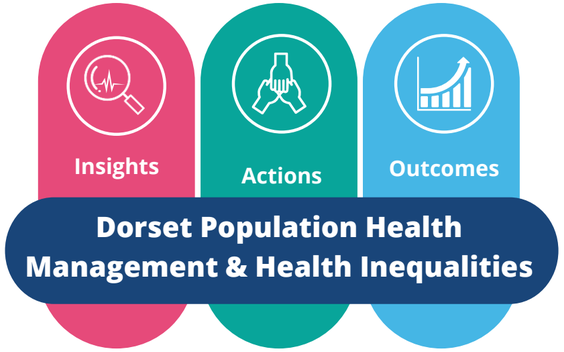

Population Health Management:
What's it all about and why does it matter?

An Introduction to the Dorset Systematic Population Health Management Approach

19th August 2025

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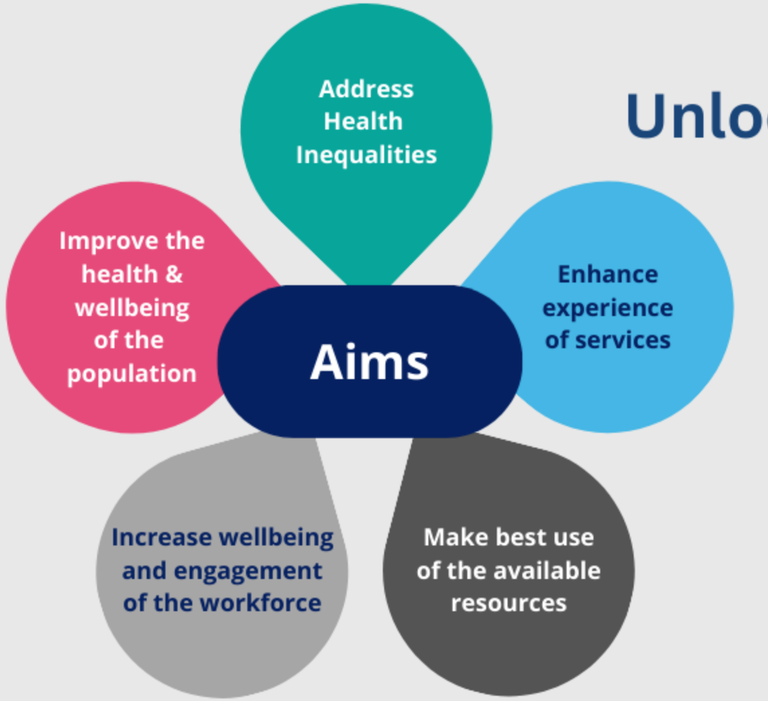
Population Health Management (PHM)

Driving meaningful change through PHM

Unlock the power of the Dorset Systematic Approach



Explore a proven, practical approach to improving health services for Dorset communities.

Using a real-world case study, we'll demonstrate how our **replicable PHM method** can deliver real impact, turning:

Insight into Action

Your Presenters Today are:

Janine Ord – Head of Population Health
Karen Stratford– Population Health Strategic Lead (PHM)
Jo Wilson - Population Health Strategic Lead (Prevention)
Nayab Nasir - Population Health Strategic Lead (Health Inequalities)

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What are Population Health & PHM?

Why does PHM matter?

Dorset Systematic Approach to PHM

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What are Population Health and Population Health Management?

Population Health

"An approach aimed at improving the health of an entire population"

(The King's Fund, 2021)

Population Health Management

Improves population health by data-driven planning and delivery of proactive care to optimise health outcomes

(NHS England, 2023)

Dorset PHM Approach

Turning Insight into Action

Why does PHM Matter?

Insights Actions Outcomes

Dorset Population Health Management & Health Inequalities

Health needs are changing

Inequalities in access, experience and outcomes

Demand for health services is not sustainable

Benefits

For People:
Improved access, experience and outcomes from health services - keep people well for longer, targeting support where it will have greatest impact

For Communities:
Builds stronger communities

For Systems:
More sustainable services – Effective, Efficient and Equitable

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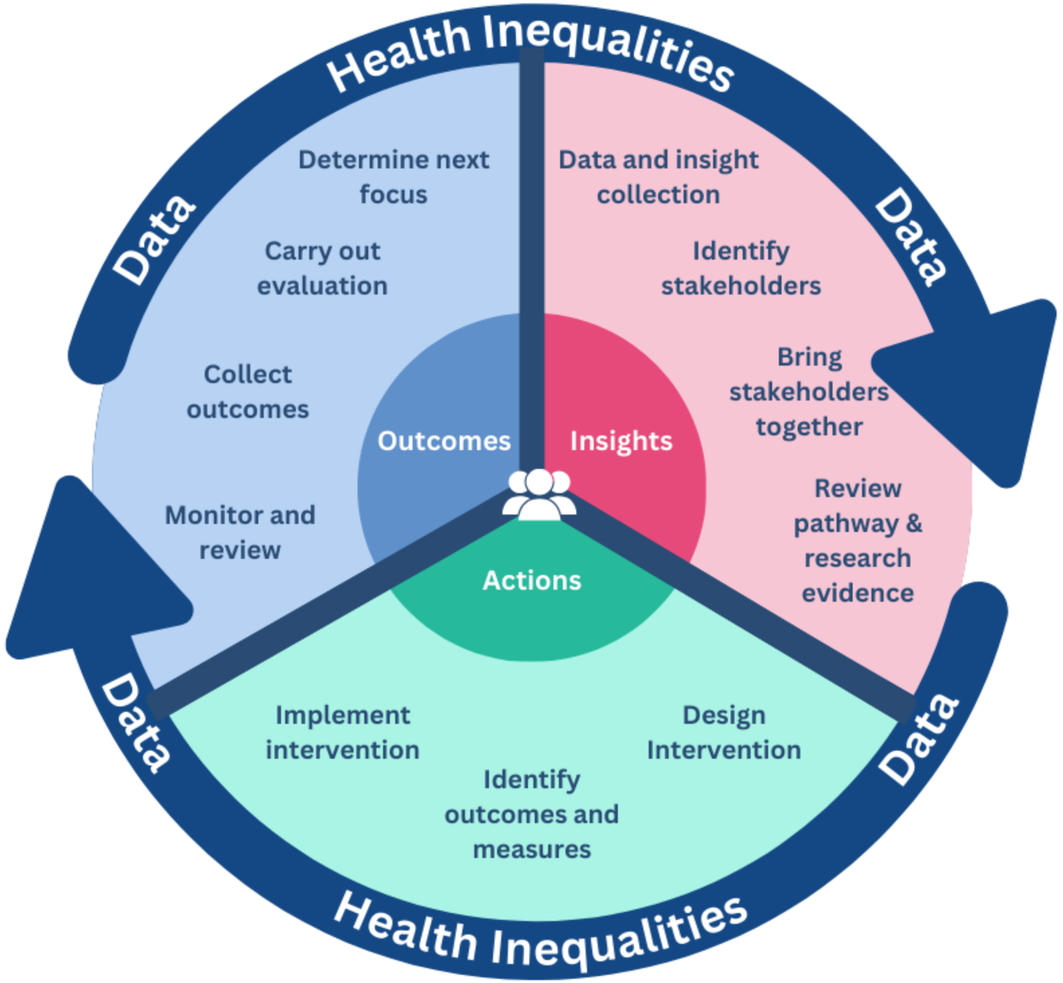
Health, care & wellbeing

Dorset Systematic Approach to PHM

Insights Actions Outcomes

Dorset Population Health Management & Health Inequalities



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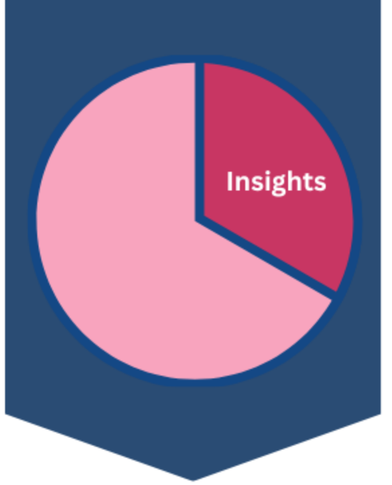

Insights

- Quantitative Data: The *What?*
- Qualitative Insight: The *Why?*
- Evidence-Based Insight: What Works?
- Dorset PHM Approach: The How?

