assurance
control
improvement
NHS
East London
NHS Foundation Trust
WELCOME

Dr Jennifer Dixon

Chief Executive Officer
The Health Foundation

The contribution of health care and the role of improvement approaches to make progress on population health

Dr Jennifer Dixon

Chief Executive

24th April 2018

Healthy life expectancy (HLE) and life expectancy (LE) for females at birth by national deprivation deciles

100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0

Years

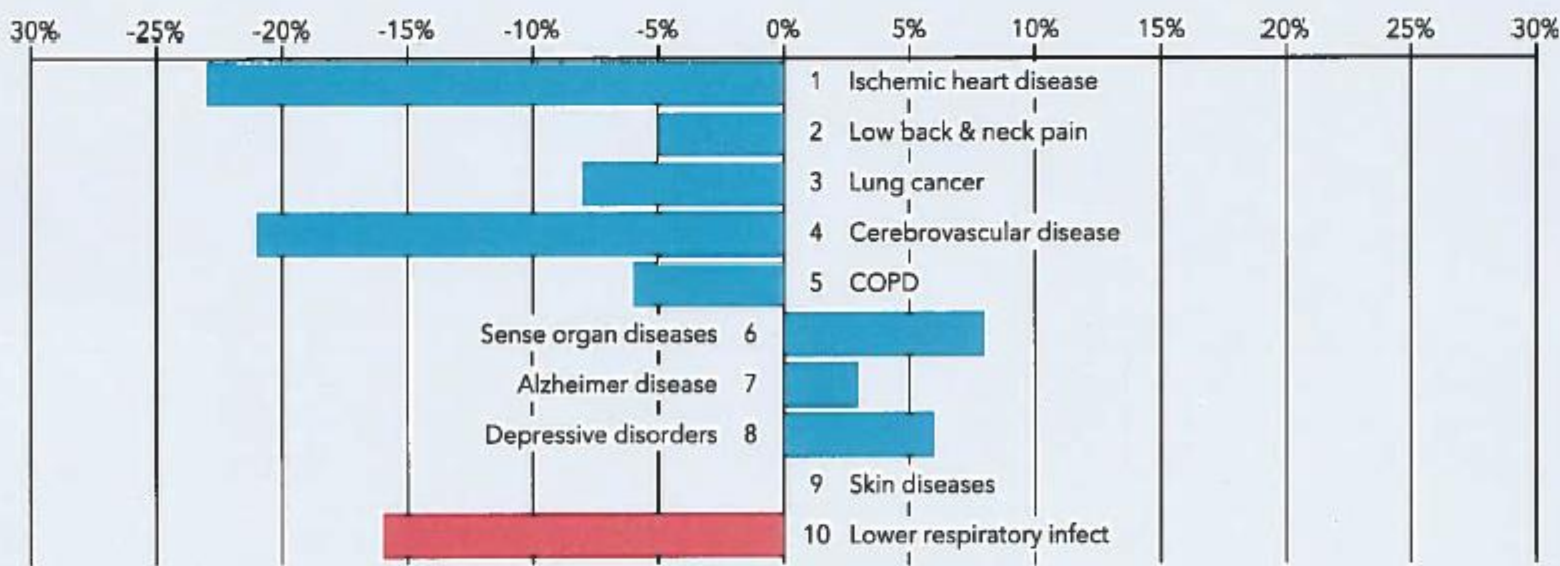
Decile 1 Decile 2 Decile 3 Decile 4 Decile 5 Decile 6 Decile 7 Decile 8 Decile 9 Decile 10

HLE LE Most to least deprived national deciles

Source: Office for National Statistics

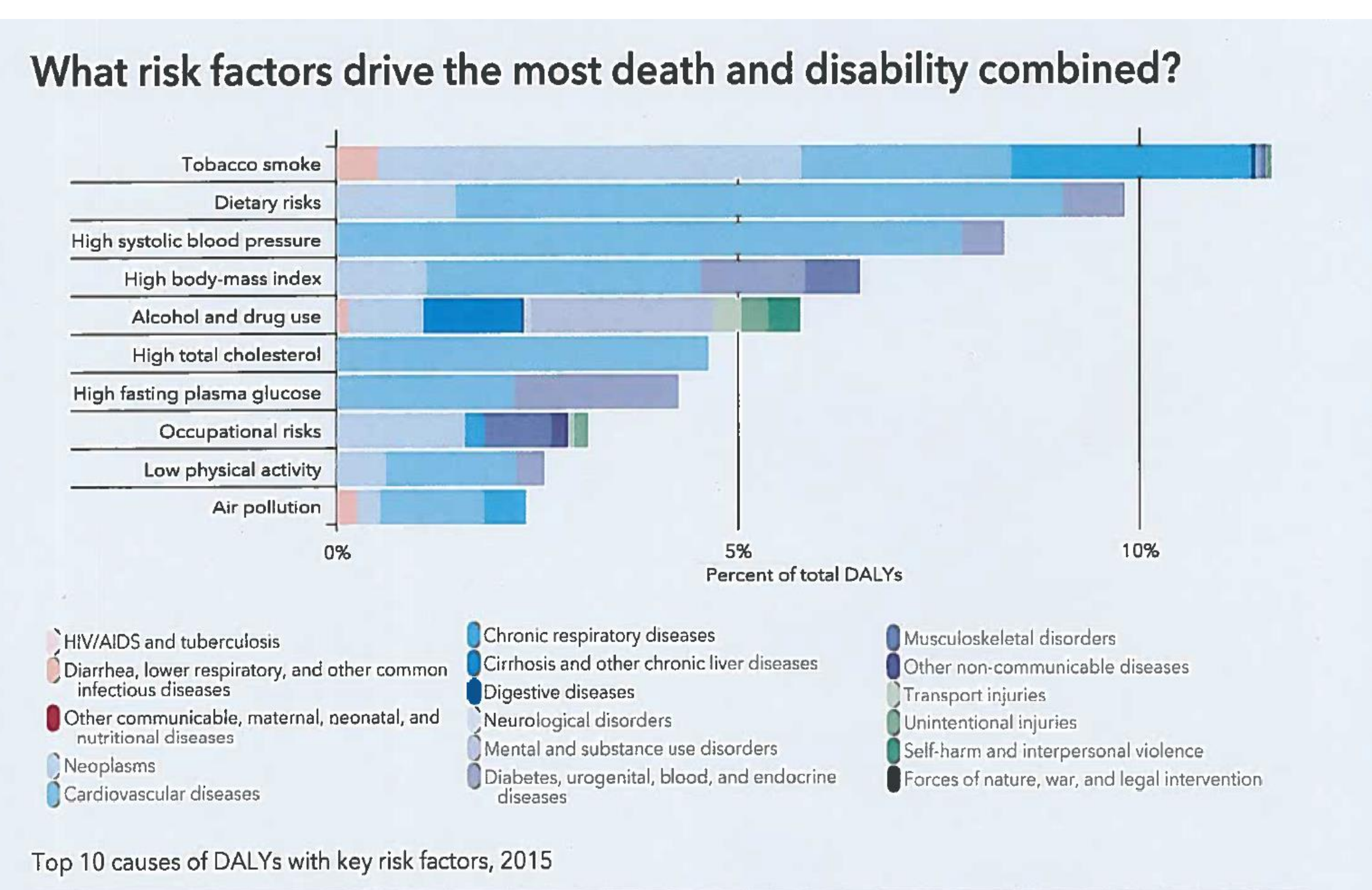
What causes the most death and disability combined?

