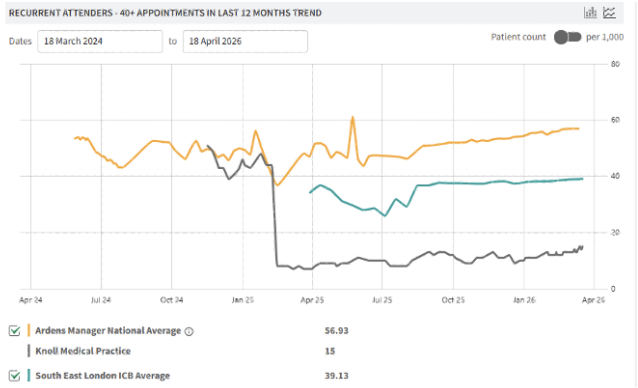
Case Study: Reducing recurrent attendance through proactive support

Regular contact, personalised care plans and referral to ICN, community providers and the third sector coincided with a sustained fall in repeat attendance.

Recurrent attenders: 20+ appointments in last 12 months



Recurrent attenders: 40+ appointments in last 12 months



What changed

- Regular contact with patients at risk of recurrent attendance
- Personalised care plans to address drivers of repeat use
- Referral to ICN and community providers for wrap-around support
- Use of third-sector services where social needs were contributing

The step-down in Knoll Medical Practice's rate appears from spring 2025 and is then broadly sustained across the following 12 months.

Where the practice is now

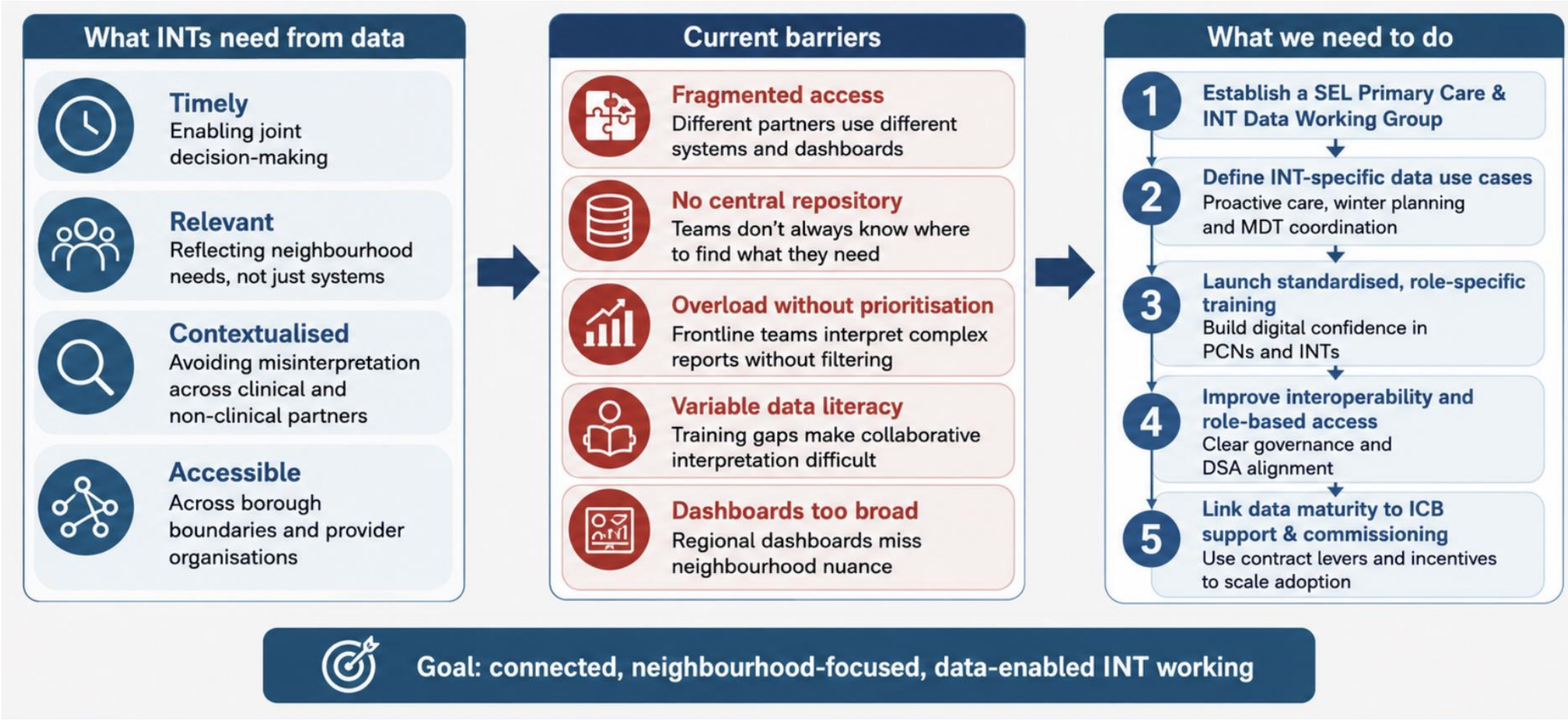
20+ attenders	**14.02**	55% below SEL ICB 69% below national
40+ attenders	**15.00**	62% below SEL ICB 74% below national

