The Integrated Care Summit: Challenges and Best Practice

9th March 2022 – Mercure Hotel Manchester

Conference Hosted by Convenzis Group Ltd

Meet Todays Sponsors

Chairs Opening Address

Dr Rajiv Sharma BMedSc (Hons), MB ChB, MRCGP, Clinical Executive for Strategic Partnerships
Primary Care Clinical Lead Executive at Black Country & West Birmingham CCG

Jonathan Daly, Strategic Programme Lead – Mental Health at Barnardo’s

Improved mental health outcomes for children and young people – an integrated path ahead

Jonathan Daly
Strategic Programme Lead – Mental Health
Barnardo's

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Agenda

- Barnardo's mental health & wellbeing work
- Challenges in the mental health system
- **Regional integration:**
  Surrey Alliance for Emotional and Mental Health and Wellbeing
- **Place based partnerships:**
  Solar Service Birmingham & Solihull, Cumbria Link Service
- A vision for an integrated path ahead

Barnardo's – big broad and deep *but still agile*

Our reach – in numbers:

359,000

CYP and parents/ carers supported

800

Services and partners

7,822

paid colleagues

1400

volunteers

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Children's and young people's mental health:

76

CYP mental health services

48,500

CYP supported with their mental health through our specialist mental health service and many more supported with their wellbeing through our wider service offer

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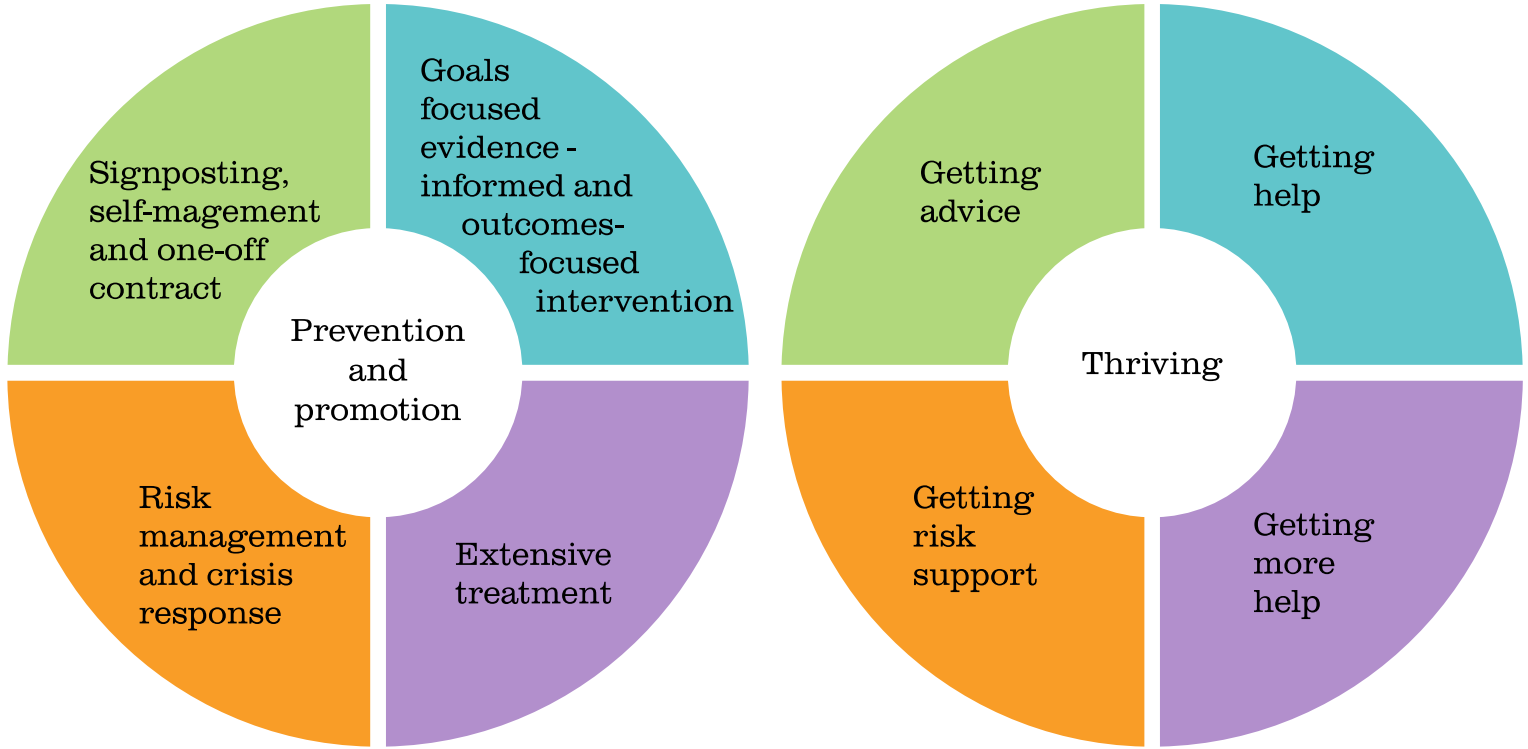
Children's and young people's mental health:

We deliver support across all of the Thrive categories working with a wide range of commissioners and partners



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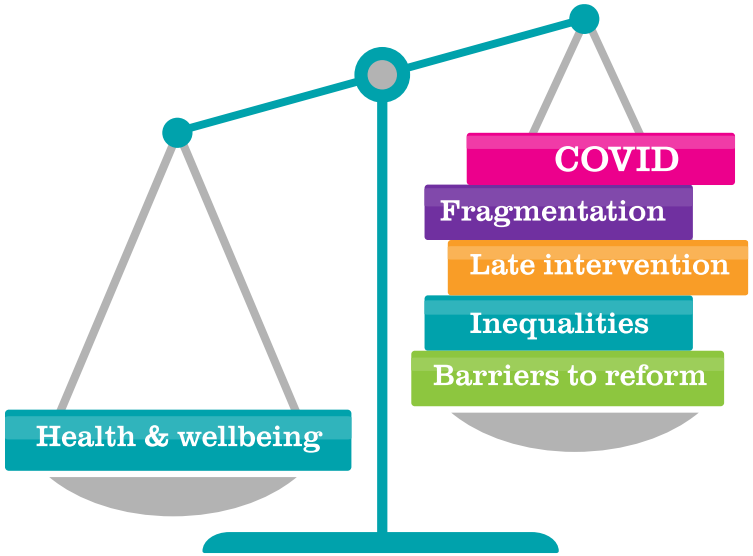
The Mental Health system

The health system faces significant challenges to meet the needs of CYPF:

Inequalities	Wide disparity in outcomes and access between most and least deprived deciles.
Late intervention	Long waiting lists and service gaps for CAMHS, eating disorders and perinatal mental health. Huge acute cost from preventable non-communicable diseases.
Fragmentation	Challenges in effectively integrating health and social care budgets and service pathways.
Barriers to reform	Achieving effective blended digital and face-to-face offers. Workforce and recruitment crisis.[1] Shifting spend to early intervention and moving services into community settings.



Notes: (1) Total vacancies are projected to reach 350,000 by 2030. 25% of current vacancies are for mental health nursing.

The Health Foundation (REAL Centre), Building the NHS nursing workforce in England, December 2020.

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Impact of the pandemic on children's mental health

Children’s wellbeing and mental health has suffered as a consequence of the pandemic:

In 2020, **one in six (16%) children** aged 5 to 16 years were identified as having a probable mental disorder, increasing from one in nine (10.8%) in 2017.

81% increase in referrals for children and young people’s mental health services.

59% increase in urgent or emergency crisis care referrals for children and young people.

The number of children and young people waiting to start treatment for a suspected eating disorder has **quadrupled** from pre-pandemic levels.

1 in 5 Children and young people waited **more than 12 weeks** for a follow-up appointment with mental health services between April 2020 and March 2021.

Sleeping problems affected more than a quarter of 6-10 year olds, a third of 11-16 year-olds, and half of 17-23 year olds in 2021.

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Integrated Care System case study:

Surrey Alliance for Emotional & Mental Health & Wellbeing

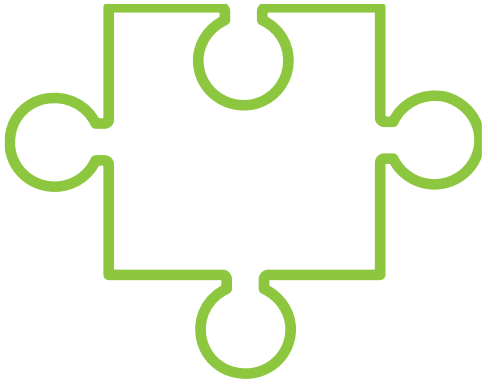
The vision and journey

- Whole systems change vision
- Joint commissioning between Surrey County Council and CCGs
- 7-to-10-year contract designed to move funding year on year from clinical services to early intervention and prevention
- The third sector as an equal partner in Emotional Health and Wellbeing Service Delivery across Surrey
- Early intervention and prevention better than overloading clinical teams

The Surrey Wellbeing Partnership

- Commissioning process allowed for creation of a Joint Venture Agreement through Surrey Wellbeing Partnership
- 13 charities, large and small
- Collaboration vs. competition
- Developed trust and mutual respect
- Shared language

Key components:



- Leaders' willingness for partnership and collaboration with the Voluntary Sector
- Equal partners and recognition of expertise
- Shared value base: provision of service for children and young people at the point of need
- Young people at the heart of decision making
- Strengths-based approach
- THRIVE model of intervention

The Mindworks Surrey service offer

Service focus:	Service offer:
Access & advice	Advice, signposting to existing support or passing through to specialist or clinical support.
Building resilience	Early support in the local community, such as counselling, mentoring or a wellbeing project.
School-based needs	Advice, support and signposting for children, young people, parents/carers and school staff, including 1-1 support and group work, both in and out of school settings.
Reaching out	Multi-agency support for isolated and vulnerable children, includes young offenders, children in need and those not in education, employment or training.
Neurodevelopmental Service	Supports those living with conditions such as autism and ADHD Service (Attention Deficit Hyperactivity Disorder).
Crisis admission avoidance	Teams deliver crisis & intensive support alongside children, avoidance young people and their family/carers.
Intensive intervention	Extensive or intensive treatment specialist work to address, for example; eating disorders; sexual trauma or children in care.

Place based partnership case studies:

Solar

LINK

Social Prescribing, Cumbria

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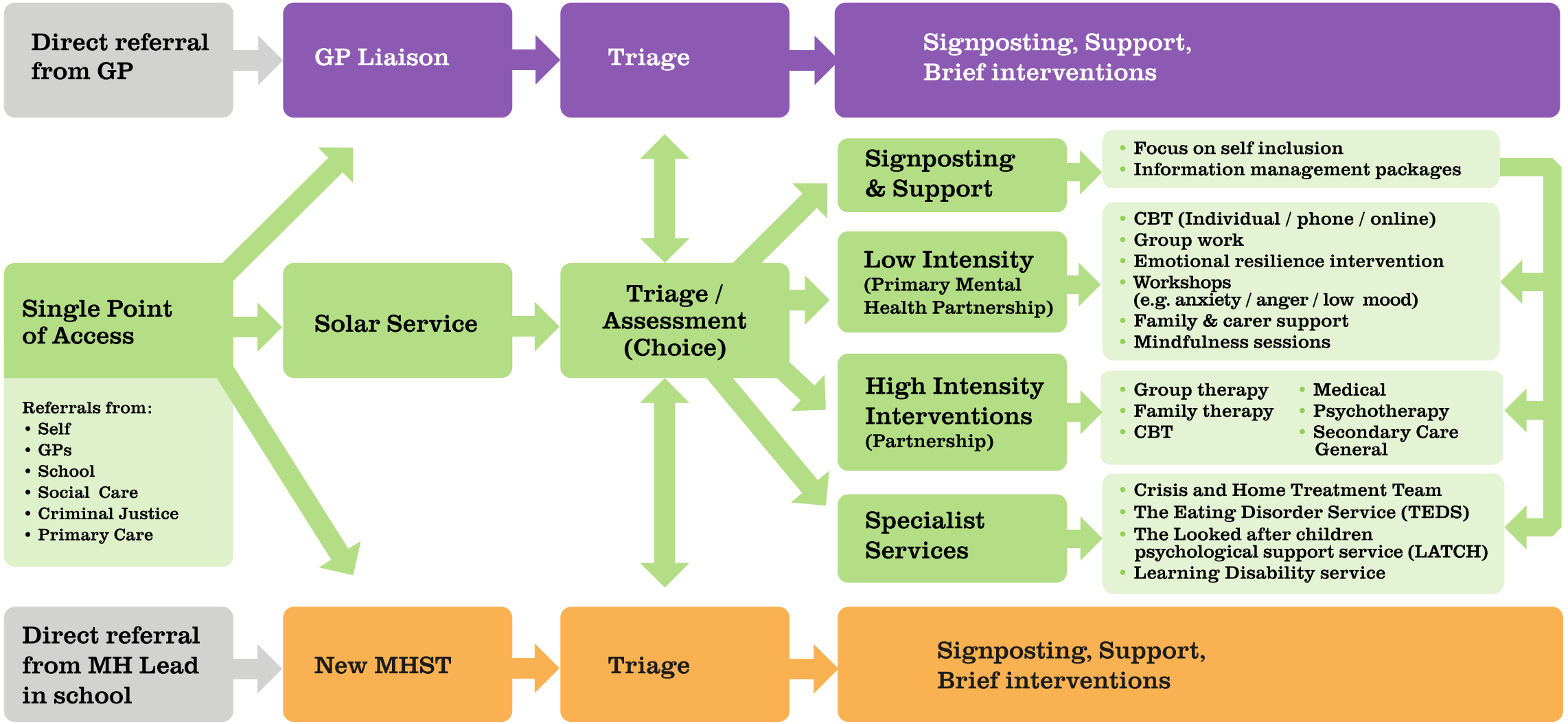
Solar

An integrated local mental health offer

- Solar is a **partnership** between Birmingham and Solihull Mental Health NHS Foundation Trust, Barnardo's and Autism West Midlands and is the service that provides Emotional Wellbeing and Mental Health Services to Children, Young People and Families in Solihull (0-19).
- Solar was set up as a service not about thresholds or tiers but **about timely access to appropriate support** in line with children and young people's needs.
- It is **a truly integrated service** with staff from Birmingham and Solihull Mental Health Foundation Trust, Barnardo's and Autism West Midlands working alongside each other.
- The integrated model is at the heart of the working culture within Solar, with **professional respect and integrity** between all professionals, recognising the value and skills that each bring to the service.

Solar: An integrated local mental health offer



Cumbria Link

CYP Social prescribing

Why CYP social prescribing:

- **40% of GP appointments** are for CYP.
- 21% of CYP A&E admissions are classed as **non-urgent**.
- Many CYP **need non-medical solutions** to their mental health and wellbeing issues.
- The term **"social prescribing"** is used to describe the provision of workers to help children and young people socially connect to local well-being boosting services within their local communities.
- CYP Social Prescribing model is developing as **a holistic model** with referrals and delivery broadening out into schools, MHSTs, CAMHS and VCSE.

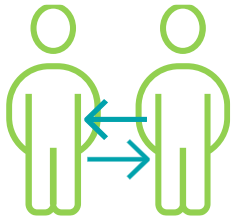
Cumbria Link

CYP Social prescribing

- Running since **September 2020**.
- **Funded by Primary Care** via the Additional Roles Reimbursement Scheme. Cumbria Link service works with **Three Primary Care Networks** across a rural North Cumbria geography.
- Between September 20-21 the service **supported 301 CYP** aged between 5 and 19 (96% referrals accepted, 76% referrals came from GPs, 24% referrals came from education, CAMHS, youth workers & self-referral, 37% referrals for anxiety).

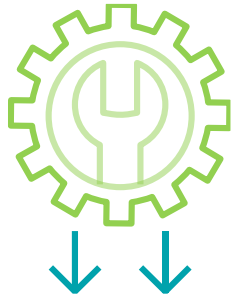
What Cumbria Link offers:

Support and activities



1 to 1 support with a link worker

who will support, guide and listen using a range of interventions and skill sets

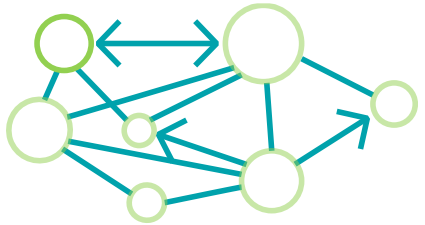


Assessment tools

based on *Signs of Wellbeing*

Drop-in wellbeing groups

in various settings



Working widely with other community groups

to connect young people to appropriate resources best suited to their needs, interests and circumstances

Tailored Offer:

- 1:1 support for 6-12 weeks,
- Group activities, volunteers,
- wellbeing drop ins,
- school support,
- signposting & coordination

Support for a variety of health and wellbeing needs including:

Low mood, anxiety, emotional wellbeing, peer pressure, confidence, self-esteem, social isolation, negative thinking, relationships

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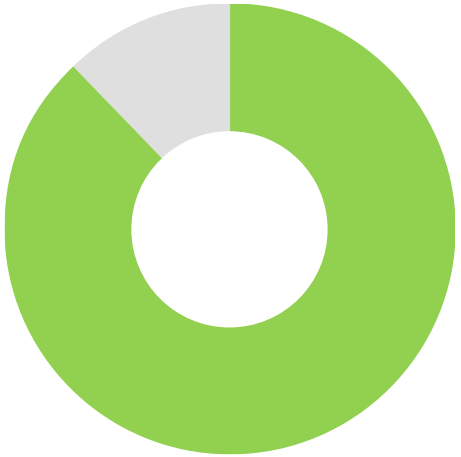
Link service outcomes for children and young people:

Outcome 1

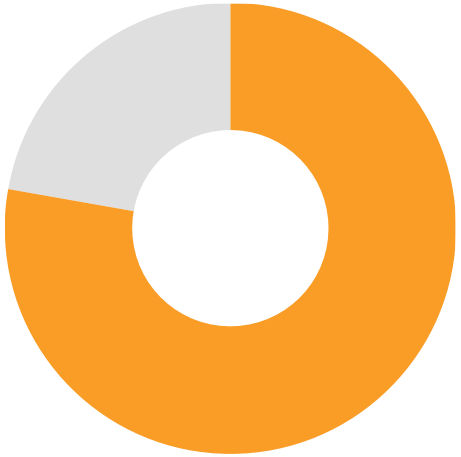


88%

feel less isolated

- % of CYP feel less isolated

Outcome 2

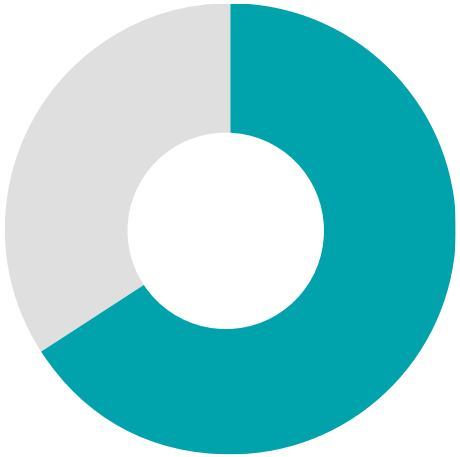


78%

have increased self-awareness

- % of CYP able to manage emotions through increased self-awareness

Outcome 3



66%

improved relationships with friends and family

- % of CYP experiencing improved relationships with friends & family

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A vision for an integrated path ahead

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A vision for an integrated path ahead

ICS Level

- Universal services and an open front door provide a gateway to reach families across a spectrum of need
- Set a **vision for what different & good looks like**
- **Accessible** services **for all**
- Rapidly adjust policies, set priorities, target resources, ensure multi-sectoral responses
- ICSs not reinventing the wheel, but being a springboard to leverage and catalyse change

Place based level

- Availability of **a spectrum of social and clinical support** (including digital)up to the age of 25
- Prioritise by **listening to children and coproducing to achieve better outcomes**
- Develop partnerships at a place-based level to ensure a system wide response to wider determinants of health
- Interrogating data & **open conversations about solutions**

Practice level

- Children & young people **telling their story once**
- **Flexible delivery**, recognising the need to shift focus as the needs of individual CYP and families change
- **Support frontline delivery**
- Intervene early to impact downstream and cost benefits over a life-course
- Ensure long waiting lists are not a cliff edge, triage vulnerable people, offer support solutions
- Good informal relationships with workers to identify challenges parents may be reluctant to disclose

Thank you

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Ian Male, Consultant Community Paediatrician/Honorary Senior Lecturer, Sussex Community NHS Foundation Trust/ Brighton and Sussex Medical School

CAN INTEGRATED CARE PATHWAYS DELIVER A NEURODEVELOPMENTAL APPROACH FOR CHILDREN WITH POSSIBLE AUTISM AND/OR ADHD?

DR IAN MALE

CONSULTANT COMMUNITY PAEDIATRICIAN AND HONORARY SENIOR LECTURER

THE INTEGRATING HEALTH AND SOCIAL CARE CONFERENCE MARCH 9TH 2022

INTRODUCTION

- The Challenge: Increasing Referrals, Increasing Waiting Lists, Disjointed Service Delivery
- Diagnostic Complexity
- NHSE Long Term Plan
- RE-ASCeD Study
- Neurodevelopmental vs Condition Specific Approach
- How do we Achieve This. Beware Unforeseen Consequences

WHY THE LONG WAITING LISTS

Diagnostic Complexity

Increasing Referrals

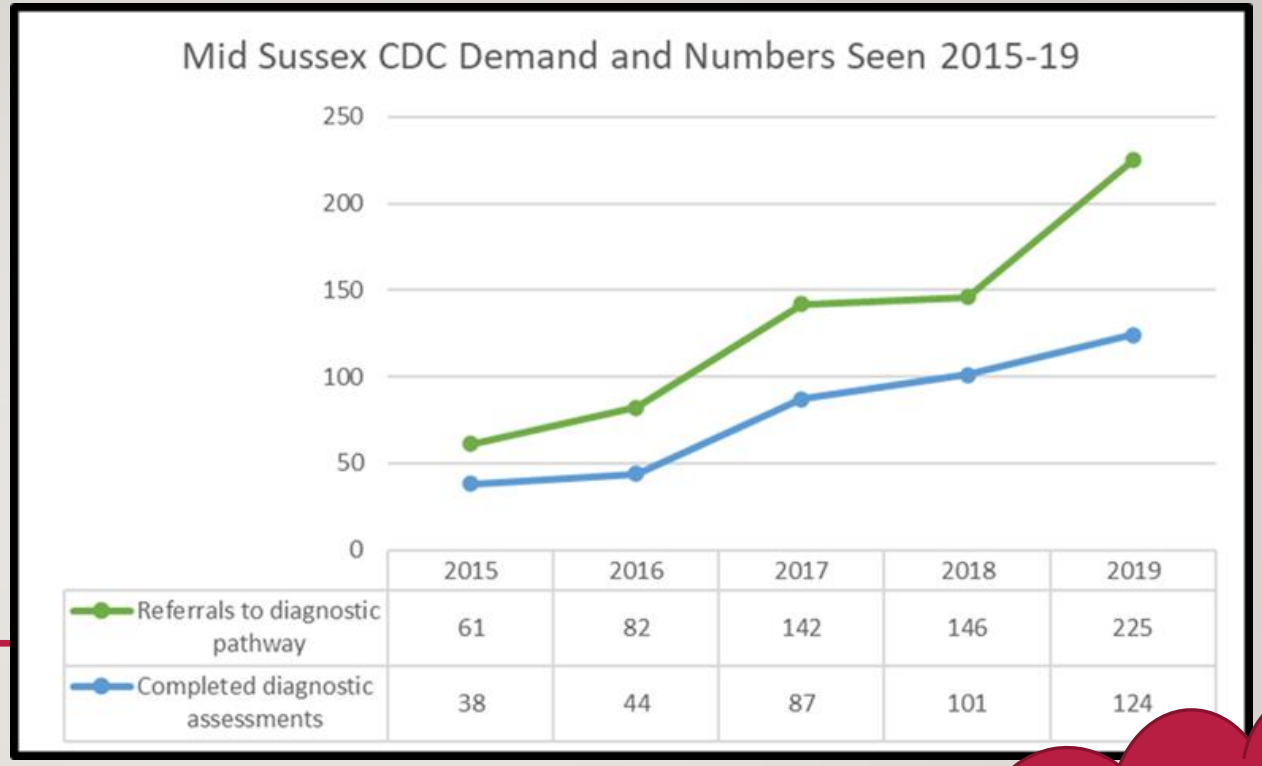
Lack of Investment

Recruitment and Retention across MDT

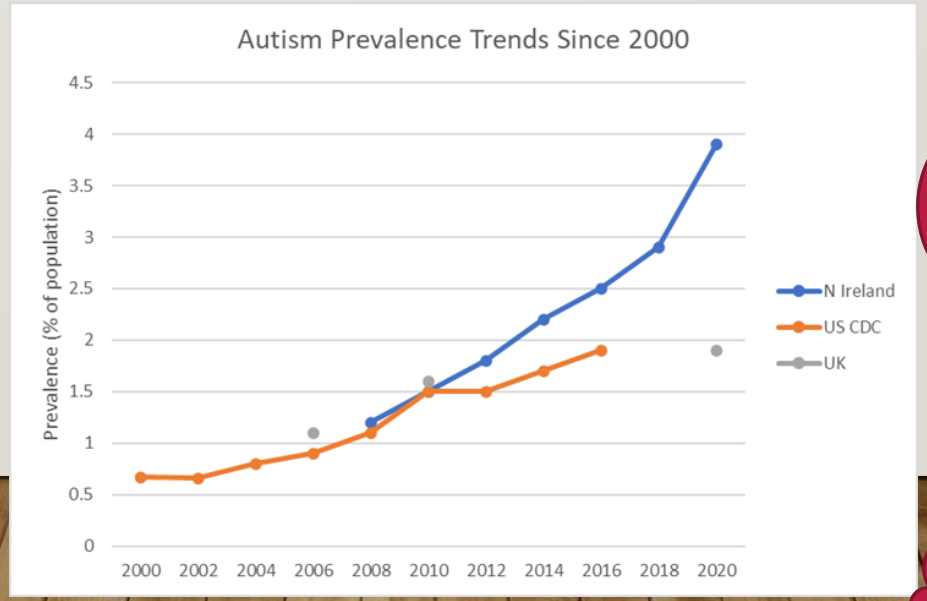
Lack of Training

Priorities e.g. Shape of Training focussed on acute careers

Covid

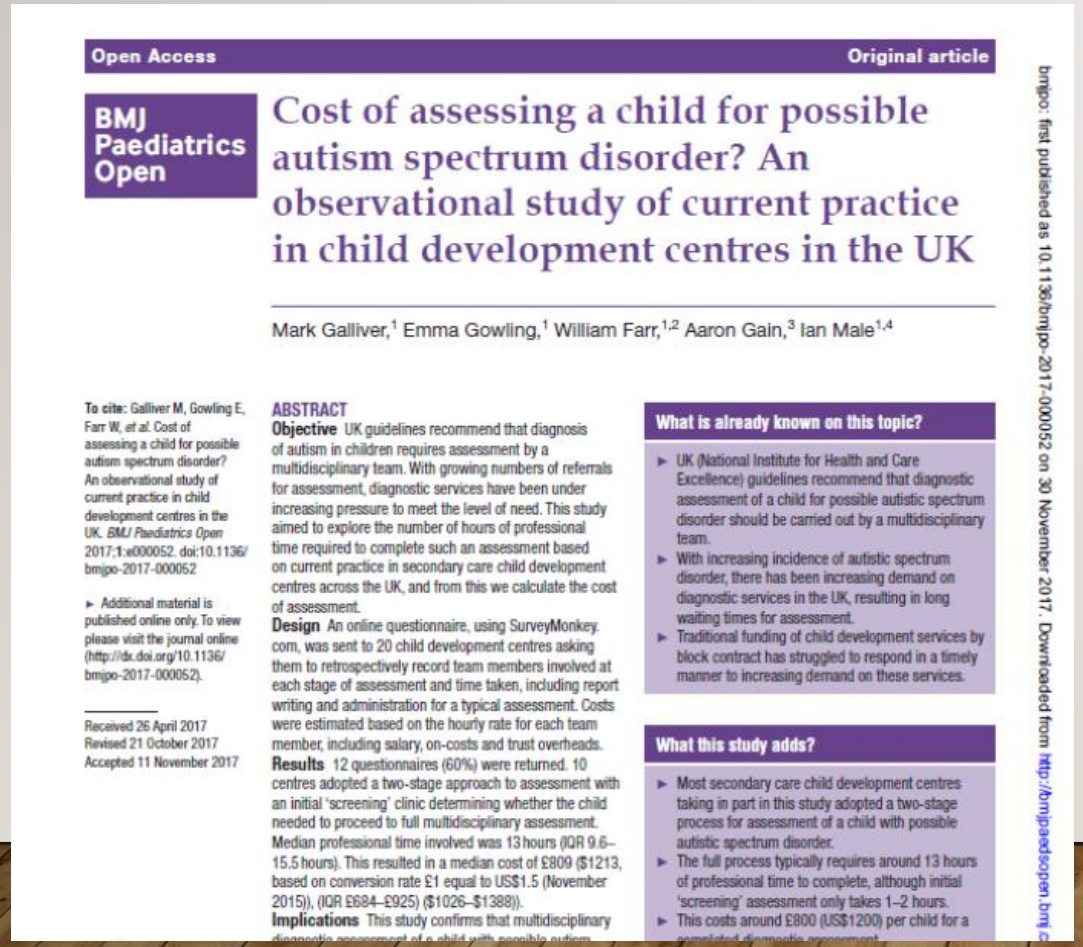


	2015	2016	2017	2018	2019
Referrals to diagnostic pathway	61	82	142	146	225
Completed diagnostic assessments	38	44	87	101	124



"the service was developed to see 60 children a year, its about trebled…we see 2 children a week, and get 8 referrals."