Communicable, maternal, neonatal, and nutritional diseases
Non-communicable diseases
Injuries



Leading causes of DALYs in 2015 and percent change, 2005-2015

Institute for Health Metrics and Evaluation



Institute for Health Metrics and Evaluation

Improving health in a population

ENTIRE POPULATION

POPULATION SHARE	40-60%	20-25%	5-15%	2-3%
RISK STRATIFICATION	HEALTHY / LOW RISK	AT RISK 60+	CHRONIC	ACTIVE DISEASE
RELATIVE COST	5-10%	15-20%	30-40%	40-50%
POTENTIAL FOR IMPACT?	?	?	?	?

Improving health in a population

	Primary prevention	Primary prevention	Secondary prevention	Active management
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Improving health in a population

Wider social determinants ⟷ Health care

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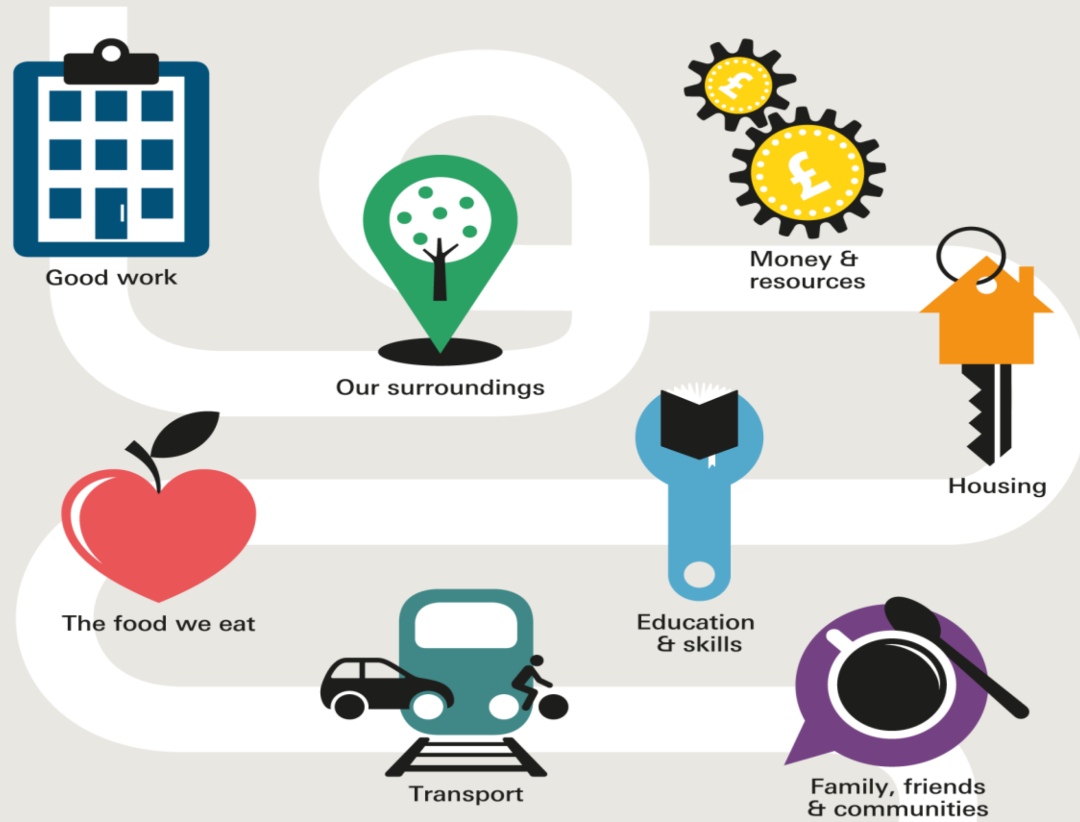
POTENTIAL FOR IMPACT?	?	?	?	?

What makes us healthy?

AS LITTLE AS
10% of a population's health and wellbeing is linked to access to health care.

We need to look at the bigger picture:



But the picture isn't the same for everyone.

The healthy life expectancy gap between the most and least deprived areas in the UK is: **19** YEARS

References available at www.health.org.uk/healthy-lives-infographics

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What influences population health?

