WELCOME TO

The Integrated Care Summit North

SEE THE AGENDA

16th May 2023 - 8:00am – 3:30pm – Manchester

Conference hosted by Convenzis Group Limited

The Integrated Care Summit North 2023

Headlined by: Content Guru

The Integrated Care Summit North

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Welcome to the conference, what are you looking to gain out of today’s conference?

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The Integrated Care Summit North

Chairs Opening Address

Dr Gurnak Singh Dosanjh

GP and ICB Clinical Lead for **Home First**

Leicester, Leicestershire and Rutland ICB

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SPEAKING NOW

CONVENZIS

Professor Martin Green OBE

Chief Executive - **Care England**

I will be discussing...

"Integrating Health and Social Care: Time to act"

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Panel Discussion

Dr Gurnak Singh Dosanjh

GP and ICB Clinical Lead for Home First
Leicester, Leicestershire and Rutland ICB

Professor Craig Harris

Chief of Health and Care – Integration -
Lancashire and South Cumbria Integrated Care Board

Linda Vernon

Lancashire & South Cumbria Integrated Care Board **- Interim Head of Digital Empowerment**

We will be discussing…

"ICB Leadership and Productivity Panel Discussion"

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The Integrated Care Summit North

SPEAKING NOW

CONVENZIS

Martin Taylor

Deputy CEO - **Content Guru**

I will be discussing...

"ICS Command Centre: A Key Tech Enabler for Integrated Care Systems"

Connectedness in Healthcare: The Tech Enabler for Integrated Care Systems

Martin Taylor – Deputy CEO

Agenda

Challenges in ICSs

A Unified Patient Experience

Examples of Excellence

Introduction to Content Guru

REDWOOD TECHNOLOGIES GROUP

REDWOOD TECHNOLOGIES

est. 1993

Weston Digital Technologies

est. 1996

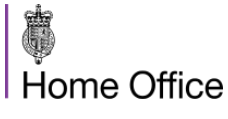
CONTENT GURU

est. 2005

Europe's **leading** CCaaS Cloud Contact Centre Provider

Analyst Recognition

NHS and UK Public Sector Clients



SVCC AND IRP

Single Virtual Contact Centre

Intelligent Routing Platform

1

Challenges in ICSs

ICSs

Scope and Size

ICSs cover areas ranging from **0.5 to 3 million** citizens across various regions[1].

Consistent issues are seen across ICSs:

1. Non-unified patient experience due to differing patient engagement strategies
2. Chronic staffing shortages, extreme resource strain and health inequalities