COSTLY AND TIME CONSUMING



Open Access Original article

BMJ Paediatrics Open

Cost of assessing a child for possible autism spectrum disorder? An observational study of current practice in child development centres in the UK

Mark Galliver,[1] Emma Gowling,[1] William Farr,[1,2] Aaron Gain,[3] Ian Male[1,4]

To cite: Galliver M, Gowling E, Farr W, *et al*. Cost of assessing a child for possible autism spectrum disorder? An observational study of current practice in child development centres in the UK. *BMJ Paediatrics Open* 2017;**1**:e000052. doi:10.1136/bmjpo-2017-000052

► Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/bmjpo-2017-000052).

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ABSTRACT

Objective UK guidelines recommend that diagnosis of autism in children requires assessment by a multidisciplinary team. With growing numbers of referrals for assessment, diagnostic services have been under increasing pressure to meet the level of need. This study aimed to explore the number of hours of professional time required to complete such an assessment based on current practice in secondary care child development centres across the UK, and from this we calculate the cost of assessment.

Design An online questionnaire, using SurveyMonkey.com, was sent to 20 child development centres asking them to retrospectively record team members involved at each stage of assessment and time taken, including report writing and administration for a typical assessment. Costs were estimated based on the hourly rate for each team member, including salary, on-costs and trust overheads.

Results 12 questionnaires (60%) were returned. 10 centres adopted a two-stage approach to assessment with an initial 'screening' clinic determining whether the child needed to proceed to full multidisciplinary assessment. Median professional time involved was 13 hours (IQR 9.6–15.5 hours). This resulted in a median cost of £809 ($1213, based on conversion rate £1 equal to US$1.5 (November 2015)), (IQR £684–£925) ($1026–$1388)).

Implications This study confirms that multidisciplinary

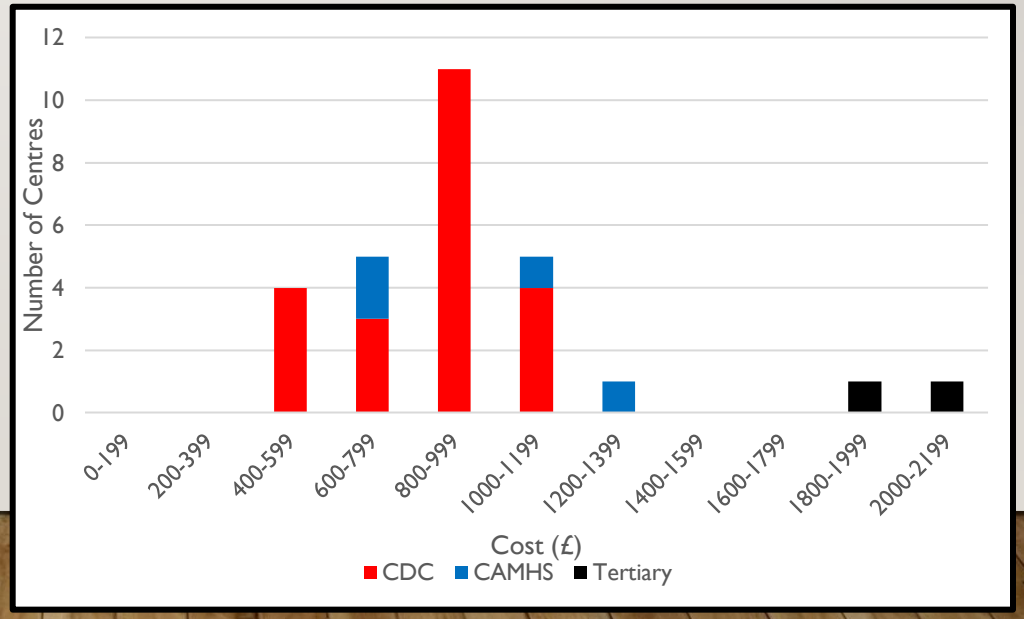
What is already known on this topic?

- UK (National Institute for Health and Care Excellence) guidelines recommend that diagnostic assessment of a child for possible autistic spectrum disorder should be carried out by a multidisciplinary team.
- With increasing incidence of autistic spectrum disorder, there has been increasing demand on diagnostic services in the UK, resulting in long waiting times for assessment.
- Traditional funding of child development services by block contract has struggled to respond in a timely manner to increasing demand on these services.

What this study adds?

- Most secondary care child development centres taking in part in this study adopted a two-stage process for assessment of a child with possible autistic spectrum disorder.
- The full process typically requires around 13 hours of professional time to complete, although initial 'screening' assessment only takes 1–2 hours.
- This costs around £800 (US$1200) per child for a

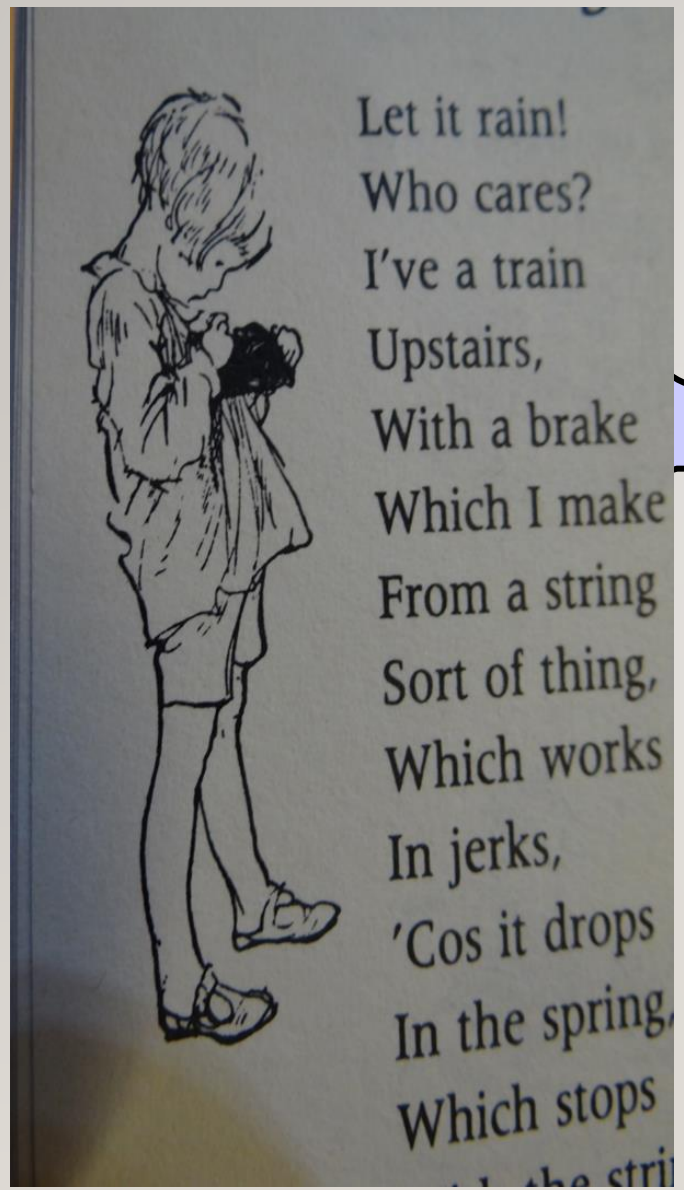
- Based on what we think we do
- 13 hours professional time
- £850/child. Follow on study £900/child

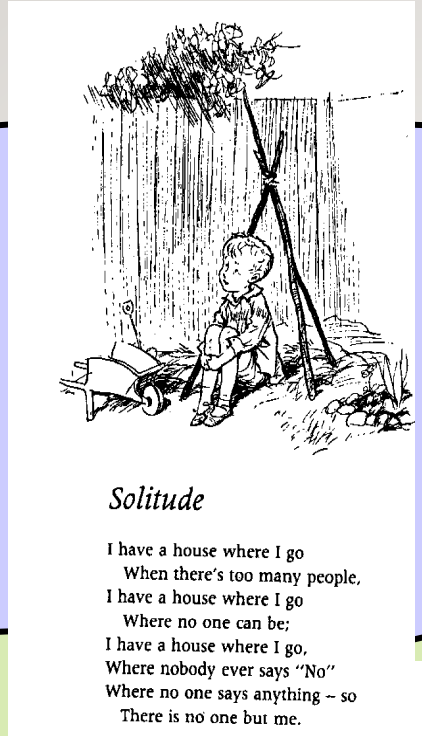


DIAGNOSTIC COMPLEXITY

- Diagnosis relies on history and observation.
- There is no blood test or Xray
- Tools to aid diagnosis e.g. ADOS, Qb Test
- Autism and ADHD overlap with each other (40% have both), and can look like each other
- Presence of ADHD delays autism diagnosis and vice versa
- Also overlap with other neurodevelopmental e.g. learning disability, language disorder; and mental health conditions-e.g. anxiety, depression, anorexia
- Girls difficult to diagnose, often first present with severe mental health condition (e.g. anorexia) in tier 4 inpatient CAMHS

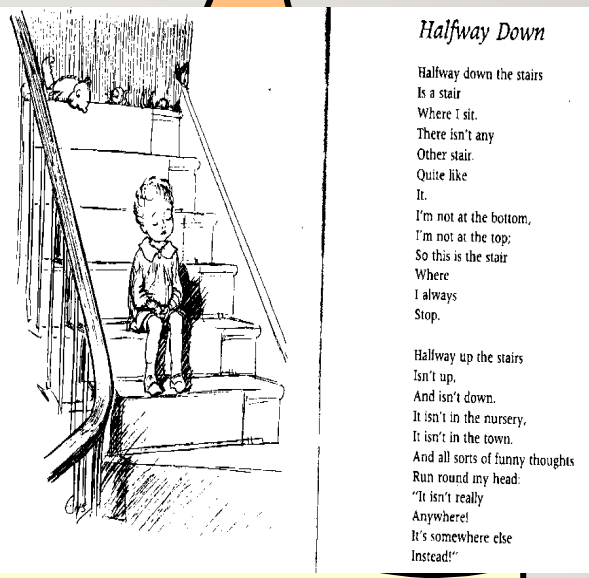
- *"If there is an MDT assessment by a team with **competencies in child neurodevelopment and mental health** (context), then Autism will be recognised as a **complex condition** that relies on **detailed history and observation across settings** (mechanism) leading to an accurate diagnosis, recognition of **associated comorbidity** such as ADHD and intellectual disability (outcome), and the ruling out of complex **differential diagnoses**.*
- *This will also create accurate pictures of **child strengths and needs** to inform individualized packages of support and intervention through health, education and social care (outcome)."* (program theory RE-ASCeD study, Abrahamson et al BMJ Open 2020)





Solitude

I have a house where I go
When there's too many people,
I have a house where I go
Where no one can be;
I have a house where I go,
Where nobody ever says "No"
Where no one says anything – so
There is no one but me.



Halfway Down

Halfway down the stairs
Is a stair
Where I sit.
There isn't any
Other stair.
Quite like
It.
I'm not at the bottom,
I'm not at the top;
So this is the stair
Where
I always
Stop.

Halfway up the stairs
Isn't up,
And isn't down.
It isn't in the nursery,
It isn't in the town.
And all sorts of funny thoughts
Run round my head:
"It isn't really
Anywhere!
It's somewhere else
Instead!"

NHSE LONG TERM PLAN 2019

- *3.33. Over the next three years, autism diagnosis will be included to test and implement the most effective ways to* ***reduce waiting times for specialist services****.*
- *This will be a step towards achieving timely diagnostic assessments in line with best practice guidelines…*
- *we will jointly develop packages to support children with autism or other neurodevelopmental disorders including attention deficit hyperactivity disorder (ADHD) and their families, throughout the diagnostic process.*

RE-ASCED STUDY

THE AUTISM DIAGNOSIS PATHWAY STUDY

A Realist Evaluation of Autism ServiCe Delivery (RE-ASCeD): Which diagnostic pathways work best, for whom, when, and at what cost?

- **Research Question**

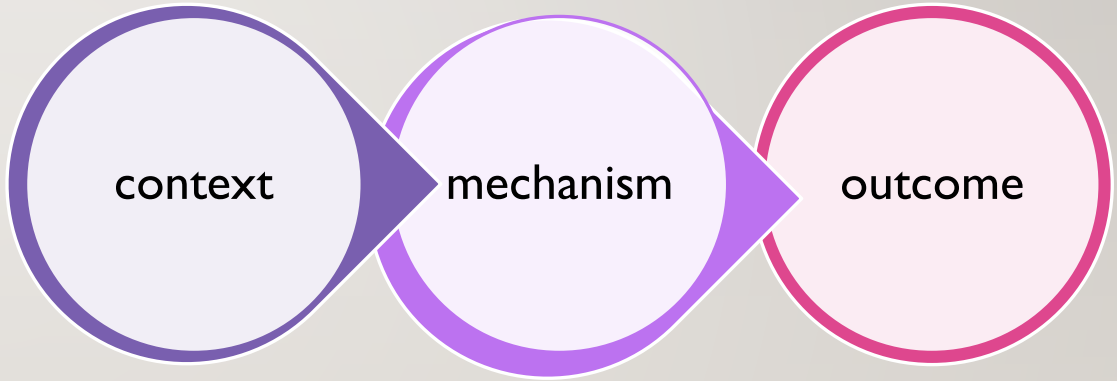
- Which autism diagnostic pathways work best, for whom, in what circumstances, and at what cost when providing timely and high quality diagnostic services?

- **Secondary Research Questions**

- What factors underpin timely diagnosis service delivery success or failure?
- What needs to be in place to identify the needs and create individualized, holistic pathways of diagnosis for the child and their family?

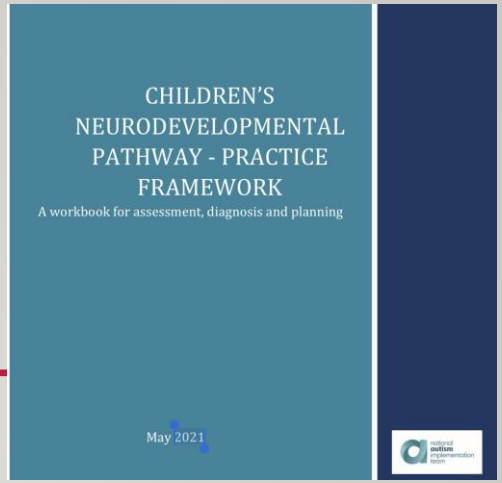
REALIST EVALUATION: CONTEXT MECHANISM OUTCOME CONFIGURATIONS

- Take outcomes and work backwards to identify underlying contexts and the resulting mechanisms at play that lead to the outcomes
- Used to assess complex services / interventions-eg ASD assessment
- Asks "what works for whom, under what circumstances, when, (and in our case) at what cost?"
- Mixed Methods




Urban vs Rural
Collocation or not
Single vs multiple provider trust -
Priorities eg LAC, Neurodisability, Anorexia, Suicide, KPIs
Variable knowledge in referrers-delays in referral
Service Contexts
MECHANISMS
• Difficult to develop one size fits all solution
• Mistrust between organisations
• Priority setting-eg KPI for LAC so prioritised over ASD waiting list where no KPI
• Potentially inefficiencies
How important are these contexts to success of models such as Peterborough integrated CAMHS/CDC team? Can we train referrers?

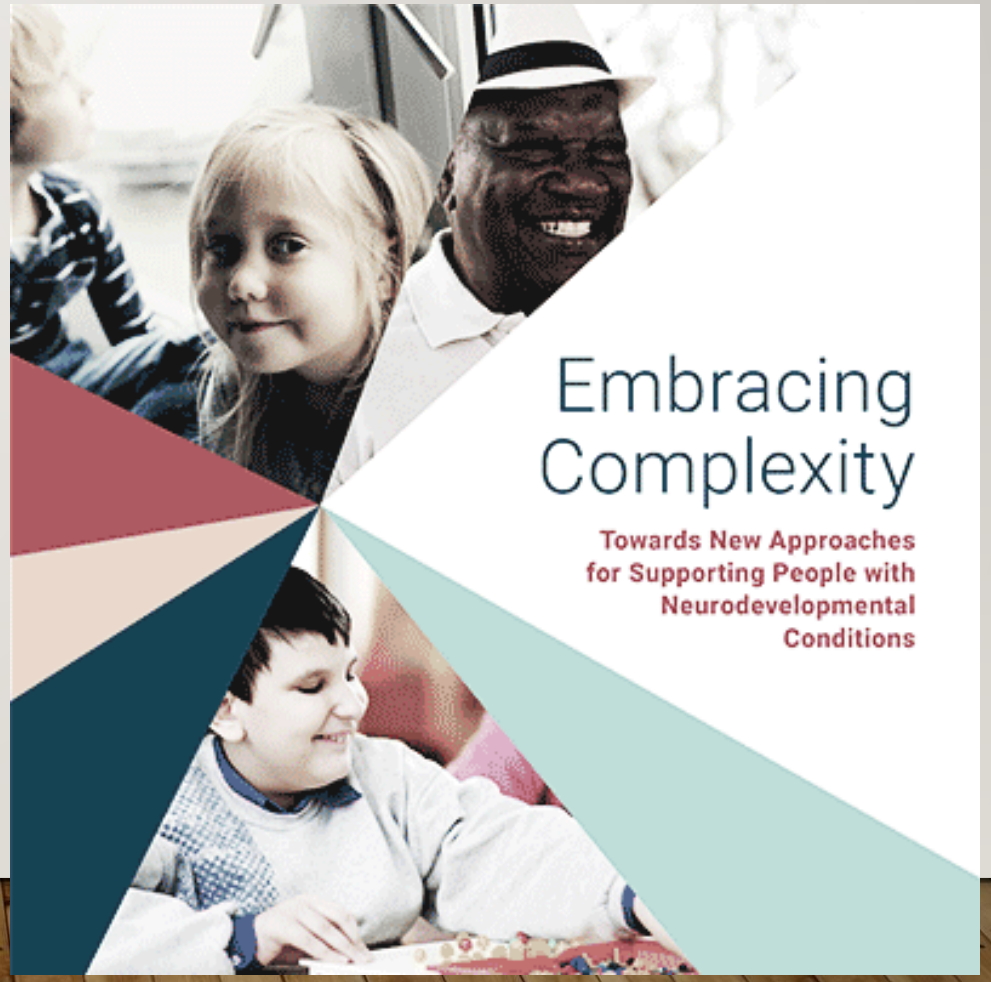
NEURODEVELOPMENTAL DISORDERS



- Neurocognitive functions are selective aspects of brain functions - the ability to learn and use language, the ability to regulate attention, emotions, impulses (including movements and spontaneous utterances), social behaviours, and process sensory stimuli.
- A Neurodevelopmental disorder is a term reserved for those who present with a 'functional' impairment in day to day life due to difference in one or more neurocognitive function which lie at the extreme of, or out with the normal range
- Neurodiversity is the statistical normal range of a function in a population at a particular age. Diversity is a trait of the whole group, not a specific individual
- Neurodivergent describes individuals where a selective neurocognitive function falls out with the prevalent range.

NEURODEVELOPMENTAL APPROACH

- Approach recommended by NICE/quality standard
- Needs based, holistic picture including autism, ADHD and other neurodevelopmental and mental health comorbidities
- Need access to competencies across neurodevelopment and mental health
- From INSAR should we be changing emphasis to supporting families / child with neurodevelopmental difficulties and reduce emphasis on specific diagnoses such as ASD and ADHD. This is being suggested in LMIC.



SEPARATE CAMHS AND CDS PATHWAYS

- From RE-ASCeD survey of current national practice (128 NHS responses) identified that where CAMHS or CDS work in isolated pathway:
- CAMHS only 11% had physical examination, unlikely to investigate e.g. for underlying genetic disorders. Sometimes no medical input so may be nurse and/or psychologist only.
- CDS often lack access to psychology and psychiatry, CAMHS to SALT, OT, paediatrics
- CAMHS often unable to assess/manage comorbid developmental disorders e.g. Developmental language disorder
- CDS often unable to assess/manage child's mental health, e.g. depression, anxiety
- Both struggle in areas like Early Developmental Trauma/Attachment, FASD
- Where does ADHD fit? Bear in mind research suggests 40% children with ASD also have ADHD

CAN INTEGRATED APPROACH REDUCE COSTS AND JOURNEY TIME TO DIAGNOSIS?

Open access Viewpoint

Integrated Healthcare Journal

Should clinical services for children with possible ADHD, autism or related conditions be delivered in an integrated neurodevelopmental pathway?

Ian Male ,[1,2] William Farr,[1,2] Venkat Reddy[3]

To cite: Male I, Farr W, Reddy V. Should clinical services for children with possible ADHD, autism or related conditions be delivered in an integrated neurodevelopmental pathway? *Integrated Healthcare Journal* 2020;**2**:e000037. doi:10.1136/ihj-2019-000037

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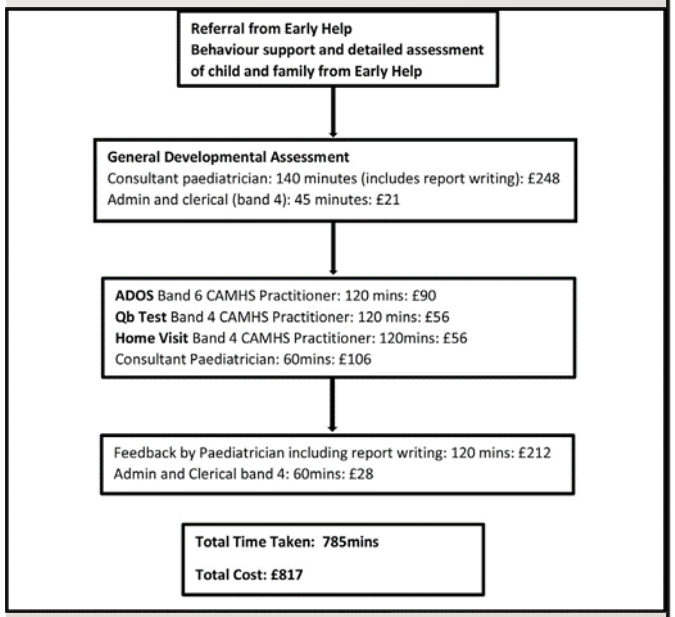
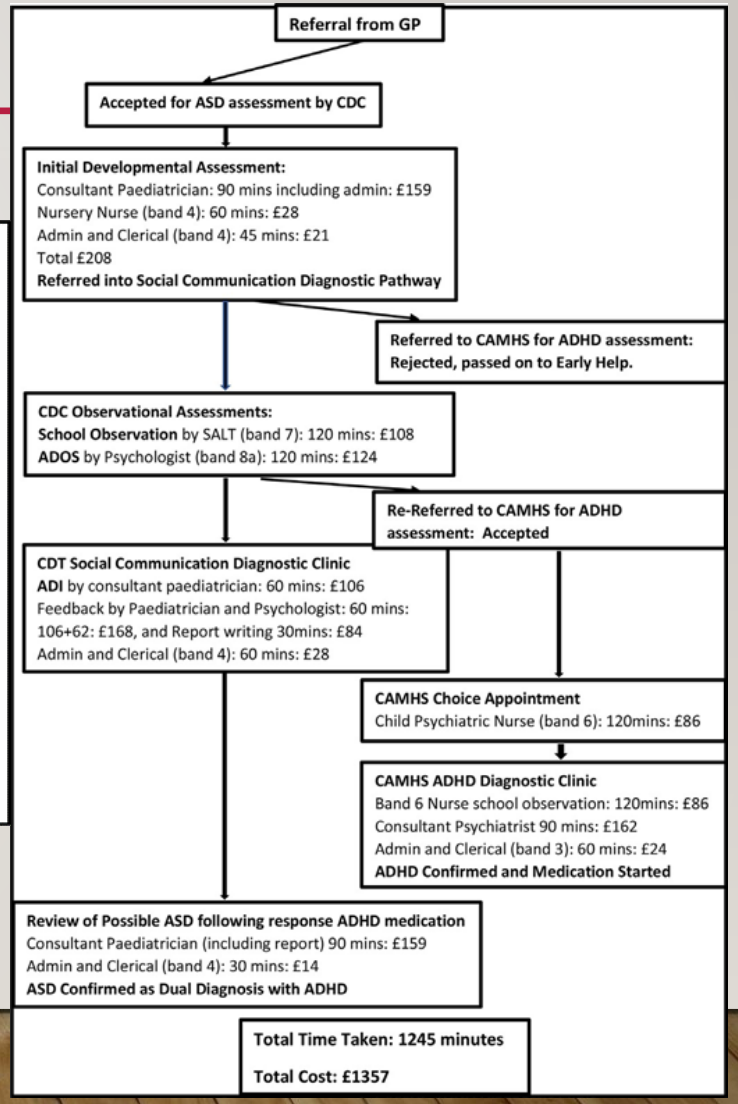
INTRODUCTION

Recent increases in the numbers of children diagnosed with autism spectrum disorder (autism)[1 2] have led to growing demand on clinical services, with evidence of long waiting times for diagnostic assessment.[3 4] In response, the National Health Service (NHS) Long Term Plan[3] expresses the desire 'to test and implement the most effective ways to reduce waiting times … achieving timely diagnostic assessments… [and] support children with autism or other neurodevelopmental disorders including ADHD'.[3] In line with the healthcare, each child will also spend much of their time within educational settings and may also receive support from social and related care services, such as 'Early Help'. Boundaries around services vary nationally, so for example some CDTs will only see children of preschool age with possible autism, while others see children up to age 19 years.[12 13] Similarly, in some centres ADHD is managed in CDTs, while in others this comes under CAMHS. In reality, National Institute for Health and Care Excellence (NICE) guidelines[10 11] advise a multidisciplinary





WILL IT WORK

- The idea of Neurodevelopmental pathway rather than condition specific makes sense for reasons above
- Better for family experience
- Potentially more efficient use of resources
- Needs access to skills from CAMHS and CDCs

- From survey 10 out of 128 centres have integrated CAMHS/CDC.
- Even then may have separate teams for ASD, ADHD, LD etc.
- Lots teams already overwhelmed-no capacity for additional work
- Beware UNFORESEEN CONSEQUENCES-danger teams crash and no longer to deliver on other work e.g. neurodisability, suicide

Context

- Separate trusts
- Separate buildings
- Overstretched Workforce
- Challenge to recruit
- Big increase in referrals
- Teams hierarchical

Mechanism

- Mistrust between organisations
- Lack opportunity to work together
- Overwhelmed workforce
- Resistance to new approaches
- Imbalance demand and capacity

Outcome

- Failed integration
- Persistence condition specific approach
- Persistence long waiting lists
- Bouncing of referrals
- Good staff move elsewhere

Context

- Teams used to working together
- Collocated
- Workforce in place
- Good reputation so able to recruit
- Big increase in referrals
- Teams non-hierarchical
- Innovative leadership and workforce
- Well resourced

Mechanism

- Trust between organisations
- Already work together
- Happy workforce
- Open to new approaches
- Able to address imbalance demand and capacity
- Able to expand workforce to deliver neurodevelopmental approach
- Access to practitioners competent both in child development and child mental health

Outcome

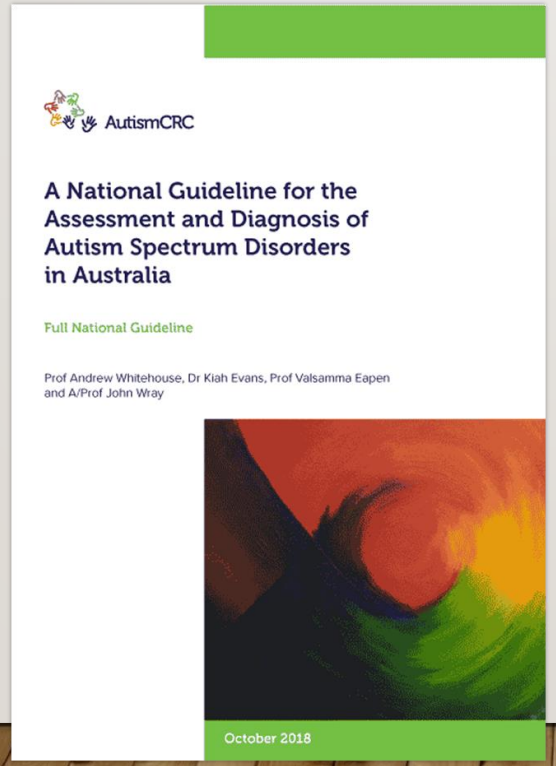
- Successful integration
- Move to Neurodevelopmental approach
- Addressing long waiting lists
- No more bouncing of referrals as shared caseload
- Attractive to good staff and trainees

WHAT ELSE HELPS?