GENERAL SOCIO-ECONOMIC, CULTURAL AND ENVIRONMENTAL CONDITIONS

LIVING & WORKING CONDITIONS

WORK ENVIRONMENT

UNEMPLOYMENT

EDUCATION

WATER & SANITATION

AGRICULTURE & FOOD PRODUCTION

HEALTH CARE SERVICES

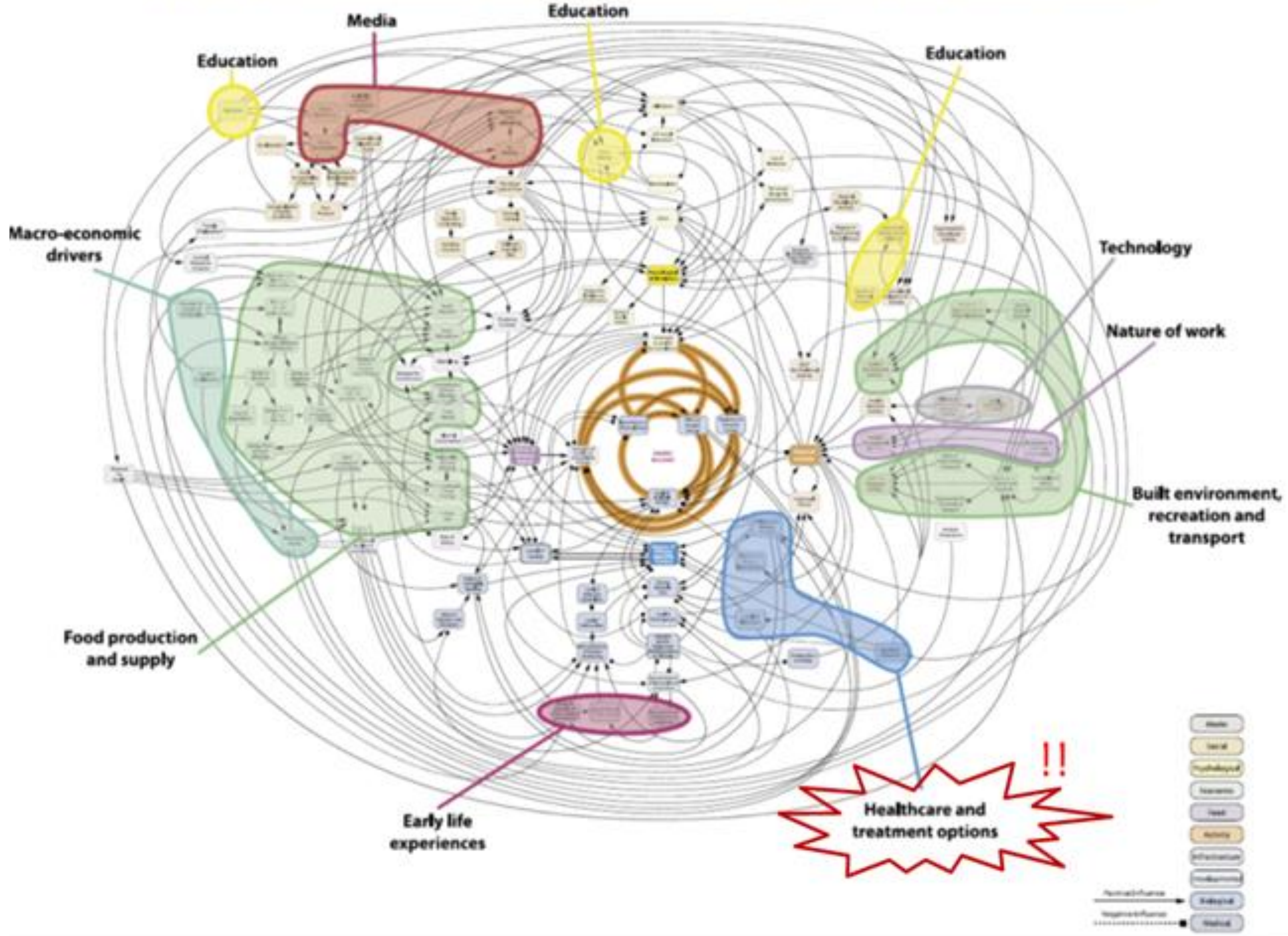
HOUSING

SOCIAL & COMMUNITY NETWORKS

BEHAVIOURAL FACTORS

AGE, SEX & CULTURAL FACTORS

Foresight Report obesity ecosystem causal linkages and ability to influence



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POTENTIAL FOR IMPACT?	?	?	?	?

External context

- External prods: financial incentives; regulation; directive/plans
- Increasing policy focus on prevention & population health including through NHS Five Year Forward View new models, investment in primary care, mental health, prevention (diabetes), food sold in hospitals.
- Move towards place based models of care including through devolution and Sustainability & Transformation partnerships (STPs) focusing on communities, populations and collaboration
- Data and analytics: access, capability and support
- Initiatives such as 'Make Every Contact Count' to encourage staff to use every opportunity in health care encounter to deliver brief advice to improve health and wellbeing

The NHS 5 Year Forward View – getting serious about prevention

FIVE YEAR FORWARD VIEW: One Year On

Preventing ill-health

- Targeting 10,000 people at risk of diabetes to reduce the £1 in every £10 of NHS money spent on the disease
- Healthier hospital food for patients, staff and visitors through national negotiation and the standard contract
- Creating the NHS healthy workforce programme to reduce the £2.4bn annual staff sickness bill, starting with 55,000 NHS workers
- Working with town planners, councils and developers to put health at the heart of communities and new towns
- A new deal for primary care will support the recruitment, retention and return to work of more GPs

50 vanguards

Integrated care pioneers

Primary care home

STPs

New business models:
- ICSs
- ICPs
- ACOs

GP Federations

Better Care Fund

Briefing
March 2017

Briefing: The impact of providing enhanced support for care home residents in Rushcliffe

Health Foundation consideration of findings from the Improvement Analytics Unit

Therese Lloyd, Arne Wolters and Adam Steventon

About this briefing

The analysis within this briefing was conducted by the Improvement Analytics Unit, a partnership between NHS England and the Health Foundation. This Health Foundation briefing considers the findings of the analysis.

The briefing looks at the impact of a package of enhanced support for older people living in care homes. The enhanced support was introduced in April 2014 and was developed by Principia, a local partnership of general practitioners, patients and community services that aims to provide better quality of care for people in Rushcliffe in Nottinghamshire, England.

The briefing outlines the enhanced support package, then describes the methods the Improvement Analytics Unit used to derive the linked data used in the analysis, select a matched comparison group, and compare hospital utilisation between the two groups. The briefing describes the results of the analysis and discusses the findings. It concludes by looking at the implications and priorities for future research and improvement activity.

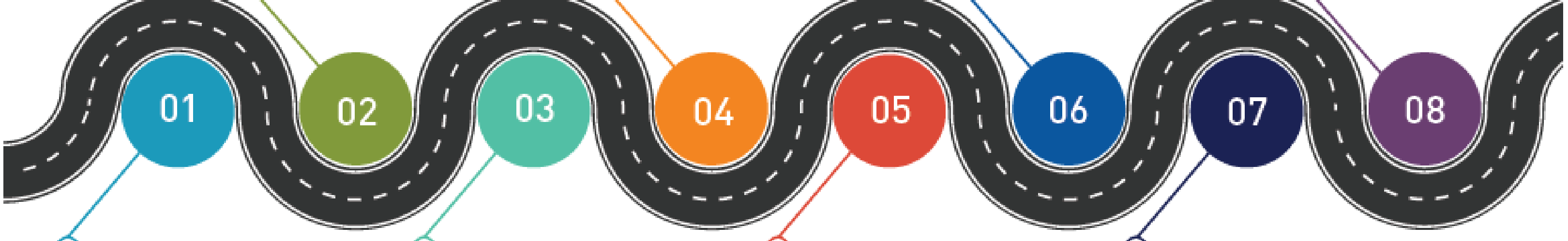
More detail about the methods used is available in an accompanying technical appendix, available from www.health.org.uk/publication/improvement-analytics-unit-analysis-principia

Principia care home residents attended accident and emergency (A&E) departments 29% less often than the matched comparison group, and were admitted to hospital as an emergency 23% less frequently.