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Quantitative Data - *The What?*

Fingertips
Public health data

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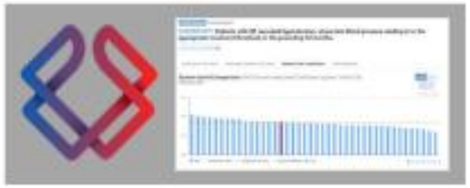
SHAPE



JSNA

NHS
Federated Data Platform

Supporting Information: Secondary Uses Service

The NHS Data Model and Dictionary provides a reference point for assured information standards to support health care activities within the NHS in England.

datadictionary.nhs.uk

Joint Strategic Needs Assessment (JSNA) - Public Health Dorset - Dorset Council

Public Health Dorset is no longer a shared service for Dorset and BCP councils. For health and wellbeing information, please visit

Public Health Dorset

GIRFT

Shape

SHAPE is an online, interactive, data mapping, analysis and insight tool that supports service planning and estates strategy development.

Shape | 11 Jan 2023

CVDPREVENT

See an overview of the data specific to your STP, CCG, PCN or Practice.

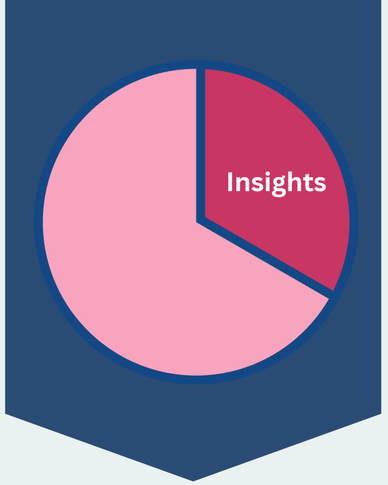
CVDPREVENT

NICE National Institute for Health and Care Excellence

Fingertips | Department of Health and Social Care

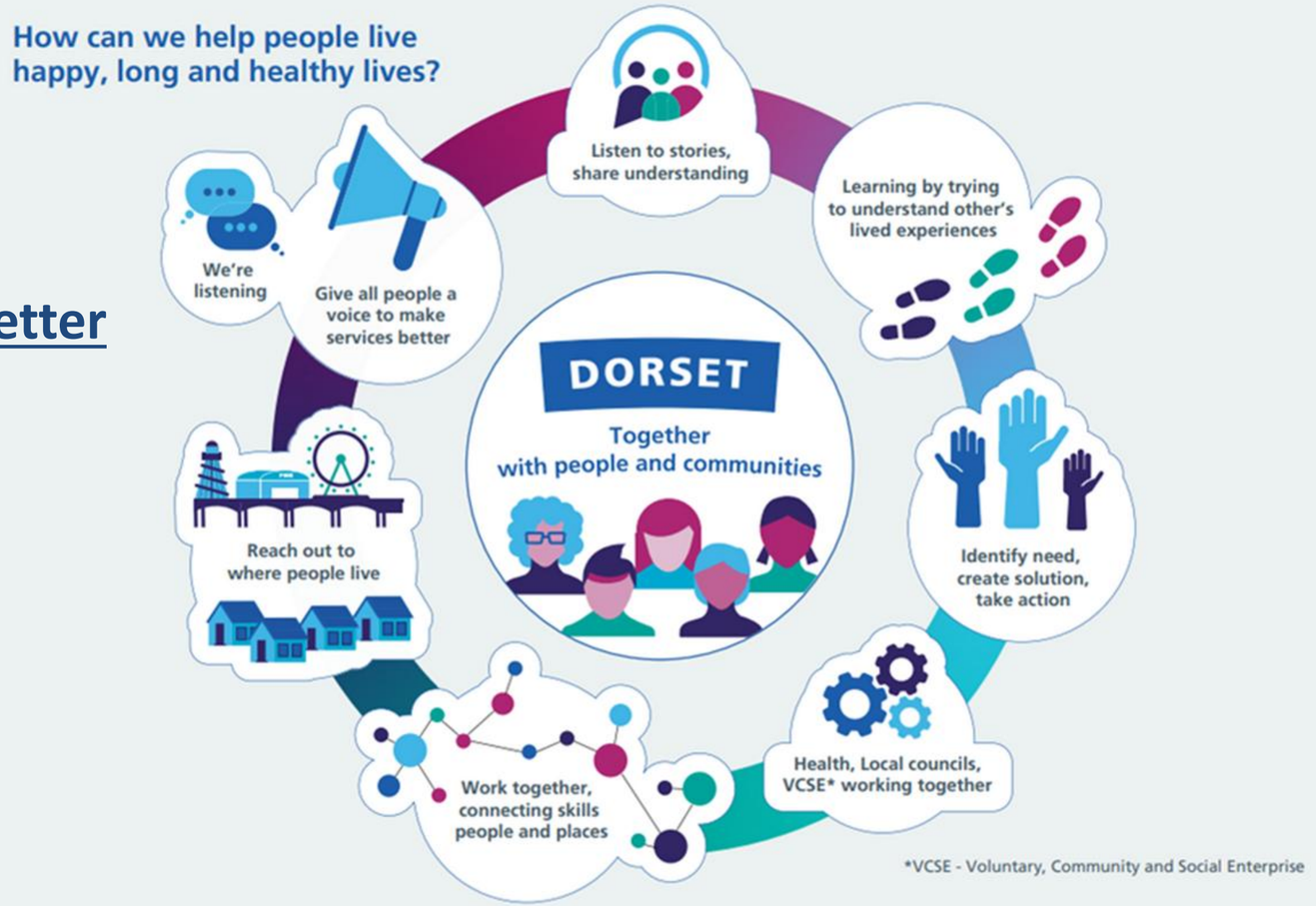
Fingertips is a rich source of indicators across a range of health and wellbeing themes designed to support JSNA a...

phe.org.uk



Qualitative Insight: *The Why?*

- Community Conversations
- Neighbourhood Conversations - Listening better
- Ongoing conversations
- Listening better
- Care Opinion
- Healthwatch Dorset
- NHS Dorset equity, equality, diversity and inclusion pages
- Coming soon - Insights bank



The Evidence: What Works?

NICE
National Institute for Health and Care Excellence

Tackling health inequalities: seven priorities for the NHS

Health inequalities · Equality and diversity

Local Government Association

Population Intervention Triangle toolkit

Place based approaches for addressing health inequalities, material developed by the LGA and Public Health England.