Overall message The sustained gap below local and national rates is consistent with earlier follow-up and better-supported community alternatives.

South East London Integrated Care System

Connecting INTs Through Better Data

NHS South East London



South East London Integrated Care System

NHS South East London

Applying PHM in an Integrator

Rachael Smith

South East London Integrated Care System

NHS South East London

How does PHM support Integrators?

- **Population health management** (PHM) makes effective use of data from different organizations to enable proactive and predictive care. Shifting us away from delivering reactive care.

- It can give us visibility of patients across multiple services identifying gaps in care or duplication in care to support workforce efficiency and service redesign.

- It can help us identify and address inequalities in patient outcomes from care

- It will be the foundation for INTs enabling them to proactively identify patients and deliver targeted interventions.

- It will allow us to track patient outcomes and the impact of the interventions we are delivering – allowing us to continually review and redesign.

Cohort Selection Process in the INT Case Finding Dashboard

Segment: Cohort Selection Criteria → **Prioritise:** by Disease State → **Stratify:** by Impact on Acute Activity → **Flag:** of Information to Shape/Personalise Care and appointment length

Patients with the highest number (3/4) of **unoptmised diagnosed and undiagnosed** CVD LTCs

Approx 4000 in Lewisham

**Excludes care home and palliative care patients*

Review Split by <80 80+

- **3-4** unoptimised LTCs and/or undiagnosed conditions
- **2** unoptimised LTCs and/or undiagnosed conditions
- **1** unoptimised LTCs and/or undiagnosed conditions

Risk of hospital admission

Safety netting based on criteria for high score (BP and HbA1C) but further down the list of risk of admission to ensure those patients don't get 'left' waiting.

Longer appts based on:
- Reading / language difficulties
- LD
- SMI
- Autism
- Main language not English