Learning from new care models

- Care model design
- Evaluation
- Workforce redesign
- Leadership
- Harnessing technology
- Self care
- Communications and engagement

** 8-STEP GUIDE TO DELIVERING SUSTAINABLE AND TRANSFORMATIVE CHANGE



01 USING LOGIC FOR LEARNING

- Confirm team's intended impact logic model and theory of change
- Identify metrics and tools needed to drive change
- Identify priorities for learning and evaluation
- Assess relevance of experience sourced from UK, US, other countries

02 LEARNING FROM VARIATION

- In process & outcome to improve quality and safety
- In practice & preferences to improve value
- In needs & wants of patients to improve co-production
- In local area contexts to implement innovation & adapt to achieve scale

03 DELIVERING WHAT IS VALUED

- Focus on team's front line learning priorities for quality/safety & value
- Examine logic for local context and beneficiaries
- Identify opportunities for high value co-production
- Assess relevance of experience sourced from UK, US, other countries

04 MEASURING WHAT MATTERS

- Focus on patient reported measures including needs and preferences
- Measure decision quality as well as process quality
- Measure engagement and teamwork in co-production
- Achieve real-time data feedback to learn & adapt while innovating for value

05 DELIVERING WITH TEAMS

- Design microsystem teams for learning and meeting patients' needs & wants
- Fill each role with people working at highest & best use of skills and training
- Leverage skills with IT to support co-production
- Measure & reward care coordination by providers

06 ORGANIZING FOR INNOVATION

- Distinguish innovation from improvement
- Hold dedicated innovation team leaders responsible for learning & adapting
- Ensure innovation leaders flexibility to define new roles within care models
- Identify and learn from similar efforts elsewhere

07 LEADING FOR ACCOUNTABILITY

- Agree design principles for organisations & systems
- Focus on outcomes with improvement in quality & total cost of care
- Support patient choice & accommodate diversity
- Measure competencies & capabilities for risk-based payment models

08 GOVERNING FOR STEWARDSHIP

- Build IT for continued learning and improvement
- Govern with accountability for stewardship goals
- Lead with integrity of purpose and transparency in reporting to stakeholders
- Sustain system impact & value through reallocation of resources as needed

Place Based Care Network Programme

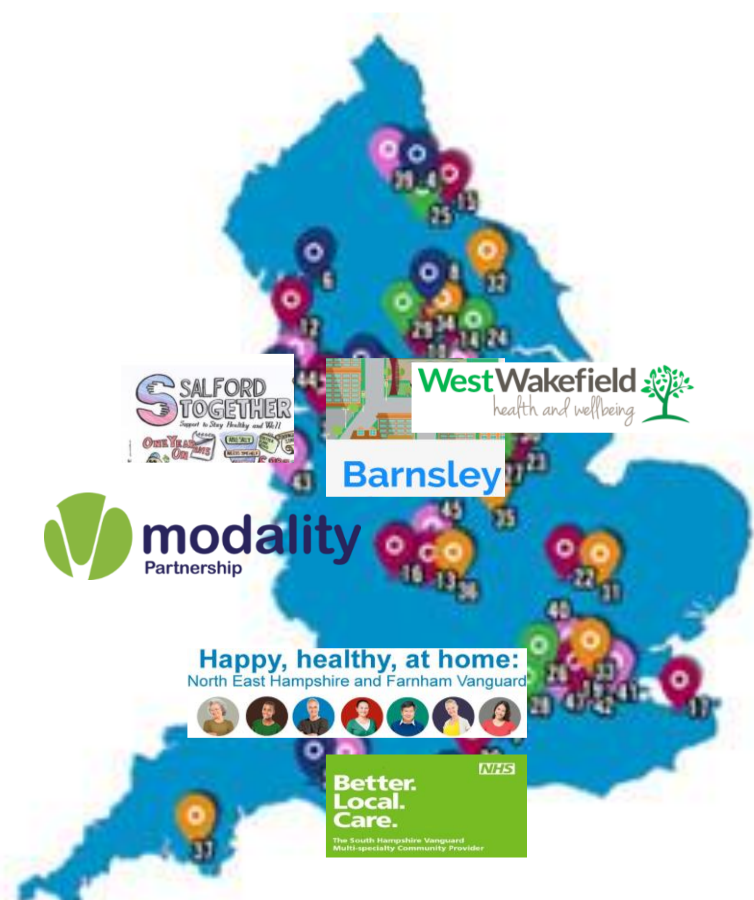
- NHSE and Dartmouth designed a 6-month pilot to develop a Place Based Care Learning Network. (See Appendix.) The PBCN Programme was commissioned and launched in the spring of 2016.

- ***The Goal of the PBCN pilot*** was to learn whether the teams would be more engaged and empowered by working together as a learning network using common measures and management tools to move from the 'what' to the 'how' of new care model implementation.

- PBCN 2016 teams were selected based on responses to a request for Expressions of Interest. They included:
  - 3 Multispecialty Community Providers
    - Better Local Care in Southern Hampshire,
    - West Wakefield Health and Wellbeing, and
    - Connected Care Partnership in West Birmingham)
  - 2 Integrated Primary and Acute Care Systems
    - Salford Together, and
    - Happy, Healthy, at Home in Northeast Hampshire and Farnham.
  - 1 Integrated Care Pioneer
    - The Barnsley Accountable Care Partnership Board.

- Other vanguards and, later in the programme, STP leadership teams joined

*



Improving health in a population

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POTENTIAL FOR IMPACT?	?	?	?	?

Better Health and Healthcare

- The Health Foundation's mission is to bring about better health and health care for people in the UK.
- We have historically focused on improving health care delivery.
- We recently began to support action on the wider determinants of health outside of health care services, publishing Healthy Lives Strategy in Jan 2017
- Healthy Lives work focuses on social determinants of health *outside* the NHS/formal health and care services
- However the NHS (including through formal delivery of care) does have a contribution to make to health.

NHS role in health: focus of our work to date

Place
Institution
Individual

1. Supporting the NHS to get better at prevention

2. Supporting the NHS to focus on the context of the individual and wider social determinants

Data analytics

Behavioural insights

Point of care
RCN

Democracy
Collaborative

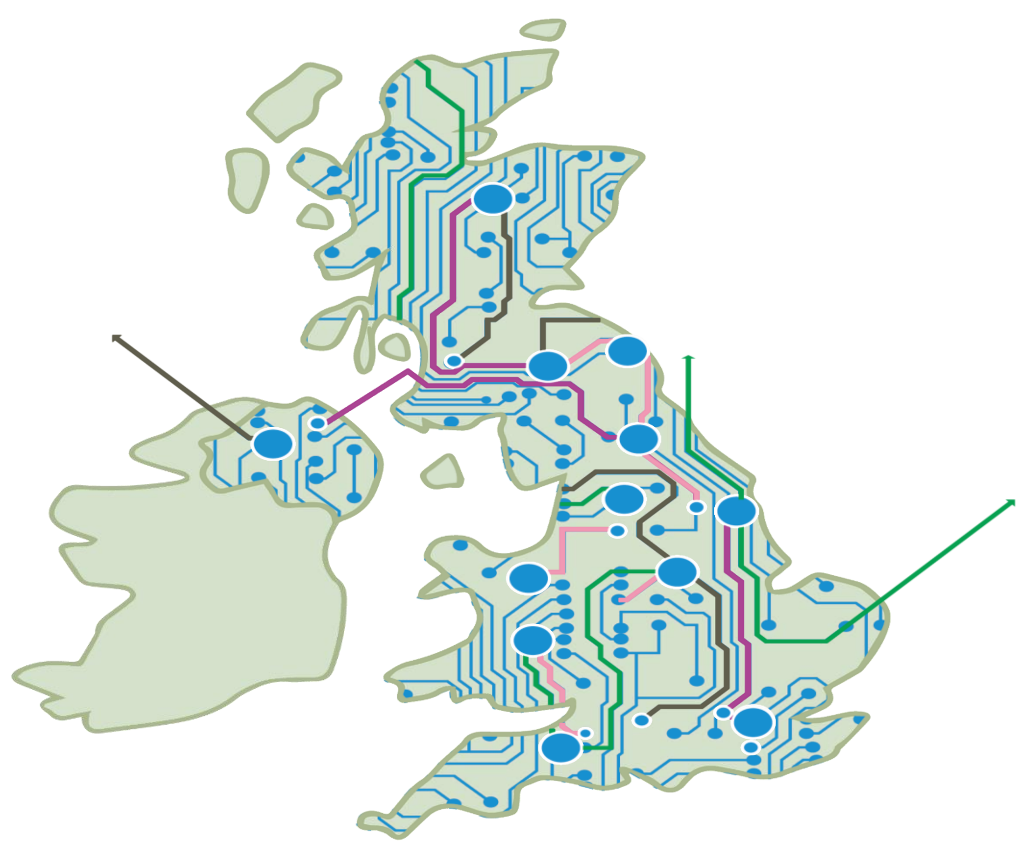
3. The NHS as a leader for health as an employer and anchor institution