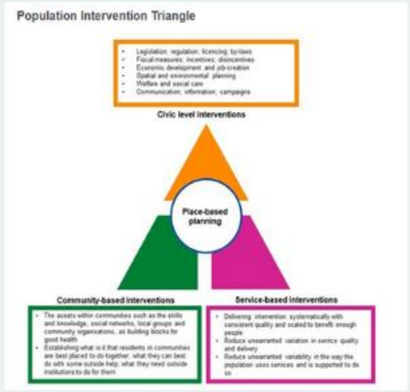
GOV·UK

Office for Health Improvement & Disparities

Guidance

Addressing health inequalities across allied health professional (AHP) services: a guide for AHP system leaders

Published 9 May 2024



Public Health England · Local Government Association

Place Based Approaches for Reducing Health Inequalities:

Summary and examples of how to use a place-based approach to reduce health inequalities

Prevention before cure
Prioritising population health

The King's Fund — ideas that change health care

Supporting people to manage their health
An introduction to patient activation

What is a population health approach?

Integrated care · Population health

The Health Foundation — Insights, analysis & data — Events

Home

Towards a new model of evidence for population health improvement

The King's Fund
Bold thinking for better health

Dorset PHM Approach - *The How?*

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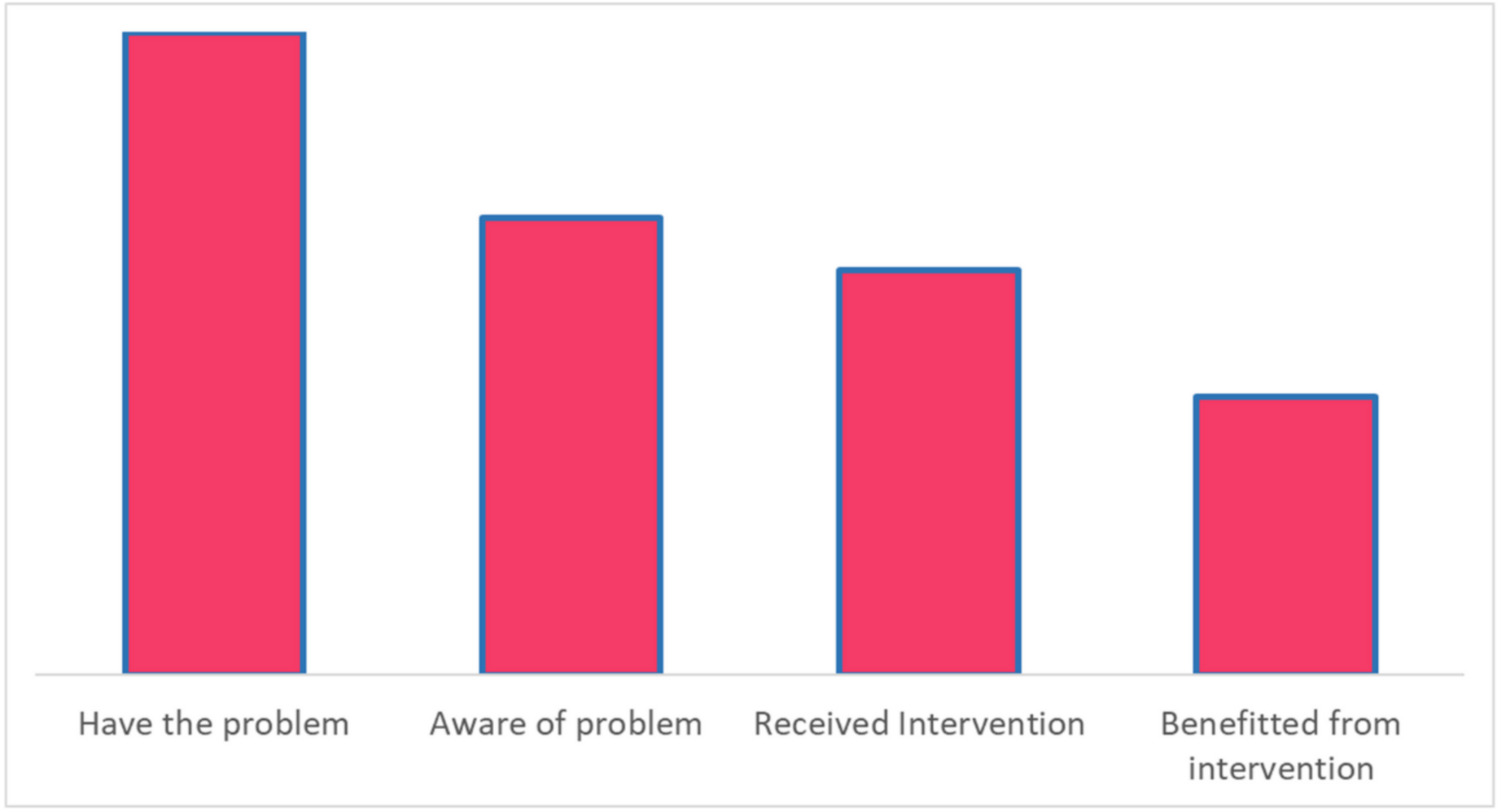
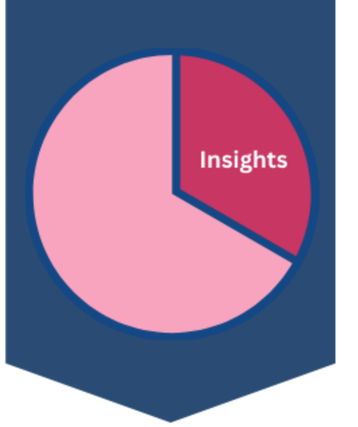
Systematic approaches that can help



Bentley (2016), Reducing Health Inequalities: System, Scale and Sustainability



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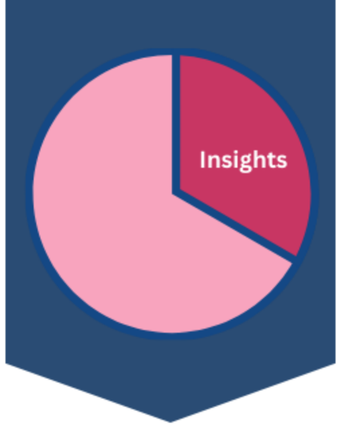
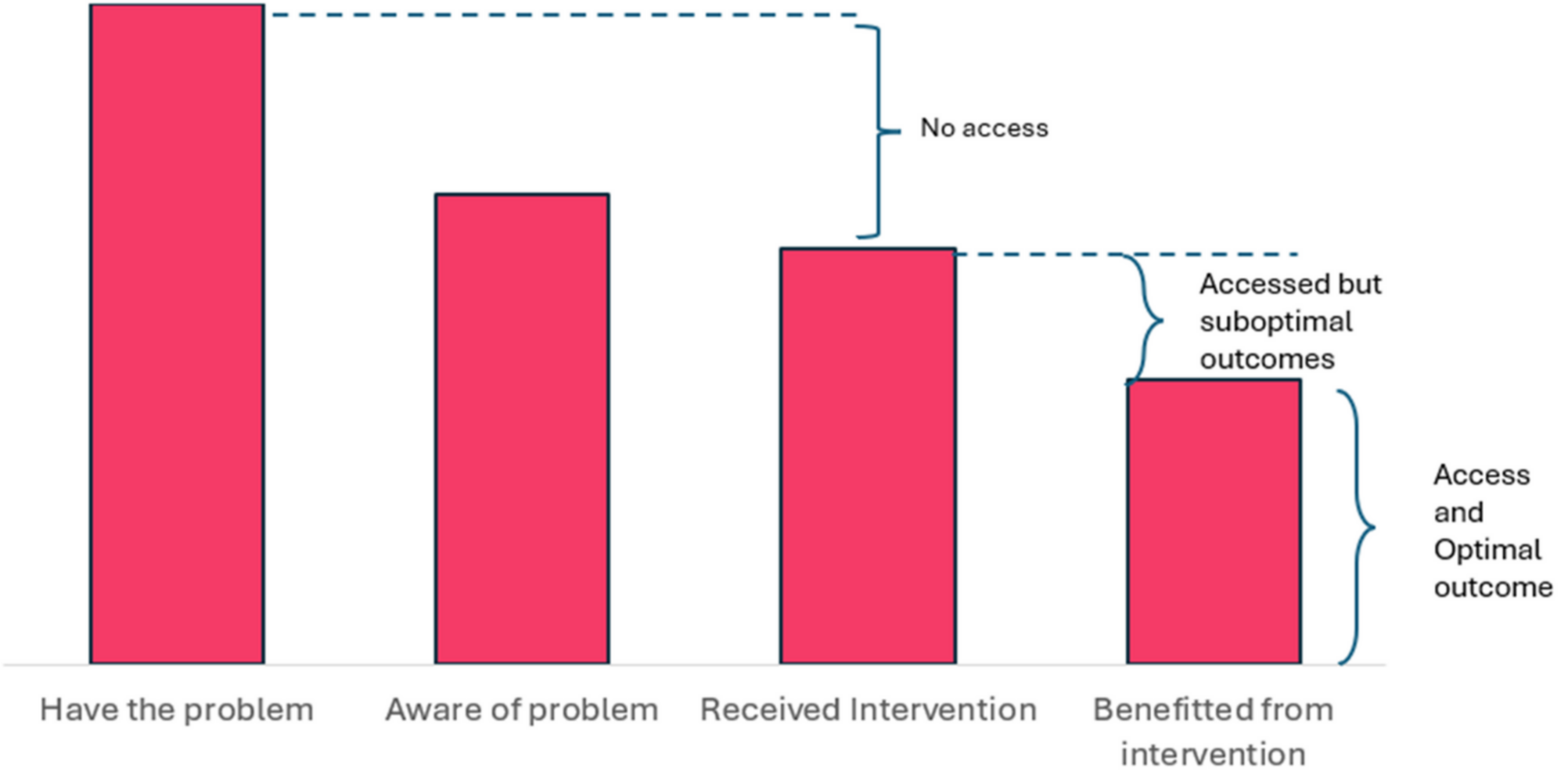
Systematic approaches that can help





