NHS Confederation

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Breakout session

Insight into impact: turning data into impact for neighbourhood-based primary care services

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In partnership with:

Optum

We’ll b using Slido for Q&A. Please scan the QR code opposite or go to slido,com and enter #CC2H.

Please ensure you select the Harpley room.

NHS
North East London

Building Population Health Management that works

Lessons learned from the past 2 Years in North East London

Why I'm here

- I’ve been in post 2 years leading PHM implementation across North East London (NEL).
- We have 37 Integrated Neighbourhood Teams, 7 boroughs, ~2.5 million population.

- This isn't a victory lap - Here to share what worked, what didn't, and what I'd do differently
- If you’re in that middle ground between “We’ve decided to do PHM” and “We have a mature programme”, then hopefully this will be useful

NEL PHM backstory

The good:

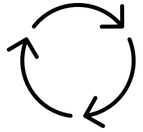
- Great linked data
- Genuine appetite for data and improvement
- Great PHM team (3 FTE + analysts in BI + partners)

The messy:

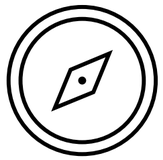
- Struggle to access the data
- Good analytics with no direct link to action
- IG headaches
- Analyst resource bottleneck
- "We already do this" / "Another acronym" scepticism

The choices that mattered most

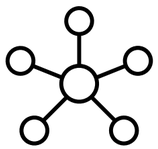
1. Critical to have a **vision for PHM:** A fundamental shift from a service based perspective to value based care for populations – everything else follows from here



2. We see PHM as a data driven outcome **improvement cycle** that scales from local to system



3. PHM **positioned in strategy**, <u>not</u> business intelligence. Why? Without a strategic framing, risks becoming interesting and not useful



4. PHM **as connective tissue** to a range of strategic priorities – The HOW for strategic commissioning, neighbourhoods, incentives, outcomes, prevention etc

5. Approach to PHM **<u>has</u> to link to action**, **<u>has</u> to enable easier evaluation** – keeping momentum is critical

Lesson 1: Be more ambitious on IG than you think

What we needed: IG agreements from 268 GP practices, re-identification, non-NHS access

What we were told: 12 months minimum, likely longer

What we did: 3 months (>98% sign-up)

The game-changers:

- Map every programme, every committee, go and see them – Getting clinical champions on board with the vision was key
- Re-identification enables link to action (not just insight)
- Non-NHS access brings VCFSE into the cycle, makes it a true system endeavour
- Both felt ambitious but became fundamental to the model

Lesson: Push for maximum capability from day one - retrofitting is harder

Lesson 2: Choose platform for workflow, not analytics

Our aim: Democratise the data, create a **common shared language** and **get value** from the linked data

The test: Can a neighbourhood team go from cohort to evaluation in one place? If not, we were building in lots of opportunities for the loss of momentum

Why we cho

- **Workflow support** for whole of PHM cycle - not just analytics dashboards
- **Re-identification** capability built in – link to action
- **Intervention library** – evidence base of what to do
- **Evaluation** pathway included so important – it's the easiest bit of PHM to drop
- One-stop shop **prevents** dead ends and **loss of momentum**

Lots of platforms stop here

Lesson 3: Culture eats strategy (and technology) for breakfast

- The platform is **necessary but not sufficient to make lasting change** – we needed a change in culture as well