4. Implementing improvement methods approaches to improve health

Q
Alumni
Projects

National support and leadership: Q

- UK wide long term 'home' connecting those doing improvement from across the UK
- Seeks to support people in their existing improvement work: making it easier to share ideas, enhance skills and make changes that benefit patients



Activities in Q

How we used the Sensemaker tool to work with complexity: learning from pioneering Public Health projects (12.30pm)

Join the 'Closing the Gap: developing improvers for a complex world' Q SIG to learn about projects using the Sensemaker narrative analysis tool in health projects.

A collaborative approach: Early Years Collaborative, Scotland

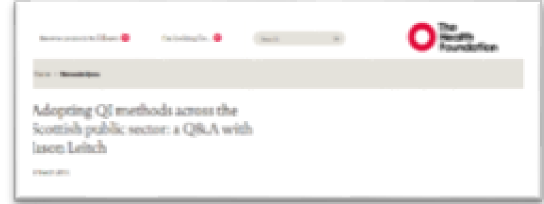
Programme aimed at making early years, health, family services and schools more effective and responsive in tackling inequality and improving children's outcomes. Achieve this by supporting widespread learning & application of QI approaches.

Context

- Success of using improvement methods in healthcare and patient safety
- Others outside of healthcare wanted to replicate approach using improvement methods to deliver change

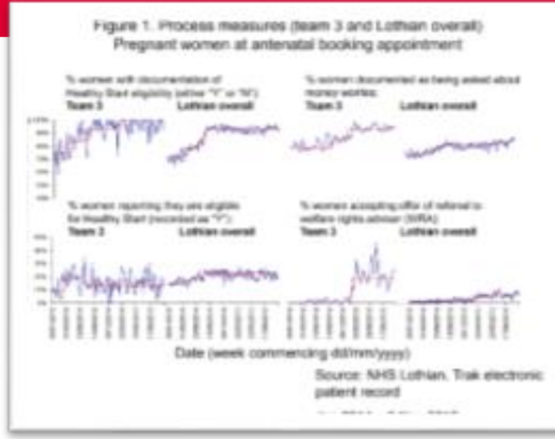
Approach

- Set up large scale improvement collaboratives across the whole country to apply improvement method to raise attainment and focus on early years
- Improvement Advisors supported teams to devise and implement improvement projects
- Combined all work with children and young people into a larger overarching collaborative with regional collaboratives on different areas
- Central 'Leading Improvement Team', working on broader public sector improvement



Outcomes

- Increased access to financial advice for pregnant women on low incomes, helping to increase income by up to £5,000 per family
- Improved children's literacy and numeracy skills in nurseries and primary schools in areas of deprivation
- Helped dads in prison understand their children's needs & build family relationships
- Ensured more low income families receive Healthy Start Vouchers so pregnant women and children get the nutrition they need

