Population health transformation

Needs assessment

A White Paper

May 2016

Purpose

The *Five Year Forward View*[1] has set out the need for "Foundations for Change". A Kings Fund paper *Population Health Systems - Going beyond Integrated Care*[2] has framed a whole new market place for decision support tools, collaborative processes and complex care evidence.

The purpose of this White Paper is to start to progressively define the needs of this new market. We will achieve this by engaging a diverse range of stakeholders covering the NHS, LGA, academia and industry. This will allow us to define those needs in a single place.

Furthermore, this engagement will start a process of developing solutions under the overarching challenge of "How do we make complex population change happen at a local community level?"

About the Authors

This White Paper has been authored by the Ethos Partnership. It is based on their research into population health transformation over a period of five years. The research was carried out in collaboration with and across a wide and diverse number of key stakeholders.

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[2] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/population-health-systems-kingsfund-feb15.pdf

1. Introduction

Long term healthcare transformation is one of the largest global challenges. The most significant barrier to success is the **human factor** - a challenge for every health economy stakeholder. Community teams must be able to work together more effectively to overcome the cultural, organisational and motivational barriers that prevent successful change - at an individual, a cohort and at an overall population level.

2. Five Year Forward View

The plan sets out the need for **Foundations for Change**. However community teams continue to lack access to whole system decision making tools, collaborative working processes and complex care evidence bases. Complex transformation programmes are often 'fact free zones' dependent on 'guesstimated' evidence. This is a major **unmet need** with many difficult questions persisting:

- What are the real complex needs of a population? Physical? Psychological? Both?
- Which new innovations or technologies may be beneficial? Or may not?
- Which alternative care models might be appropriate? At what cost?
- What are the anticipated outcomes? The financial impact? The risk?
- How can results be monitored? Corrective action be taken? Learning assimilated?
- How will transformational change become 'a way of life' - at a personal and population level?

3. Population Health Systems

The 2105 Kings Fund paper **Population Health Systems - Going beyond Integrated Care** has framed the high level market response.

This document characterises these high level market needs in greater detail. The requirements are expressed in very practical terms and the focus is simple:

"How-to effect complex population change at a local health community level."

4. Market drivers

The underlying market needs are driven by a wide and diverse range of issues:

- Right Care
- Accountable care models
- 5YFV new care models
- Outcome based commissioning
- 'Devo' management
- Better Care Fund
- Sustainable Transformation Plans
- Digital health

However, all these issues and challenges can be distilled down into two core challenges: how to effect change at community level (the FYFV "Foundations for Change") and, managing health at a population level (the Kings Fund's 'Going beyond Integrated Care").

An over simplification, but if the reader accepts this generalisation, the detailed needs for:

- Whole systems decision tools;
- Collaborative working processes; and
- Complex care evidence bases

becomes a much simplified, almost generic task with each and every stakeholder trying to achieve the same ('triple aim') outcome: better care quality and experience, improved population health and wellbeing whilst reducing costs in line with efficiency targets.

In this light. let us now examine the overarching areas of need.

5. Needs assessment

Although often interdependent, needs can be characterised across six areas:

1) ***Complex care*** - Whole system decision making tools which extend the traditional focus on disease silos to support complex, multi morbid care.

2) ***Awareness and education*** - Stakeholder engagement methods for teams to adopt different thinking, a new 'language', different mind sets and changed ways of working.

3) ***Pathway management*** - Collaborative working processes which engage teams across the care continuum to focus on condition pathway not episodic/organisation based care.

4) ***Capability development*** - Decision support tools based on reliable intelligence to support local teams at each (and every stage) of the transformation cycle.

5) ***Change environment*** - An environment where teams can test, fail, learn and evolve together, developing a new evidence base based on shared experiences.

6) ***Continuous development*** - Integrating one-off service redesign programmes into a more formalised population health management base on continuous system development.

The reader should note these needs (by definition) traverse the traditional boundaries of public health, health care and social care. (As far as is possible) a balanced approach is maintained in terms of the “bio medical versus social prescribing” debate.