20%

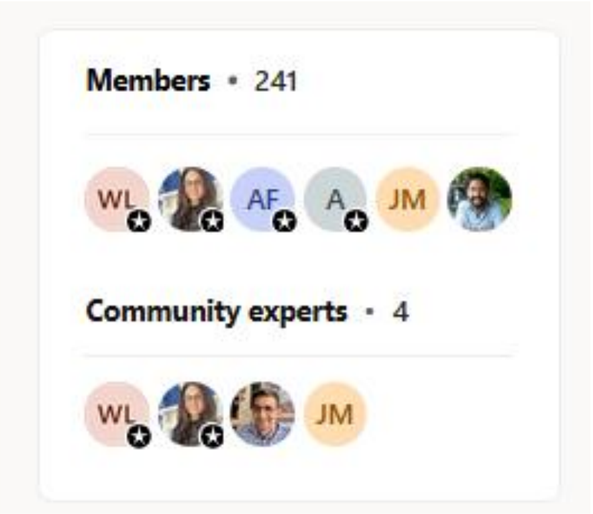
- What drives adoption of PHM – **people feeling confident and supported**!
- We built a range of **overlapping offers**
  - Community of practice
  - Targeted training sessions for different audiences
  - Early Adopter Programme – Series of facilitated PHM cycles for INTs with expectation of *see one, do one, teach one* learning
  - Lots of ad hoc hand holding!

80%

Lesson: Budget for ongoing change support, not just training materials if you want this to be self-sustaining

Where we are today (4 months post launch)

- **Current status:**
  - > 300 platform users, >240 in Community of Practice
  - Facilitated PHM cycles in 6 of 7 places – Action Learning Sets working through the detail
  - Wide range of projects and closely tied to neighbourhood strategy and strategic commissioning development



- **Reality check:** Lots of work still to do!
  - Keep supporting our neighbourhood teams with all things PHM
  - Work with providers on a ‘specialist’ PHM offer
  - Generate evaluation data, expand to LA data, advanced analytics
  - Finance reconciliation exercise – aiming for ‘single version of the truth’

Ongoing/ Upcoming challenges (aka things that keep me up at night)

- **The sustainability question:** Enthusiasm alone isn't sustainable – the need to link PHM to commissioning and payment
- **The standardisation paradox:** Balancing broad implementation with local flexibility in e.g. cohort selection
- **The moving target:** How we navigate the restructuring changes to ICB/Region/National pictures

What I'd tell my 2-years-ago self

Do again:	Do differently:	Accept:
• Position in Strategy, not BI • Be ambitious on IG • Invest in training and culture building • Choose platform for workflow, not just analytics • Link PHM to existing priorities, don't make it separate work • Keep lots of plates spinning!	• Start executive engagement even earlier – omni-crisis • Set realistic expectations on evaluation timelines • Engage providers from day one - Alignment with Integrator agenda = light bulb moments	• You can't boil the ocean – work out your leverage points • Not everyone will jump on board at the start - Early adopters are gold - nurture them • It takes longer than you think, but less time than you're told!

NHS
North East London

The biggest risk isn't getting the platform/analytics wrong

It's treating PHM as a data project instead of strategic transformation

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Questions?

Turning data into impact for Neighbourhood Services

NHS
Lincolnshire
Integrated Care Board

Sarah Button, Head of PCN Transformation

04/03/2026

Services designed to reflect population need

- Lincolnshire is a large county c.820,000 population with diverse communities - Urban, Rural and Coastal
- Establishment of PCNs in 2019 created an opportunity :-
  - GP practices to work together
  - A vehicle for population health management
- To facilitate this, PCN profiles were prepared by public health.
  Annual Reports :: Lincolnshire Primary Care Network Alliance
- Principle of designing services to reflect the needs of local populations/communities was established

PHM applied examples

High Intensity Use

- PHM data has been used for a pilot in one PCN which identified patients aged 18 and over with 7+ A&E/UTC attendances in preceding 12 months, excluding PEOL.
- A desktop review was undertaken to confirm suitability for support by a non-medical HIU Worker.
- Patients were tracked through the joint data set meaning we were able to view their activity across all providers.
- Provisional evaluation showed a 40% reduction in A&E/UTC attendances and a 60% reduction in Emergency Admissions for the cohort.
- The outputs from the pilot were used to develop a business case for social investment to enable HIU Leads to be commissioned in all PCNs in Lincolnshire.
- Contributing to the delivery of our UEC plan and priorities set out in the 2025 Neighbourhood Health Guidance.