Components of Unmet Need for Hypertension in Dorset Access and outcomes from care

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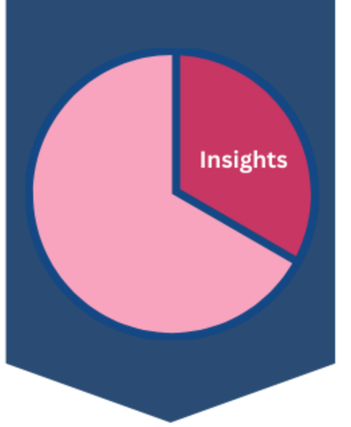
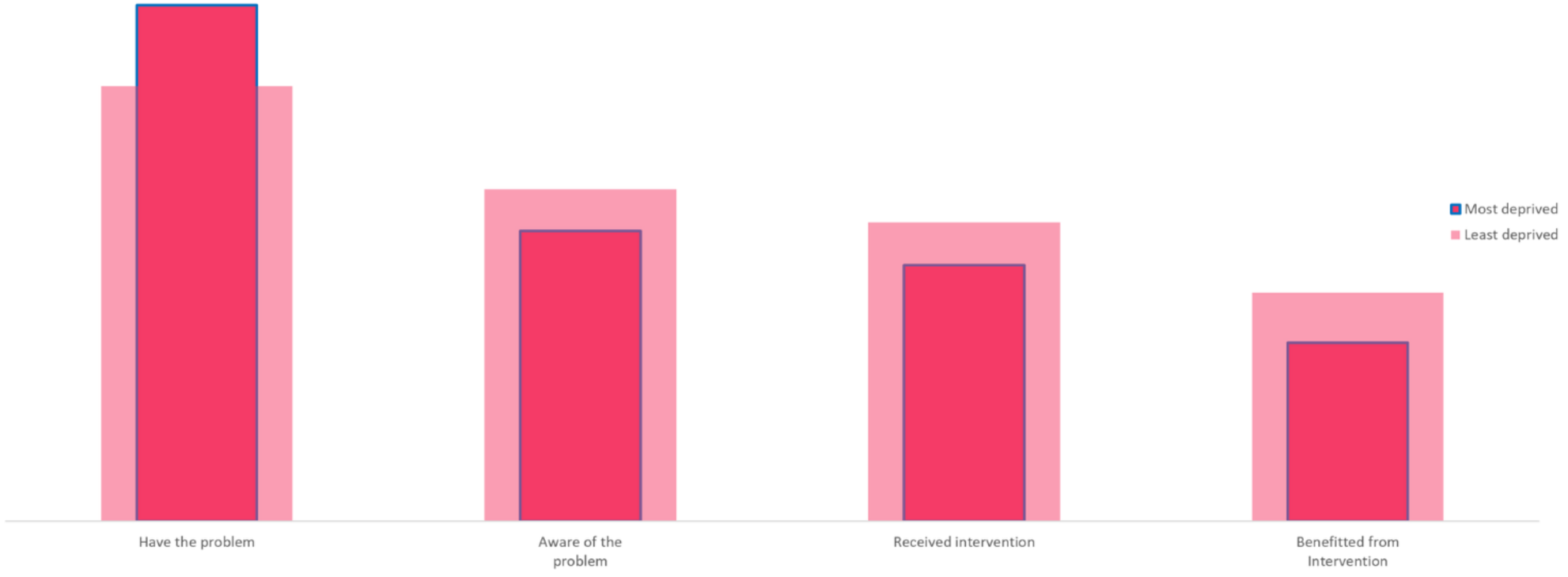
Unwarranted Variation: A Systematic Approach





Hypertension and Deprivation in Dorset August 2025

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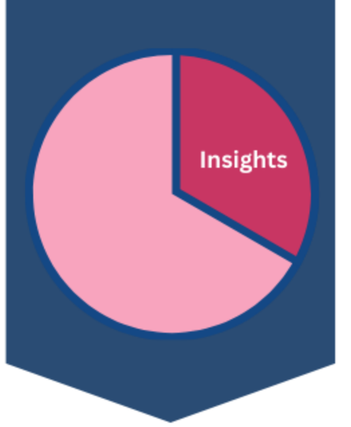
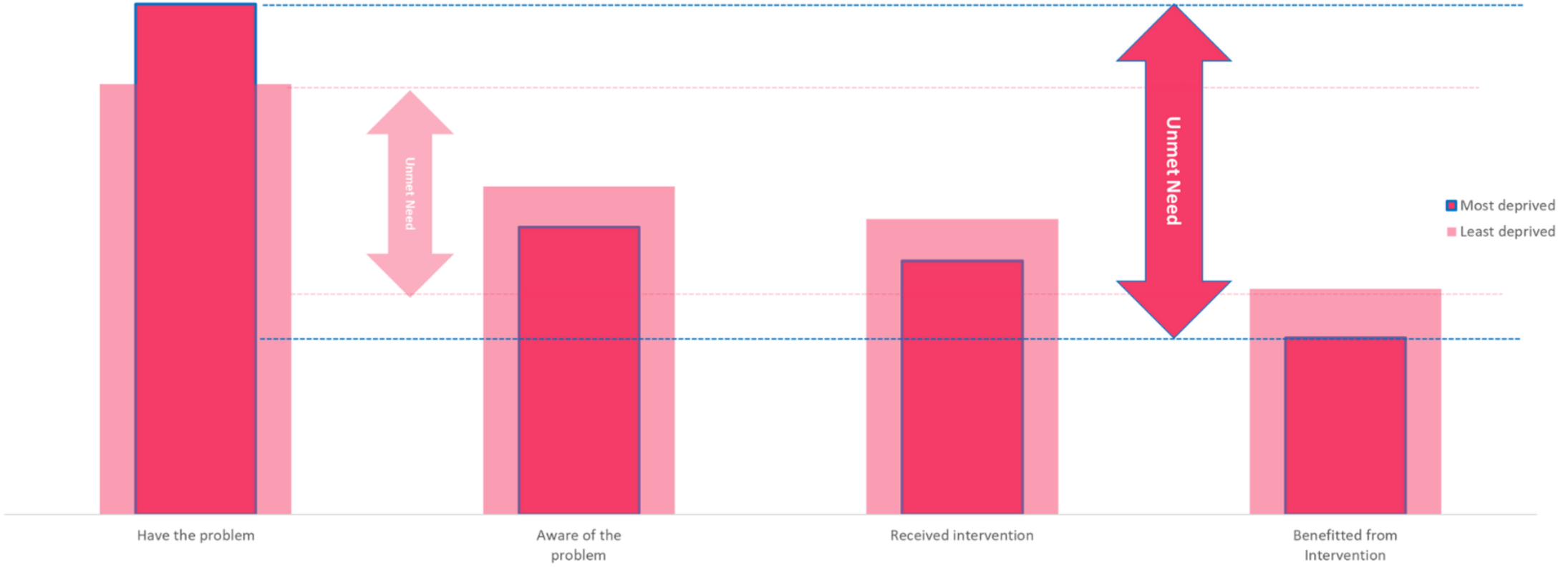
Unmet Need