6. Complex care

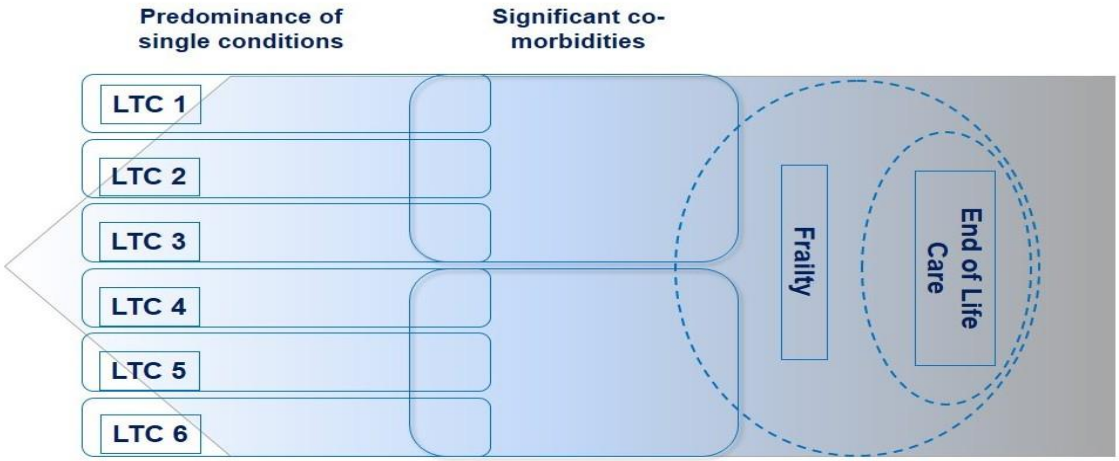
People don't think of themselves as having ‘conditions’. They have collections of ‘symptoms’ or ‘needs’. Transformation activity must focus on a balanced set of outcomes in this light. No one long term condition can be viewed in isolation. The focus must be on multiple, co-morbid needs.

Traditional healthcare has focussed on the progression of ‘parallel conditions’ in individuals. Service responses can become disconnected based on the siloed skillsets and organisational boundaries typical of a single condition pathway approach. Person focussed transformation planning is impeded as a result.

The traditional reliance on Randomised Control Trials and/or evaluating service improvements in isolation will be greatly reduced. These approaches are necessary but are by no means sufficient for complex transformation programmes.

Modern complex care service redesign adopts a person centred approach – recognising that many individuals have more than one condition. Future complex care service model responses will be very different - based on multi-disciplinary skillsets, capacities and ‘connectedness’. The whole philosophy of care planning will change.

New complex care models will be ‘pulled’ in response to population need, not ‘pushed’ by an episodic, organisationally based care approach. This can be best illustrate diagrammatically:



This ‘pull’ approach must be informed by cohort analytics, data mining and risk stratification decision tools - supported by pro-active professional judgement where necessary. This in turn will support the development of appropriate multi service care models.

NEED - Whole system decision making tools which extend the traditional focus on disease silos to support complex, multi morbid care.

7. Awareness and education

We need to develop a common language and become more comfortable with using 'good enough' data. We need to have much better engagement across the system requiring a highly interactive and participative approach. Education and awareness needs to encompass three key learning areas;

1) ***Transformation*** - What is a pathway? How to engage multi-disciplinary pathway teams in service improvement? How to improve overall patient journey across entire condition pathways? How to balance short term Return on Investment and longer term patient outcomes?

2) ***Commissioning*** - What is commissioning? How to secure best outcome within a given budget? How to successfully deliver the new Outcome Framework and QIPP targets? How to successfully engage providers, suppliers and local authorities in commissioning decisions?

3) ***Budgeting*** - How to successfully manage a GP Consortia commissioning and service improvement budget? How to understand the impact of financial policy drivers such as Payment by Results. Financial implications of pathway based commissioning decisions.

NEED - Stakeholder engagement methods for teams to adopt different thinking, a new 'language', different mind sets and changed ways of working.