Expectations from the NHS

Expectations from the Public

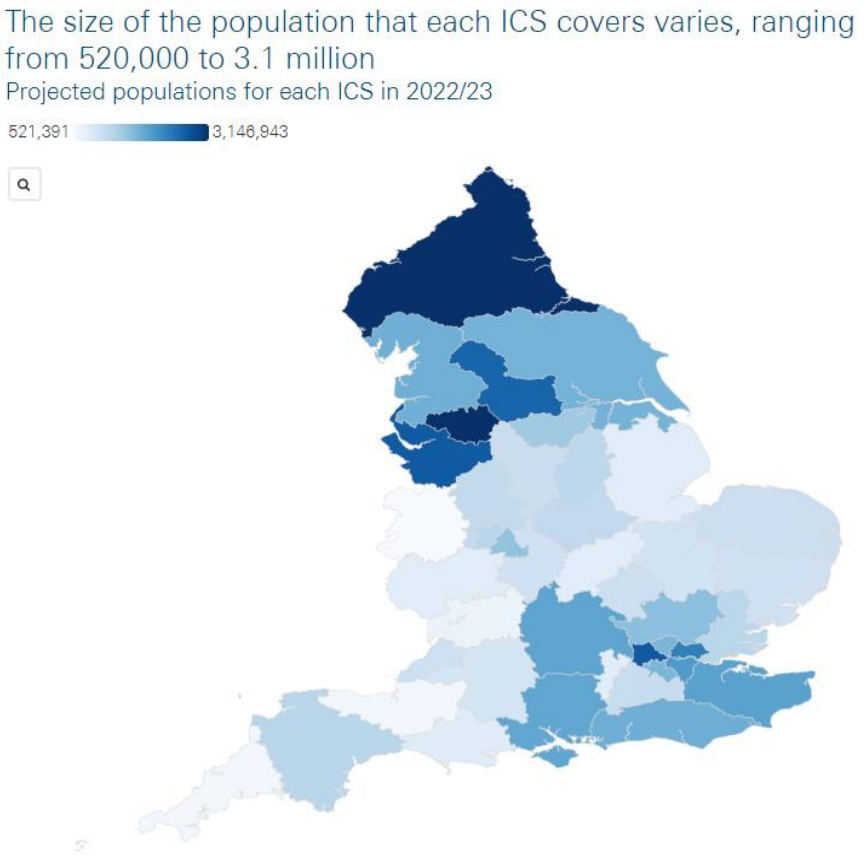


Figure 1: The health foundation: integrated care systems: what do they look like?

1. The Health Foundation

NHS: Data Saves Lives

Expectations from the NHS

Mandated by the NHS: Data Saves Lives for a single data strategy for health and care, ICSs are faced with commitments they must achieve

1
Public guide and policy guidelines to secure data environments

2
Accreditation and monitoring regime to ensure high standards are met

3
Technical specification for interoperability, cyber security & privacy enhancement

4
Comprehensive roadmap to implement the framework with expectations & deadlines

Public Expectations

What the Public Wants from ICSs

Reduced wait times and ability to self-serve

Consistent personalised care that builds trust

57% feel the general standard of care provided by healthcare organisations has deteriorated in the last 12 months[1]

1. The Health Foundation

Jeremy Hunt

Running Cost Reductions

ICBs running cost allowances must be cut by **30%** by 2026.