Actions

- Using Population Health and PHM evidence and interventions to optimise clinical outcomes
- Feedback from Primary Care
- Next steps in the PHM approach

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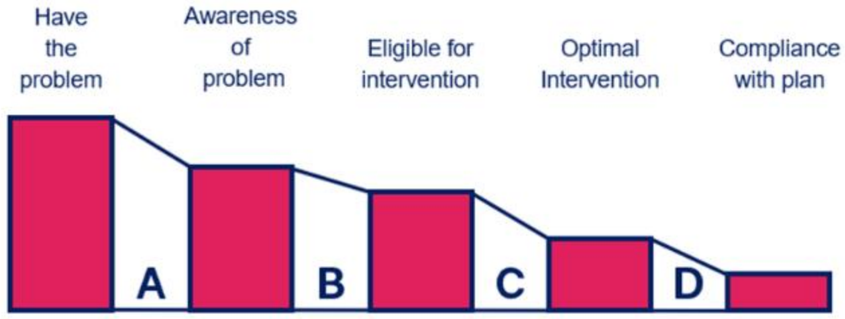
Using Population Health and PHM evidence and interventions to optimise clinical outcomes



(Bentley 2016)

Taking a Population Health approach		
Have the problem	Population with X	No. / %
Aware of the problem	Diagnosed with X	No. / %
Eligible for intervention	Diagnosed and Eligible	No. / %
Optimal intervention	Invited to the intervention	No. / %
Compliance with the plan	Benefit from the intervention	No. / %

- Increase recognition of risks and sources of help
- Address barriers and access to support, advice, interventions
- Address unwarranted variation in quality and provision
- Support people to maintain change and ongoing self-management

Evidence Based Action to Reduce Health Inequalities in Hypertension Management in Primary Care

Findings from our systematic review:

System Level Actions	Improve Access and Engagement	Improve Outcomes
✓ **Prioritise** hypertension as part of local CVD prevention strategies, with dedicated **leadership** and resources [1][3][4]	✓ Provide **flexible appointment options** like evening/weekend clinics for working patients [1]	✓ Implement **evidence-based** clinical and non-clinical treatment protocols and decision support tools in clinical systems [1][5]
✓ Use **data** to identify and address **unwarranted variations** in detection and management [3][4]	✓ Use **digital tools** like home blood pressure monitoring and virtual consultations to increase engagement [2][5]	✓ Offer regular medication reviews and **support for adherence**, considering cultural beliefs [2][5]
✓ **Incentivise and support** primary care networks to deliver enhanced hypertension services [1][4]	✓ Utilise **community health workers**, link workers, and peer supporters from local communities [1][4]	✓ Embed **lifestyle interventions** through **social prescribing** and **health coaching** [4]

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Feedback From Primary Care

What worked well in your PCN?

Recognition of risks and sources of help

- Centralised approach for overdue readings
- Posters, PCN Social Media posts
- Community events
- Workforce training
- Text message invites which enabled self – onboarding for BP@Home
- The mass onboarding events in the community centre and working closely with our Digital Care Co-ordinators and pharmacists

Address barriers and access to support, advice, interventions

- Everyone was involved - starting from receptionist to the GPs getting up to date BP at all opportunities
- Cardiovascular outreach nurse role
- Pharmacy lead hypertension clinics
- BP at Flu clinics
- Take a BP reading at every interaction / maximise opportunistic measurements
- Difficult in deprived areas like ours as patients needed BP machines for BP@home but couldn't afford them.
- Difficult to manage those who aren't technically savvy

Address unwarranted variation in quality and provision

- Multidisciplinary approach with collaboration between all teams and with full digital support made a huge difference!
- A PCN Team dedicated to focusing on CVD looking at innovative ways to improve health and reduce inequalities
- We developed a clear pathway to streamline our approach to BP management
- Changing our process from the start, technicians taking BP in every blood test

Support people to maintain change and ongoing self-management

Activation describes the **knowledge, skills and confidence** a person has in **managing their own health** and care.
Higher activated individuals are more likely to engage in **positive health behaviours** and to have **better health outcomes**

"How good are you at taking care of your health?"

Health (& SC) Professionals

Integrated Neighbourhood Teams

ICS Partners including VCSE

Tailor the offer

Digital, Apps, Self-Help

Health Improvement

Health Coaching

Social prescribing

Increased Activation

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Next Steps in the PHM Approach

Next Steps for Population Health in Primary Care - Hypertension

All PCNs are:

Increasing the number of staff trained in Very Brief Advice and Behaviour Change (LiveWell Dorset / E-Learning for Health)
Choosing a Behaviour Change project and thinking about a Team approach to delivery:

- **Designing and delivering education events at scale to optimise hypertension management in Primary Care**
- **Develop and deploy a bitesize' workforce training offer which supports Primary Care to integrate health literacy into their everyday practice**
- **Understand how a patient's knowledge, skills, and confidence can be assessed to better tailor services to their needs and improve outcomes.**

Identifying a target population or cohort – using PCN data and insights
Co-designing resources
Delivering interventions and connecting people to local services based on the principles of Activation
Tracking outcomes and sharing learning

The PHM team will be holding a Lunch and Learn in March, to reflect on success and learning. We will also be developing 'blueprints' to help PCNs implement good practice, in both hypertension and the application to other Long-Term Conditions.