- Bottom line is: even with most innovative and efficient practice the imbalance of demand and capacity has reached point where for teams to address waiting lists needs long term investment
- To quote one professional interview in RE-ASCeD "waiting list initiatives only succeed in moving the problem to another part of the system" and don't address need for long term change/investment
- Whilst cost of diagnosis may seem a lot, the implications of not diagnosing and supporting child early on are much higher-e.g. one year basic special needs support is £6000 for one child. Early recognition and intervention may reduce long term costs

APPROACHES TO CONSIDER

- Rethinking autism spectrum disorder assessment for children during COVID-19 and beyond Lonnie Zwaigenbaum et al Autism Research 2021



- Tailored/tiered assessment
- Digitech
- Skill Mix-but needs to be competency based rather than discipline or banding
- Needs based rather than diagnose and discharge
- Early support and intervention from before referred for assessment: why wait to years to get a diagnosis when support is needed now
- "Profound" autism (Lancet commission)

CONCLUSIONS

- Autism is common condition that frequently overlaps with ADHD and other neurodevelopmental and mental health conditions
- It therefore makes sense to have team with ability to assess a child referred for either autism or ADHD across this range of conditions
- Currently this is unusual with separate CAMHS and CDCs and conditions commissioned in different pathways and organisations
- To successfully integrate CAMHS and CDCs to deliver neurodevelopmental pathways will not be straightforward, will need investment, and carries a risk of crashing existing services, but does seem to be the right way to go
- We have focussed on integration within health, but best models also need to integrate EDUCATION and Social Care to deliver best outcomes for children and families. The issues for childcare and needs of children are very different to care of elderly which seems to have driven Health and Social Care Bill, but children are equally important and if we don't get it right will become the disaffected and mental health burden of the NHS for years to come

UPDATE

Yesterday, the government's amendments were debated in the House of Lords:

- ICBs will be required by primary legislation to set out the steps it will to take to address the needs of children and young people under the age of 25 in the forward plan;
- NHS England will issue statutory guidance that states that each ICB must nominate an executive children's lead, ensuring leadership for babies, children and young people on every Integrated Care Board;
- Bespoke guidance will contain provisions for ICP strategy to consider child health outcomes and integration of children's services, as well as providing that the ICP should consult local children's leadership and CYP/families themselves;

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An Integrated Care System, a review of Tameside & Glossop Integrated Care Foundation Trust

Rachel Brown

Head of Integrated Urgent Care/ Patient Flow

Healthcare Reform (1)

- The current reform in Health care policy is Integrated Care and Healthcare Devolution (6)
- Greater Manchester established the Greater Manchester Health and Social care partnership in 2015 to take charge of decisions related to health and social care in the city (2)
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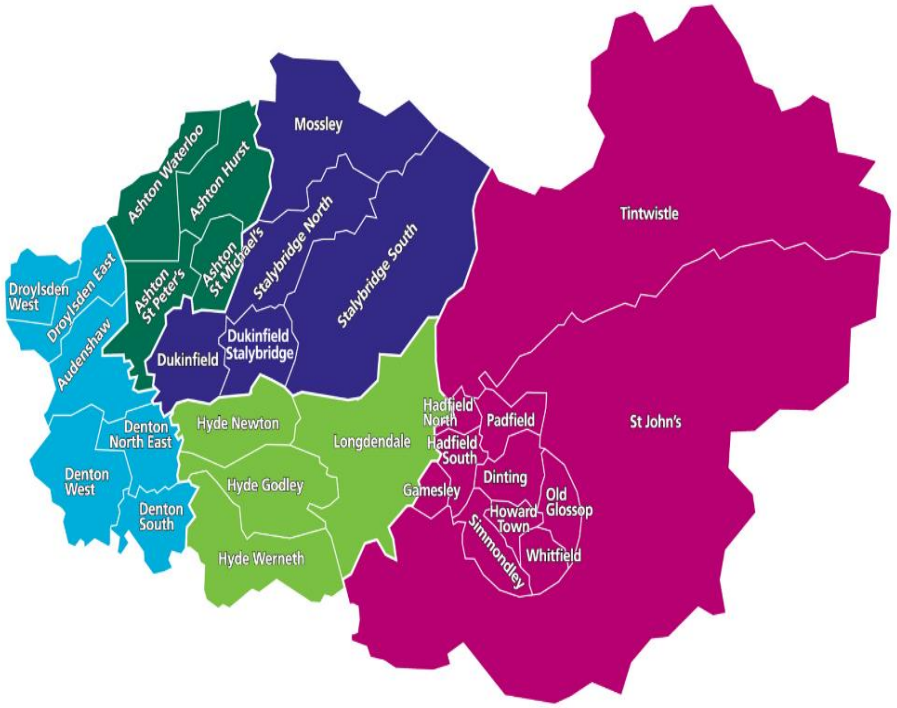
- T&GICO became an Integrated Care Foundation Trust combining with the local Authority and a Single commissioning board was created in 2015 (11)
- Transformation of the Operations functions of the ICO was required to achieve its strategic ambition

Our Services and Activity Summary (10)



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52,000 in-patients

3,000 elective

18,000 day cases

31,000 non-elective

527 total beds

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14 Community Sites

88,000 + A&E Attendances

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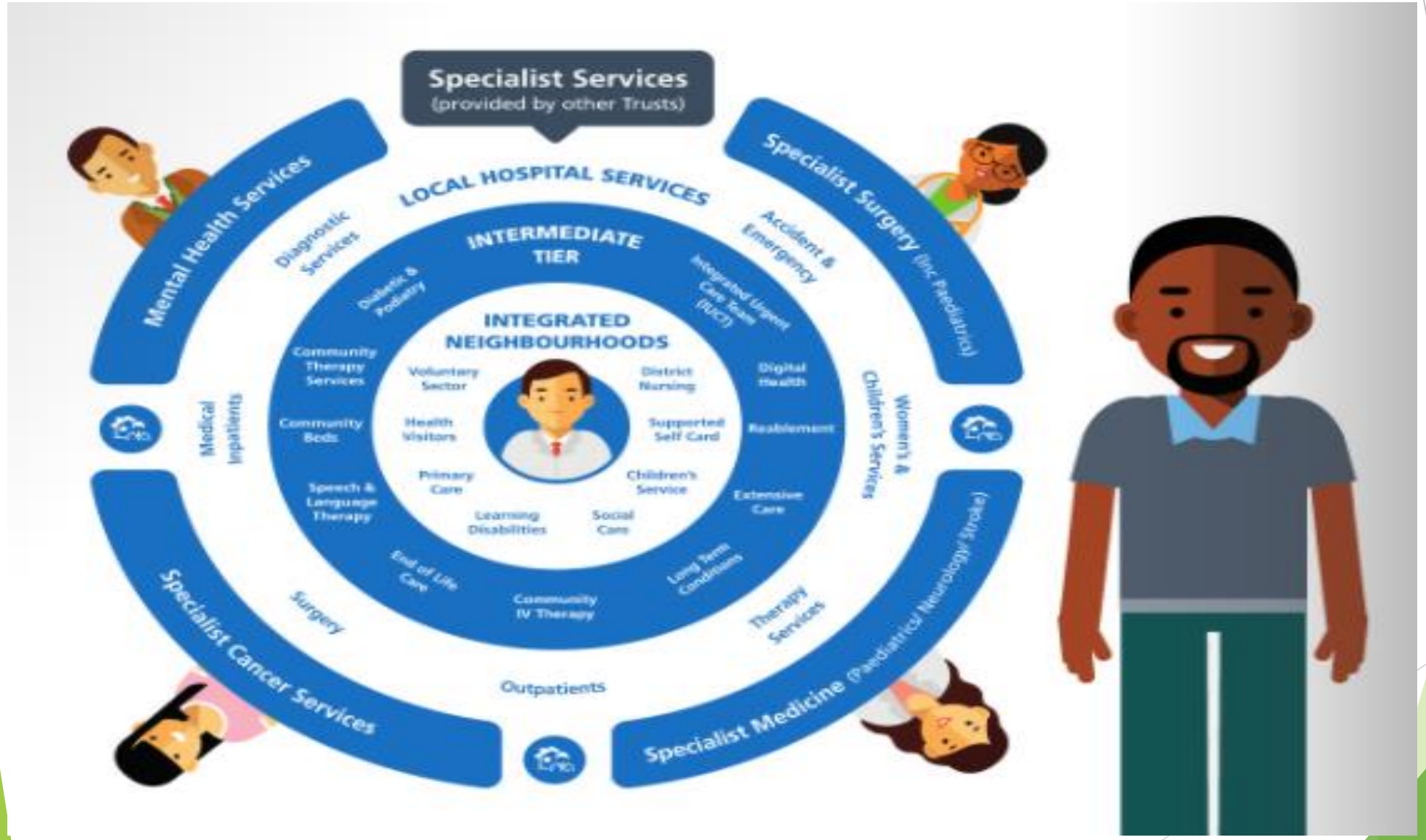


OUR INTEGRATED URGENT CARE TEAM

The team comprises of Nurses, Physiotherapists, Social workers/Assessors, Assistant Practitioners, Occupational Therapists and Support workers (Care Quality Co-ordinators), Customer care officers and Community care officers.

The team works proactively together to make a single joint health and social care assessment, responding rapidly (where necessary within the hour) to prevent deterioration and avert crisis.

'Integration has made us realise the power we have in the team'
Adult Social Care Assistant Manager

We don't just do this job and go – we all work together to make the things better and improve care'
Team leader

WHAT WE DO

SYSTEM-WIDE INTEGRATED WORKING / REFERRAL PATHWAYS

- IUCT is a co-located team
- Uses the Trusted assessor model
- Data sharing with TMBC
- Easier & quicker access for people
- Patient centred care
- Works with Successful transformation teams
- Digital Health
- IV therapy
- Home First
- Extensive care

Integration has had a transformative effect on the team – Increasing the teams confidence in working together and developing a service that really works for the people of the local area

WHAT WE ACHIEVE TOGETHER

PATIENT SAFETY

- 1 hour crisis response – National Target 2 hours
- Reablement within 24 hours - National Target 2 days
- Admission avoidance
- Reduced hospital length of stay
- Reduced delayed transfers of care (DTOCs)
- Holistic assessment, with wrap around care
- System-wide integrated working with a multi-disciplinary approach
- Supporting and empowering people to stay safe within their own home
- Improved patient experience

INTERGRATED CARE

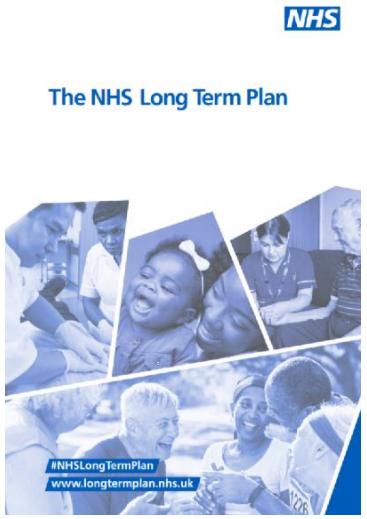
PATIENT SAFETY- DELIVERING VALUE FOR MONEY

- 'Out-of-hospital' care
- Early supported discharge
- Reducing demand on urgent care services
- Reducing hospital length of stay
- Delivering financial benefits to the local economy
- Investment and development in staff to support staff retention

We used existing resources to design the service model, didn't need to invest large amounts of money.

"Build not buy".

THE AMBITION ACHIEVED



Urgent Community Response

- A programme that aims to **increase the capacity** and **responsiveness** of community services
- The programme will involve the early identification of people in need of urgent care input and provision of timely, well-coordinated recovery and rehabilitation services within **new 2 hour/2 day delivery standards**
- This includes responding to and meeting the needs of people at the **end of their life**
- The programme will also entail **joint working between health, social care, local government and VCSE providers and commissioners** and aim to prevent unneccesary hospital admissions and support early community discharge

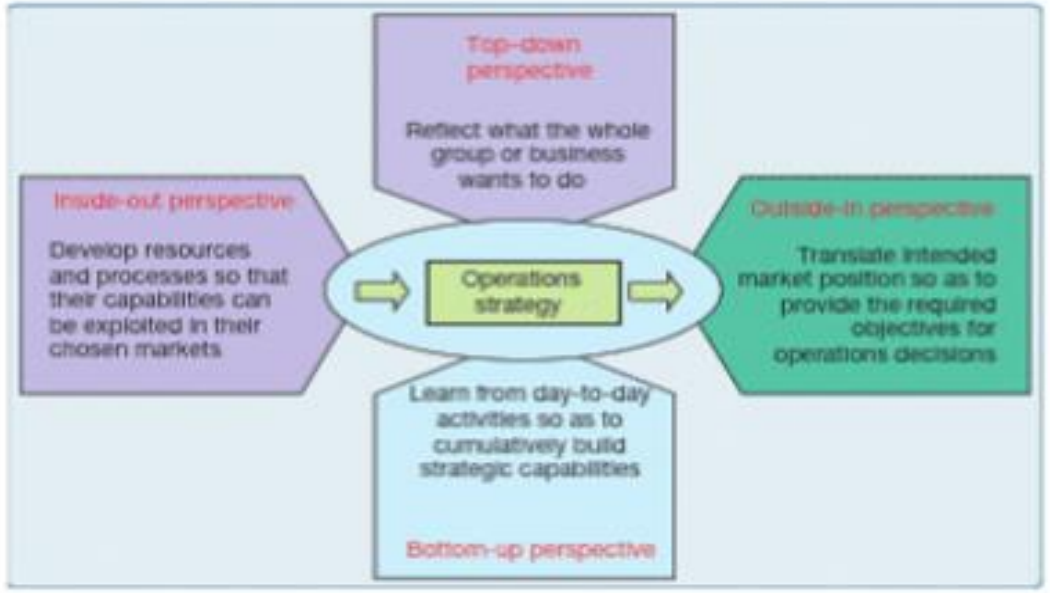
The NHS Long Term Plan

#NHSLongTermPlan / www.longtermplan.nhs.uk

Integrated Urgent Care Team

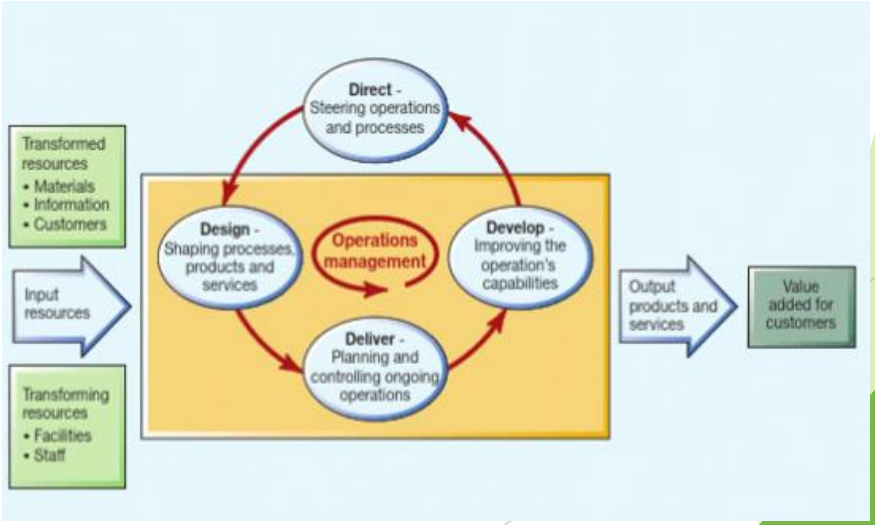
OPERATIONS STRATEGY – Coordination between marketing and operations is imperative to an organisations success (5)

The Organisation had to consider the influences of the ICO strategy and how these would allow for transformation of existing structures, into an ICO (9)



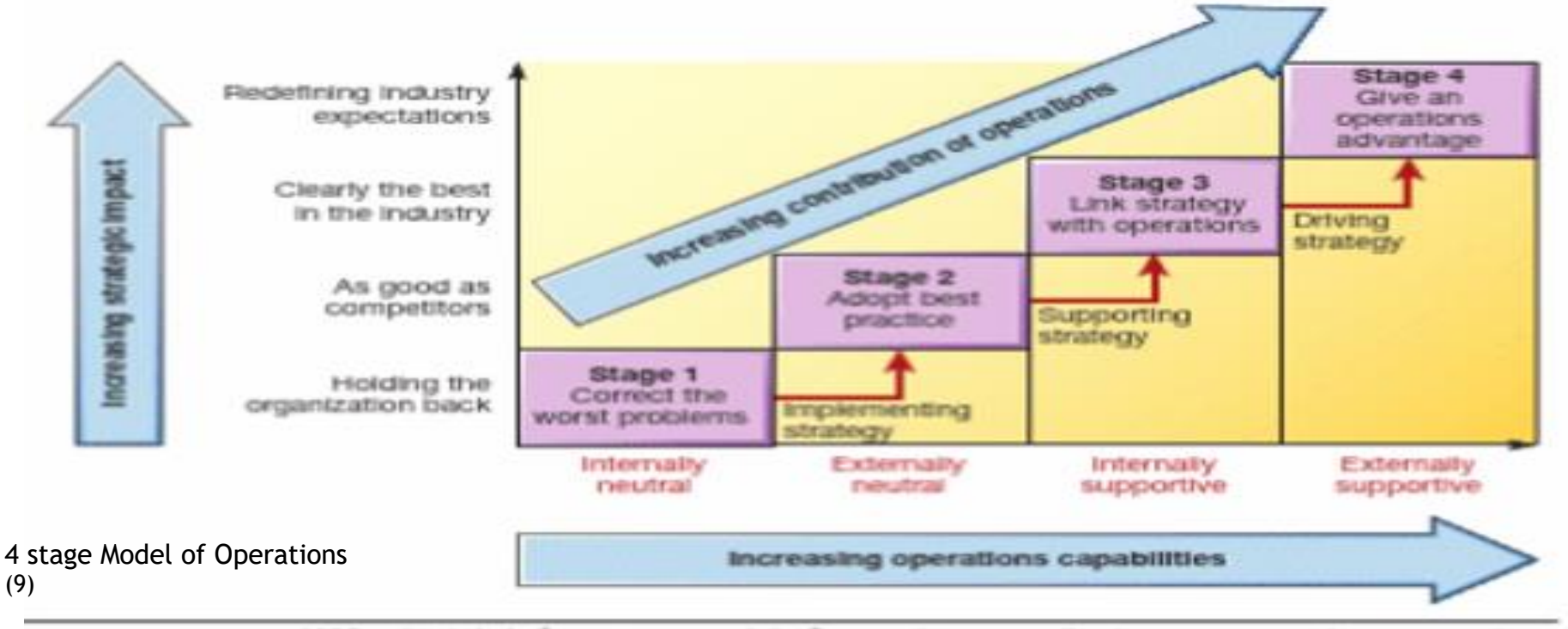
Effective Operations Strategy Model - taken from Slack & Brandon-Jones (2019)

Transformational Model –taken from Slack & Brandon-Jones (2019)



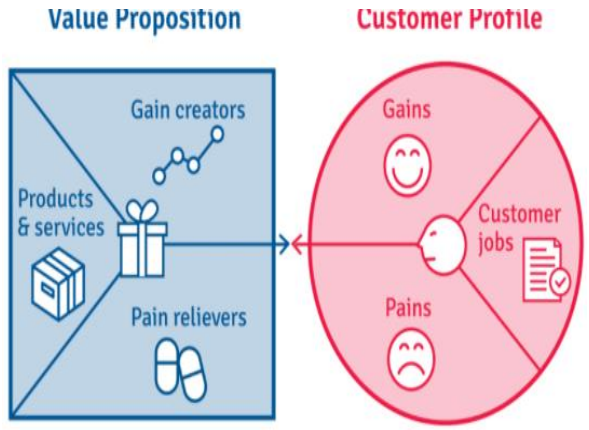
Alignment of Marketing & Operations Functions for Competitive Advantage

By using a RBV and Lean Methodology (4) whilst aligning Marketing & Operations functions has allowed for integration and innovation in ways that have been critical to the Organisation, especially during the Covid Pandemic, driving the Organisation's ambition of being an ICO further through innovation and Creating Competitive Advantage.

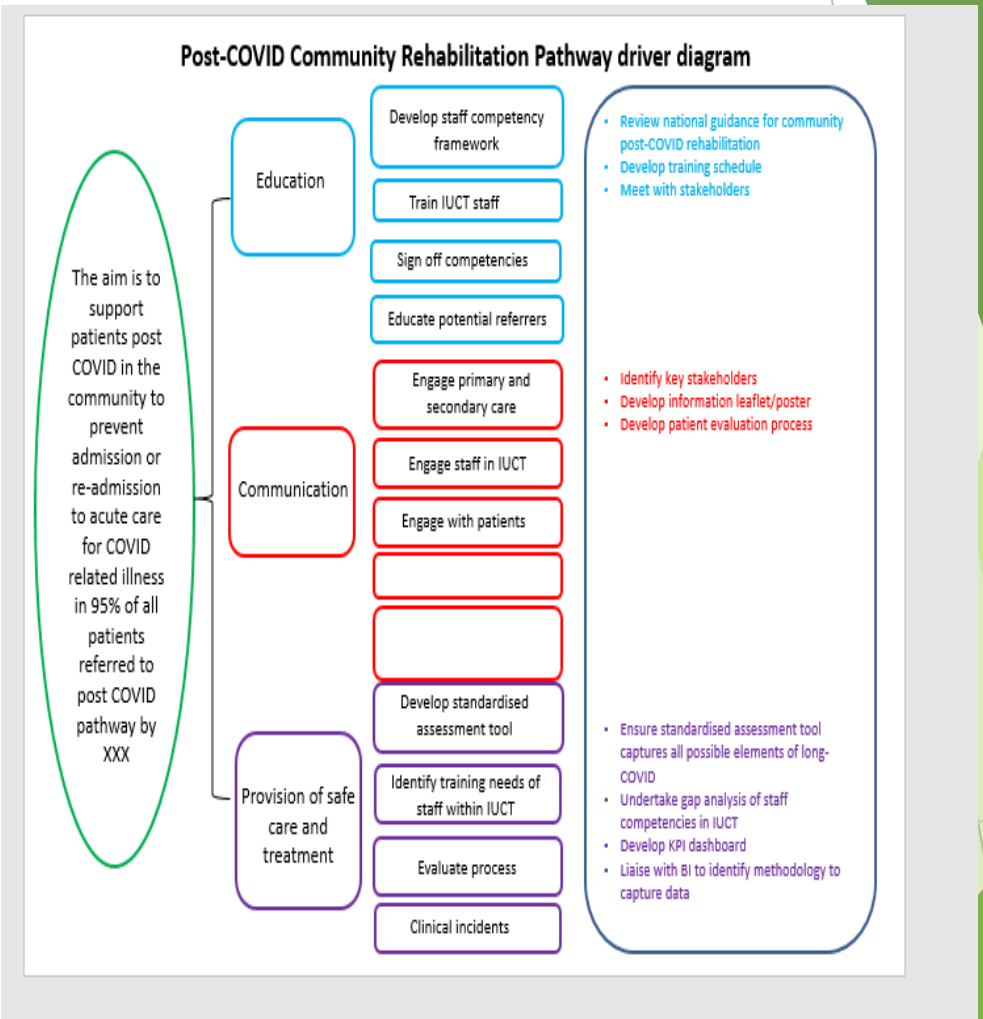


4 stage Model of Operations (9)

Projects, Integration & Competitive Advantage



The value proposition tool (8) was used to build projects/services around key principles of customer pains, gains. Therefore using this marketing concept whilst aligning with the Organisation capabilities using lean and RBV, fostered innovative integrated pathways.



NWAS & IUCT HANDOVER AT SCENE PILOT

NWAS Attends

Comprehensive Handover to Digital Health

Referral to IUCT for urgent response (2hrs) Usually 1 hour

IUCT Treat minor injuries at home

Same day Reablement care if required, surpassing 2 day threshold

A Partnership between Tameside & Glossop ICFT, TMBC and North West Ambulance Service, to provide a handover on scene pathway to allow the patients to be seen and treated within their own homes to avoid unnecessary ambulance transfer and ED attendance.

WIDENING OUR SCOPE & SPREAD

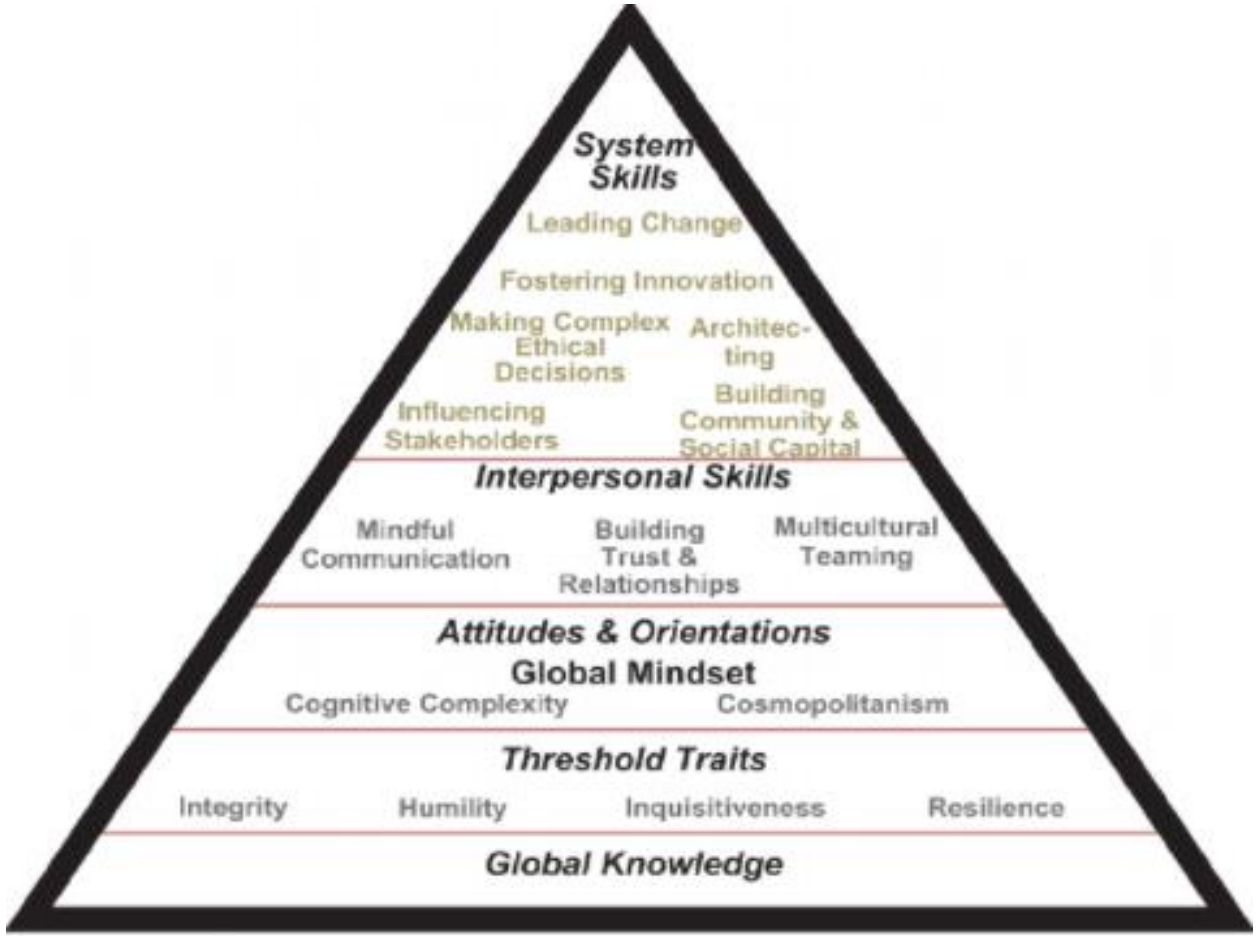
We are continually reviewing our scope to respond to changing need

SUMMARY

- Integration of Operations and Marketing functions enabled the Organisation to become an ICO and encouraged innovative pathways such as the Home first, Digital Health, Covid Rehab Pathway, and NWAS hand over on scene which decreased Length of Stay, increased Admission Avoidance and improved patient care pathways

- To maintain a competitive advantage the Organisation must continue to pull on the models of RBV and Lean methodology to foster sustainable ways of working such as expanding its Digital provision alongside it's current resources & capabilities and avoid internal silo working and disjointed inefficient services.