Integrated Care Systems

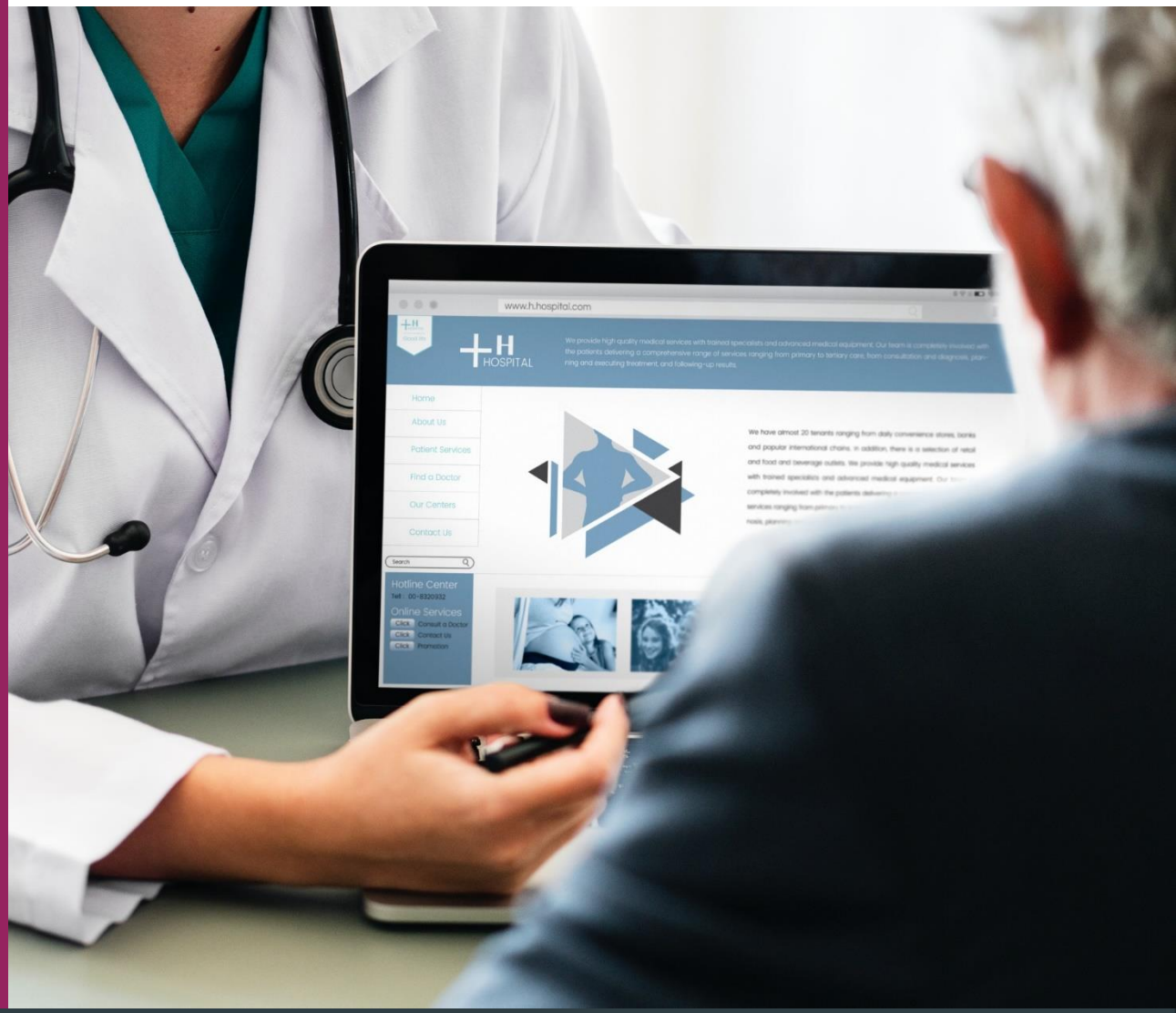
Key Aims for the Service

ICSs have **four key aims** they need to achieve to improve public service

- Improving population health outcomes
- Support the NHS to achieve broader social & economic development
- Tackling inequalities in outcomes, experience & access
- Enh[illegible]in[illegible] pro[illegible]lue