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Outcomes

- What are outcomes?
- What was our intended outcome – left shift
- Impact on Hypertension optimisation in Dorset
- Monitoring and evaluation
- Link between Equality & Health Inequality Impact and PHM

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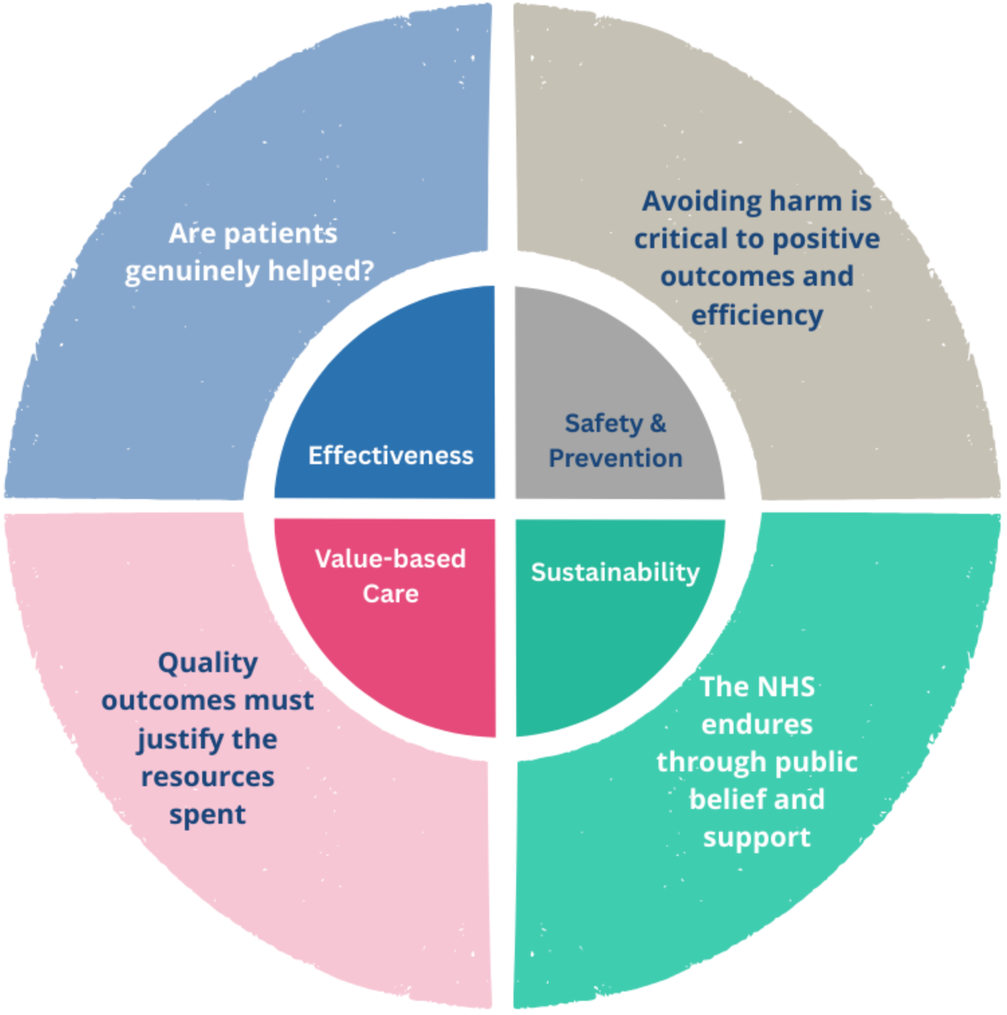
What are Outcomes?



"Outcomes, by and large, remain the ultimate validation of the effectiveness and quality of medical care"

Avedis Donabedian

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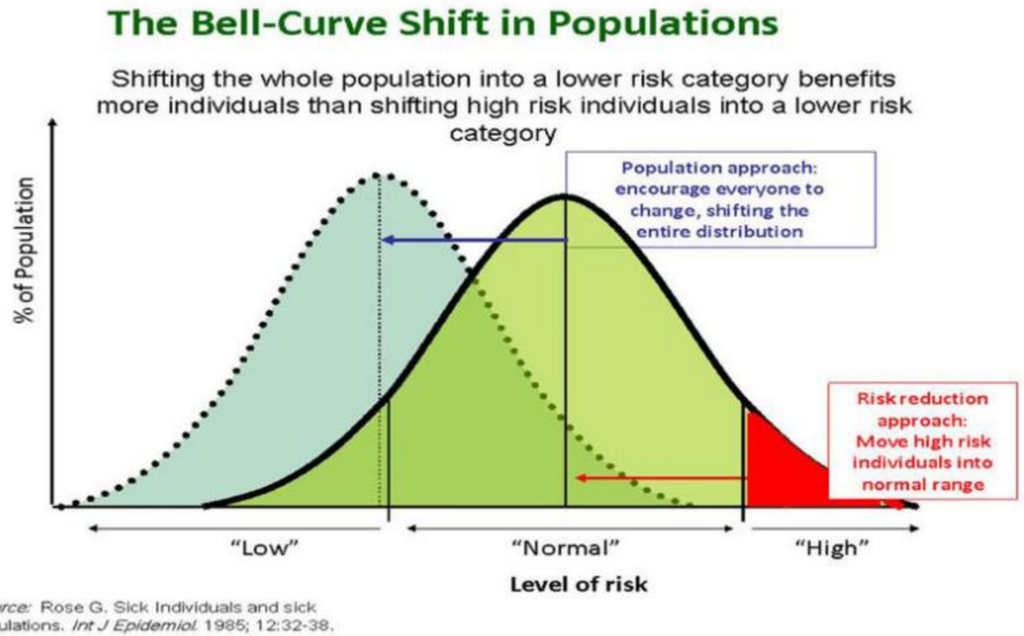
What was our Intended Outcome?

Improving whole population health & narrowing the gap (Left Shift)

Impact on whole population (move everyone a little)

Impact on health inequality groups (Move some people a lot)



Source: Rose G. Sick Individuals and sick populations. *Int J Epidemiol.* 1985; 12:32-38.

Dorset Systematic Approach to PHM: Impact on Hypertension Optimisation

Insights Actions Outcomes

Dorset Population Health Management & Health Inequalities

Improve population health

7,896*more people optimised

46** heart attacks prevented

70** strokes prevented

40** deaths prevented

Reduce health inequalities

Black ethnic group **190%*****

Mixed ethnic group **120%*****

Most deprived **175%*****

Best use of resources

£360k** not treating heart attacks

£1m** not treating strokes

£666K saved in social care**

£££ saved in wider healthcare spend

Dorset Health Inequalities and PHM Programme – Hypertension Optimisation

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*DiiS to March 2025

** Source: Size of the Prize for high blood pressure – modelled on Dorset Activity delivered in 2024/25 (based on 7896 patients optimised)