Cohort Summary

Descriptive Analytics

Population Distribution

Segmentation

PHM Dashboard

Geo-Analysis

Theograph

Diagnostic Analytics

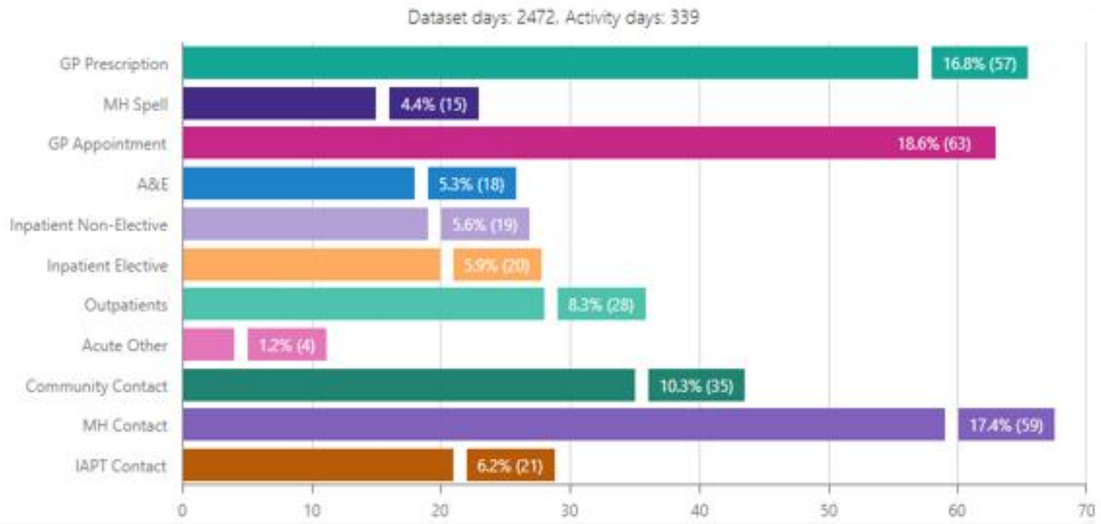
Transformation

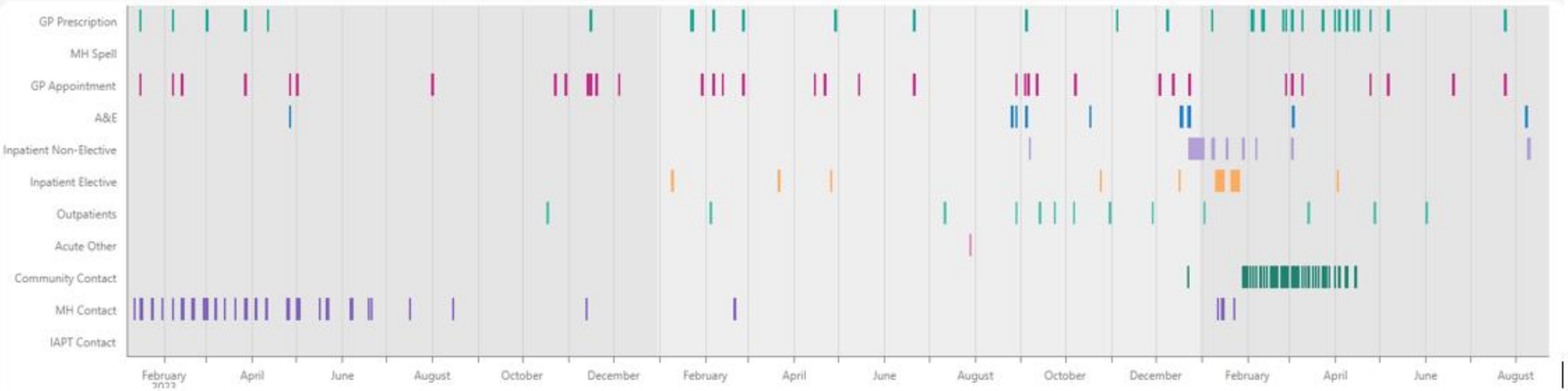
Knowledge base

High Activity Across ALL Care Settings for
Showing details for Patient ID

Configure

Age Group	Younger adults
Sex	F
IMD Decile	1
ONS Area Classification	Industrious communities
eFI Frailty	Moderate
Physical Health	Depression,
Other Characteristics	Social vulnerability,
Multimorbidity	Middle Multimorbidity
Total Utilisation (last 12 months)	£24,844