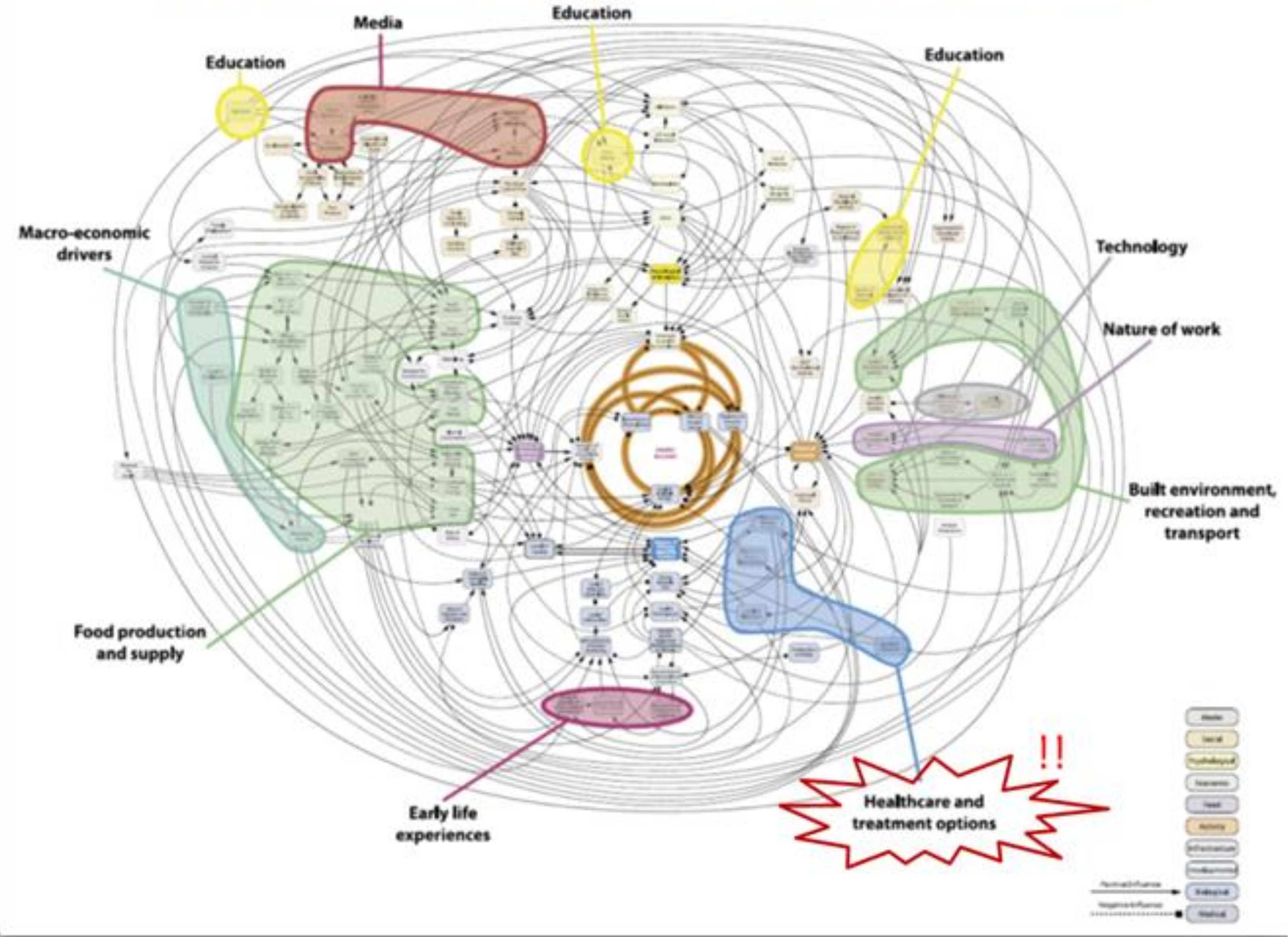


Key Lessons

- Evidence based bundles of care are harder to implement as you move away further away from hospital settings
- There are many variables that impact the success of the interventions, that are part of peoples wider lives
- Use method and not try and replicate exact approaches between places
- Sometimes data and measurement is an issue but you can teach local measurement and then teams have what they need to chart change.

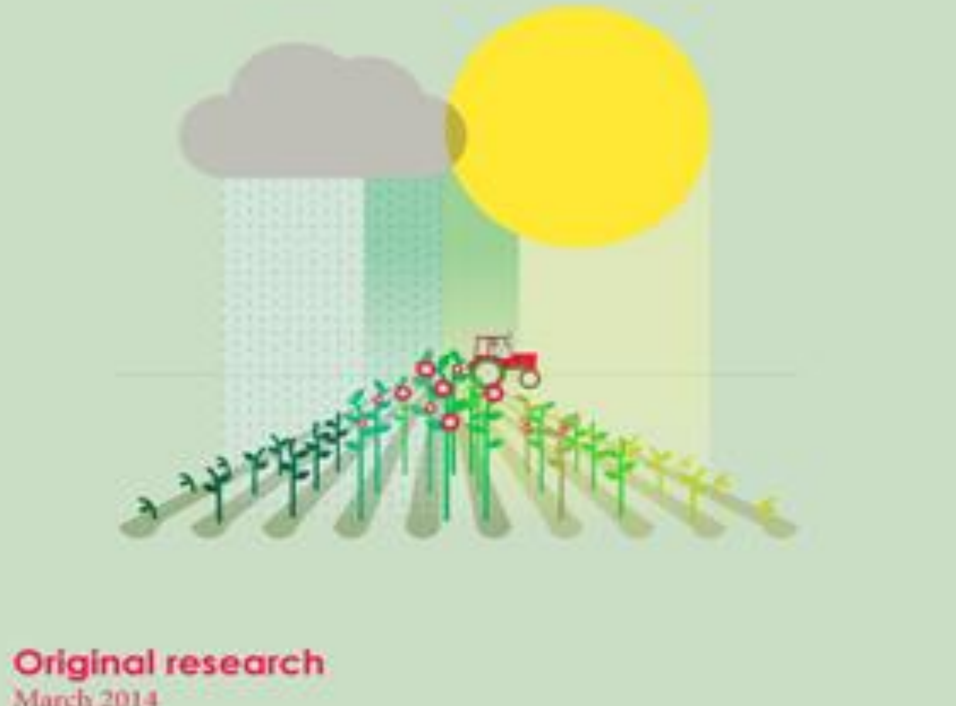
> "Often the most important thing is how you empower frontline staff and positively include service users in the change you are trying to bring about.

Foresight Report obesity ecosystem causal linkages and ability to influence



Perspectives on context

A selection of essays considering the role of context in successful quality improvement



Original research
March 2014

Improving health in a population

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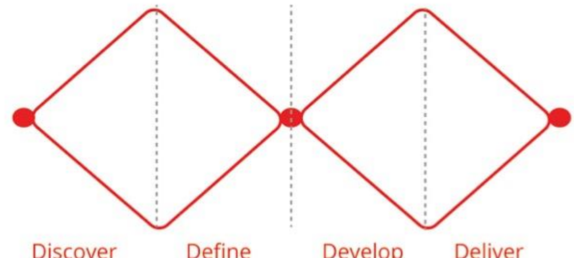
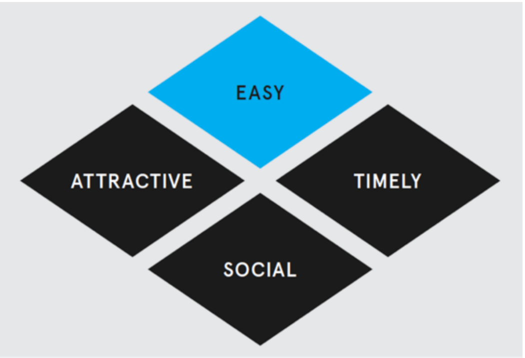
POTENTIAL FOR IMPACT?	?	?	?	?

Our improvement approaches

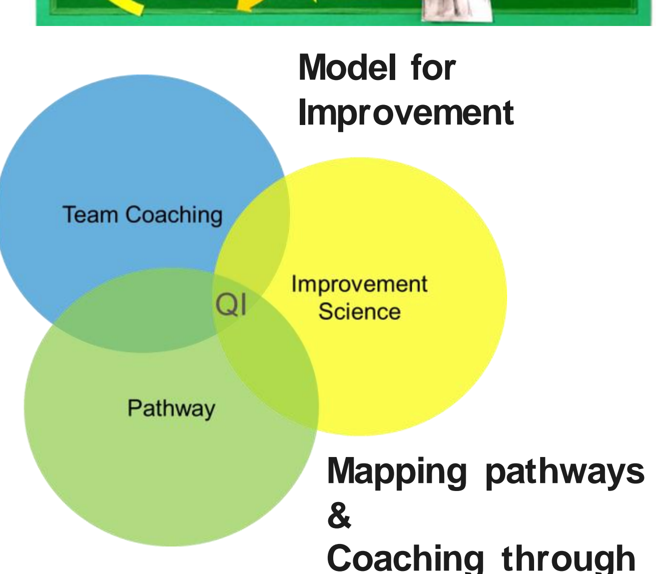
Model for Improvement

Design thinking





Behavioural Insights



Mapping pathways
&
Coaching through Flow Coaching

Big Rooms

Community organizing

Population Health Management

Whole Systems Integrated Care | Asthma Radar

Identify patients with asthma who may be at high risk and/or in need of review

Click on a traffic light to view details of the selected patient

GP Practice: (All)
Patient Segment: Children
RCP Review Filter: No filter selected
Sort by...: Number of Exacerbations

9,165 patients on list

Patient Name	Age	Number of Risk Factors	Number of A&E/UCC Attendances (past 12 months)	Number of Exacerbations: Exacerbations	Number of Prescriptions (past 12 months): Short-Acting β-Agonists	Number of Prescriptions (past 12 months): Inhaled Corticosteroids	Asthma Care: Asthma Review	Asthma Care: Inhaler technique	Asthma Care: Symptom Control Test	Asthma Care: Personal asthma plan	Lung Function: Peak Flow	Lung Function: FEV1
Patient 22121886	16	1	6	17	15	10						
Patient 5192202	10	1	0	15	1	0						
Patient 2434246	5	0	10	11	5	7						
Patient 11418090	15	2.1	4	10	12	3						
Patient 10664729	15	3	6	9	4	6						

Patient 22121886, 16
NHS #: 22121886

Latest practice update: 25/02/2017 ...