**Stroke costs to social care are given for the 1st year following stroke only

*** Source: CVD Prevent to March 2024 – March 2025 improvement relative to the whole population with hypertension

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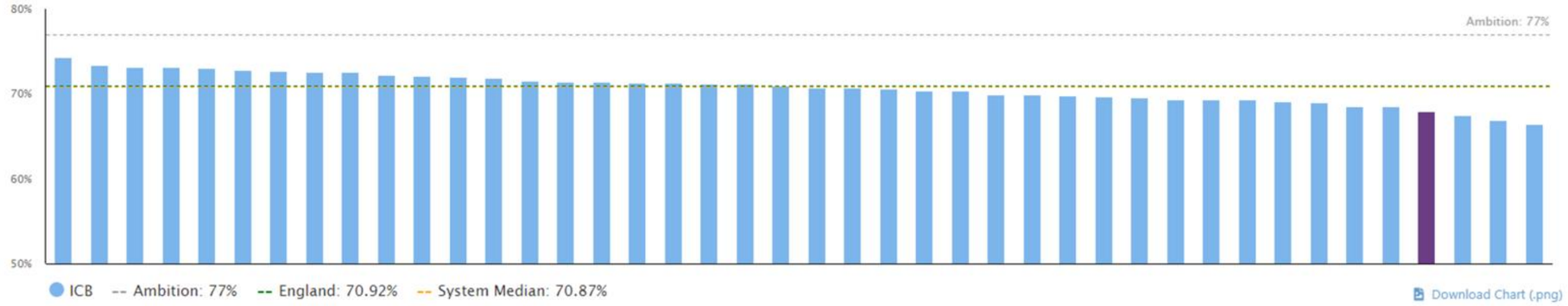
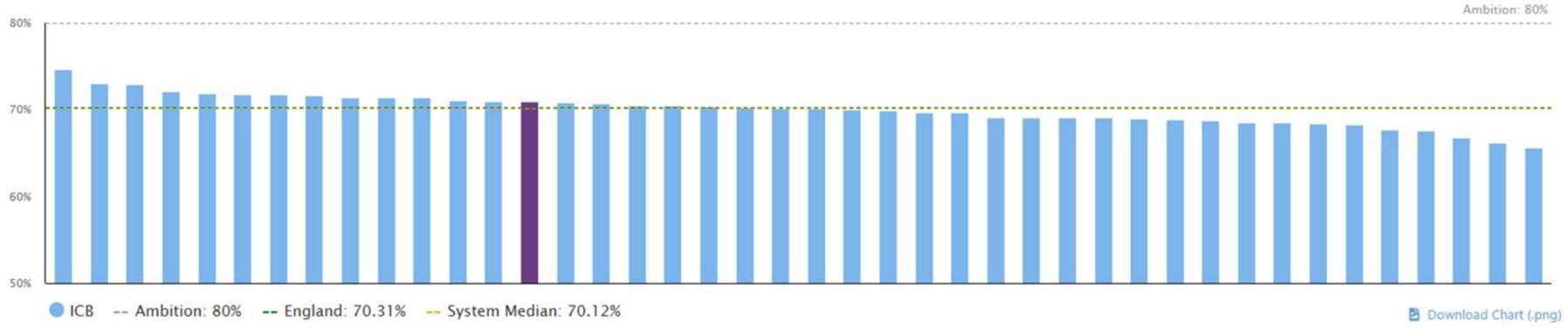
System Level Comparison: NHS Dorset Integrated Care Board against other ICBs

March 2024

Filter | Chart | Table



March 2025



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Monitoring & Evaluation

Why is this important?

Enables evidence-based decisions, supports health equity, and ensures interventions are effective, responsive and efficient to population needs.

Monitoring: Ongoing, systematic collection and analysis of data to track programme activities, service delivery, and progress toward objectives.

Evaluation: Periodic assessment to determine the effectiveness, outcomes, and impact of interventions, and to attribute observed changes to specific programs.

Top line Questions: Did it work?

- What worked and for whom? – what should be continued or adapted
- How effectively is the programme being implemented? (process evaluation)
- What are measurable outcomes?
- How does the programme address health equity and disparities in different population groups?
- How sustainable is programme? (long term outcome)
- How the evaluation influence policy and practice?
- (actionable recommendations)

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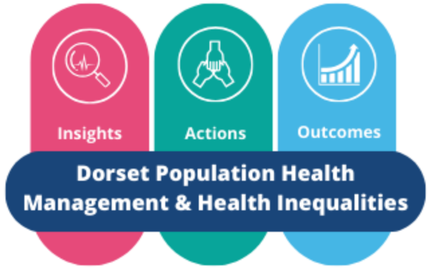
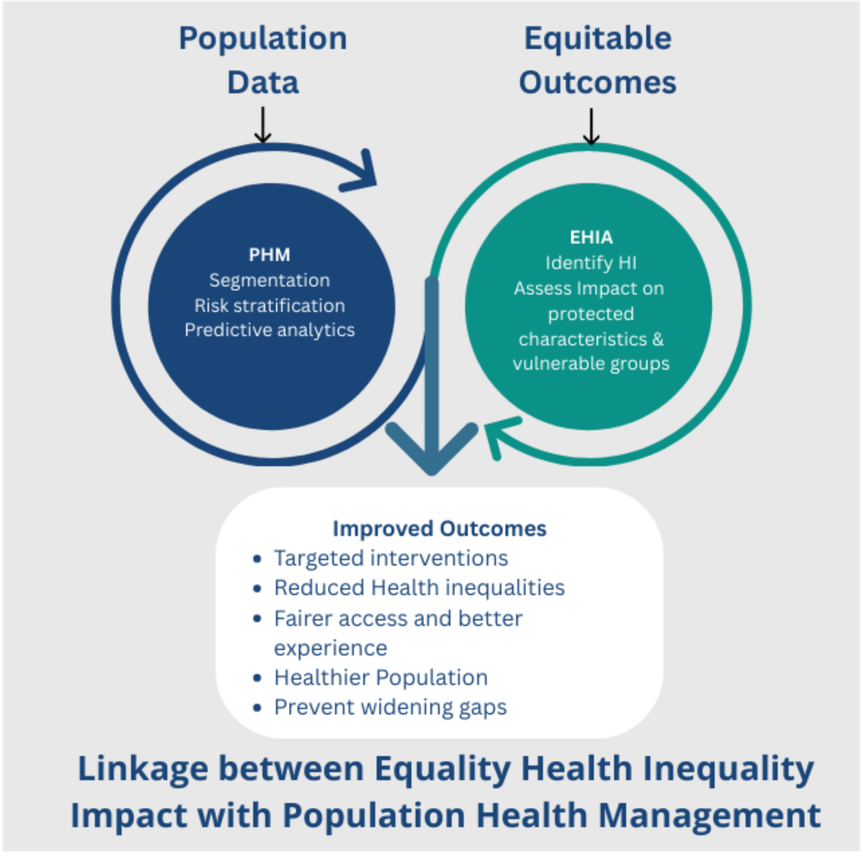


What we hope to achieve through this intervention:

Inputs	Participants	Activities	Outputs	Short-term Outcomes	Medium-term Outcomes	Long-term Outcomes

Link Between Equality & Health Inequality Impact & PHM



Linkage between Equality Health Inequality Impact with Population Health Management

By measuring the right things, for the right groups, in the right way, every part of the system can work together to deliver healthier and fairer outcomes for all.

What next: We will be delivering Lunch and Learn sessions on EHIA. We will continue to work with our commissioning and system colleagues to redesign services on the principles of proportionate universalism and equality lens making sure no one is left behind.

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“We’re incredibly proud of what Dorset has achieved in such a short time. High blood pressure is often called the silent killer, but through proactive care, community engagement, and data-driven decision-making, we’ve turned the tide.

These results aren’t just numbers - they represent lives saved, strokes prevented, and families spared the heartbreak of sudden loss. It’s a powerful reminder of what’s possible.”

Dr. Forbes Watson, GP and Chair of Dorset General Practice Alliance

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Insights Actions Outcomes

Dorset Population Health Management & Health Inequalities

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It Works! A clinician's perspective

Martin Longley, CVD Lead GP, Dorset ICB

Insights Actions Outcomes

Dorset Population Health Management & Health Inequalities

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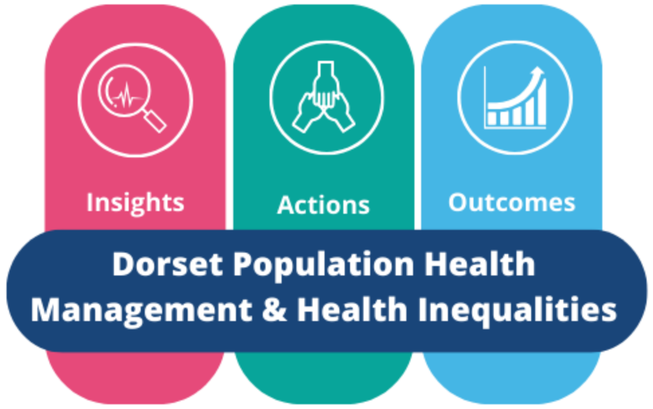
Summary



- Dorset PHM Approach (The What?)
- Systematic / replicable approach (The How?)
- Underpinned by key value-based concepts (The Why?)