Consideration to Leadership for ICS



Sources: Adapted from Bird & Osland (2004); Osland (2008)

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(10)Tang, Christopher S. "A Review of Marketing–operations Interface Models: From Co-existence to Coordination and Collaboration." International Journal of Production Economics 125.1 (2010): 22-40. Web.

(11)Tameside & Glossop ICO. 2020. Our Strategy 2017-2022: Beyond Patient Care to Population Health. Retrieved from https://www.tamesidehospital.nhs.uk/about-us/ [Accessed on 10/03/2020]

THANK YOU FOR LISTENING

ANY QUESTIONS?

People.Health.Care.

Workforce and clinical transformation through partnership working

Courtney Attewell – Commercial Manager, L&R

The National Picture

1 million patients

Which equates to 2% of the UK adult population affected with a Leg Ulcer [1]

£3.1b

Annual estimated healthcare cost associated with Leg Ulcers [1]

Wound care accounts for around

50%

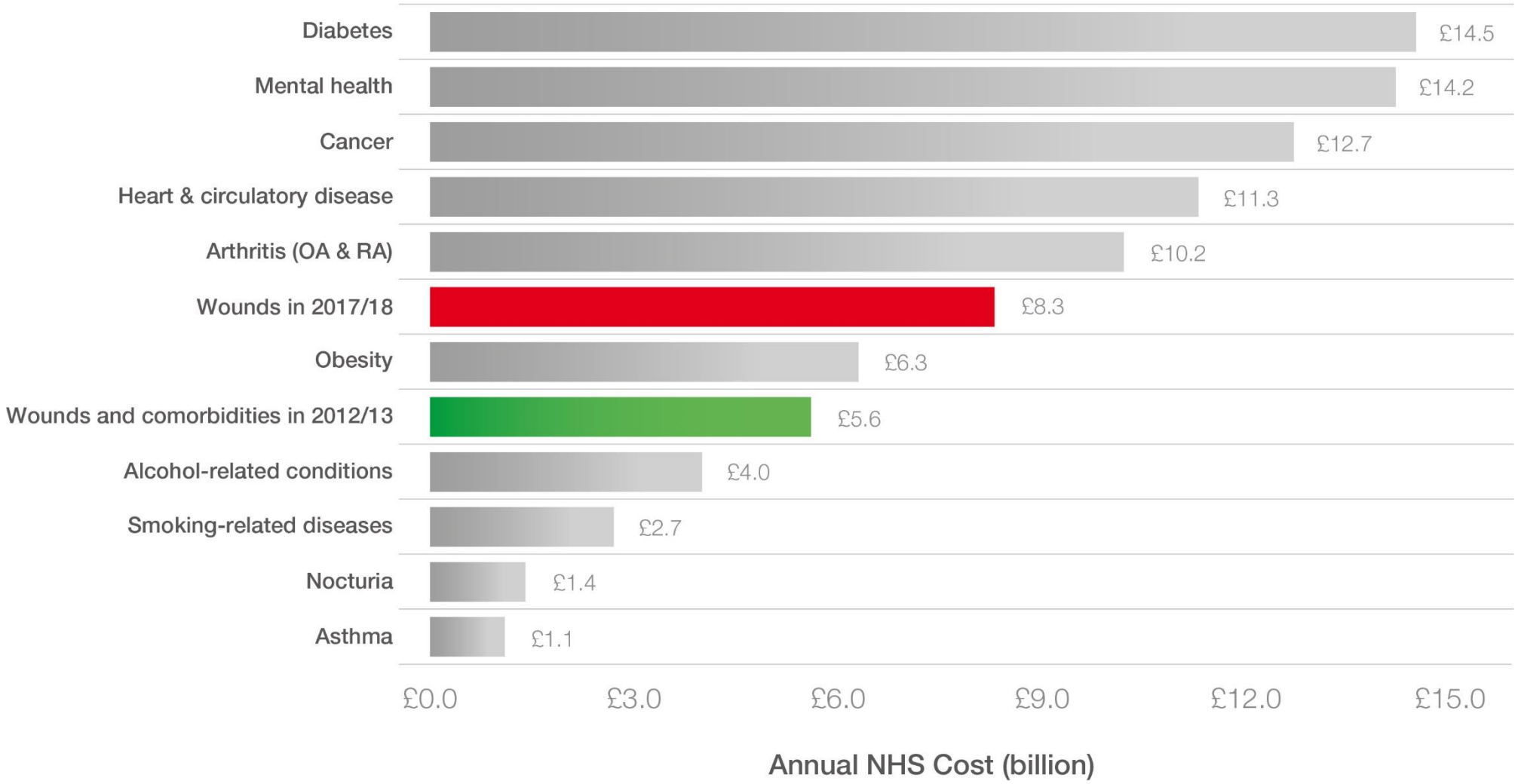
of the community nursing workload

www.Lohmann-Rauscher.co.uk

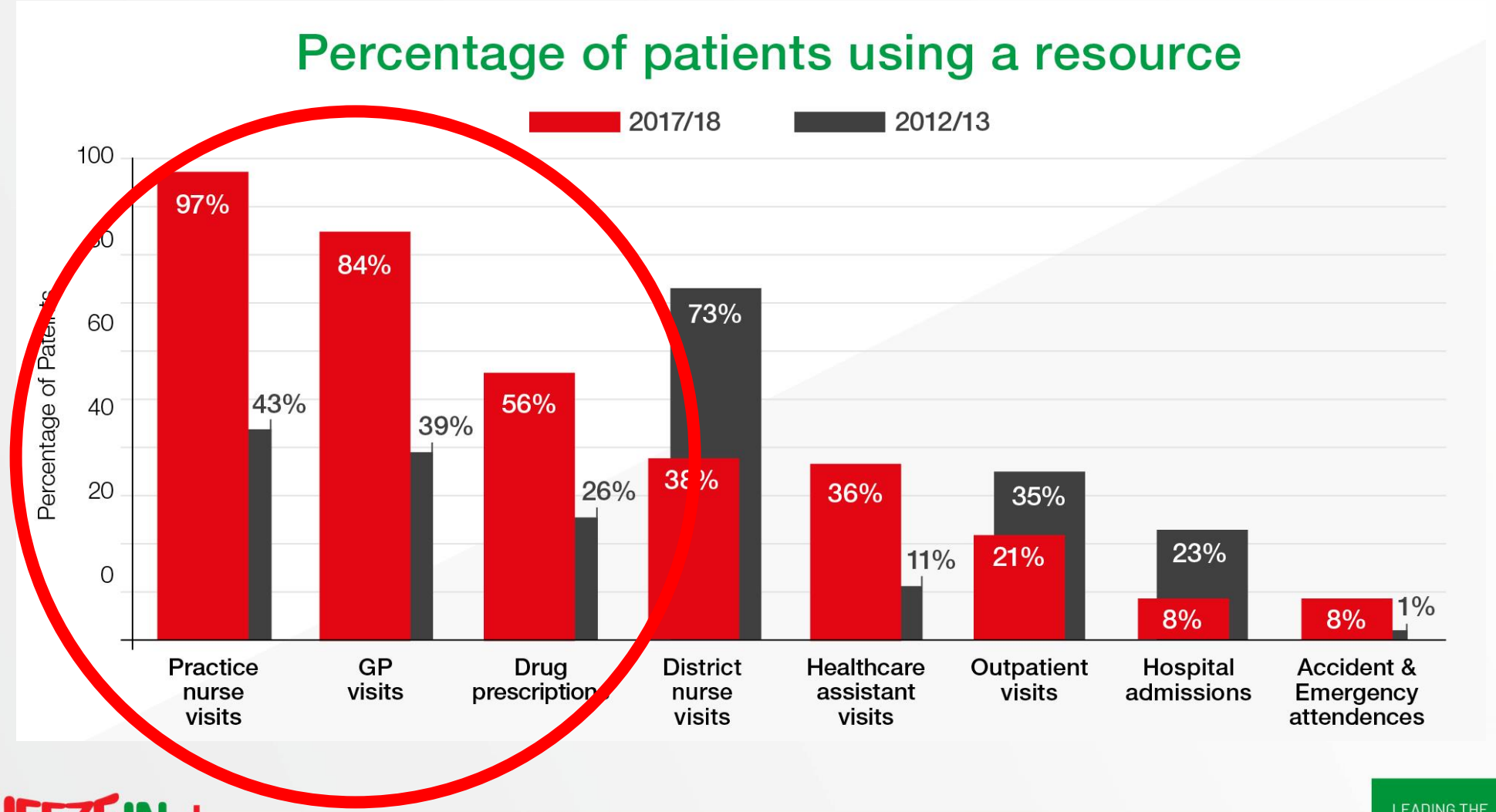
1. Guest et al. 2020
2. NWCSP, 2020

Figure 1

Burden of illness league table (2015) updated to 2017/18 prices (ref3)



Percentage of patients using a resource



The real impact

“I am upset about the life I could have had, the career I should have had and for the person that I should have been.
I always thought I would be somebody and achieve something in life but I feel like I have had that opportunity stolen away. I hate feeling self-conscious, disabled and unattractive and I hate that this leg ulcer has taken away my self-confidence”

Leg ulcer patient

RightCare

Betty's Story

Financial information

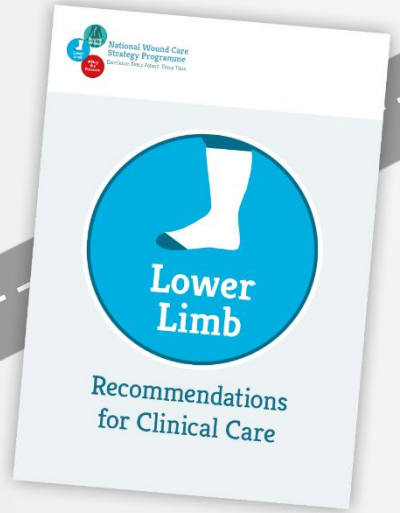
NHS RightCare

Analysis by provider	Sub-optimal	Optimal
Acute	£1,703	£0
Ambulance service	£466	£0
Community teams	£2,167	£12
Primary care	£1,334	£346
Pharmacist	£3	£3
Leg ulcer pathway	£0	£144
Grand total	**£5,673**	**£505**

In the suboptimal scenario:
- Dressings represent £1,353 (24%) of the total costs versus £88 in the optimal pathway.
- Clinical time represents £2,139 (38%) of the total costs versus £195 in the optimal pathway.

The need to optimise the patient pathway is evident:

1. National Wound Care Strategy Programme (NWCSP) Lower Limb recommendations for clinical care



2. NHS White Paper: Integration and Innovation

3. NHS Long Term Plan

The roadmap for the redesign of patient care in the NHS.

A solution for the whole patient journey

By partnering with the NHS to implement a solution for the whole patient journey, we aim to deliver transformative outcomes for leg ulcer service provision, to achieve:

- A reduction in unwarranted variation, improving clinical outcomes and healing rates
- Significantly reducing the demand on workforce capacity and associated cost of care
- Significantly reduce patient touch points and limiting face-to-face contact
- Improving patient benefits, empowering them to manage their own condition and motivating them to self care

Case Study: Barnsley CCG

£11 million

Annual estimated cost

3,916

Leg Ulcers in 12 months

up to 2,506

Leg Ulcers could reoccur annually

Based on:

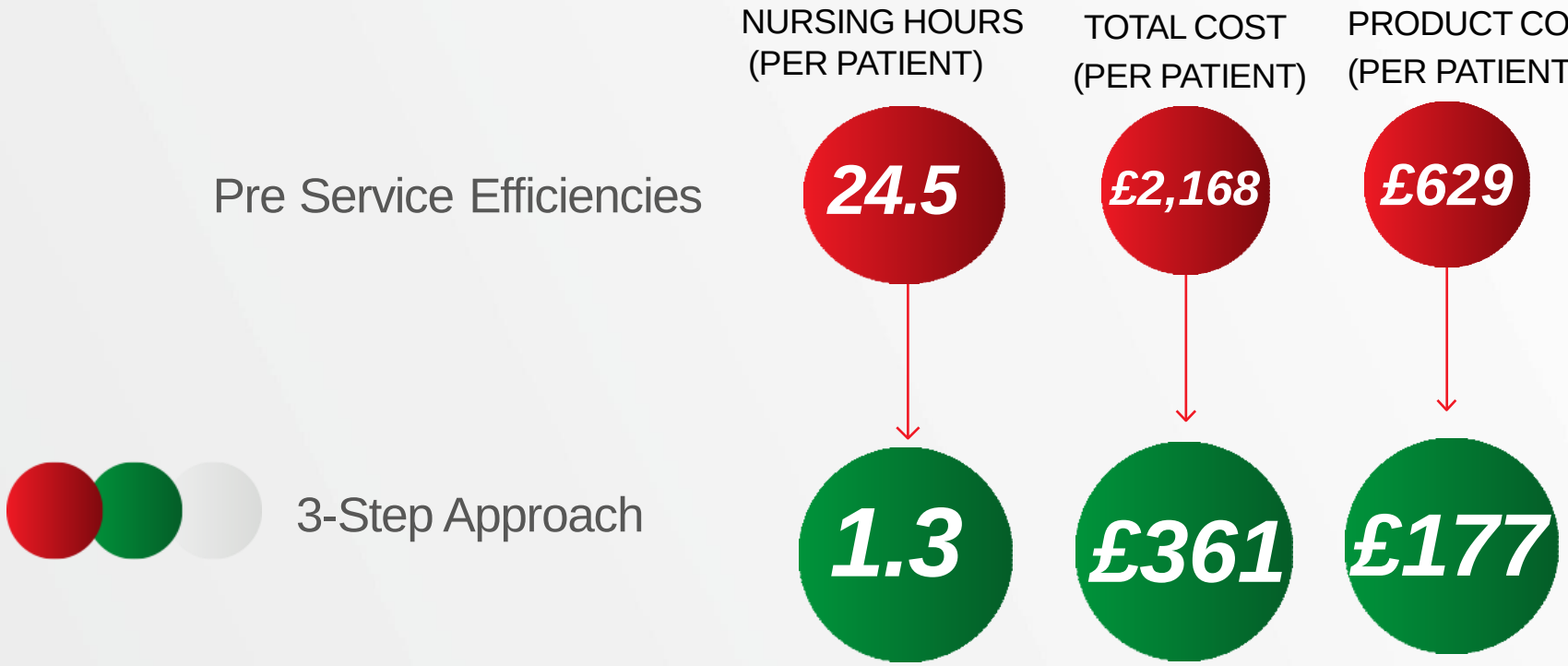
1. Guest et al. 2020
2. Harding et al. 2015

www.Lohmann-Rauscher.co.uk

We implemented a **3 step approach…**

THE BIG SQUEEZE

1.Hallas-Hoyes et al. (2021).



Achieved along with 72% healing at 18 weeks and 99% healing at 42 weeks

Hallas-Hoyes et al. (2021).

National Scalability

Per 100,000 population:

(total cost release or cost avoidance)

£903,500

If 25% of patients with leg ulcers were supported by the self care delivery model

Per 100,000 population:

(product cost release or cost avoidance)

£226,000

If 25% of patients with leg ulcers were supported by the self care delivery model nationally

Hallas-Hoyes et al. (2021).

System wide improvements:

Staff Health and Wellbeing Improvements:

100% *of staff reported an* ***increased level of motivation*** *to support patients to self-care*

80% *of staff said they could* ***spend more time*** *with patients who cannot self-care and on other care duties*

67% *of staff believe that using a self care model has* ***reduced their workplace stress levels***

Sustainability:

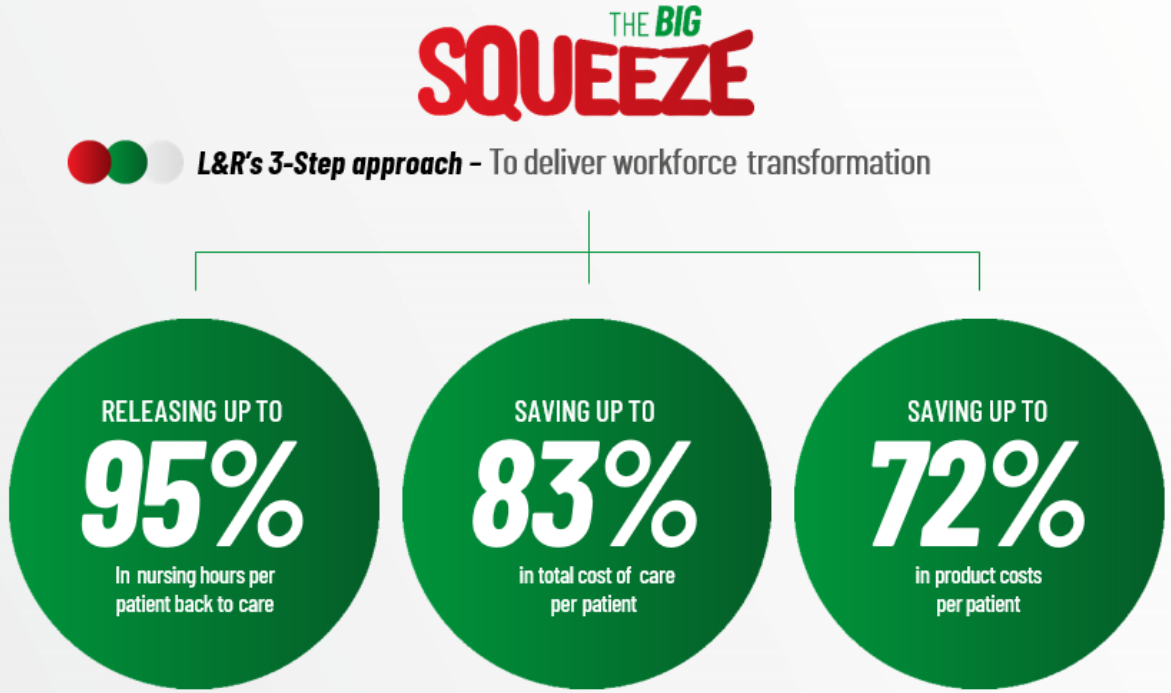
60% *reduction in miles driven (where patients are treated on the Self Care Model)*

£535 *saving in fuel costs per 100 patients*

1,471kg *saving in CO2 per 100 patients*

Summary

- The burden of wounds is growing, placing a significant impact on the patient population and the NHS
- This is compounded by the community workforce challenge that is more prevalent than ever before
- Working together we can achieve workforce transformation by implementing a self care programme, reducing the demand on workforce capacity, improve service efficiencies and deliver wider benefits for both patients and the clinical team.



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Claire Darbyshire – Head of Social Care & Health Technology at Agilisys

Rachel Brown, Head of the Integrated Urgent Care Team at Tameside Hospital NHS Foundation Trust

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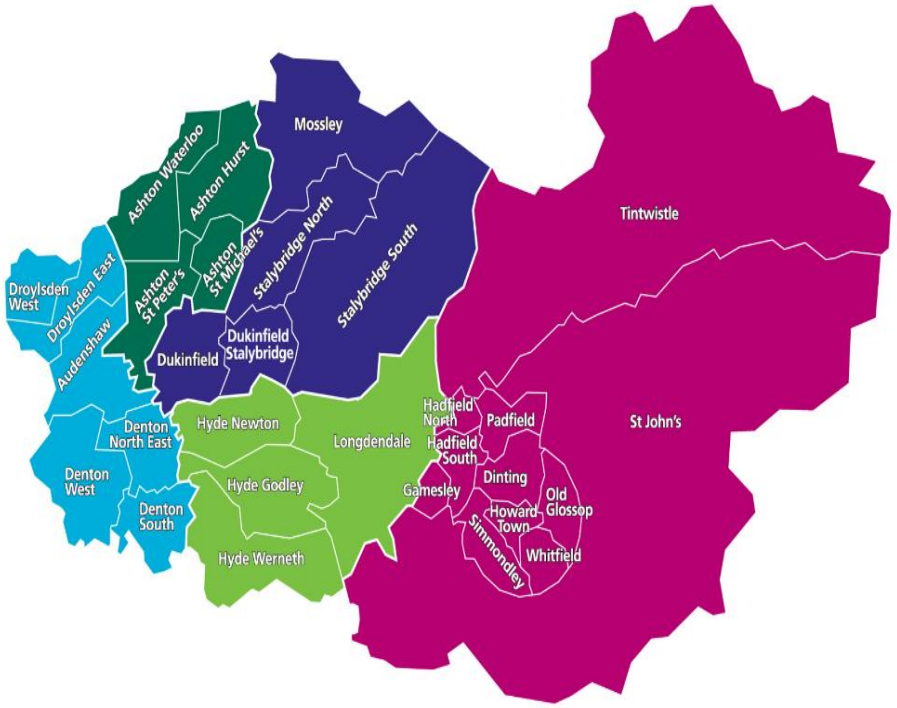

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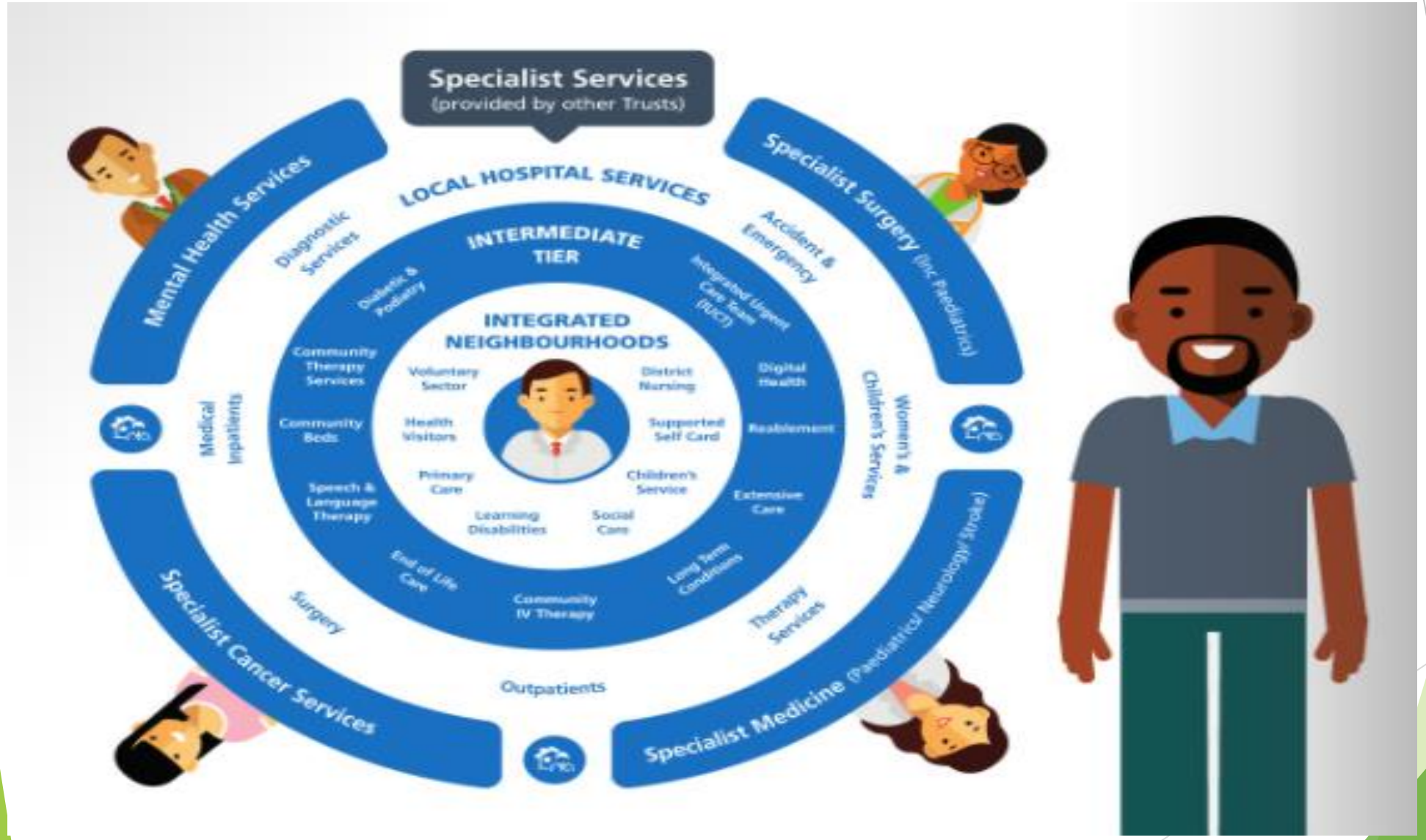

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WHAT WE ACHIEVE TOGETHER

PATIENT SAFETY

- 1 hour crisis response – National Target 2 hours
- Reablement within 24 hours - National Target 2 days
- Admission avoidance
- Reduced hospital length of stay
- Reduced delayed transfers of care (DTOCs)
- Holistic assessment, with wrap around care
- System-wide integrated working with a multi-disciplinary approach
- Supporting and empowering people to stay safe within their own home
- Improved patient experience

INTERGRATED CARE

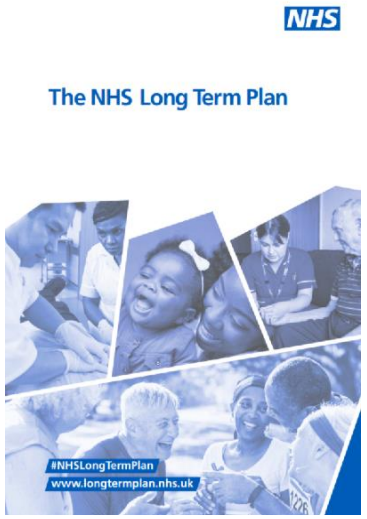
PATIENT SAFETY- DELIVERING VALUE FOR MONEY

- 'Out-of-hospital' care
- Early supported discharge
- Reducing demand on urgent care services
- Reducing hospital length of stay
- Delivering financial benefits to the local economy
- Investment and development in staff to support staff retention

We used existing resources to design the service model, didn't need to invest large amounts of money.

"Build not buy".