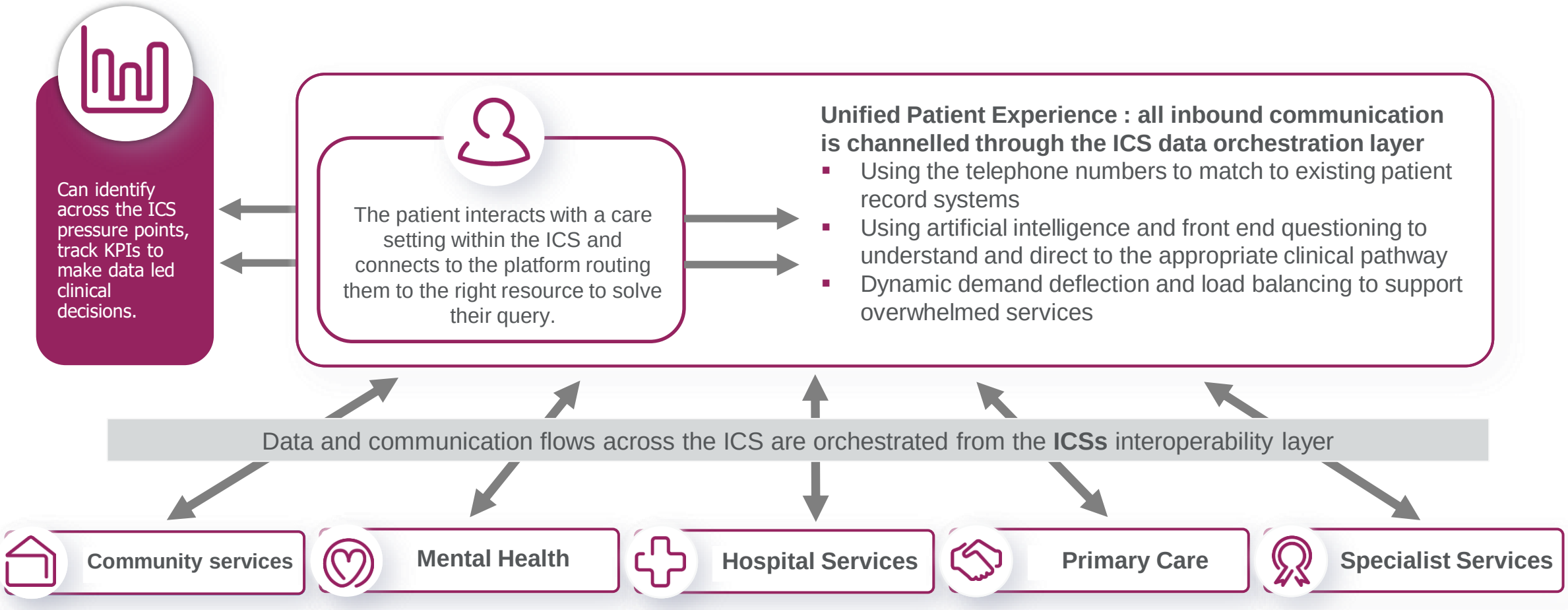
2

A Unified Patient Experience



Integrating Technology into ICSs

Command Centre



Unifying the Patient Experience

Technology and Integrated Care

Create a unified system using the correct tools, to support your professionals in delivering a high standard of care

Virtual Environments

Virtual Front Door
Virtual Wards

Modern Tools

Natural Language Processing
Intelligent Routing
Self-Service
Machine Automation

Virtual Front Door

Managing Demand within Primary Care

Virtual Front Door

Patient fills an online symptom assessment

- Telephone numbers to match patient to existing records
- AI and patient-specific questioning to understand intent
- Automated contact with patient at each step, delivering instructions and empathy

Depending on assessment outcome patient is directed towards appropriate care setting

Where appropriate video consultation can be used, increasing capacity for face-to-face consultations

Assessment uploaded to primary care record, informing relevant HCPs if required

Virtual Front Door

ED Referral

Patient routed away from acute care to other services e.g. mental health or primary care services

1. NHS 111 receives ED disposition, call routed to virtual front, placed into call-back or queue or ED triage clinician

- Hold prioritised outbound call queue in call platform
- Takes into account existing care plans and clinical notes/encounter history
- Patients confirmed to ED or signposted to more appropriate source of care

2. Call handler advises patient that they should present at ED and asks to wait for an SMS

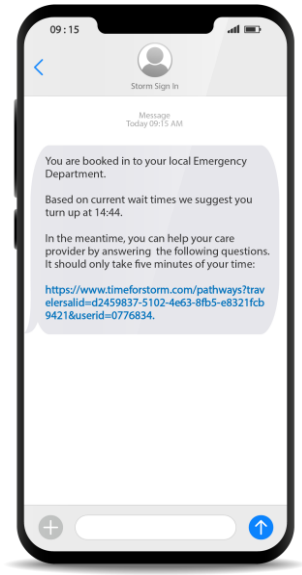
3. Patient's referral information captured and sent in an automated SMS to the patient to book in

4. Data is captured and booked into the sign in where it enters the virtual appointment queue

5. Optional pre-arrival triage based on symptoms and situation where the patient can be further assessed

6. Comfort messaging sent to patient whilst providing option to request escalation call/video if deteriorating

7. Where remote consultation closes case, patient receives post event message with summary and next steps



Virtual Wards

At Home Care Supported by Command Centre

Patient monitored by smart devices; data captured is used to update the virtual ward platform

Omni-channel platform hosted in secure UK cloud infrastructure

Records updated using HL7/ FHIR-based API integrations to keep clinicians informed

Command Centre
Prioritised call-out list for HCPs, based on vital signs

Seamless Communication
Alerts sent to patients directly via a variety of channels

Demand Management
Capacity of Healthcare Facilities monitored, for effective steering

Modern Tools

Natural Language Processing and Intelligent Routing

Natural Language Processing (NLP)

NLP can process basic details such as caller identity, nature of query and linking relevant medical data.