Our Dorset PHM approach aims to take people on the journey of INSIGHTS into ACTION.

We hope we have inspired you!

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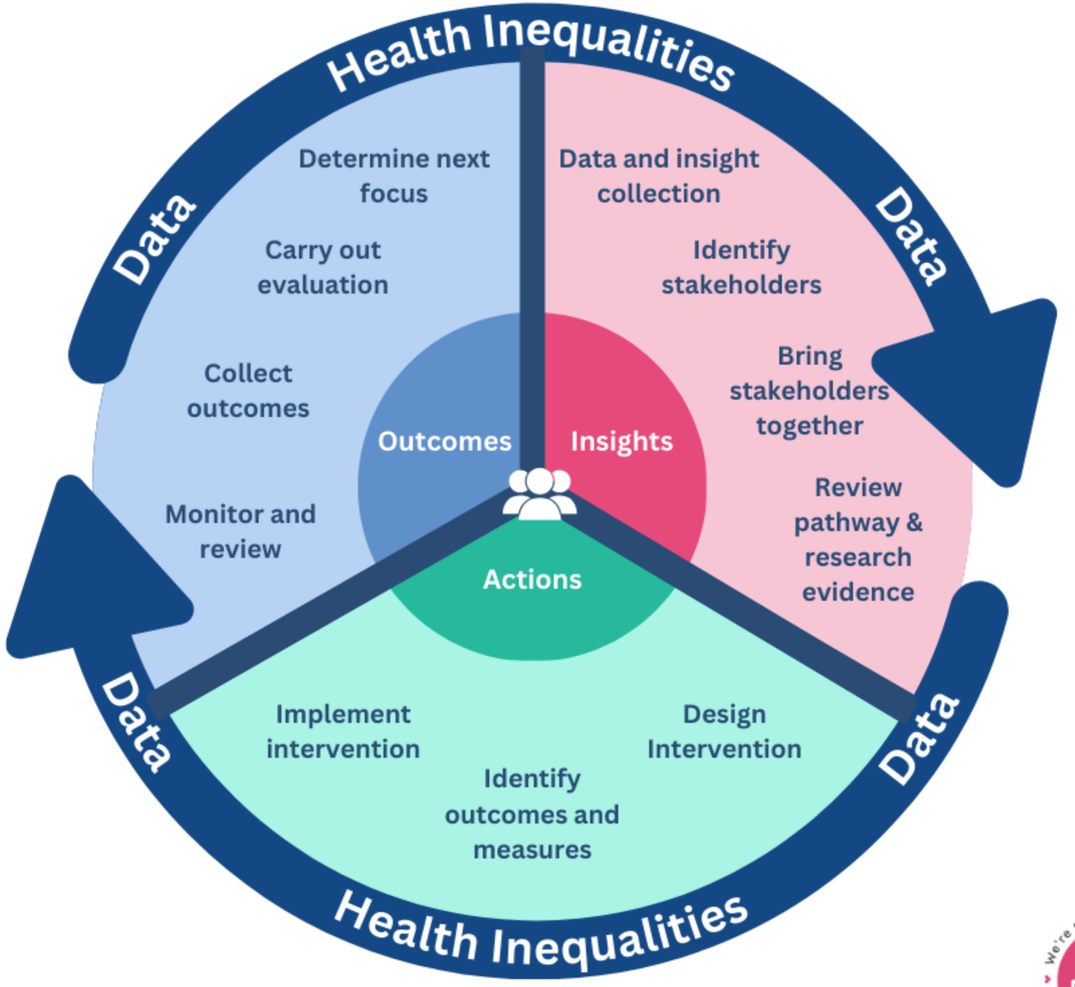
What Next...?

- Send out slide deck with notes
- Request for support form
- Newsletter
- EHIA module
- HSJ Award shortlisted
- Launch of Toolkit for Strategic Commissioners



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Q&A

Where does the data come from which says x number have the problem? is there a formula which says if Y have the problem identified, then x will be the total group?

These come from modelling which will take into account demographics in a population and then the model estimates prevalence - so the total population is taken into account to predict prevalence rather than looking at who has already been identified

Does the DiiS still protect personal identifiable data using the University of Nottingham's pseudonymisation service?

Data is pseudonymised at source using our own pseudonymisation tool to protect personal data.

How many of the inequality group hypertension improvements were for those who accessed a digital intervention?

17-20% of the hypertensive population used a digital intervention. While uptake varied across cohorts, the digital offer supported equity by freeing practice time for those less able to use digital and helped practices manage the large number of patients needing BP reviews. Efficiency and productivity of those 20% adoptive cohort helped the capacity of clinical teams and helped the left shift activity.

Your slide said that you will be delivering lunch and learn session on EHIA so you know if this will include the quality elements and the SQEEIA?

Nayab and Surendra are working with Karen Payne on updating the system quality equity equality impact assessment (SQEEIA) process which includes EHIA and quality together and are looking at joint training

What plans do you have for delivering bite size training to increase knowledge of health behaviour change relevant for those working in a secondary care setting?

We are working closely with LiveWell Dorset to co-design training, which reflects local offers. We also are testing some bitesize Health Literacy training, which we can test with partners to understand how it can be best implemented and have impact at scale. This is part of the Prevention Community workplan.

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Insights Actions Outcomes
Dorset Population Health Management & Health Inequalities

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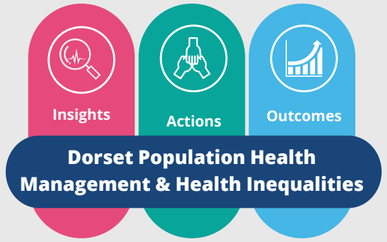

References and Useful Links:

Introduction to PHM

NHS England » Population health management
What Is A Population Health Approach? | The King's Fund
Population Health Management - elearning for healthcare

Insights

Hospital Episode Statistics (HES) - NHS England Digital
Supporting Information: Secondary Uses Service
Homepage | NICE
Joint Strategic Needs Assessment (JSNA) - Public Health Dorset - Dorset Council
Health Inequalities annual report 2024
Hospital Episode Statistics (HES) - NHS England Digital
Fingertips | Department of Health and Social Care
NHS RightCare
NHS England - Model Hospital
SHAPE – Shape
Community Conversations
Neighbourhood Conversations - Listening better
Listening better
Healthwatch Dorset

Multiple conditions and health inequalities: addressing the challenge with research
Tackling Health Inequalities | Seven Priorities For The NHS | The King's Fund
Health disparities and health inequalities: applying All Our Health - GOV.UK
Population Intervention Triangle toolkit | Local Government Association
Towards a new model of evidence for population health improvement
What Is A Population Health Approach? | The King's Fund
prevention-before-cure-prioritising-population-health-report-bma-march-2019-1.pdf
fair-society-healthy-lives-full-report-pdf.pdf
Browse content | NIHR Evidence

Actions

[1] Public Health England, Tackling high blood pressure, From evidence into action
[2] Health Innovation West of England, Reducing high blood pressure health inequalities
[3] Public Health England Guidance, High blood pressure: Plan and deliver effective services and treatment
[4] NHS England, Under control: why getting to grips with blood pressure is a win-win intervention for healthcare systems
[5] UCL Partners, Blood Pressure Optimisation Programme

Outcomes

Size of the Prize for high blood pressure
Regional & ICS Insights | CVDPREVENT