Herefordshire and Worcestershire

Primary Care System Wide Seminar On

Population Health Management

Tuesday 27th April 12:30-14:30pm

Virtual Online

Summary Information :

NAPC's ethos is to work with the broadest possible workforce to address population health and wellbeing needs, to promote and develop collaboration, to share and evaluate learning to allow teams to continue to improve to deliver the best possible outcome.

NAPC developed and implemented the Primary Care Home (PCH) model in the Autumn of 2015. It brought together a range of health and social care professionals to provide enhanced personalised and preventative care for their local community based on their specific health & wellbeing needs.

Through this work NAPC has developed a method and suite of tools including a practical approach to population health management. This is based on tried and trusted evidence from our work with PCH/PCNs and best practice nationally and internationally and are tailored to the requirements of the NHS.

To book on to this seminar please visit the Primary Care Training Hub Website on the below address:-

www.primarycaretraininghub.co.uk

For support and enquiries please either Email & Telephone us at: traininghub@taurushealthcare.co.uk | 01432 270636

Population Health Analysis

Analyse > Plan > Act > Spread

- Clinically led process, focussed on agreed priorities
- Identifies patient cohorts where action and change can be delivered
- Simple process and analysis. Easy for handover to practices. Repeatable

Development Cycle

1. Engagement
2. Understand population health data and needs
3. Care model development
4. Workforce, training, education, culture and planning
5. Alignment of resources and financial drivers
6. Evidence and evaluation

The Development Cycle opposite describes the typical journey that PCNs embark upon with each Population Health priority

Principles of our approach to supporting the system develop Population Health capability:

1. **Clinically led approach**, benefitting from learning across over 300 PCNs
2. Adapted to be **delivered fully remotely**
3. Focuses on translating **data and guidance into practical action** with a changed care model
4. Leaves **legacy of capability** with the clinicians, managers and their teams
5. Builds **system collaboration** now and in the future
6. Is **simple, fast and cost effective** and produces simple and practical interventions at a low cost per patient