8. Pathway management

There are over 120 identifiable long term conditions. Together they account for 74% of all health and care activity. Whilst the transformation challenges can be very different for different conditions, the underlying disease progression and condition pathway are identical – represented diagrammatically as follows:

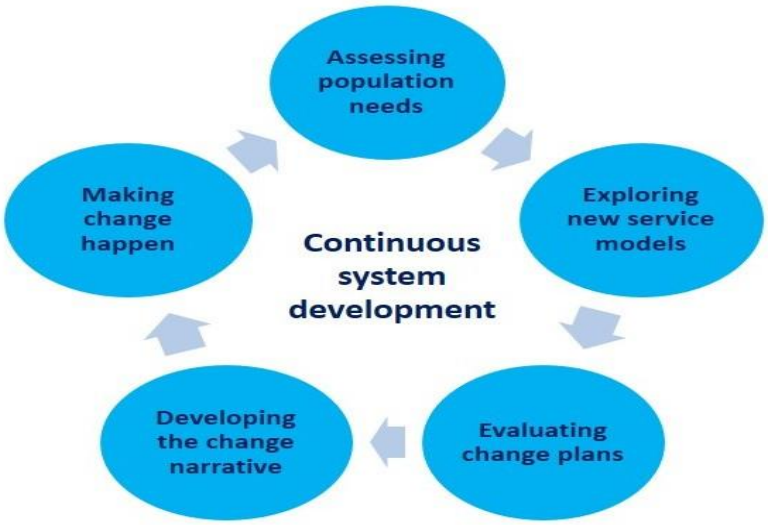
As the disease progression/care pathways structures are universally similar for all long term conditions. This naturally lends itself to repeatable solutions.

The twelve highest disease burden areas and their related multi morbidities, no long term condition can or should be considered in isolation, account for circa 60% of all healthcare activity.

NEED - Collaborative working processes which engage teams across the care continuum to focus on condition pathway not episodic/organisation based care.

9. Transformation capabilities

There is a need for a range of step change capabilities at each (and every) stage of a typical transformation cycle:



- ***Assessing population needs*** using reliable cohort level intelligence and creating common picture of desired outcomes.
- ***Exploring new service models*** on a systematic basis as local service responses to those emerging population needs.
- ***Evaluating change plans*** in terms of the need to consider the impact of new care model proposals in a simple common language everyone can understand - healthcare outcomes.
- ***Developing the change narrative*** in terms of a common consistent story about change plan so that everyone can understand them locally.
- ***Making change happen*** and translating all the 'good talk' into realistic action plans that provider organisations can deliver.

The objective is to arm service redesign teams with the intelligence to have better arguments! Expressed in more prosaic terms, better questions, lead to better answers… and outcomes.

NEED - Collaborative working processes which engage teams across the care continuum to focus on condition pathway not episodic/organisation based care.

10. Change environment

Complex, multi morbid care is just that - complex. Currently there is little or no evidence to support complex transformation programmes. The old ‘gold standard’ Randomised Control Trial approach is unlikely to be helpful. Indeed, it may actually be counter-productive in understanding complex needs, we need new methods.

A test environment is needed where teams can form a deep understanding of real population needs and the likely impact of proposed service responses - measured against Triple Aim outcomes.

Teams need to able to **test, fail, learn and evolve together**. They need a ‘crucible’ where the case-for-change can be co-developed based on a shared experience of the best available evidence. People from diverse backgrounds with (sometimes widely) differing views need the means to achieve consensus on complex transformation programmes,

NEED - An environment where teams can test, fail, learn and evolve together, developing new evidence base based on shared experiences.

11. Continuous development

Continuous system development is key to the transformation success. Changing the behaviour of health communities and professionals is a long continuous journey - almost by definition. ‘Instant results’ are unlikely and indeed potentially undesirable - as the industry seeks a once in a generation cultural change in how it supports people with complex needs.

Lessons must be learnt (for better or worse) and change plans monitored and adapted as and when necessary. This is the whole essence of the Learning Health System approach. Teams must be able to test, fail, learn and evolve together. Again, the traditional reliance on one-off Randomised Control Trials and/or evaluating service improvements in isolation will be greatly reduced. Decision tools, collaborative processes and evidence bases must recognise these changing circumstances.

Extending the reasoning one stage further, continuous system development must be formalised into ongoing population health management routines which are an ongoing part of the fabric of any health economy.

NEED - Integrating one-off service redesign programmes into a more formalised population health management approach based on continuous system development.