Optum | Pathfinder

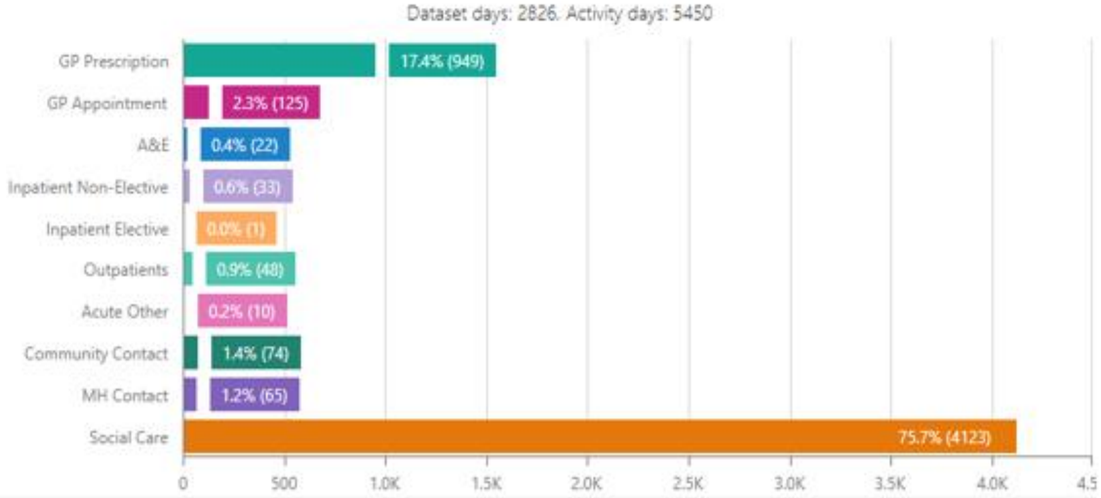
Activities | Accou

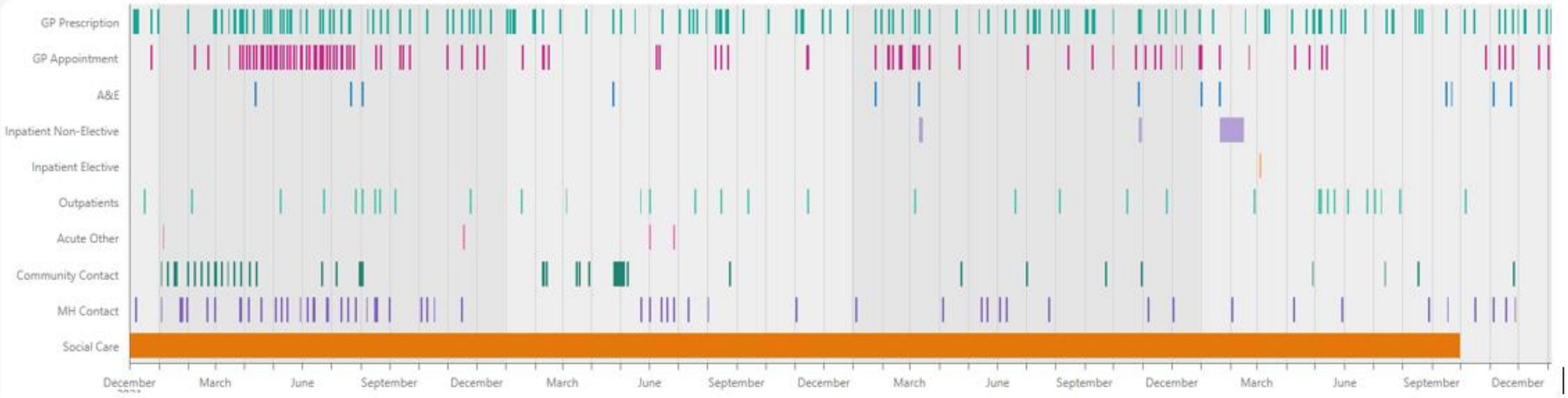
Configure

High Activity Across ALL Care Settings fo
Showing details for Patient ID

- Cohort Summary
- Descriptive Analytics
  - Population Distribution
  - Segmentation
  - PHM Dashboard
  - Geo-Analysis
  - Theograph
- Diagnostic Analytics
- Transformation
- Knowledge base

Age Group	Older adults
Sex	M
IMD Decile	5
ONS Area Classification	Countryside living
eFI Frailty	Severe
Physical Health	Hypertension, Learning Disabilities,
Other Characteristics	History of falls, Social vulnerability, Has a carer, Has a care plan,
Multimorbidity	High Multimorbidity
Total Utilisation (last 12 months)	£117,110





PHM applied examples

Frailty

- PHM data has been used to identify patients across Lincolnshire with Mild, Moderate and Severe Frailty and the potential opportunity impact if more proactive interventions are delivered upstream.
- This data has helped shape the Lincolnshire Older Peoples Strategy which was developed with system partners and places an emphasis on preventative and proactive care which is anchored in neighbourhoods.
- Neighbourhood Health pillar with objectives of delaying the onset and slowing the deterioration of Frailty.
- PCNs have used PHM data to identify cohorts of patients to focus on to provide proactive case management.
- Facilitated sessions with a Senior Data Analyst and Frailty Project Manager to test out hypothesis and look at different condition/characteristic flags which has informed how their capacity is utilised to manage frailty.
- This has enabled PCNs to identify manageable sized cohorts and target interventions where there are the greatest opportunities.

PCN Frailty Cohort Example

Showing data for ([PCN] is any of (PCN) And [Age] is greater than or equal (65) And [Learning Disability] is present (No) And [Care Home] is present (No) And [Life Course Segment] is none of (3 - End of Life) And [Frailty Score (eFI)] is any of (Mild) And [Hypertension] is present (Yes) And [Diabetes] is present (Yes) And [High Cholesterol] is present (Yes))

Expand cohort

PHM Dashboard

Utilisation data for: **Dec 2024 - Nov 2025**
GP prevalence data to: **13th Jan 2026**