THE AMBITION ACHIEVED



Urgent Community Response

- A programme that aims to **increase the capacity** and **responsiveness** of community services
- The programme will involve the early identification of people in need of urgent care input and provision of timely, well-coordinated recovery and rehabilitation services within **new 2 hour/2 day delivery standards**
- This includes responding to and meeting the needs of people at the **end of their life**
- The programme will also entail **joint working between health, social care, local government and VCSE providers and commissioners** and aim to prevent unneccesary hospital admissions and support early community discharge

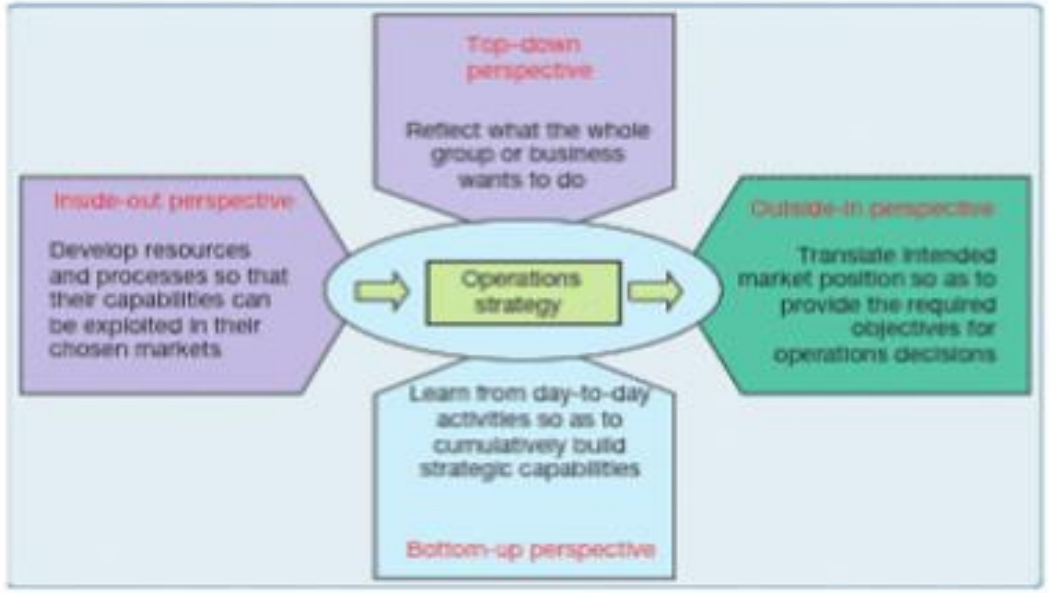
The NHS Long Term Plan

#NHSLongTermPlan / www.longtermplan.nhs.uk

Integrated Urgent Care Team

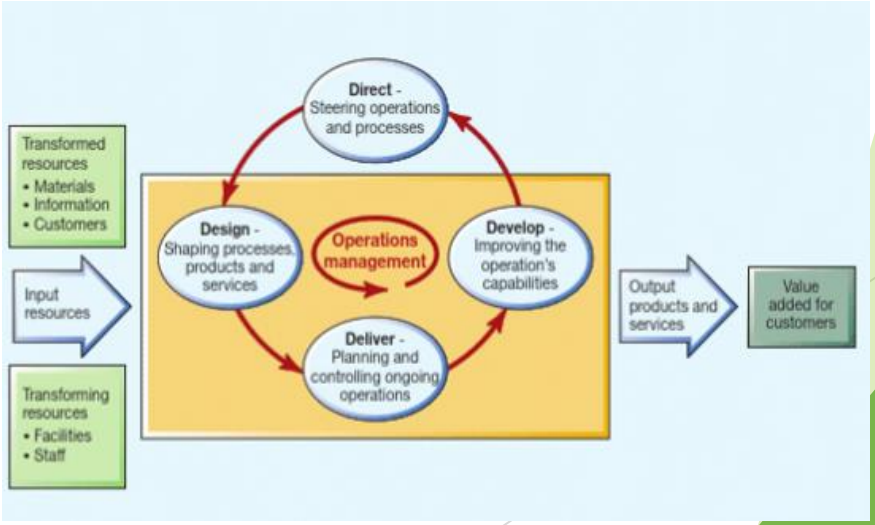
OPERATIONS STRATEGY – Coordination between marketing and operations is imperative to an organisations success (5)

The Organisation had to consider the influences of the ICO strategy and how these would allow for transformation of existing structures, into an ICO (9)



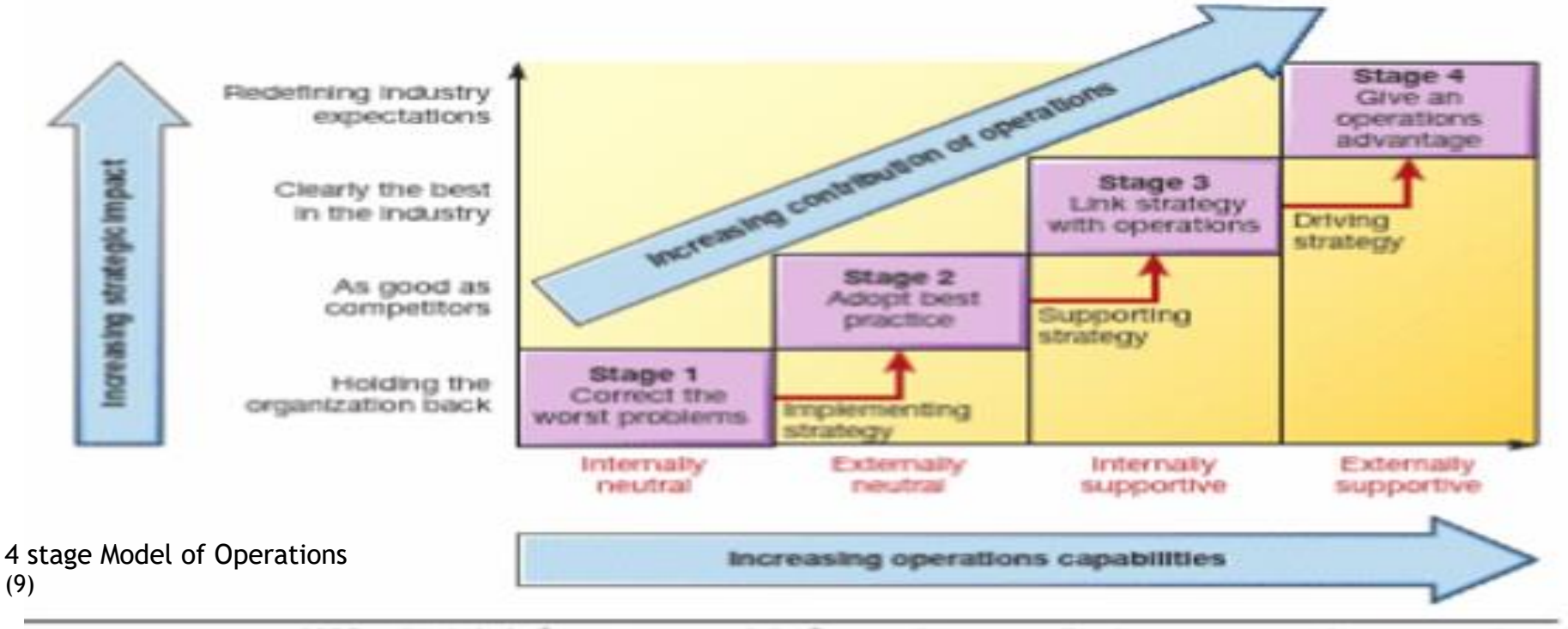
Effective Operations Strategy Model - taken from Slack & Brandon-Jones (2019)

Transformational Model –taken from Slack & Brandon-Jones (2019)



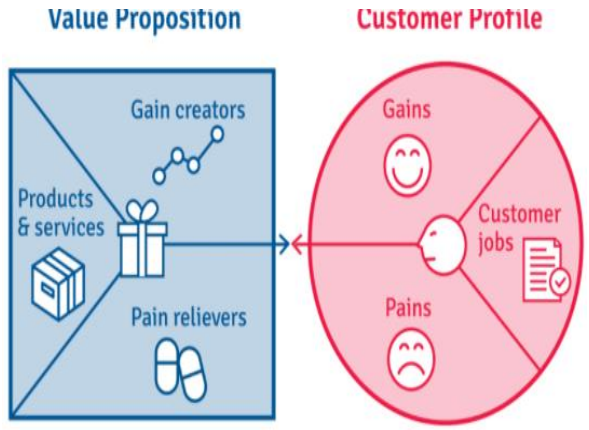
Alignment of Marketing & Operations Functions for Competitive Advantage

By using a RBV and Lean Methodology (4) whilst aligning Marketing & Operations functions has allowed for integration and innovation in ways that have been critical to the Organisation, especially during the Covid Pandemic, driving the Organisation's ambition of being an ICO further through innovation and Creating Competitive Advantage.

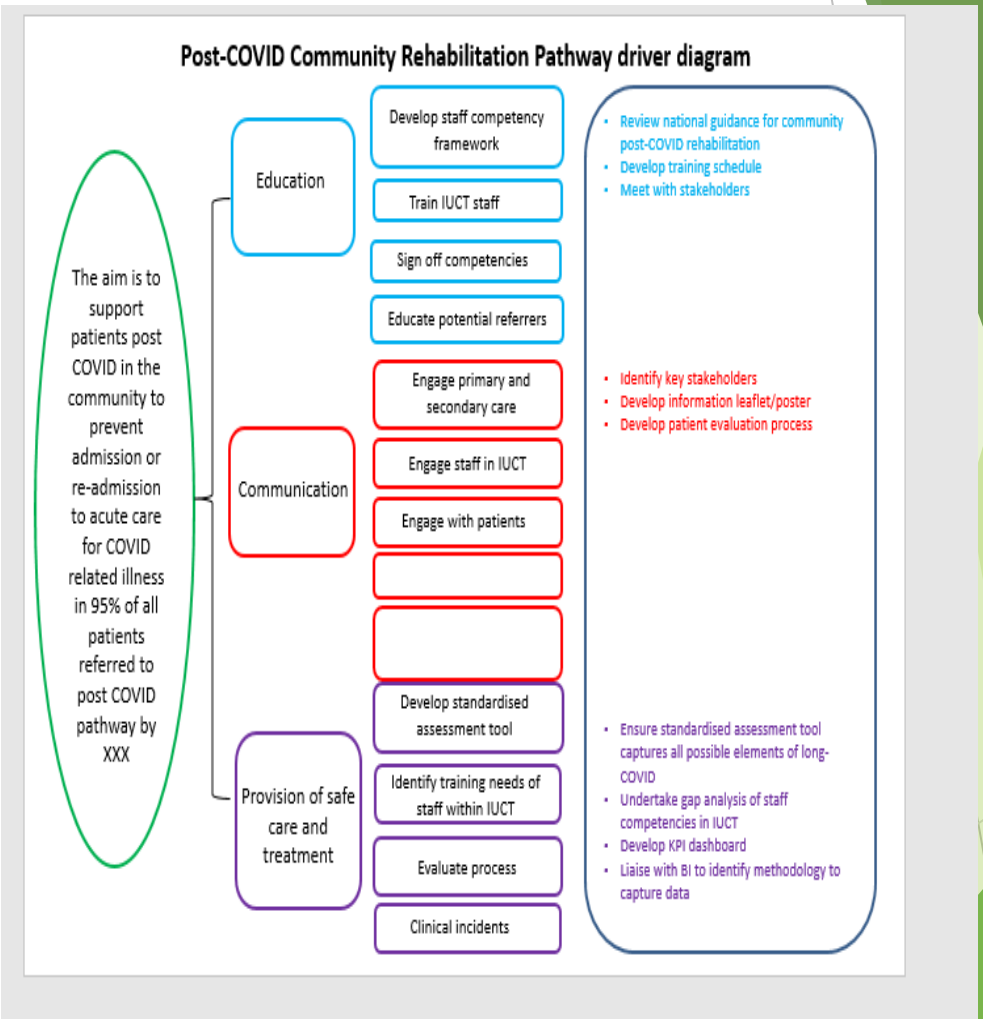


4 stage Model of Operations (9)

Projects, Integration & Competitive Advantage



The value proposition tool (8) was used to build projects/services around key principles of customer pains, gains. Therefore using this marketing concept whilst aligning with the Organisation capabilities using lean and RBV, fostered innovative integrated pathways.



NWAS & IUCT HANDOVER AT SCENE PILOT

NWAS Attends

Comprehensive Handover to Digital Health

Referral to IUCT for urgent response (2hrs) Usually 1 hour

IUCT Treat minor injuries at home

Same day Reablement care if required, surpassing 2 day threshold

A Partnership between Tameside & Glossop ICFT, TMBC and North West Ambulance Service, to provide a handover on scene pathway to allow the patients to be seen and treated within their own homes to avoid unnecessary ambulance transfer and ED attendance.

WIDENING OUR SCOPE & SPREAD

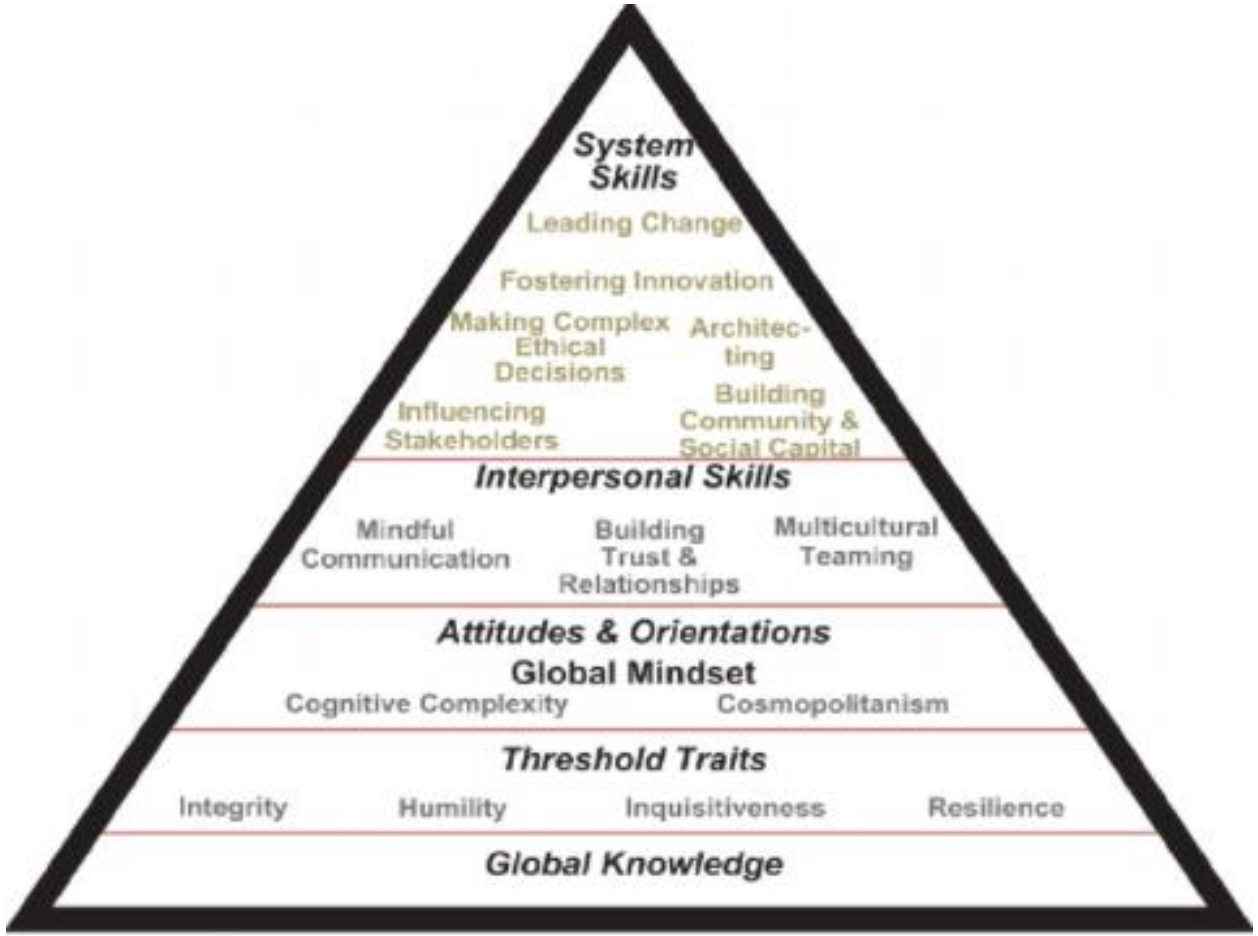
We are continually reviewing our scope to respond to changing need

SUMMARY

- Integration of Operations and Marketing functions enabled the Organisation to become an ICO and encouraged innovative pathways such as the Home first, Digital Health, Covid Rehab Pathway, and NWAS hand over on scene which decreased Length of Stay, increased Admission Avoidance and improved patient care pathways

- To maintain a competitive advantage the Organisation must continue to pull on the models of RBV and Lean methodology to foster sustainable ways of working such as expanding its Digital provision alongside it's current resources & capabilities and avoid internal silo working and disjointed inefficient services.

Consideration to Leadership for ICS



Sources: Adapted from Bird & Osland (2004); Osland (2008)

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(1)Gibbs (1988) Gibbs, G. (1988). *Learning by doing: a guide to teaching and learning methods*. Oxford: Further Education Unit, Oxford Polytechnic.

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THANK YOU FOR LISTENING

ANY QUESTIONS?

Julian Young, Director of Consulting at Operose Health / AT Tech

Dr Chris Whittle, Chief Innovation Officer at eConsult Health

eConsult

March 2022

Dr Chris Whittle

Chief Innovation Officer

NHSX AI Award 2021

Digital Health London Accelerator

HSJ 2017 Awards Partnered with de Poel health+care WINNER

thebmjawards FINALIST 2018

Patient Safety Awards 2018 Winner Information Technology

Winner Health Tech Digital Awards 2019

SBRI Healthcare Award 2021

Founded in one GP practice in the NHS in 2013, eConsult is now live in over 3,300 GP practices across the UK

2013

hurley group

NHS GP Partnership of 11 practices, 4 Urgent Care Centres, GP Out of Hours, 100,000 registered patients

First pilot with 20 practices, covering 130,000 patients. Tested 50 condition specific templates

TOWER HAMLETS

eConsult

100+ condition specific, symptom led and admin templates

eTriage

Launched in Bexley UCC

eHub

Centralised working model launched across Hurley Group practices

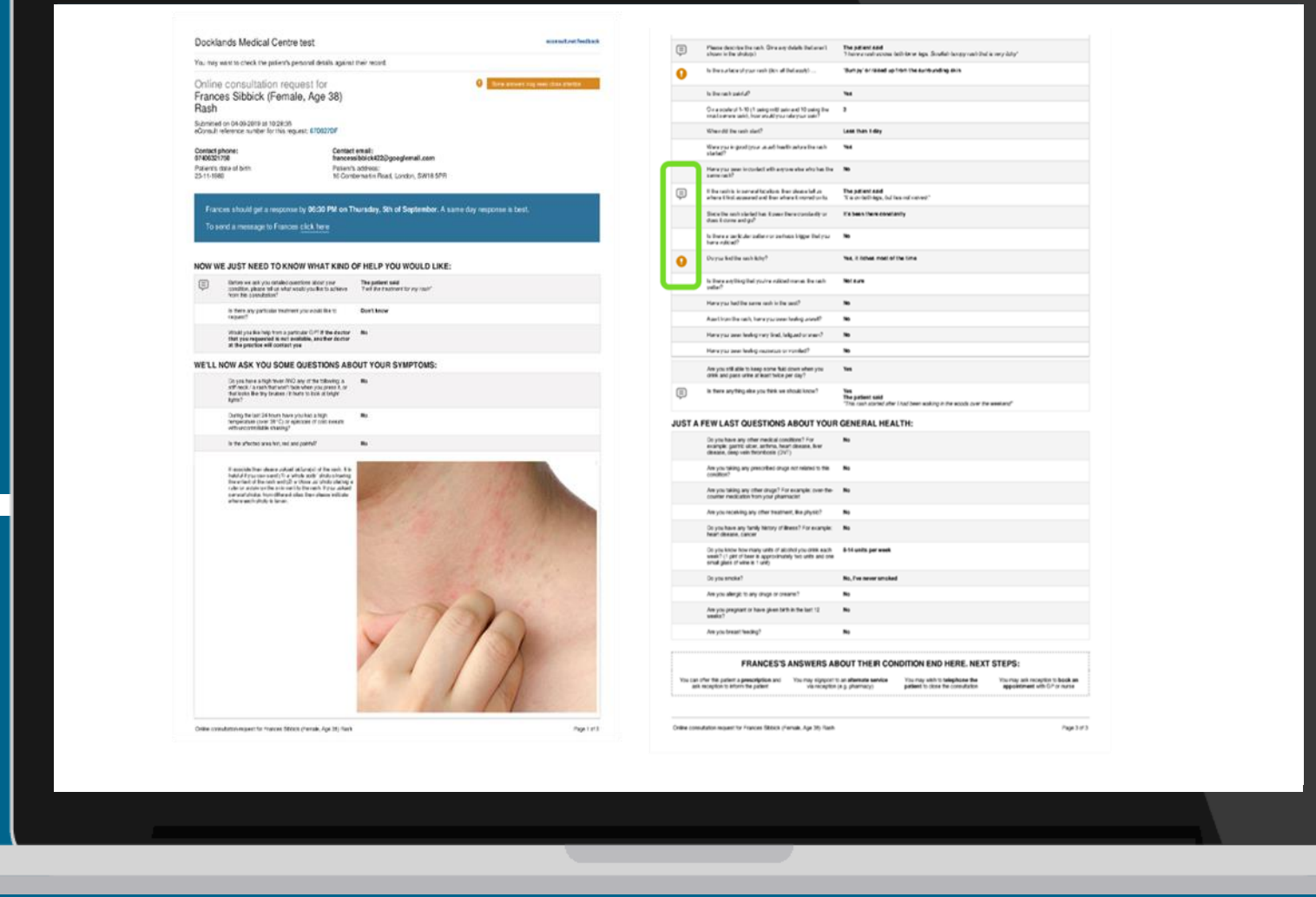
Adds SMS and video functionality

NHS app integration

Covid....

2021

Patients access the platform via their practice website or the NHS App



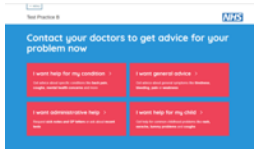
econsult

Patient flow through eConsult

1.2m online consultations/month and >22m processed to date

Patient or parent/ guardian

NHS app
or



GP Practice website

- ✓ Uses NHS login
- ✓ Common journey
- ✓ Available 24/7
- ✓ eConsult lite

- Self care
- Pharmacy
- Local services

Online consultation

GP

Triaged and closed by team

- ✓ Admin
- ✓ Care navigator
- ✓ Pharmacist
- ✓ Physio
- ✓ MHT
- ✓ Physician Associate
- ✓ Practice Nurse
- ✓ Advanced Nurse Practitioner
- ✓ GP

Remote closure	Pre-Covid	eConsult
Message	30%	40%
Phone	40%	48%
Video	1%	2%
F2F appointment	30%	10%

Synchronous….

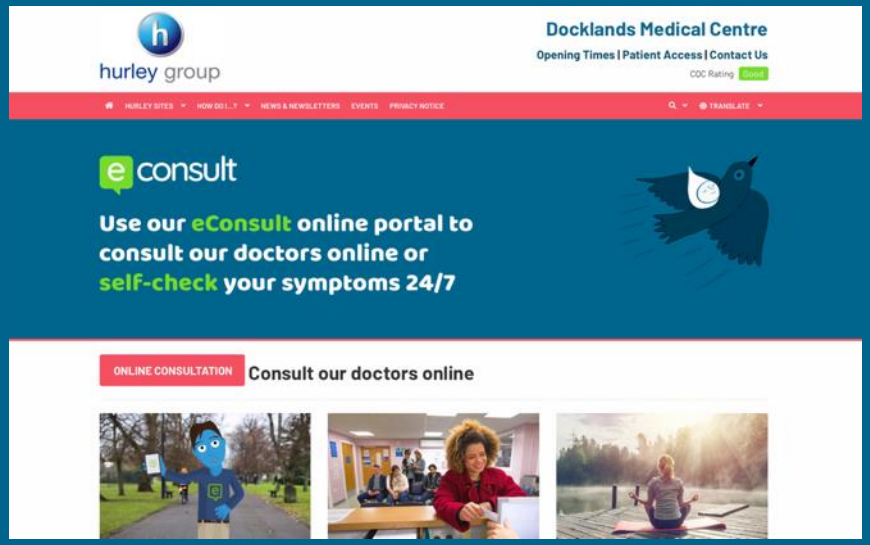
vs.

…asynchronous

Still accounts for most journeys

300M+ per year in GP
25M+ per year in UEC
120M per year in out-patients

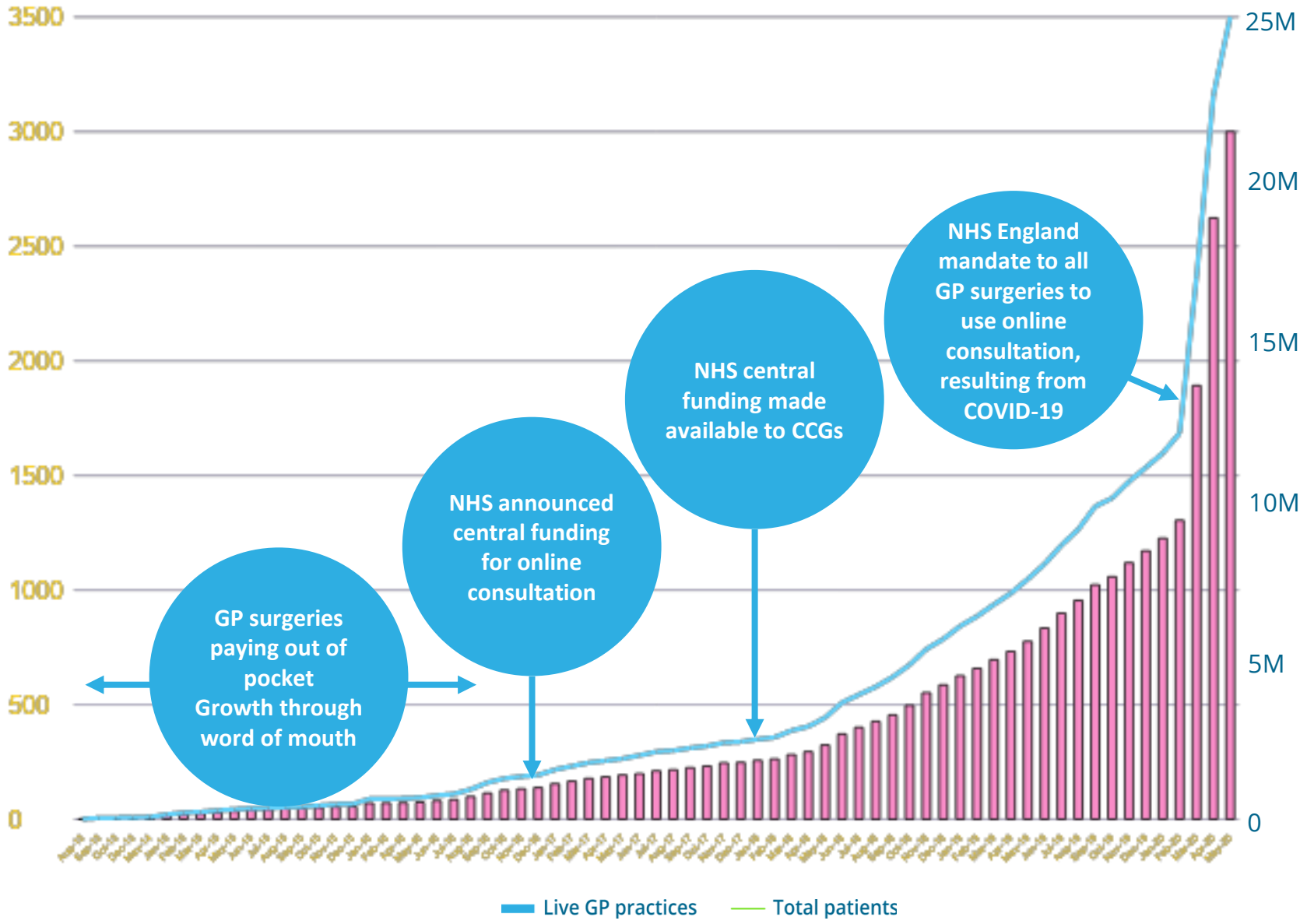
On the rise… and will only grow…..



1.2M eConsults a month
Around 2M online consults in total
That’s 8% of the 26M contacts a month
Many practices are much higher

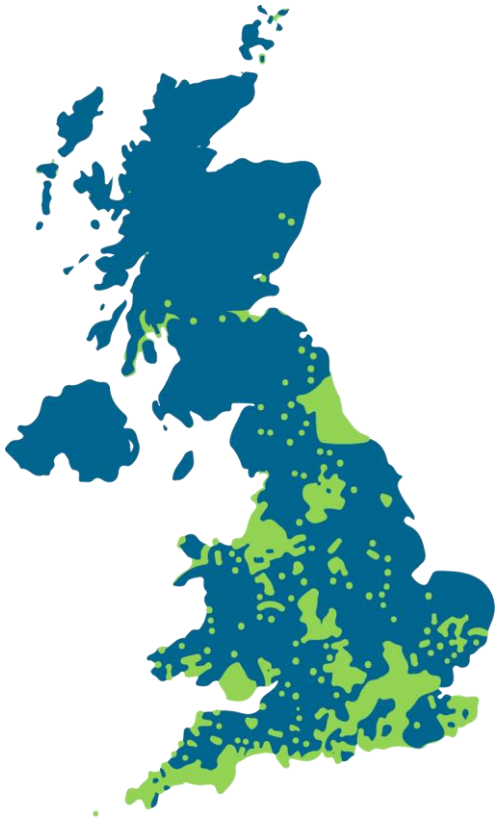
The eConsult journey from idea to business as usual in general practice.