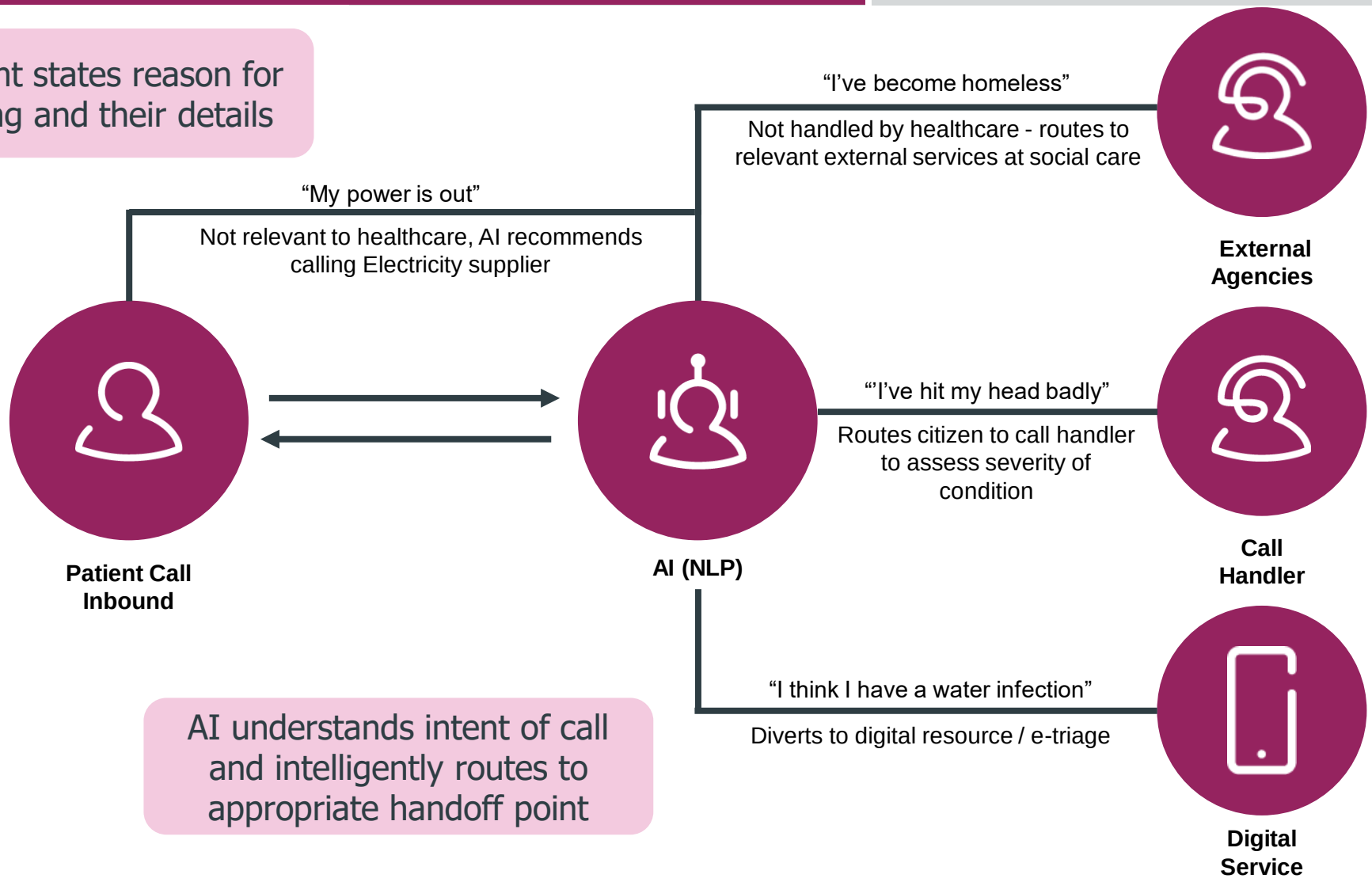
Intelligent Routing with AI

AI can route the patient to the most appropriate healthcare professional, improving the chance of first contact resolution and increasing the efficiency of communication systems.