Send Cohort

Segmenting by Local Frailty Indicator

Configure

Local Frailty Indicator	Mild	Moderate	Severe	Unknown	Cohort Population	Whole Population
Overall Population Measures						
Population	56	123	<6	424	**606**	823,846
Age	76	74	75	73	**74**	44
Male %	58.9%	52.0%	66.7%	58.5%	**57.3%**	49.7%
Deprivation	3.2	2.3	1.3	2.7	**2.6**	5.2
Minority Ethnic	5.5%	3.3%	33.3%	2.4%	**3.0%**	7.1%
Avg. Multimorbidities	4.1	3.9	4.3	3.8	**3.8**	1.2
Outcomes						
Outpatient Attendances	3.3	2.7	0.3	2.9	**2.9**	1.5
Elective Admissions	0.5	0.2	0.0	0.3	**0.3**	0.2
A&E Attendances	0.5	0.7	1.0	0.5	**0.5**	0.4
Emergency Admissions	0.2	0.2	0.3	0.2	**0.2**	0.1
Non-Elective Other Admissions	0.0	0.0	0.0	0.0	**0.0**	0.0
GP Appointments	11.1	9.0	6.7	9.5	**9.5**	5.7
GP Prescriptions	94.6	119.4	140.7	96.9	**101.4**	26.5
Community Contacts	4.7	2.2	6.3	1.6	**2.1**	1.3
Mental Health Contacts	0.5	0.0	0.0	0.1	**0.1**	0.4
Mental Health Admissions	0.0	0.0	0.0	0.0	**0.0**	0.0
Talking Therapies Contacts	0.4	0.0	0.0	0.1	**0.1**	0.1
Social Care	0.1	0.3	0.0	0.1	**0.1**	0.2
111 Calls	0.0	0.0	0.0	0.0	**0.0**	0.0
Ambulance Calls	0.0	0.0	0.0	0.0	**0.0**	0.0
Ambulance Conveyances	0.0	0.0	0.0	0.0	**0.0**	0.0
CHC Care Packages	0.0	0.0	0.0	0.0	**0.0**	0.0
CHC Referrals	0.0	0.0	0.0	0.0	**0.0**	0.0
CHC Reviews	0.0	0.0	0.0	0.0	**0.0**	0.0

PCN Frailty Cohort Example

Segmenting by Local Frailty Indicator

Configure

Local Frailty Indicator	Mild	Moderate	Severe	Unknown	Cohort Population	Whole Population
Asthma	23.2%	16.3%	33.3%	13.9%	**15.3%**	11.4%
Cardiovascular Diseases	21.4%	35.0%	66.7%	30.2%	**30.5%**	8.8%
Fall (In Year)	0.0%	0.0%	0.0%	0.5%	**0.3%**	1.3%
History of Falls (eFI)	1.8%	4.1%	0.0%	4.7%	**4.3%**	5.9%
Obesity	64.3%	81.3%	100.0%	62.5%	**66.7%**	20.5%
Social Vulnerability (eFI)	8.9%	4.9%	0.0%	3.5%	**4.3%**	3.1%
Stroke	5.4%	1.6%	33.3%	6.4%	**5.4%**	1.6%
Transient Ischaemic Attack	0.0%	6.5%	0.0%	2.1%	**2.8%**	1.1%
Mental Health & Learning Disability						
Other Characteristics						
Comprehensive Geriatric Assessment	0.0%	0.0%	0.0%	0.0%	**0.0%**	0.0%
Dementia Assessment	10.7%	3.3%	33.3%	4.7%	**5.1%**	3.3%
Diabetes Annual Review	91.1%	94.3%	100.0%	93.4%	**93.4%**	8.7%
English Not First Language	0.0%	0.8%	0.0%	0.2%	**0.3%**	6.3%
Falls Risk Assessment	0.0%	0.8%	0.0%	0.0%	**0.2%**	0.9%
Frailty Assessment	33.9%	6.5%	0.0%	4.5%	**7.6%**	6.5%
Frailty Assessment Declined	0.0%	0.0%	0.0%	0.0%	**0.0%**	0.0%
HBA1C 100+	1.8%	2.4%	0.0%	2.4%	**2.3%**	0.2%
HBA1C 76-99	10.7%	10.6%	0.0%	9.0%	**9.4%**	0.7%
Lives Alone	8.9%	1.6%	0.0%	1.4%	**2.1%**	1.5%
Not Fit for Work (In Year)	0.0%	3.3%	0.0%	1.4%	**1.7%**	5.7%
Opioid Prescription	44.6%	34.1%	33.3%	31.6%	**33.3%**	10.2%
Personalised Care Support Plan	0.0%	0.0%	0.0%	0.0%	**0.0%**	0.8%
Personalised Care Support Plan Declined	0.0%	0.0%	0.0%	0.0%	**0.0%**	0.0%
Structured Medication Review	23.2%	19.5%	0.0%	21.0%	**20.8%**	16.1%
Structured Medication Review Declined	0.0%	0.0%	0.0%	0.0%	**0.0%**	0.1%