Today, it is used in over 40% of UK GP surgeries.



eConsult: Trusted across the NHS

Trusts, Primary Care & ICS



Born of the NHS, made by NHS clinicians for NHS clinicians

Proven in Primary Care (**29m patients**, **>22m consultations**)

Now also live in **Urgent and Emergency Care** and **Outpatients** settings nationwide

econsult

Joining the system up

Primary Care ▸ Urgent Care
e.g. Route into Clinical Assessment Service

Urgent Care ▸ Primary Care
e.g. P5 redirects

Primary Care ▸ Specialist Care
e.g. 2 week wait cancer direct referral

Urgent Care ▸ Specialist Care
e.g. Same day emergency care routing

The patient journey in most UEC settings:

Book in

- Queues at reception
- Non-clinical
- Patient reluctance in sharing clinical info

Wait 15 mins

- Unless identified by reception, timings are static
- At busy times, long waits
- No clinical overview

Triage nurse

- First clinical contact
- Capture history, obs and ECDS
- Data capture may be inconsistent
- Some repetition with info provided at reception

Wait ~4 hours

- First point where waiting times are considered based on need

Decision maker

- Potential for repetition

e triage

The e triage journey

Pulse

O_2 Saturation

Temp

Blood Pressure

Respiratory rate

- Medical emergency
- Majors
- Majors/ minors
- Minors/UCC/redirection
- Pharmacy/GP/home

Automated check in, history take, ECDS capture, and triage

- No queues
- Consistent data capture (inc ECDS)
- Patient involvement
- Check-in and Triage = 5 min

Automated obs, links to record

- Triage is clinically validated and standardised
- Data deposited directly to the EPR system
- Clinical overview of the waiting room

Automated risk stratification P1-P5 + NEWS2 EPR/clinician

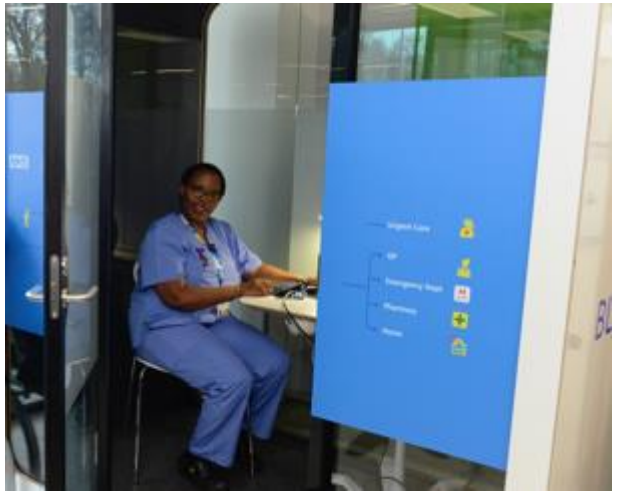
- Patients can be assessed based on acuity
- Triage nurse already has a standardised history to validate and capture obs

Route to appropriate care

- Direct patient to most appropriate care setting
- Can be customised to local workflows (SDEC, Covid zones etc)
- Improvements in KPIs

…all within 5 mins of arrival through the front door

Queen Mary's Hospital, Sidcup



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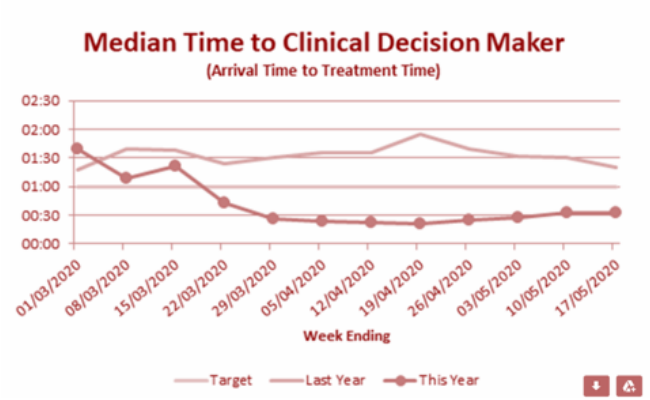
Independent analysis of Queen Mary's and West Sussex

>350k

Automated digital triage and consultations

5 mins

Average time for check in and triage



26%

65 years and above

75% → 100%

Improve initial assessment KPIs (first assessment within 15 minutes)

>90%

Patients self selecting automated check in and triage on iPads

Critical life threatening symptoms picked up early

0

Waiting time to check in and be triaged

econsult

Type 1 EDs Live

NHS
Western Sussex Hospitals
NHS Foundation Trust

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

Going Live soon

NHS
Poole Hospital
NHS Foundation Trust

NHS
Homerton
University Hospital
NHS Foundation Trust

NHS
East Sussex Healthcare
NHS Trust

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

NHS
East Sussex Healthcare
NHS Trust

NHS
East Kent

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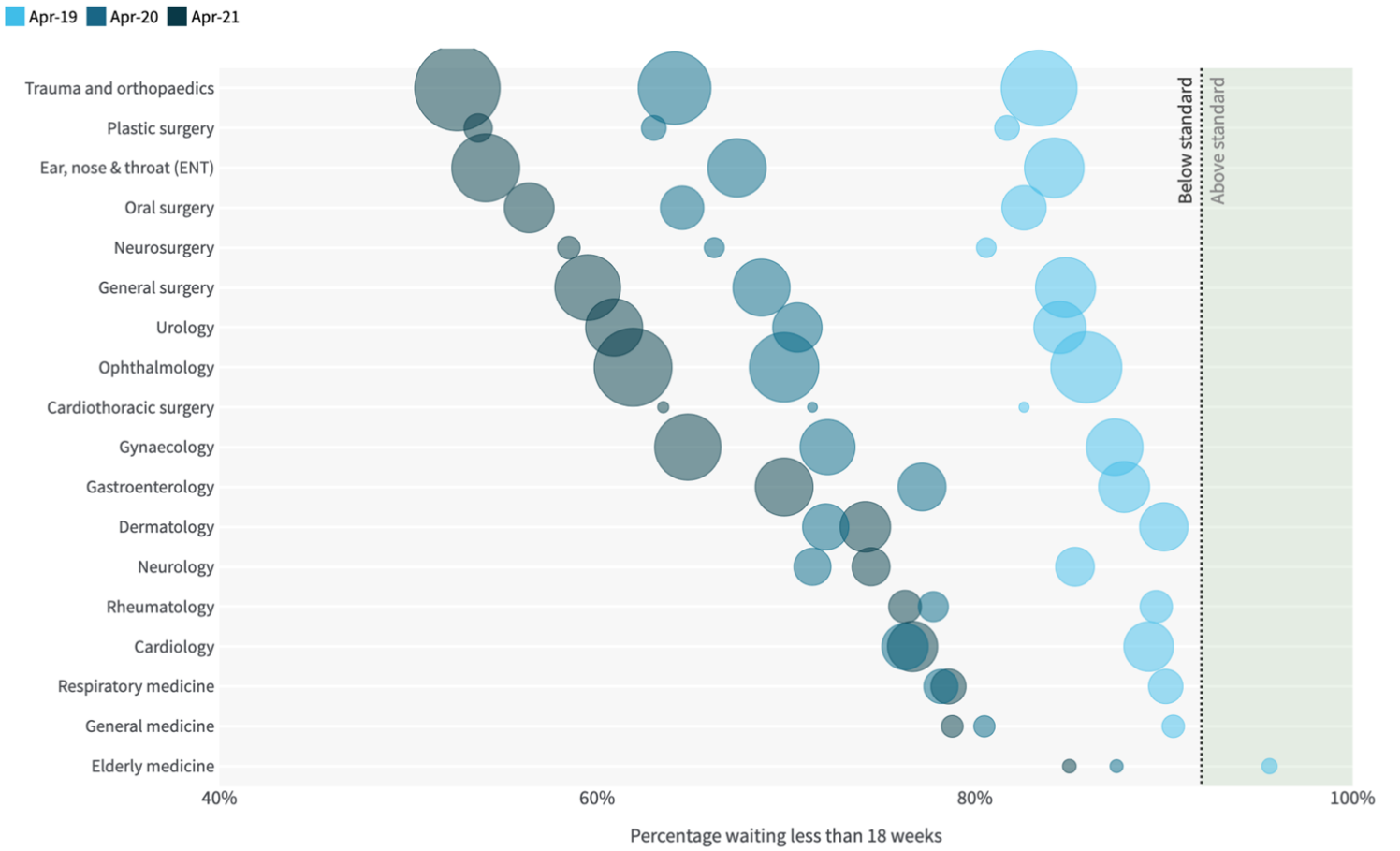
The problem in Outpatients: Covid backlog

All specialties have seen a fall in performance against the RTT standard between April 2019 and April 2021

Dots scaled to show the size of the waiting list



Source: NHS England
Excludes 'other'. x-axis truncated to show trend more clearly.

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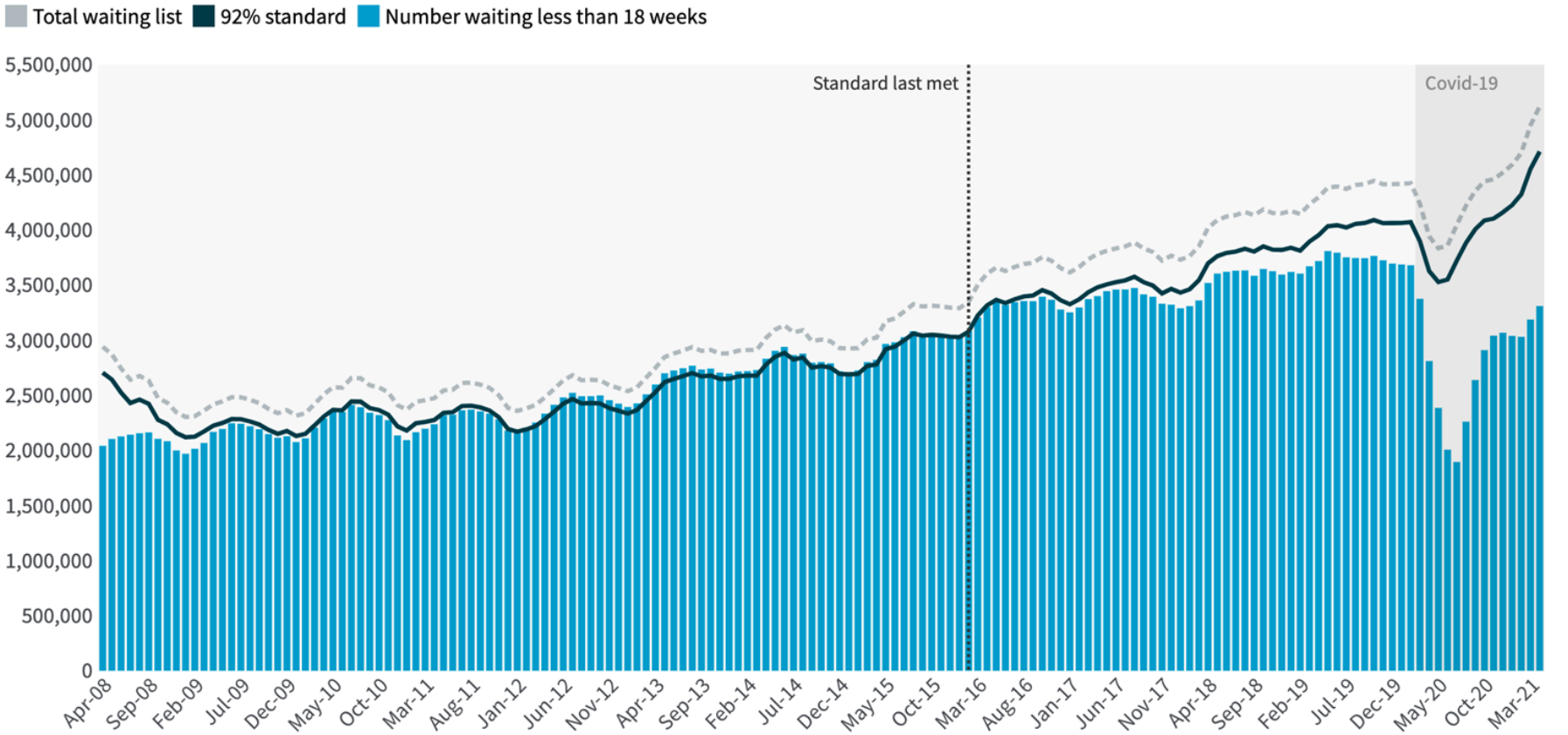
The King's Fund

Covid backlog

To meet the RTT standard 92% of people on the waiting list need to have been waiting less than 18 weeks, but current performance is significantly below that

Number of people on the RTT waiting list



Source: NHS England Consultant-led Referral to Treatment Waiting Times

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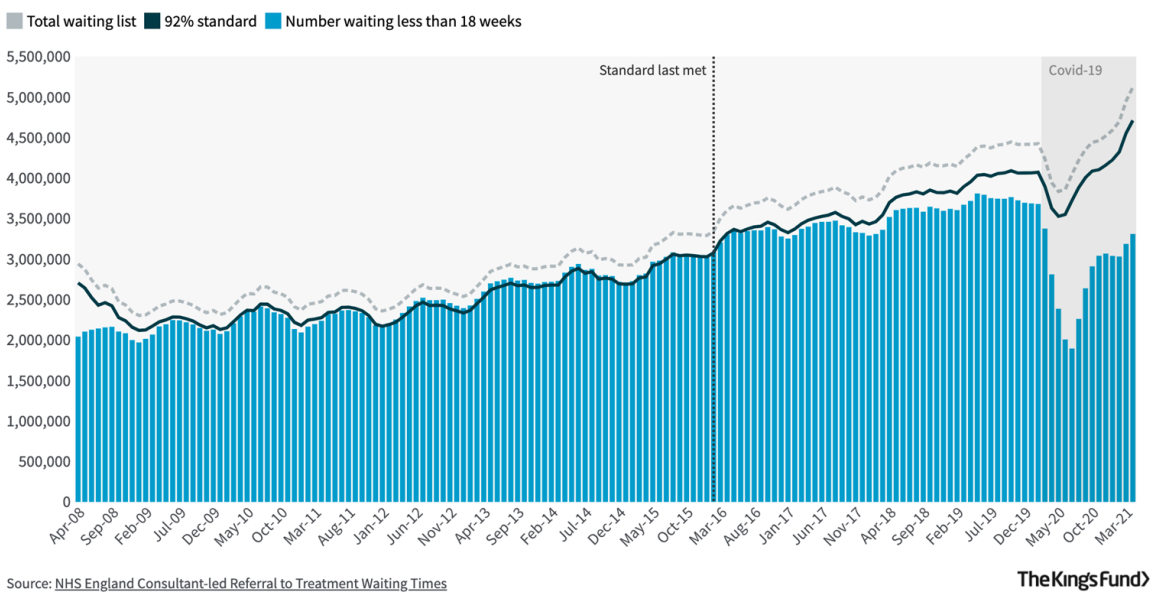
The King's Fund

Covid backlog

How do we get back on track?

To meet the RTT standard 92% of people on the waiting list need to have been waiting less than 18 weeks, but current performance is significantly below that

Number of people on the RTT waiting list



Source: NHS England Consultant-led Referral to Treatment Waiting Times

The King's Fund

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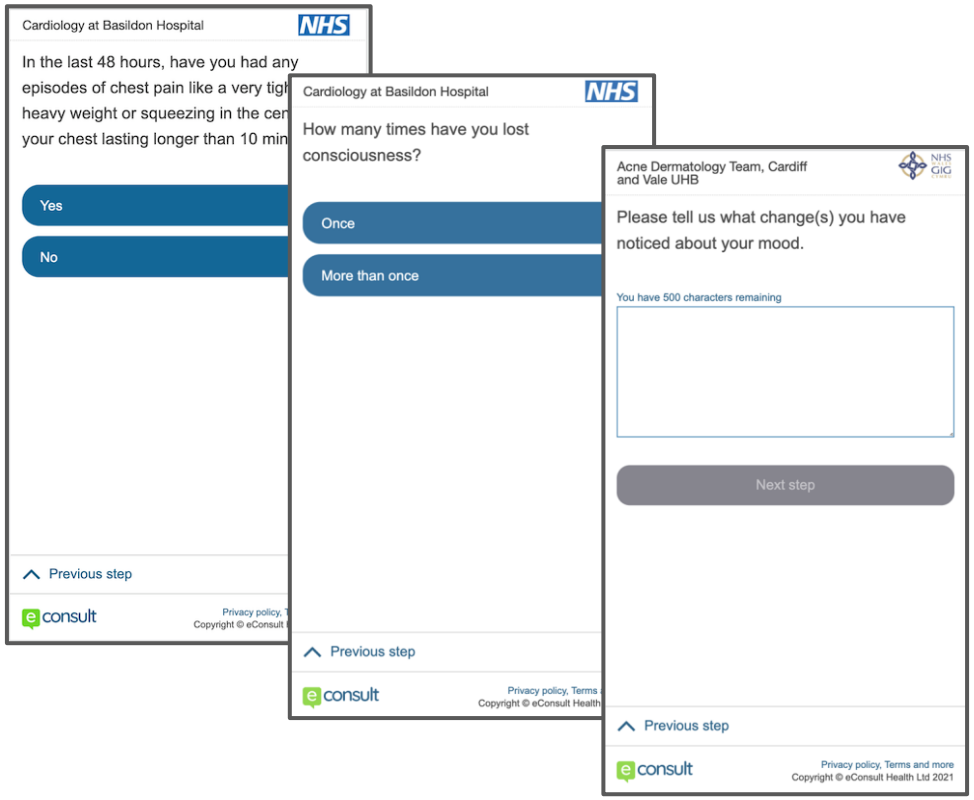
Largest waiting list ever recorded

England alone: 6 million known, potentially further 6-7m unknown

Technology is a huge part of the answer

eConsult specialist

Reducing waiting lists by improving patient pathways



Outpatient triage and waiting list reduction solution

Benefits

1) Identification and removal of unnecessary or inappropriate appointments (referral triage, PIFU, pre-appointment)
2) Optimisation of clinics themselves (DNA rate reduction, gathering history up front)
3) Enabling workforce delivery across geographies (remote consultation, networks)

Significant **waiting list** and **DNA** reduction

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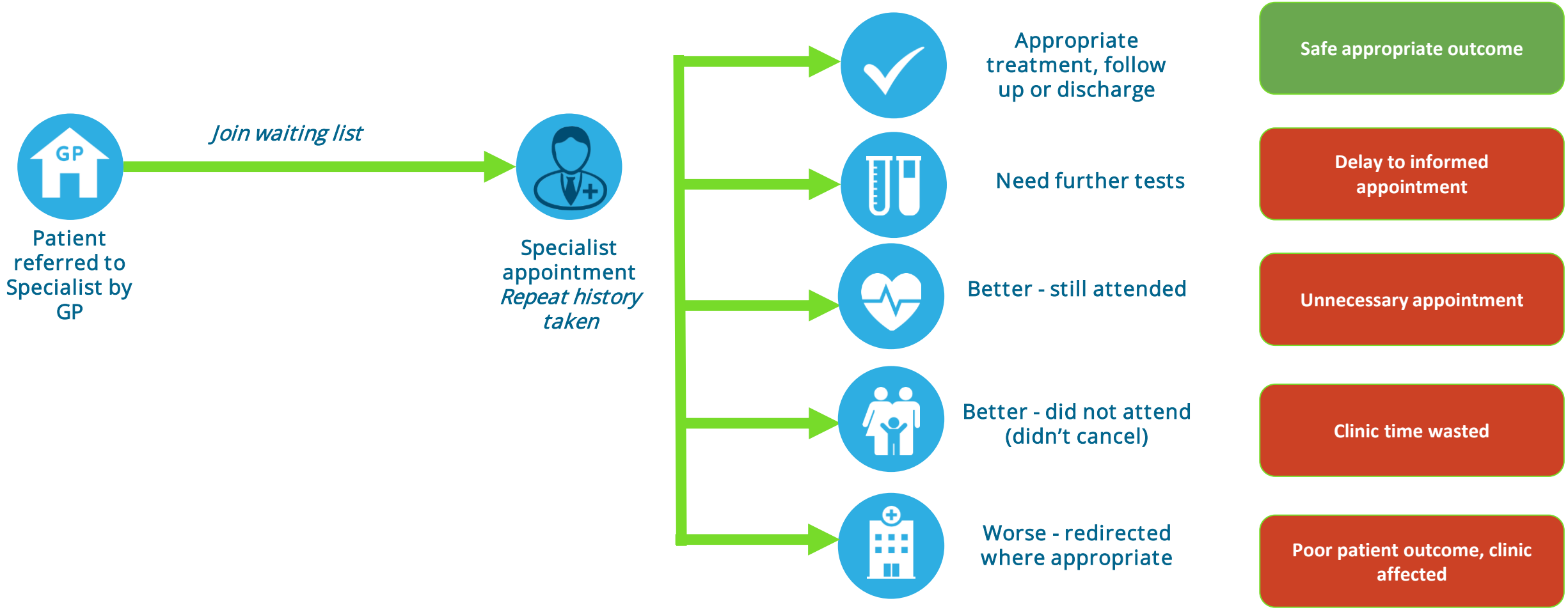
Traditional patient flow



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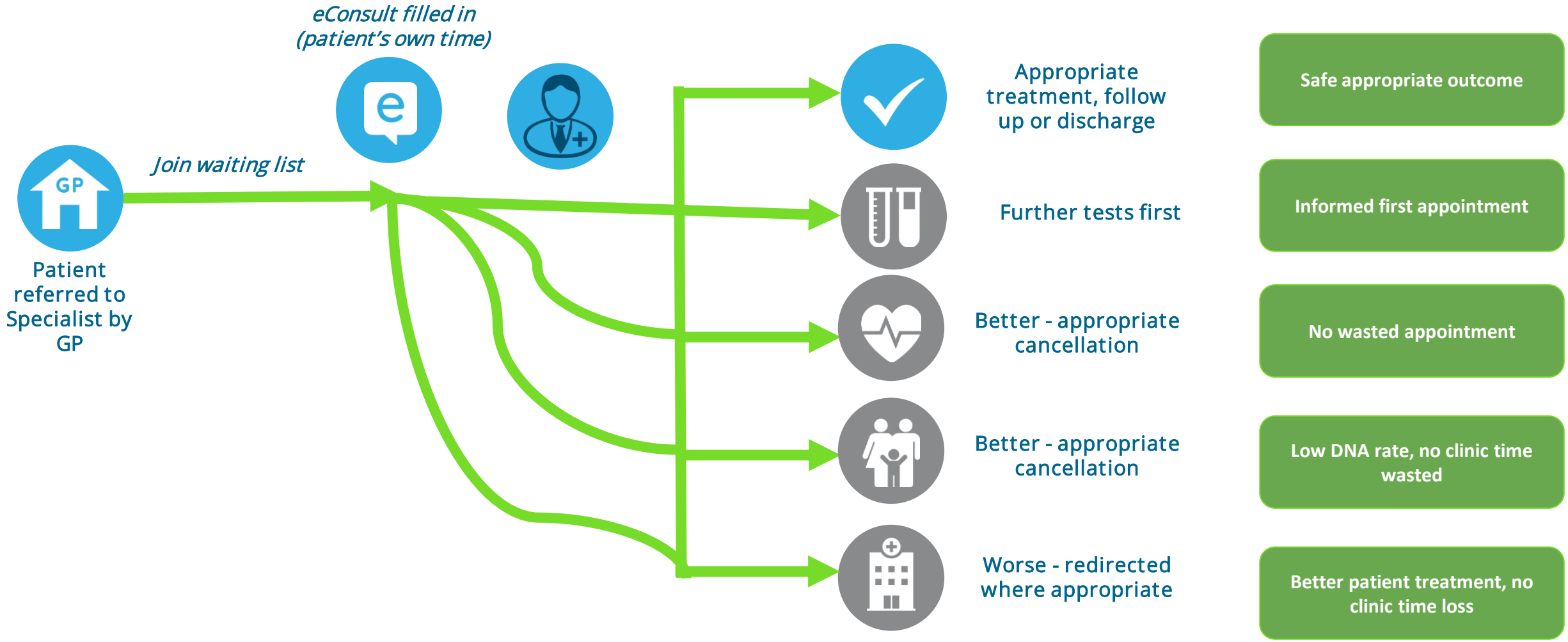
eConsult enhanced patient flow



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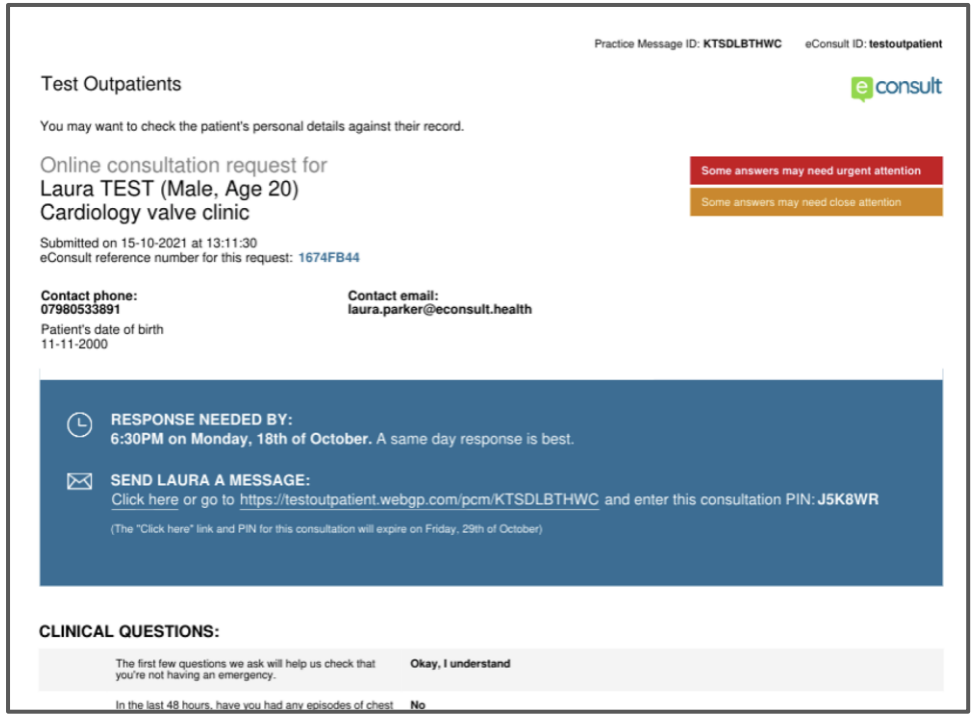
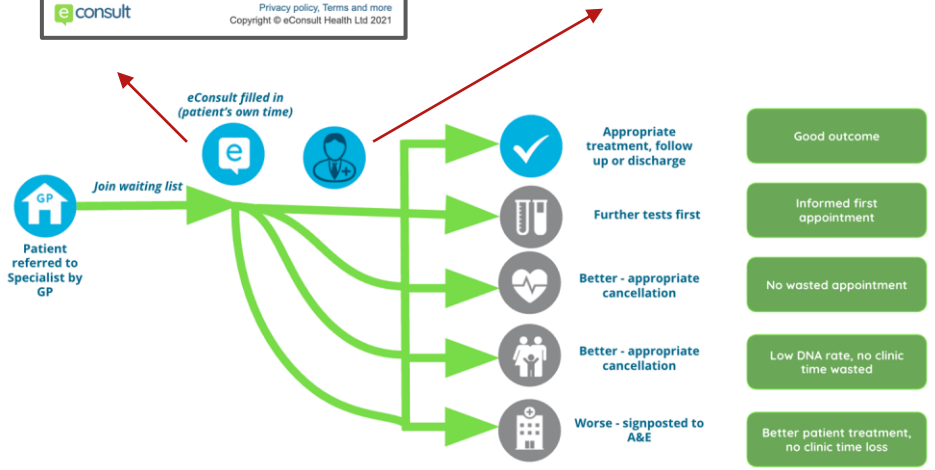
eConsult enhanced patient flow





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Specialist content created by NHS trusts

Mid and South Essex NHS Foundation Trust

GIG CYMRU NHS WALES

Fed through eConsult's tried and tested Clinical Governance process

9 specialties live, 40 specialties commissioned across England and Wales

Implementation with existing specialties

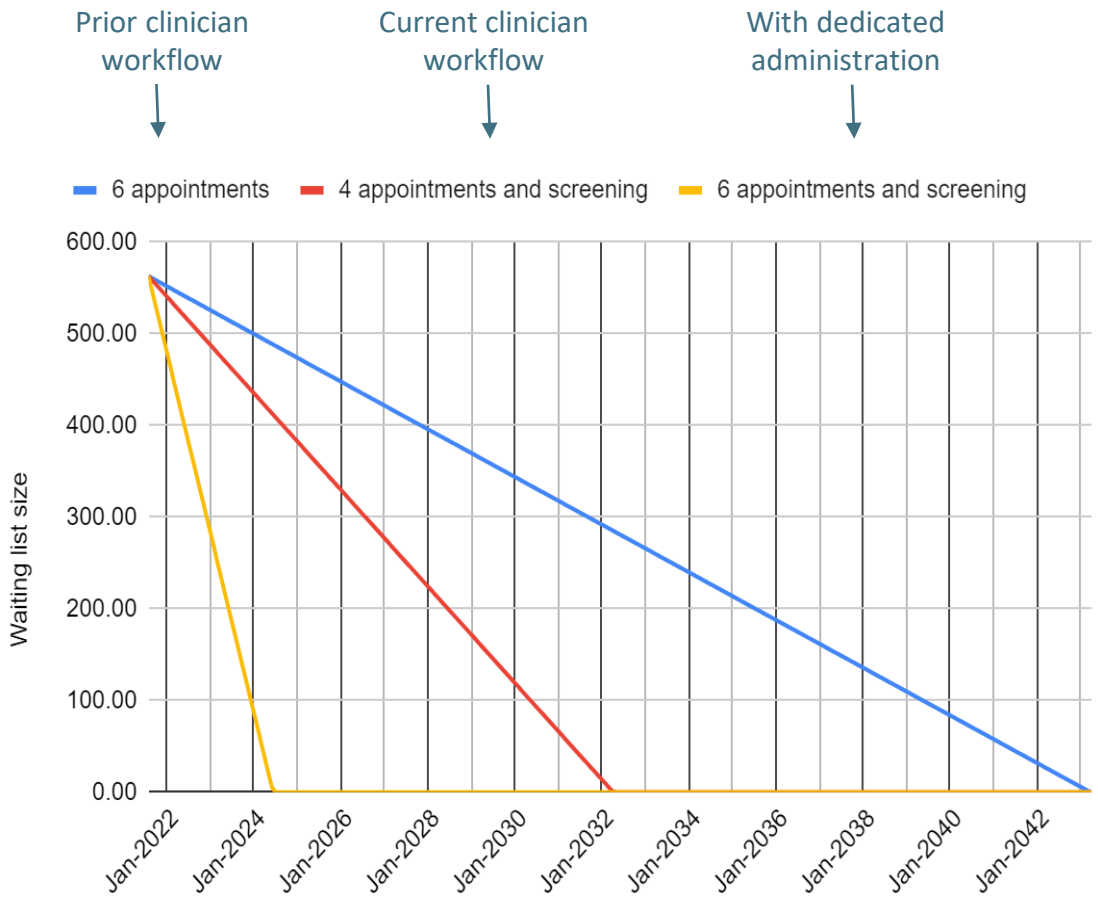
- Consultative approach
- Supporting change management
- Governance sign off
- Baseline data to compare with KPIs