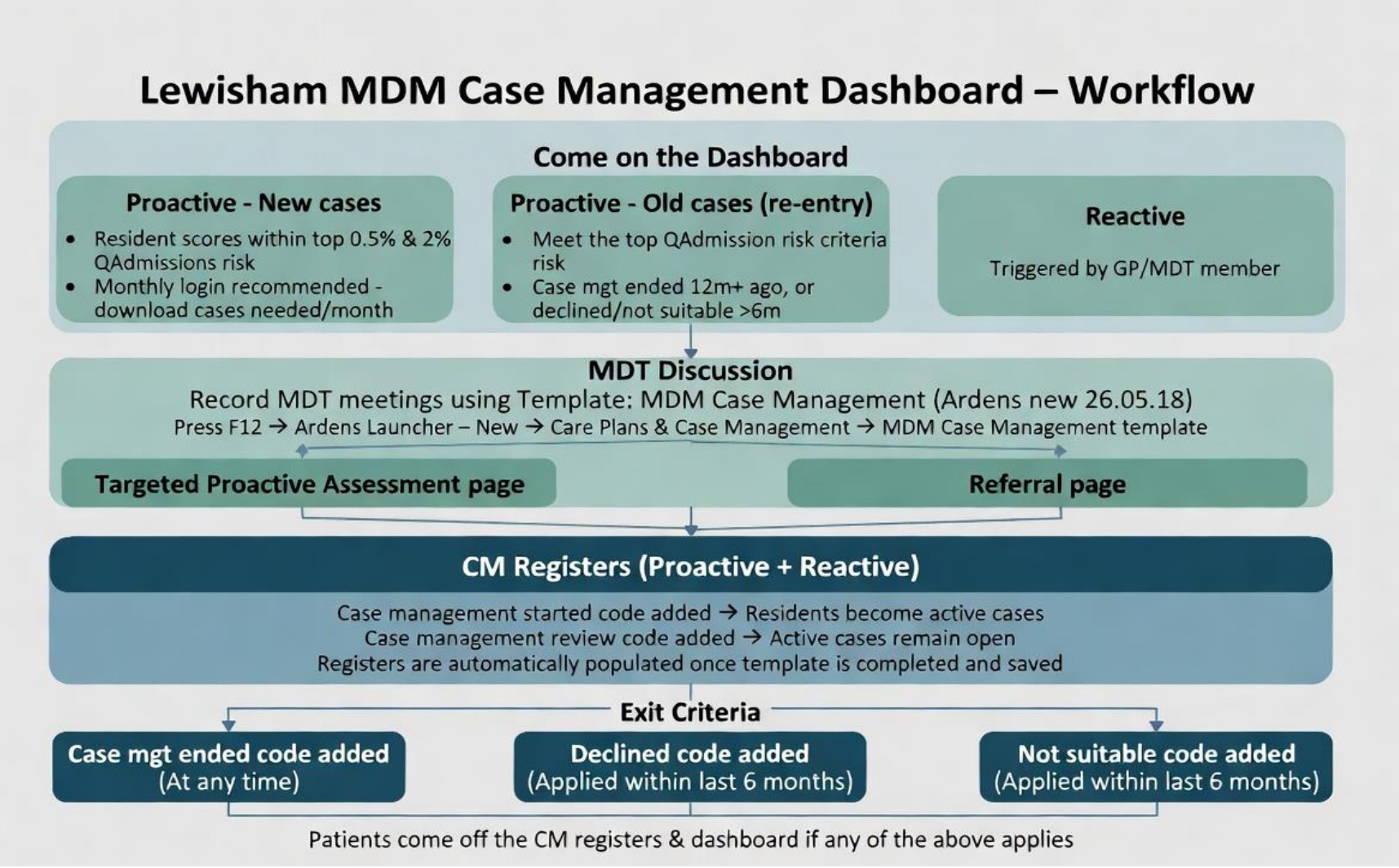
Useful columns of data:
Name / NHS no. / tel no. / what LTCs and if undiagnosed or unoptimised / all factors in the other boxes/ on a waiting list Y / vulnerabilities.

For every 100% caseload selected, efforts are made to keep the complexity balanced and manageable: **Red – 30%**, **Amber – 30%**, **Green – 20%**, and **Safety netting – 20%**.

Dashboard 'drop off' criteria: once seen and case management ended has been coded they are withheld from the dashboard for 12m with PIFU. DNA x 3 exclude for 6m. CNC x 3 exclude for 6m

Lewisham INTs are comprised of a non-clinical caseworker and a pharmacist for each neighbourhood with three core interventions: Getting to know you / Hollistic health review / lifestyle medicine

MDM example: Combining PHM proactive casefinding and reactive referrals together



Proactive cases

Use the **'Targeted Proactive Assessment' page** within the template to document MDT discussions

Reactive cases

Use the **'Referral page'** to document reactive cases discussed at MDT meeting

lg.pophealthlewisham@nhs.net

Summary

- PHM is a core enabler of neighbourhood working and proactive care
- As a system we are committed to establishing a shared infrastructure and tools for everyone to avoid starting from scratch and to help expedite PHM across SEL.
- However, if we want to make a difference the **delivery team and interventions are critical.** Data alone won't make a difference.
- We recommend using EMIS templates to easily code and track your patients. This will allow you to see the patient outcomes and which interventions are having the most impact to support continual change.
- Explore the tools available to you e.g. the ICB's dashboards for insight, Ardens for primary care data casefinding dashboards, and in time Snowflake for multi source integrated data casefinding dashboards