3. Moving to population health planning

We have been working together to consider what the requirements set out in the NHS Long Term Plan mean for our residents, staff and health and care partner organisations across North Central London (NCL). We have a collective commitment to deliver changes that will improve the health and wellbeing of residents and have listened to what residents and communities have told us is important to them.

This draft plan builds on existing plans and work already underway across NCL and sets out how we will deliver the commitments in the Long Term Plan. It has been developed by, and with the insights from, representatives working in NCL, including staff working in health and social care, and clinical leaders and managers, patients and residents, and our partner organisations from across the NHS, social care, voluntary sector and beyond. Local leaders across our partner organisations, including NHS trusts, general practice, commissioners and local authorities have been closely involved in shaping and overseeing the development of these plans. We are continuing to work closely with all of these groups as we refine the plans and move into delivery and implementation of the commitments.

If you would like to feedback or contribute to this work as we further develop our plans and implementation, please see the 'Listening to residents and communities' section for more details on how to get involved.

Introduction

Our health and care needs are changing: our lifestyles are increasing our risk of preventable disease and are affecting our wellbeing, we are living longer with more multiple long-term conditions like asthma, diabetes and heart disease and the health inequality gap is increasing.

A new approach – called Population Health Management (PHM) – is helping us understand our current, and predict our future, health and care needs so we can take action in tailoring better care and support with individuals, design more joined up and sustainable health and care services, and make better use of public resources.

It is how we use historical and current data to understand what factors are driving poor outcomes in different population groups. It is how we then design new proactive models of care which will improve health and wellbeing today as well as in 20 years' time. This could be by stopping people becoming unwell in the first place, or, where this isn't possible, improving the way the system works together to support them.

There is huge potential to use data, insight, and evidence systematically and more effectively across our local public services in North Central London to improve the health and wellbeing of our patients, residents, and communities, reduce health inequalities, and to make more efficient use of resource.

While there are some pockets of good work, our approach to using data and analytics has historically been fragmented. This means that we are not using it to drive change in population health outcomes at scale and proactively enable improvements in place-based systems, such

as boroughs and neighbourhoods, including on the wider determinants of health. We are also not using it systematically to identify 'gaps in care' and opportunities for quality improvement.

We have already made some progress in changing this all and we have big aspirations to change the way we collaboratively work together, including with communities, patients and residents, to make improvements. While appreciating the need to understand ethical risks and acceptability, we also want to capitalise on the emergence of newer digital and analytical technologies, such as machine learning. We also want to make best use of the capabilities of our partners outside of North London Partners, including those at regional and national levels, and within local academia and other organisations to make this a success.

We consider this a key and cross-cutting enabler to achieve our ambitions for better health and wellbeing within our long term plan — that will also allow us to measure and evaluate impact — which is why we are prioritising it.

What we are doing now:

- We have set up an Analytics Board to lead and oversee the development and use of analytics across North London, where it makes sense for us to work together.

- We are committed to ensuring that we are fully transparent about how we are using data and analytics and that it is in a way that is lawful, ethical, and acceptable to patients and residents. As well as having members of the public on our Boards, we are setting up an ongoing patient and resident reference group (as part of our joint governance with Digital) to advise us and support wider engagement across North London, and to link in to activities in the One London programme. Importantly, this group will be equivalent to the health and care professional reference group.

- Via the STP's digital workstream a population health management platform (Cerner's HealtheIntent) is being deployed across North London:

    - Through the use of registries which identify what evidence-based care measures you would expect to be delivered for a particular population group (e.g. control of blood sugar for people with diabetes), this will enable our frontline services, with the NHS and social care, to identify where there are 'gaps in care' for the individuals they see, as well as at a population level. We will be looking across the life course (conception to death) to identify key population groups and associated measures for North London including across NHS and local government services.
    - We will also be using the platform to enable front line health and care professionals to identify where there is unwarranted variation to improve the quality of care and case finding to make the shift towards prevention and earlier intervention. This will specifically support the quality improvement initiatives within our primary care networks in the first instance.
    - Over time, we hope to be able to use the data to deliver a person held record which would enable patients and residents to better manage their own health and care.
    - To enable us to deliver a joined-up health and care record within HealtheIntent and to support other analytics, we are working across NCL to digitalise health and care records, map key datasets, and improve data quality. This is all vital to enabling safe and effective care. It is a major undertaking which is going to

take require continued dedicated focus and investment through our digital programmes as well as cultural change among health and care professionals.

- Our analysts have been working more collaboratively together to provide strategic analytics to drive system planning and prioritisation, starting with childhood asthma for the children and young people's STP programme.

- We were successful in receiving two small grants from NHS Digital to build a collaboration with LSE and NEL CSU to look at whether we can use de-identified social care 'free text' data to better predict escalation of needs to improve prevention and early intervention.

- Beginning in Islington, and funded by the Health Foundation, we are looking at whether we can use de-identified household-level data to quantify the impact of the social determinants of health (e.g. housing) on health and care service utilisation and vice versa. If successful, this would inform how services could work better together to improve population health.

- We have been exploring how we could better enable our trusted academic partners to undertake research using joined-up data to improve quality, care and outcomes.

- With our partners at NIHR CLAHRC North Thames, we have been undertaking some qualitative research to understand how system leaders use analytics to inform a wider survey and potentially a programme for continuing professional development in this rapidly developing and complex area.

What we are also planning to do:

- Together we will determine the 'key' questions that we want to use data and analytics to help answer so that we can co-develop an overarching vision, strategy and associated plans for what we want to be able to deliver at different levels of the system (e.g. ICS, borough partnerships, PCNs), as well as being clear what we need from a London and national level to enable this.

- Building on what's been done in other areas, we will look at how analysts from across the different parts of the health and care system can start working together more collaboratively to share knowledge and skills, and up-skill where required. This is particularly important as we start to use more joined-up data and move towards more advanced analytics.

- We will work collaboratively to determine what outcomes, including inequalities, we are measuring across the whole system and within specific programmes, and how we know whether we are making an impact on these. This will include looking at how we are capturing clustering of risk factors and multi-morbidity. We will also proactively work to include more 'subjective' measures (e.g. kindness, social cohesion) that capture the relational aspects of health and wellbeing which are crucial to improving population health outcomes, and the wider determinants of health.

- We will continue to look at where there are opportunities to use more advanced analytical methods to predict and model escalation of needs and reduce demand, identify where we can make the greatest impact, improve quality, and make service

planning and delivery more efficient and cost-effective. This is likely to include the use of methods for population segmentation, risk stratification and agent-based modelling, for example. We will also look at how we can better evaluate the impact of interventions and change across different parts of the system. To be successful, this will all require the ongoing and continued improvements in data quality and digitalisation of health and care records.

- Being able to translate data and analytics into easily accessible information for action is important if we want to enable change. We will specifically work with frontline health and care professionals to determine how we can make this work well for them, so that they can take evidence-based action but spend their time focussing on what matters most – delivering care.

- We recognise that to reduce health inequalities and improve the health and wellbeing outcomes of our most vulnerable residents we need to be working with communities themselves, including through the voluntary and community sector. We will work to change the way we describe the needs of communities and population groups in a way that is more meaningful to them. Working across the different levels of our North London partnership, we will seek to co-develop the narrative around North London as a place ensuring that over time community-based assets, needs and views are better described alongside routine health and care data.

- Finally, in addition to measuring the impact on outcomes, we will develop and improve our methods for monitoring and evaluation of programmes and work across the system to influence prioritisation and resource distribution, which will include the impact of digital and analytics programmes.