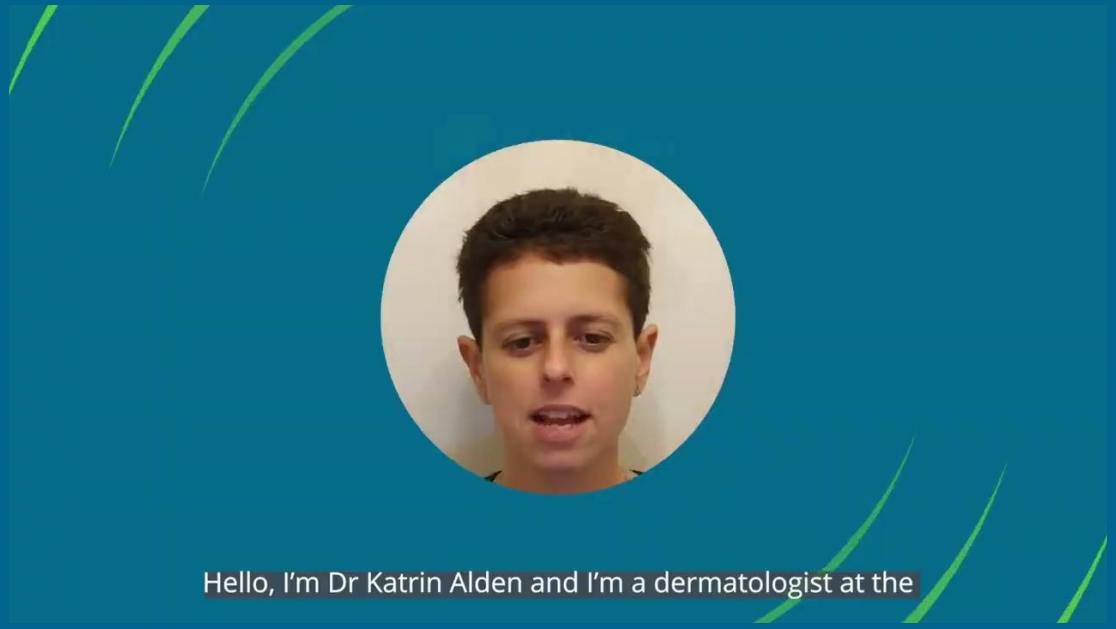
Innovation partnership

- Co-design with lead clinicians
- Clinical QA

University Hospital of Wales

Acne Clinic Pre-screening questionnaires





DNA rate **40%** to near **zero**

Waiting list **22 years** down to **10 years**

With dedicated administration, waiting list down to **2 years**

econsult

Part of the solution

We are here to help you to address the backlog

- **Significantly reduce your waiting list**
- **Make every outpatient appointment count**
- **Create a safer patient experience**

Cardiology / Rheumatology/ Gynaecology / Dermatology / Urology / Hepatology / ENT / Gastroenterology / Chronic Pain

- Start now with one of **9 live specialities**

  and/or

- Become an **innovation partner** to co-develop clinical templates

For more information, get in touch here, or email chris.whittle@econsult.health

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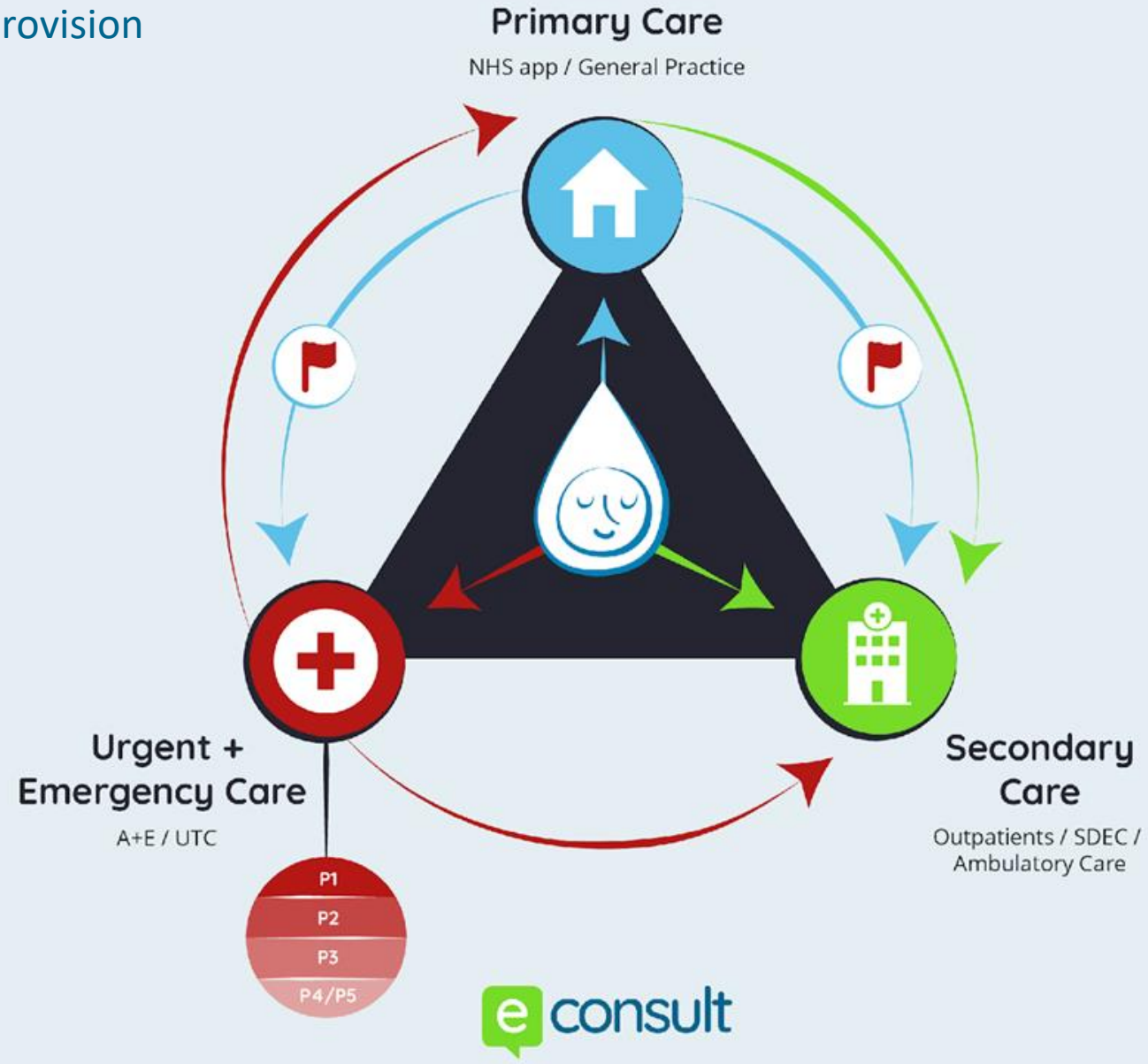
One connected digital ecosystem, routing to the most appropriate provision



Primary Care

A patient submits an eConsult through the NHS app or GP practice.
No red flag warnings triggered - the eConsult goes to their practice.
Red flags triggered - consultation is diverted to ED or UTC.
GP practice reviews the eConsult, a healthcare professional can also refer the patient into SC. Or, connected to CPCS or local pharmacy services if appropriate.

Urgent + Emergency Care

A patient submits an eTriage and walks into an ED or UTC.
The patient symptoms are then triaged into a 1 - 5 priority score...

P1 - Medical emergency
P2 - Majors
P3 - Majors and minors
P4/P5 - Minors and redirection

If a patient is triaged into P5, they are redirected back to PC.
A patient could also be referred to a specialist in SC.

Secondary Care

A patient may be consulted by their GP after completing an eConsult and then referred to a SC specialist.
Or, a Patient submits an eSpecialist. The consultant receives pre-consultation information to enable ordering and remote management, with the option for a video consultation.

Any questions?

chris.whittle@econsult.health

Tapiwa Mtemachani FInstLM,
Director of Transformation and
Partnership at Black Country
and West Birmingham CCG

Strategic Transformation and Partnership

Health and Housing

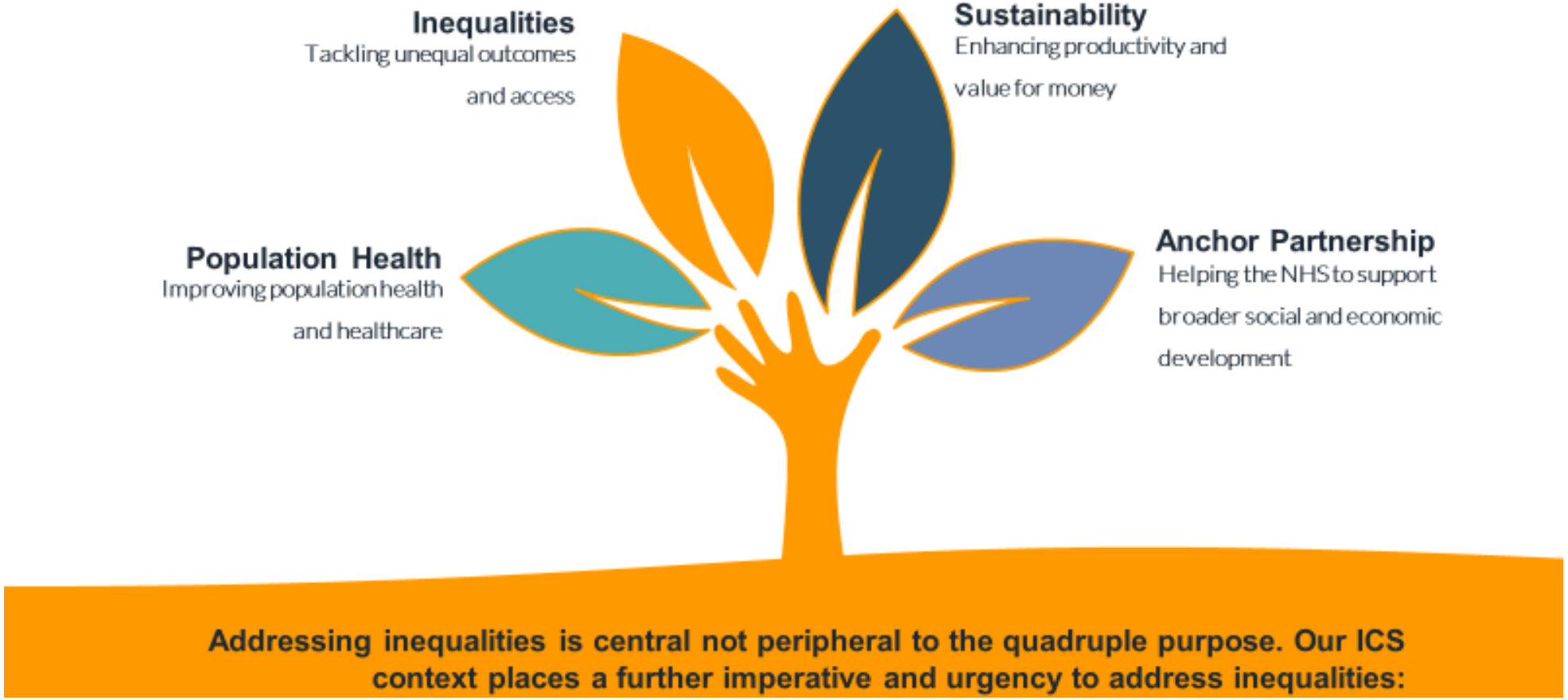
Taps Mtemachani

MBA, MSc, PGDip, PgCert, HND, FInstLM, RGN

BCWB CCG Director of Transformation and Partnership

ICS SRO for Health Inequalities and Strategic Prevention

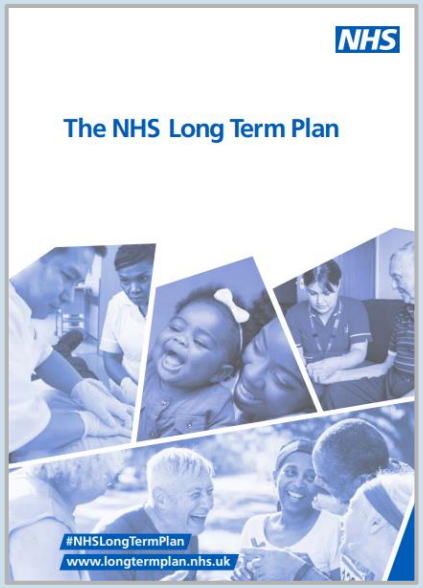
ICS Quadruple Purpose

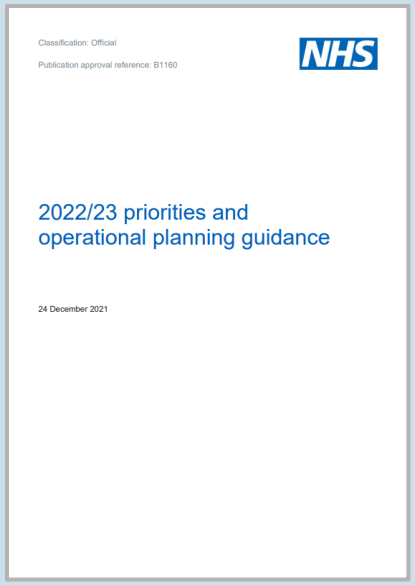


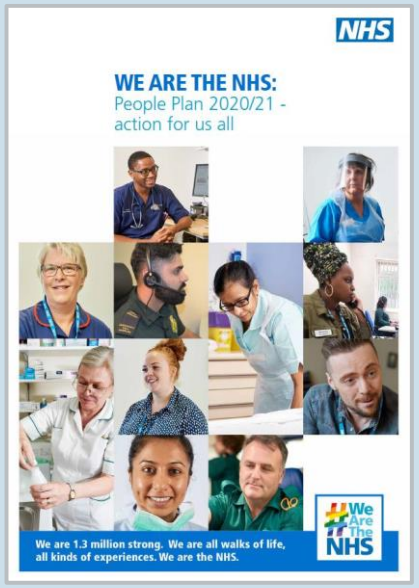
The 4th principle of the ICS relates to supporting broader socio-economic development. This is key if ICS's are to make any real impact on Health Inequalities. There is no silver bullet, concerted effort must be made to look beyond the parapet of health centric interventions into the wider ecology of community centric delivery partnerships such as housing.

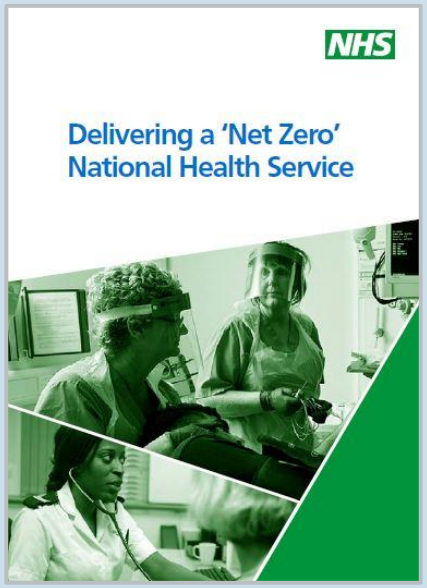
NHS in the community

'Anchor institutions are large, public sector organisations that are unlikely to relocate and have a significant stake in a geographical area – they are 'anchored' in their surrounding community. They have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and buildings and land'









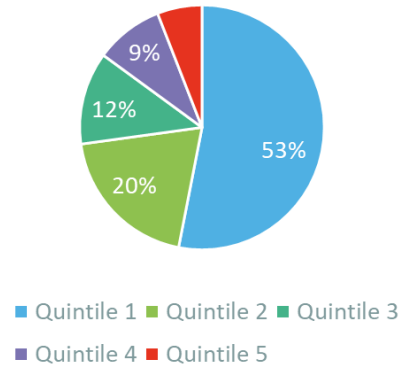
The opportunity

Social determinants are a far larger factor in someone's health than the quality and amount of health care they receive. An individual's employment status, wellbeing, living conditions and income all have a greater impact on their health than the accessibility and quality of care provided by health services. As the biggest employer in England and a significant economic force in local communities, the NHS has a unique opportunity to use its resources to influence the wellbeing of the population it serves and reduce the health inequalities that exist in England.

Kings Fund

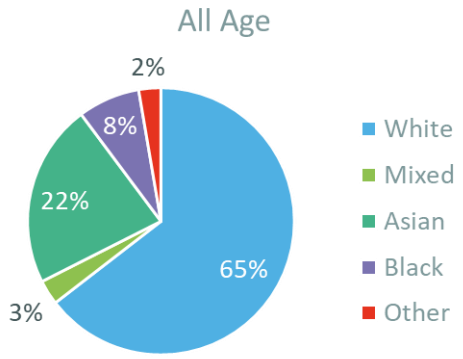
The Big Issue – Causal and Compounding Factors

Over half the population of the Black Country and West Birmingham live in the most deprived national quintile. There is variation across our five places with Dudley in particular having fewer people living in areas in national IMD quintile 1 and more people living in quintiles 4 and 5.



+

35% of the population of Black Country and West Birmingham is from Black and Ethnic Minority communities. This is higher in our under-18 population with 44% of the populatio being from Black and Ethnic Minority communities. This is significantly higher than England at 23%.



Compound Crisis – COVID-19

90% of those who died with COVID had significant prior poor health.

Only 10% of people who died with COVID were in good health

Many of those who died had health conditions that could have been prevented.

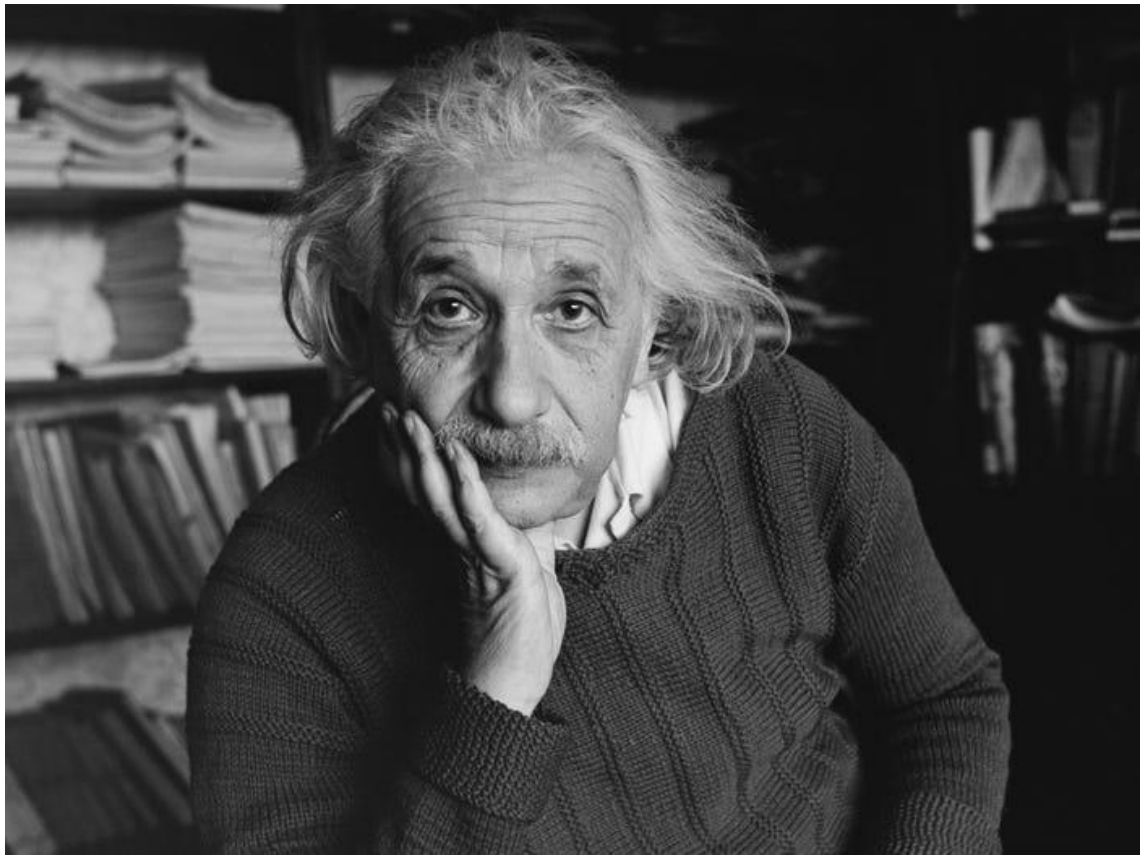
BCWB had 288 per 100,000 - over 3x more than South Cambridgeshire with 68 per 100,000.

BCWB would have had over **2,500 less deaths** if our COVID mortality rate had been as low as the least deprived place.

Devastating impact, exposing our population's poor health and inequalities

More deprived places had much higher COVID mortality rates;

The Big Issue



"We cannot solve our problems with the same thinking we used when we created them"

Albert Einstein

Beyond Health

Health initiatives account for 20% of health outcomes. 80% of impact comes from wider determinants of health:

- 30% health behaviours – choices e.g. smoking, alcohol;
- 40% socio-economic factors e.g. employment, income;
- 10% physical environment e.g. housing, transport.

e.g. Deprivation a strong correlate of A&E attendances

A&E top ACORN profiles by volume

100 = the national average

Description

- People for this profile account for **7.5%** of all low acuity attendances at A&E
- 51% of the population are BAME background, 49% White.
- Unemployment is typically double the national average.
- Incomes often very low.
- Very high rates of job seekers allowance.
- Very high levels of social renting.
- Overall disease prevalence is lower than the average but specifically high levels of respiratory disease.
- Generally less responsive to all marketing channels.
- More likely to access social media.

Profile 1:

8.2% non-conveyed ambulance calls

8.5% 111 calls

THANK YOU.

COMMENTS/QUESTIONS

Connie Jennings, Head of Health and Wellbeing at whg

H Factor

Health Hope and Happiness

Connie Jennings

Head of Health and Wellbeing

www.whg.co.uk

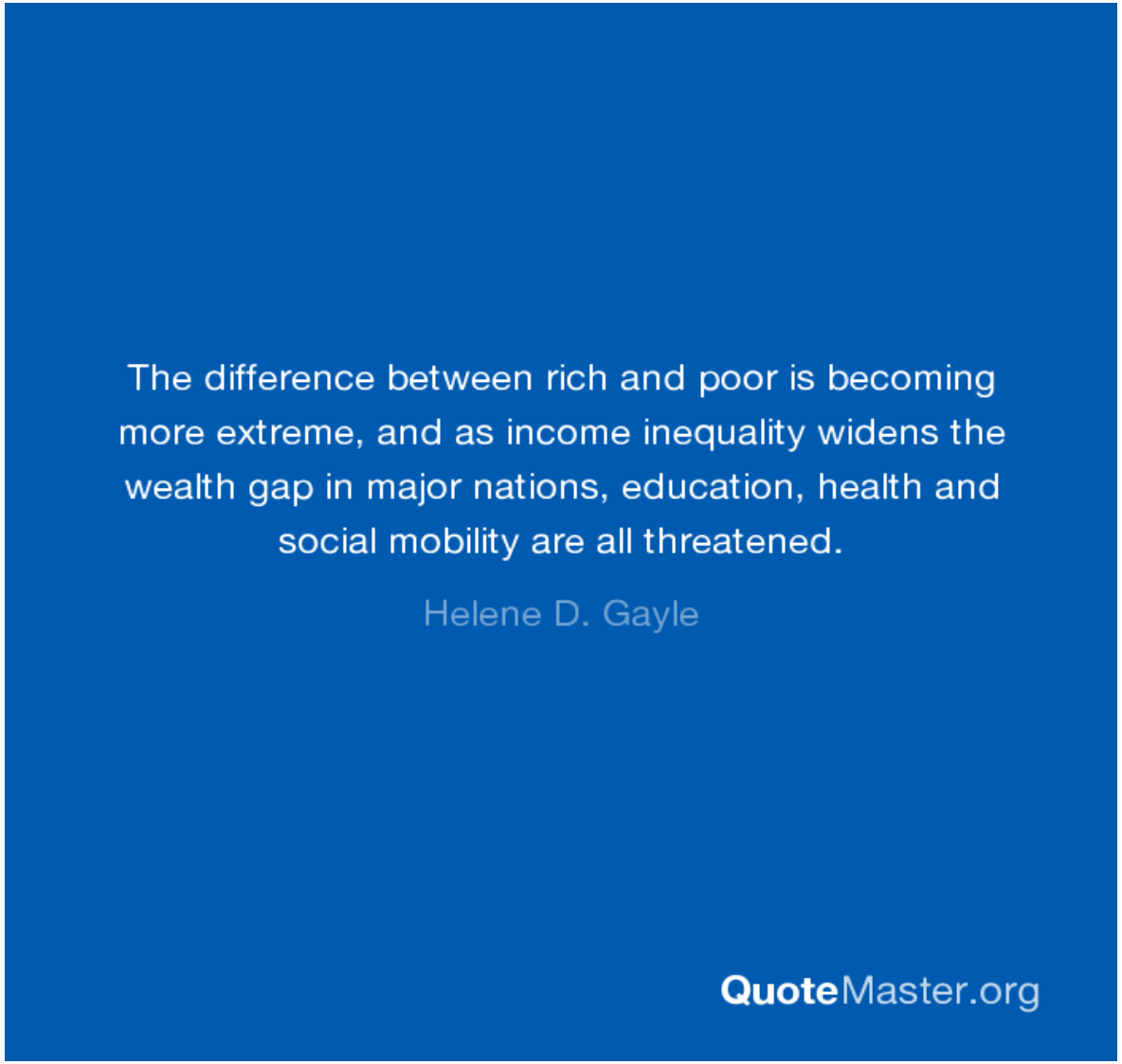
Health Hope Happiness

The H Factor
whg

Place Shapers Health Makers

Join us on our journey with our local ICP and regional ICS

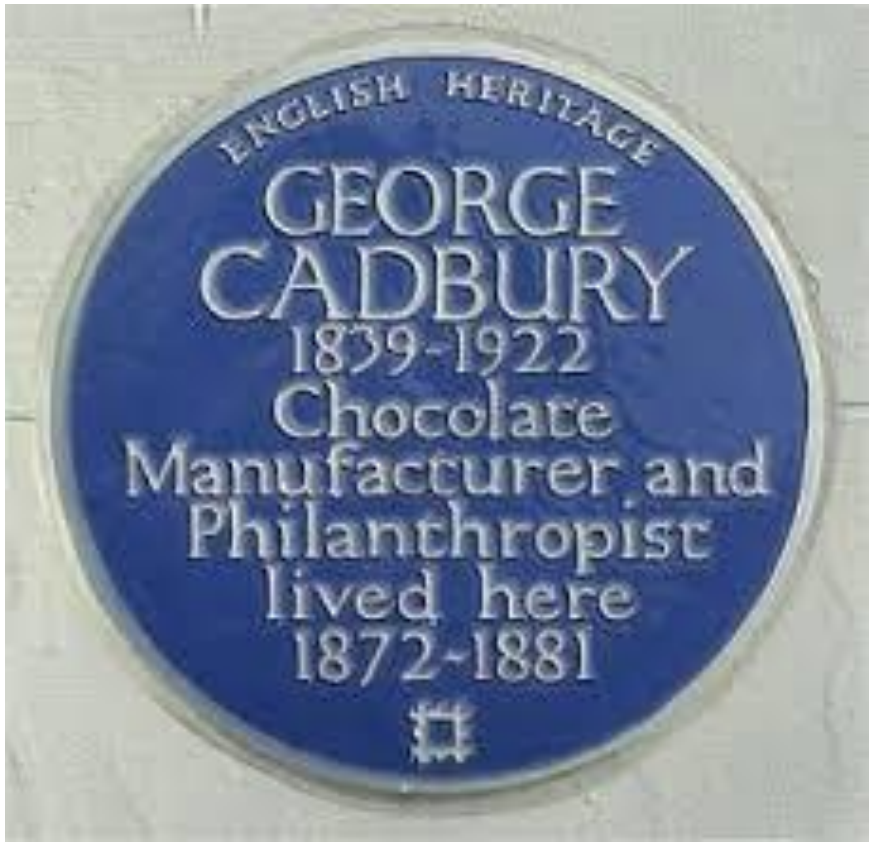
Discover why working with housing can be beneficial for all …