Risk Factors

Multiple courses of oral corticosteroids

Click to highlight traffic lights of that colour
Green Flag | Amber | Red Flag | Neutral/Unknown

	Total
Asthma Care	5
Exacerbations	24
Exacerbations (Oral corticosteroids)	19
All Emergency Care	25

Jan 13 | Jan 14 | Jan 15 | Jan 16 | Jan 17 | Jan 18

Peak flow: 0, 500, 1000
FEV1 % predicted: 0, 50, 100
FEV1
60%

Population Health Management

PATIENT TIMELINES via DASHBOARDS

Integrated Patient Summary (demo) | Activity timeline

Track this patient's activity across all care settings for the chosen time period

Financial values represent commissioner costs and include estimates or averages where payments are not linked to specific patients

Use the drop down menu below to choose your time period and hover over a bar to see more information...

View time period: Last 2 years
View costs: Yes

Latest available data ranges from 31/05/2017 to 22/08/2017.
Hover over the "i" button below for more detail.

Patient 3480329
348 032 0329
5, female

Long term condition(s):

Key outcomes
Days not in hospital: 728 / 730
Total spend: £4,092
eFI: 0.03 (Fit)

Has Care Plan
Care Plan up to date
Community Care User
Mental Health User
Social Care User

1 Aug 15 · 1 Nov 15 · 1 Feb 16 · 1 May 16 · 1 Aug 16 · 1 Nov 16 · 1 Feb 17 · 1 May 17 · 1 Aug 17

Care setting	Count
A&E	7 visit(s)
Non-elective inpatient (Acute)	2
Outpatient (Acute)	1
Outpatient - DNA (SUS)	1
Community intervention	1
Primary care prescribing	4
Primary care visit	23 event(s)
Urgent Care Certre	2

1 Aug 15 · 1 Nov 15 · 1 Feb 16 · 1 May 16 · 1 Aug 16 · 1 Nov 16 · 1 Feb 17 · 1 May 17 · 1 Aug 17

Care Type
Emergency support (RAW DATA) · Emergency support · Planned acute hospital care · Planned care outside acute hospital · Potential warning signs

Dx

IHI and Population Health

Triple Aim for Populations

Applying integrated approaches to simultaneously improve care, improve population health, and reduce costs per capita

IHI is helping partners to

- understand and stratify the needs of their populations
- activate those populations to improve their health
- map and utilize all of the assets in their communities to achieve improvements in health, experience of care, and costs.

through convening learning networks to share best practices and proven approaches, to develop capacity within organizations for population health improvement.

Quality Matters

Innovations in Health Care Quality Improvement

Publications > Newsletters > Quality Matters Archive > February/March 2012 > Improving Population Heal...

Quality Matters Archive

Quality Matters reported on emerging models and trends in health care delivery reform and interviews with leaders in the field. Please read its successor, Transforming Care.

February/March 2012 Issue

Next Article

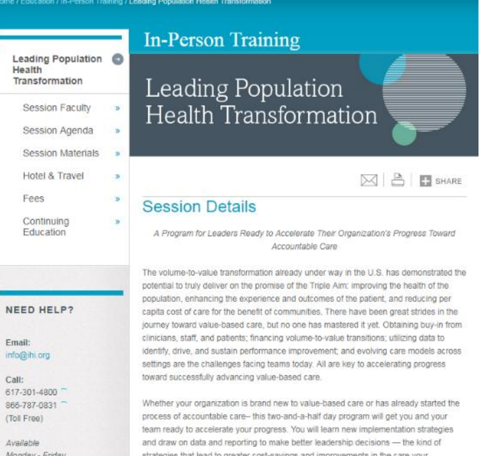
Add to My Library Print

Improving Population Health Through Communitywide Partnerships

Summary: *Community health partnerships that bring clinicians together with civic groups, social service providers, and educational leaders among many others are proving to be an effective means of improving population health. Among their benefits, the partnerships help communities prioritize health needs and streamline resources to address them.*

POPULATION HEALTH SESSIONS

- Pathways to Population and Community Health for Health Systems
- Addressing Social Determinants in a Medicare Shared Savings Program Accountable Care Organization
- Catalyzing Students and Trainees as Agents of Change
- Sustaining a Patient-Centered Medical Home Program
- Population Management: Rated G (for Geriatric)
- Improve Diabetes Care in 75 Minutes
- Aligning to Achieve Ambulatory Clinical Excellence
- Radical System Redesign: Advanced Team-Based Care
- Three Keys to Improving Health Outcomes and Reducing Costs
- A Community Coalition to Make Selma Healthier



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In-Person Training

Leading Population Health Transformation

Leading Population Health Transformation

- Session Faculty
- Session Agenda
- Session Materials
- Hotel & Travel
- Fees
- Continuing Education

NEED HELP?

Email: info@ihi.org

Call: 617-301-4800 / 866-787-0831 (Toll Free)