Population
Section (Lowest / Highest) Cohort vs Whole (Lowest / Highest)

Outcomes
Section (Lowest / Highest) Cohort vs Whole (Lowest / Highest)

Health Indicators
Section (Lowest / Highest) Cohort vs Whole (Lowest / Highest)

Colour coding refers to the values in the row

PHM Applied Examples

Carers

- Current project looking at improving health outcomes for carers
- Carer identification and support is a key intervention in the Lincolnshire Older Peoples Strategy
- Identified in the DLN Commissioning Priorities
- Using data to identify areas of greatest opportunity
- Challenge of not being able to link the carer to the person they care for
- Opportunity for social investment if we can demonstrate ROI

Is a Carer – Cohort Population Summary

Key Characteristics	Is a Carer	Aged 60+	Whole Population
Asthma	16.8%	12.0%	11.4%
Back Pain (In Year)	5.4%	4.1%	3.1%
COPD	6.1%	8.3%	3.1%
Diabetes	14.2%	17.1%	7.6%
Hypertension	37.2%	49.6%	20.4%
Moderate Frailty	5.3%	7.2%	2.5%
Obesity	36.5%	30.6%	20.4%
Rheumatoid Arthritis	2.1%	2.5%	1.1%
Severe Frailty	1.6%	2.5%	0.8%
Social Vulnerability (eFI)	6.6%	6.5%	3.1%
Stroke	2.7%	4.4%	1.6%
Dementia	2.3%	3.8%	1.3%
Depression	35.0%	21.2%	18.2%
Learning Disability	0.8%	0.4%	0.7%
New Mental Health Flag (Two Years)	7.7%	4.1%	4.6%
English Not First Language	2.3%	1.8%	6.4%
High Blood Pressure	15.3%	17.2%	9.8%
NHS Health Check (5 Years)	16.7%	14.8%	10.7%
Not Fit for Work (In Year)	7.4%	3.1%	5.7%
Palliative Care	1.4%	2.2%	0.8%

Legend — Characteristics: Lowest, Highest; Outcome: Lowest, Highest

Key Insights

Demographics
There are 31,186 people in the selected cohort. The mean age is 60. 5,407 people live in neighbourhoods that are within the top 20% most deprived nationally.

Utilisation
The cohort make up 3.8% of the total ICS registered population and use 5.5% of the total healthcare spend. On average 21.1% had at least one hospital admission in the last year.

Activity Rates Per Patient

Outcomes: Activity Detail	Is a Carer	Aged 60+	Whole Population
Outpatient Attendances	2.3	2.5	1.5
Elective Admissions	0.3	0.3	0.2
A&E Attendances	0.6	0.5	0.4
Emergency Admissions	0.2	0.2	0.1
Non-Elective Other Admissions	0.0	0.0	0.0
GP Appointments	9.7	9.3	5.7
GP Prescriptions	53.1	57.9	26.5
Community Contacts	2.2	2.9	1.3
Mental Health Contacts	0.5	0.3	0.4
Mental Health Admissions	0.0	0.0	0.0
Talking Therapies Contacts	0.2	0.1	0.1
Social Care	0.5	0.4	0.2

Data Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB, 2025.

PHM applied examples

PCN Examples

East Lindsey PCN have used PHM data to identify a cohort of patients for targeted social prescribing interventions

- 18+
- mild cognitive impairment
- excluding PEOL
- Dementia
- High Need

which gave them a cohort size of 117 patients

South Lincoln PCN developed a project to support ‘at risk’ patients by delivering proactive interventions. Used PHM data to identify a cohort

- over 40
- Chronic respiratory illness
- frailty
- and from a fuel deprived area
- excluding patients in care homes and PEOL

which gave a cohort size of 180 patients

Lincoln Healthcare Partnership PCN have used PHM data to identify patients with complex medical needs who are high users of General Practice as well as acute services. Complex care nurse recruited to case manage this cohort.

Q&A