Health Hope Happiness

Health Champions

- Octavia Hill
- George Cadbury
- William Lever

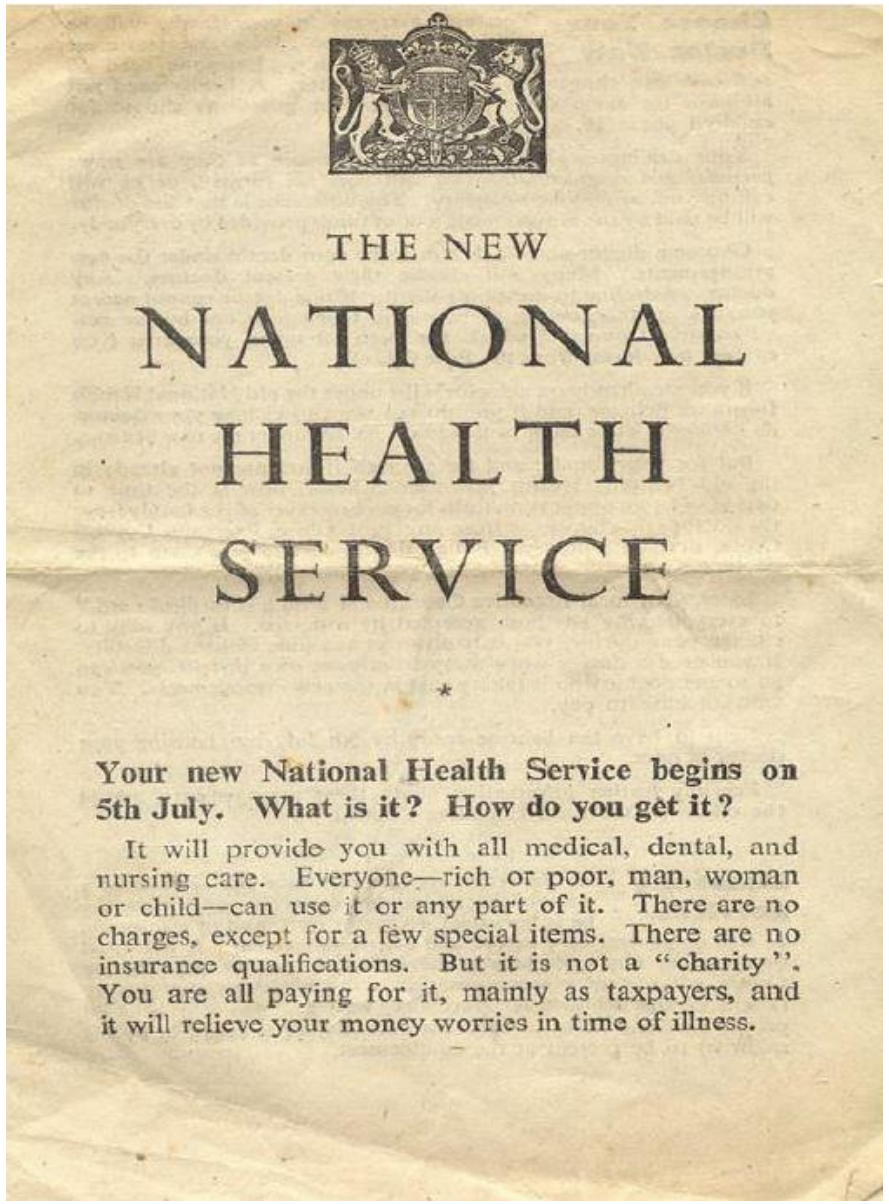


Health Hope Happiness

Health and Housing Champion

Aneurin Bevan 1897 – 1960

- In 1945 as Minister of **Health** Bevan was also responsible for developing **Housing** programmes alongside establishing the **National Health Service**



THE NEW

NATIONAL HEALTH SERVICE

*

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

Health Hope and Happiness

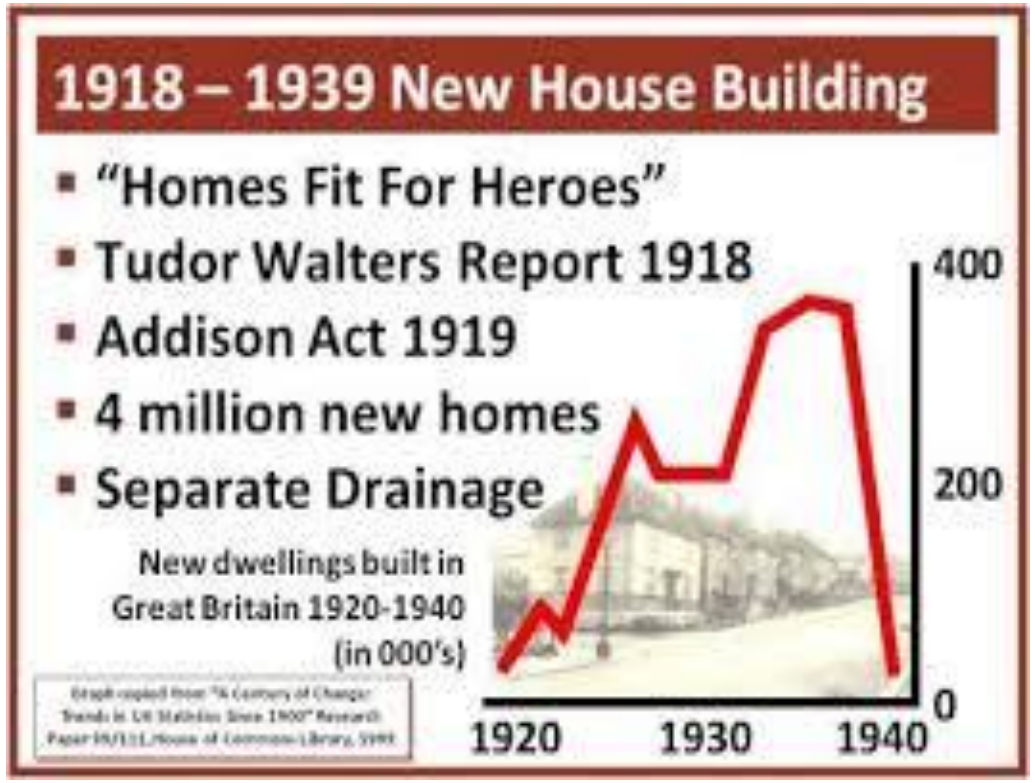
Operating Environment Walsall

Wider Determinants

- Unemployment is double the national average at over **8%** compared to **4.7%**
- Walsall ranks **17th** for Income deprivation with over **25 %** of children living in poverty
- The Infant mortality rate in Walsall is **6.8** per **1,000** births
- Healthy life expectancy in Walsall is just **56.40 years**
- In 2021 the **Centre for Progressive Policy (CPP)** placed Walsall in the top **14** list of places where the population was at a much **higher risk of dying from COVID-19**
- Our customers are your **frequent flyers**

Health Hope Happiness

Operating Environment



Social Housing

Health Hope Happiness

Operating Environment Social Housing

Mind The Gap

❖ **34%** of people who live in **social housing** are impacted by a long-term health condition or disability

❖ Leading to a **lower life expectancy** , a lower healthy life expectancy and an **overuse** and **over reliance** upon primary care and acute services **Kings Fund 2019**

Operating Environment Social Housing

- *Health inequalities are intrinsically linked to differences in social class and income . An increasing number of **social housing tenants** are adversely impacted by the wider determinants of health . Due to inherent barriers, despite being the most in need of health services social housing customers often have the **least access** to services when compared to that of the general population .*

Health Equity in England Marmot Review 10 Years On

Health Hope Happiness

Place Shaper Health Maker

We are whg

- Founded in 2003 we provide affordable good quality homes and community based services
- Our heart is in Walsall where we have over 20,000 homes enabling us to **care at scale**
- We promote health and prosperity where we can make a difference

Walsall Together

whg and the ICP

An innovative and effective **integrated care partnership** that brings together the organisations that plan and deliver health, mental health, social care, housing and voluntary services to improve health and wellbeing outcomes and create resilient communities

Health Hope Happiness
COVID-19

Issues

- Exacerbated existing health inequalities
- Ageing and vulnerable population
- Digital Exclusion
- Child Poverty
- Increased levels loneliness isolation

Response

- Stay in Stay Safe
- Kindness Bags Food Hampers
- Deployment skills- trade colleagues
- Community Responders
- Tablet distribution

Health and Wellbeing Strategy 2021 -2024

H Factor

- ❖ Reduce the impact of loneliness and isolation
- ❖ Use Social Prescribing to improve health
- ❖ Reduce the impact of poverty on children and families
- ❖ Enable customers to age well and live their best life possible

Health Hope Happiness

Health Hope Happiness

Community Champions

- Lived experience
- Cultural competence
- Authentic accessible role models
- Pied Pipers
- Human Bridge
- Model can be replicated and scaled up
- Stepping stone

Health Hope Happiness

Community Champions

- Clever Conversations
- Strength Based
- Incentives/ Hooks
- Theory of Change
- Here When You Need Us

Health Hope Happiness

Resilient Communities
whg led initiatives

- Jointly Chair
- Co production metrics
- Embed Lived Experience
- Innovation

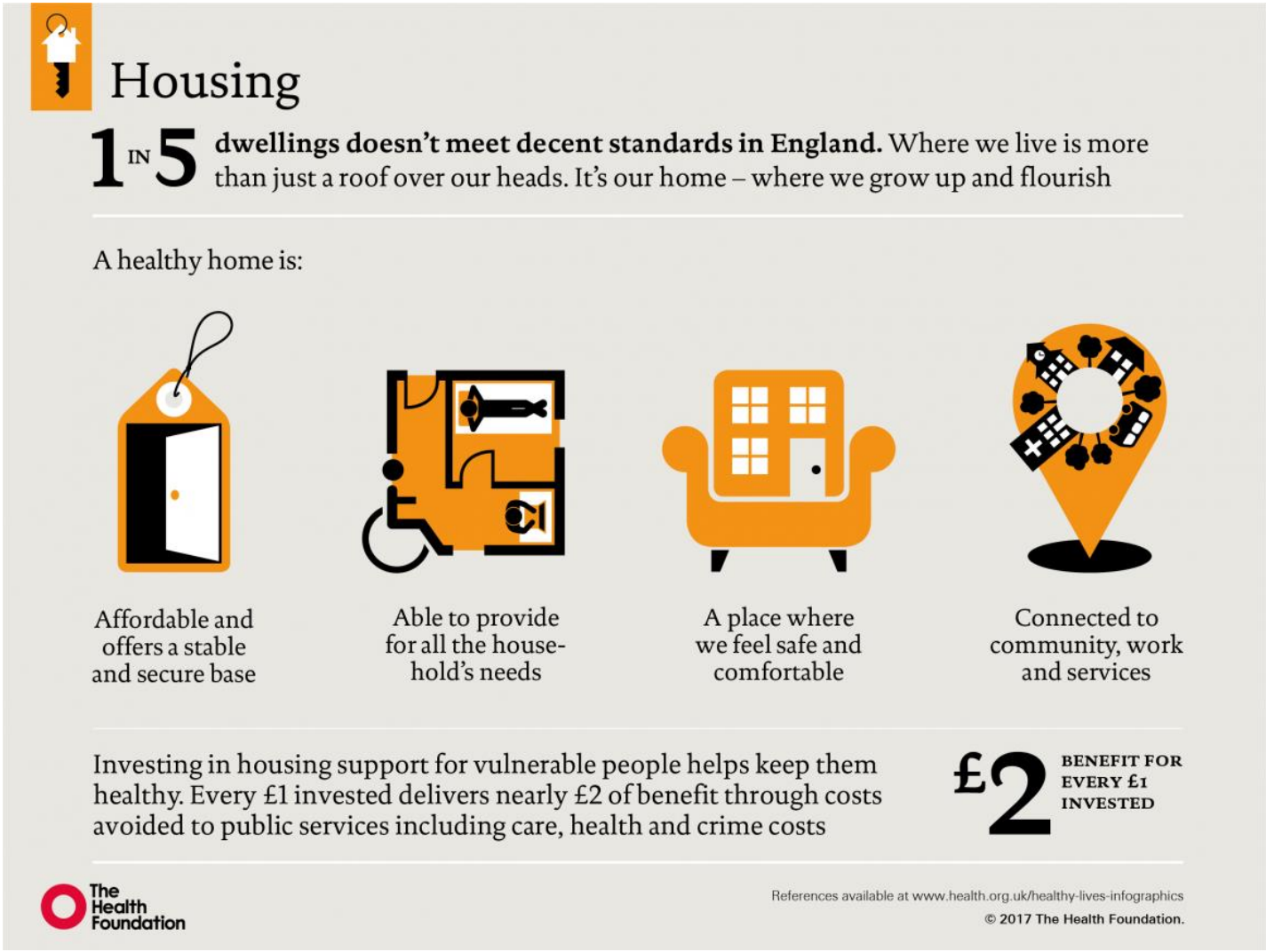
Examples

- Kindness Counts
- Work 4 Health

Health Hope Happiness

whg and ICS

- Levelling Up
- A place at the table
- Engagement
- Digital Inclusion
- Health Coaching
- Social Prescribing
- Workforce Development



Health Hope Happiness

Final Thoughts

I will not be satisfied until I can write a prescription for food and a prescription for housing

Bradford and Paradiso 2021

Connie Jennings
Head of Health and Wellbeing
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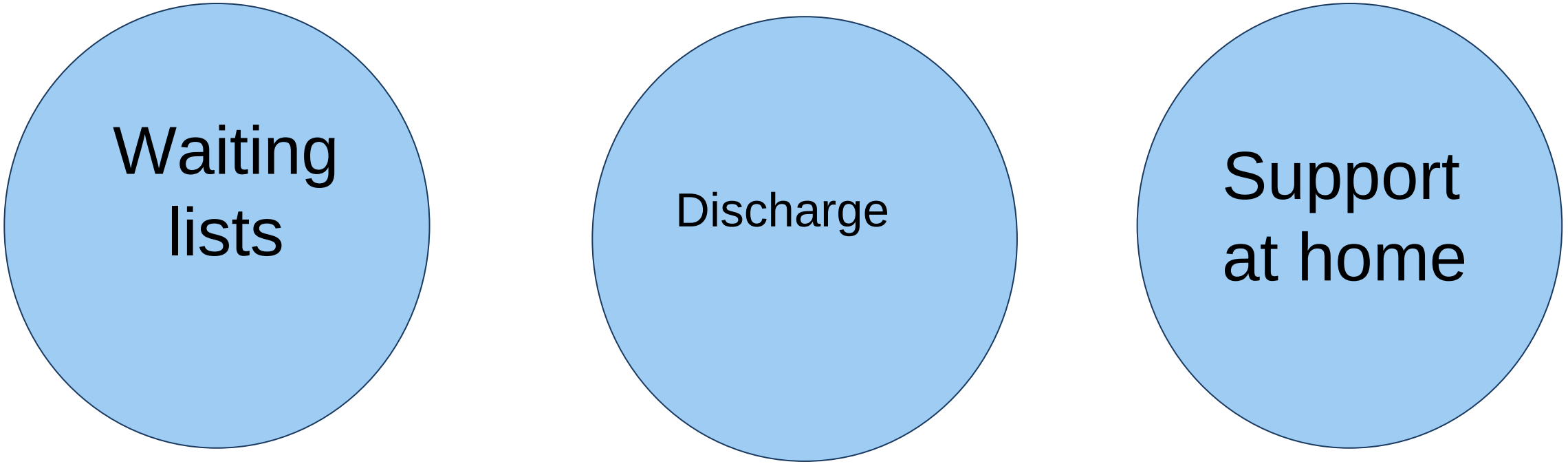
Developing an integrated health and care pathway supported by volunteers and community groups

Mark Lever
CEO Helpforce

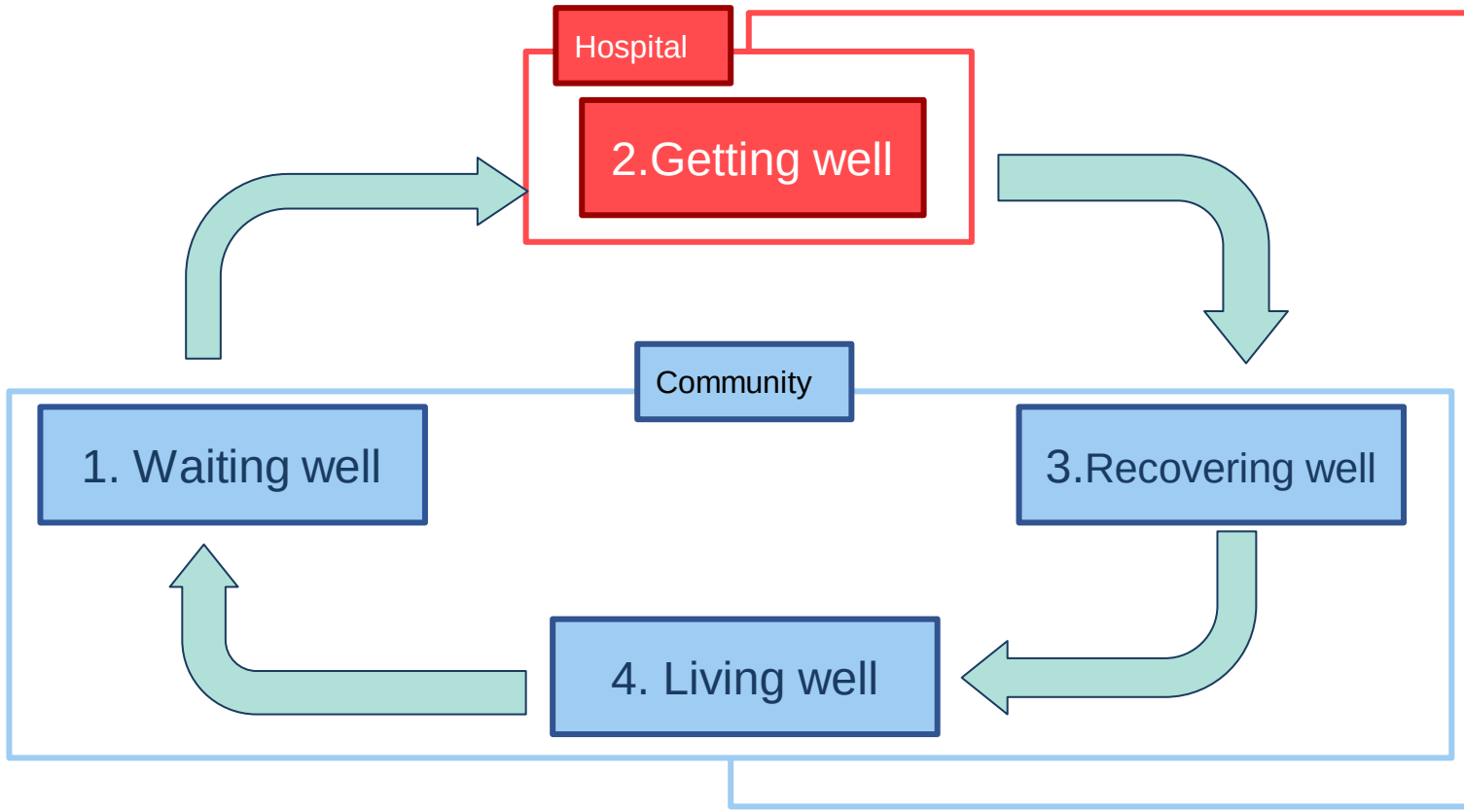
The challenges we face



The opportunity

How can we build on community response to covid?

Back to Health Pathway - overview



Developing Trust role as an anchor organisation

Reaching beyond the hospital walls to support people before they come to hospital and after they leave hospital.

Creating compassionate communities

Develop capacity and capability of existing community assets through working with others (statutory and voluntary sector) in our priority neighbourhoods.

Pathway is made up of three core volunteer based services

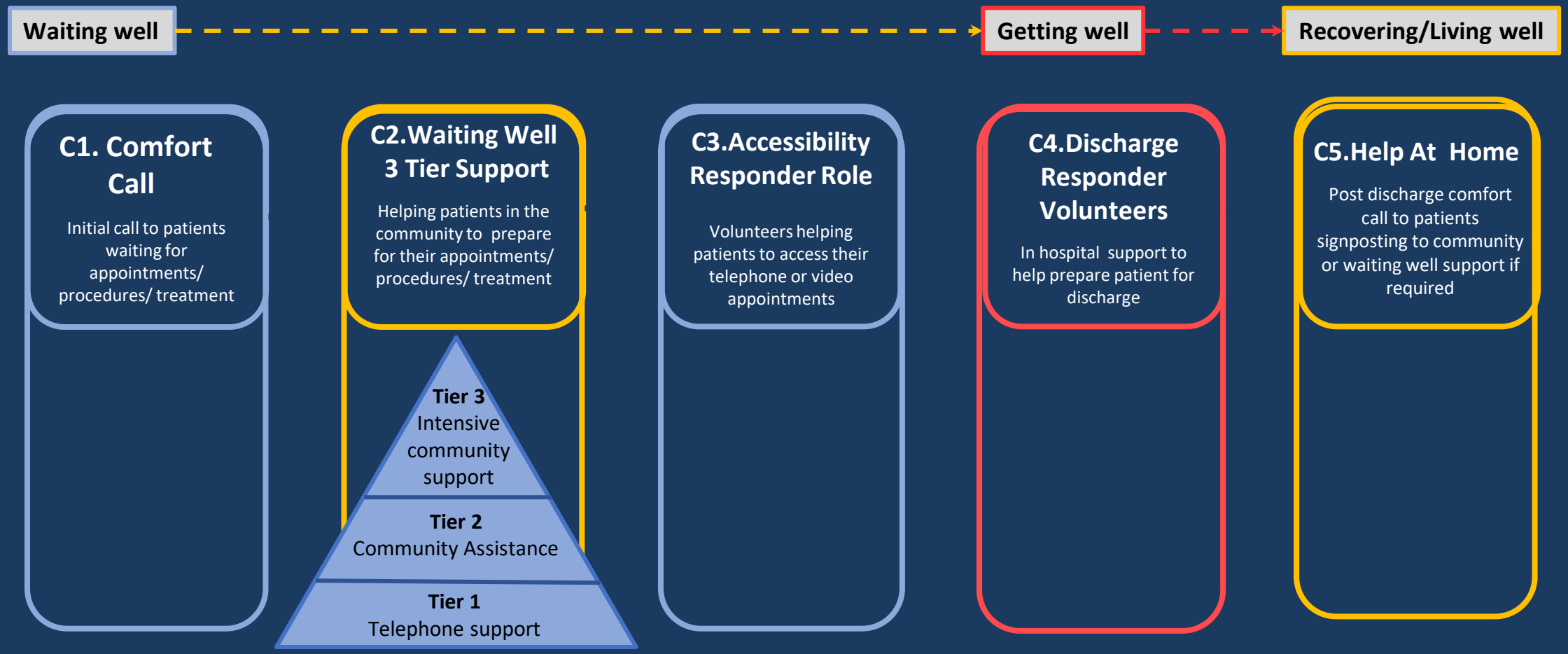
1. **Hospital based, Responder Volunteers** - delivering discharge support

1. **Contact Centre Volunteers**, based from hospital and their homes, delivering;
    - **Comfort calls** to patients on waiting lists (waiting well calls) and those recently discharged (help at home calls) to identify support needs, escalate concerns and signpost to community services
    - **Support calls** for patients identified as benefiting from support such as; how to access online appointments, preparation for hospital stay, discharge planning

1. **Community Volunteer Support*** patients identified as needing more intensive support either:
    - in their homes and/ or within community venues or
    - one to one or
    - as a group

    * managed through existing community assets

How the services fit together



C6 Compassionate Community

Building relationships with ethnically diverse groups and supporting their access to health services, information and support, whilst also encouraging their participation in volunteering.

helpforce

Unique elements of the Back to Health Pathway

- **An asset based approach** to develop the community elements of the pathway will be taken. The identified community funding within the cost model is passed through to the community to increase existing and establish new capability and capacity. GEH Community Engagement Officer role will establish the needed community relationships.

- **Data** will play a large part in ensuring the best impact is achieved. As well as providing prioritised lists for the contact centre, the analysis of the growing data and intelligence gleaned from contact centre calls and the support services provided will be actively used for escalating patient issues and service improvements both within the hospital and the community.

- **Evaluation** Data will be used to established agreed baseline positions against which any future impact will be assessed.

- **A clinical leader role** will provide quality assurance around the design of the volunteer led services and will act as a conduit ensuring that data and insight is transferred into **learning and service improvements and that there is real time escalation** of patient issues directly into the relevant specialisms.

helpforce

Four stages of volunteer support - Outcomes

1. Waiting well In the community

- Reducing deterioration whilst waiting
- Reducing pressure on hospital services
- Reducing the impact on primary care services
- Building and strengthening existing community volunteering capacity and capability
- Improving accessibility and inclusivity of services

2. Getting well In hospital

- Improving patient flow e.g. improving clinical capacity
- Reducing DNAs
- Ensuring all patients are best prepared for appointments/ procedures/ treatment
  - Identifying patient accessibility needs
- Reducing length of stay
- Reducing pressure on staff

3. Recovering well In the community

- Improving discharge support
- Reducing readmissions
- Reducing inappropriate attendance at ED
- Reducing loneliness

4. Living well In the community

- Building and strengthening existing community volunteering capacity and capability
- Preventing ill health, making every contact count
- Tackling health inequalities
- Improving personalised care, choice and control

NHS George Eliot Hospital NHS Trust

Key evidence of impact

Evidence highlights

Getting Well - in hospital

- Patients who are supported by a volunteer:
  - 91% say it improved their mood
  - 78% say it helped to reduce their anxiety
- **Staff wellbeing**
  - 71% of nurses feel less stressed with volunteer support
  - 73% of staff feel that volunteer support is helpful in allowing more time to deliver good care to patients
- **Efficiences**
  - To Take Out (TTO) collection support speeds up discharge by **44 mins per patient**
  - **Staff time released 29 mins** per TTO collection
  - Where volunteers are active, **26 mins of nurse time saved per day per nurse**
  - Digital accessibility support can **reduce DNA's by 15%**

Recovering Well - in the community (at home)

- Patients who were supported by volunteers at discharge and after returning home showed:
  - 16% reduction in loneliness
  - 45% improvement in feeling safe

Waiting/ Living Well - community based group activity

- 58% of patients receiving group focused community based sessions say it reduced loneliness
- 42% of participants felt more confident about looking after their own health.
- 40% of participants agreed they had learnt something about looking after their own health.
- 95% of participants agreed that their mood had improved over the rest of the week as a result.
- 63% of participants agreed that they now do more that benefits their overall physical health.
- 28% of participants agreed being involved in activity positively impacted other people in their life.

Source of emerging DNA evidence: Royal Free London NHS Foundation Trust, Digital Volunteer Pilot
Source of impact evidence: Helpforce VIP Report Nov 2020
Source of community activity impact: Bradford District Care NHS Foundation, Better Lives Together Service

Comfort Call, Help at Home pilot data

- +75 Yrs
- Calls made to patients 72 hr post discharge
- > 1200 patients called since Oct '21
- Average of 80 hrs volunteering p/m

Comfort Call Conversation outcomes	Monthly Average
1) Patient feels unwell at time of call	10
2) Patient needs/asks for advice or support (health)	12
3) Patient needs/asks for advice support (other)	5
4) Caller identifies potential safeguarding	1
6) Follow up call or action required	14
8) Referral	4
9) Other	19
	64
Require further assistance (average 300 patients p/m	**21%**

Signposts/ referrals to:
Age concern
PALS
Social Services
GEH department

Patient would like to be referred so she can talk to someone
Patient lives on her own daughter lives in London who visits regularly but
needs to join a group within the community of her own age.
Patient would like to be referred as nobody will help.
Patients spouse is really struggling as husband is having panic attacks
Has lost control of water works and bowels, very sleepy and not drinking, her daughter who she lives with has contacted the doctors and are waiting an assessment. Patient is unable to get out of bed wants to know what help is available
Patient does have someone at home but would like to know what other help is available- needs help to understand medication.
Patient lives on her own, nurses visit 4 times daily patient requires equipment.
Patients spouse would like to speak to someone as to what is available to her as did not have a discharge package when discharged from hospital however is finding it difficult at home.
Patient wants to speak to someone as no one is helping him struggling at home feels he needs a chair in his shower.
GP hard to get in touch with.

helpforce

Thank you

www.helpforce.community

Thank you for attending, please have a safe journey home