Available Monday - Friday 8:30am - 5pm ET

SHARE

Session Details

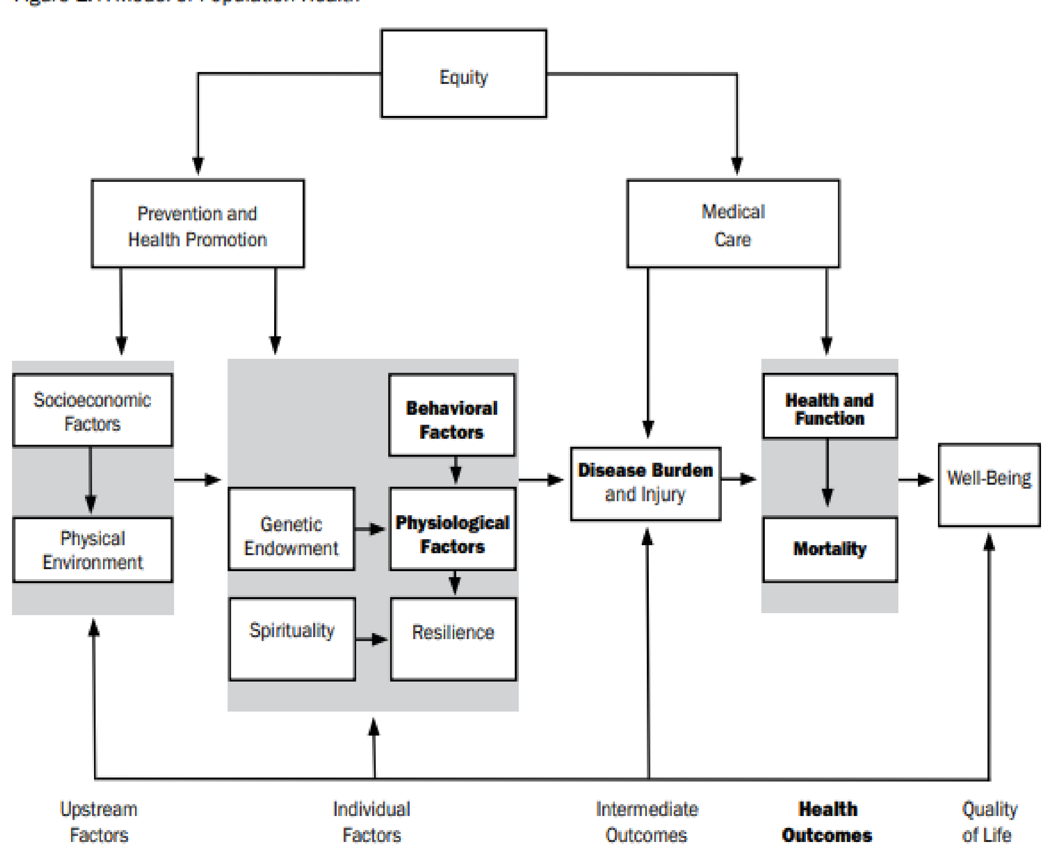
A Program for Leaders Ready to Accelerate Their Organization's Progress Toward Accountable Care

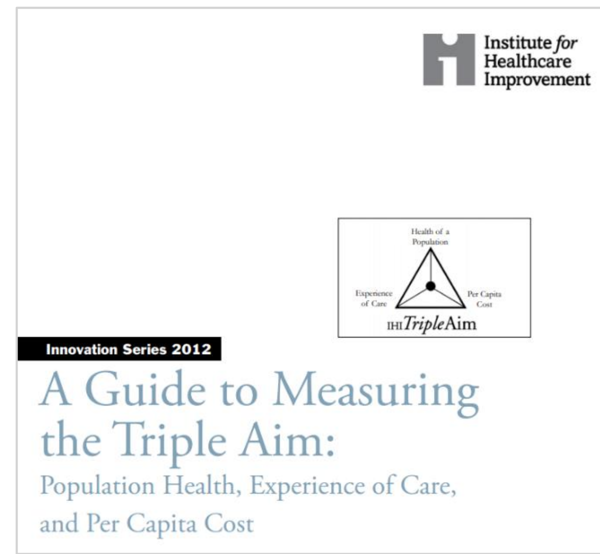
The volume-to-value transformation already under way in the U.S. has demonstrated the potential to truly deliver on the promise of the Triple Aim: improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per capita cost of care for the benefit of communities. There have been great strides in the journey toward value-based care, but no one has mastered it yet. Obtaining buy-in from clinicians, staff, and patients; financing volume-to-value transitions; utilizing data to identify, drive, and sustain performance improvement; and evolving care models across settings are the challenges facing teams today. All are key to accelerating progress toward successfully advancing value-based care.

Whether your organization is brand new to value-based care or has already started the process of accountable care– this two-and-a-half day program will get you and your team ready to accelerate your progress. You will learn new implementation strategies and draw on data and reporting to make better leadership decisions — the kind of strategies that lead to greater cost-savings and improvements in the care your organization provides. You will begin to build your own actionable roadmap to accelerate

The Triple Aim - Population Health

A measurement framework





RWJF Culture of Health

How We Work   Our Focus Areas   About RWJF   Search RWJF

How We Work / Building a Culture of Health

Building a Culture of Health

Our vision and framework for improving health, equity and well-being in America.

Our health is greatly influenced by complex factors such as where we live, and the strength of our families and communities. But despite knowing this, positive change is not occurring at a promising pace.

To accelerate progress, the Robert Wood Johnson Foundation has committed itself to a vision of working alongside others to build a national Culture of Health where everyone has the opportunity to live a healthier life.

Culture of Health Action Framework

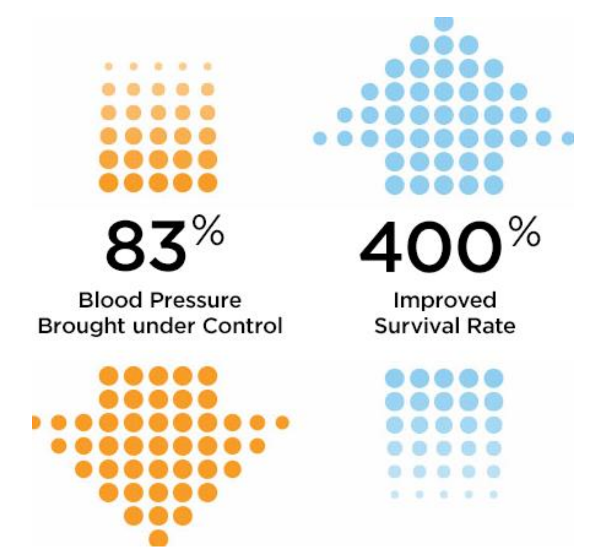
Developed in collaboration with the RAND Corporation, our Culture of Health Action Framework sets a national agenda to improve health, well-being, and equity. It contains three core elements:

- *Action Areas*: high-level objectives which can improve population health, well-being and equity;
- *Drivers*: activities or systemic factors that are critical to achieving better health; and,
- *Measures*: specific social, economic and policy data points that can help track progress over time.

The Action Framework is informed by rigorous research on the multiple factors which affect health. It recognizes there are many ways to build a Culture of Health, and provides numerous entry points for all types of organizations to get involved.

Kaiser Permanente

Tyler Norris, Total Health Partnerships, Kaiser Permanente, 2015.



A systematic approach to improving population health: some ingredients

- Identify the population
- Aims and objectives
- Identify key stakeholders (population groups themselves) and governance (80% relationships). Local government and public health.
- In detail agree priority areas, interventions, logic models, agree metrics for the outcomes of choice that are realistic.
- Mobilise support: data, QI skills, redesign, change and project management skills, investment, staff, other resources
- Small tests of change and iteration, continuous learning and adaption
- Develop management, leadership capacity, trust with key groups to progress further.

Conclusion

- Improving population health is a big challenge
- What impacts on health is a complex system
- A wide blend of approaches more appropriate to use. We are still learning what might work best
- Is room for a systematic approach
- Improving health may be too big an ask – change small things but to a coherent plan
- Lots of interest, effort and other assets
- Could learn from other examples:
  - Halving teen pregnancy
  - Improving school education in London

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