Modern Tools

Example of NLP and IR

Patient states reason for calling and their details



Humans deal with the relevant queries related to their roles

AI understands intent of call and intelligently routes to appropriate handoff point

Modern Tools

Self-Service and Machine Automation

Self-Service

Time and cost-effective way to manage queries that don't require direct interaction. **69%** wish to resolve as many issues as possible using self-service options.[1]

Machine Automation

Processes mundane, repetitive tasks freeing up staff for the human element of healthcare.

1. Zendesk 2022

3

Examples of Excellence

HUC

One of the top performing NHS 111 and Integrated Urgent & Emergency

Care providers in England, serving **4.3 million** people

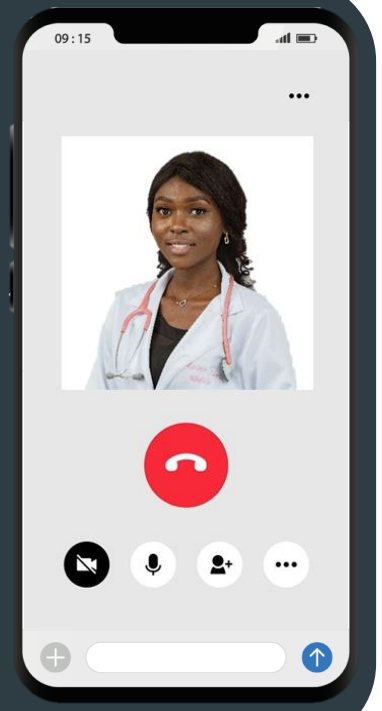
6+ years of using **storm®** to deliver 111, CAS and GP OOH services end-to-end

HSJ AWARDS 2021

On Demand Video Consultation

Clinicians send link to the patient's smartphone. Either party can terminate video and voice link will remain.

Voice and video recording for quality management.



NHS London 111

Working across **32** local authorities, up to **100,000** calls are handled per week

Approaching **7** years of using **storm®** to assist NHS 111 London Calls

Developed the Patient Relationship Management solution to route interactions in two months to MVP

Patient Relationship Management (PRM)

Automated routing to rapidly direct patients to HCPs

Clinical advisors fed relevant patient information

Comprehensive real-time view of London healthcare

Repeated callers routed to the same call handler

Summary

The Command Centre

Orchestration layer across **ICS operational units** and **systems of record**

A **two-way flow** of communications and data

Automated, AI and HCP-driven services

Modern tools and machine automation to **transform efficiency** and **manage high demand effectively**

Powers at-home triage and care to **reduce strain** on urgent and emergency care

Thank You

Continue the Conversation . . .

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Professor Martin Green OBE

Chief Executive - **Care England**

Q&A PANEL

Martin Taylor

Deputy CEO - **Content Guru**

Morning Break, Networking & Refreshments

The Integrated Care Summit North

Chairs Morning Reflection

Dr Gurnak Singh Dosanjh

GP and ICB Clinical Lead for **Home First**

Leicester, Leicestershire and Rutland ICB

UP NEXT...

People.Health.Care.

The Integrated Care Summit North

SPEAKING NOW

Rhonda Bradder

Regional Commercial Manager - **L&R**
Medical UK

I will be discussing...

"Workforce and clinical transformation through partnership working"

People.Health.Care.

Workforce and clinical transformation through partnership working

Rhonda Bradder, Commercial Manager, L&R

The community workforce challenge

"There are less nurses to care and more patients needing care"

The following comments were heard by the RCN during a community nursing forum:

- "Minimum staffing requirements aren't being met within my team"
- "I am making at least 20 patient visits per day – I don't have enough time"
- "My experienced colleagues are leaving and not being replaced - this impacts on my patients"
- "My wellbeing is suffering, and I don't have support"

RCN District and Community Nursing Forum from 492 nurses surveyed between November and December 2020

The burden of wound care is escalating…

£8.3 billion

Annual estimated healthcare cost associated with wounds

49%

of chronic wounds healed within 12 months

3.8 million patients

managed by the NHS with a Wound

71%

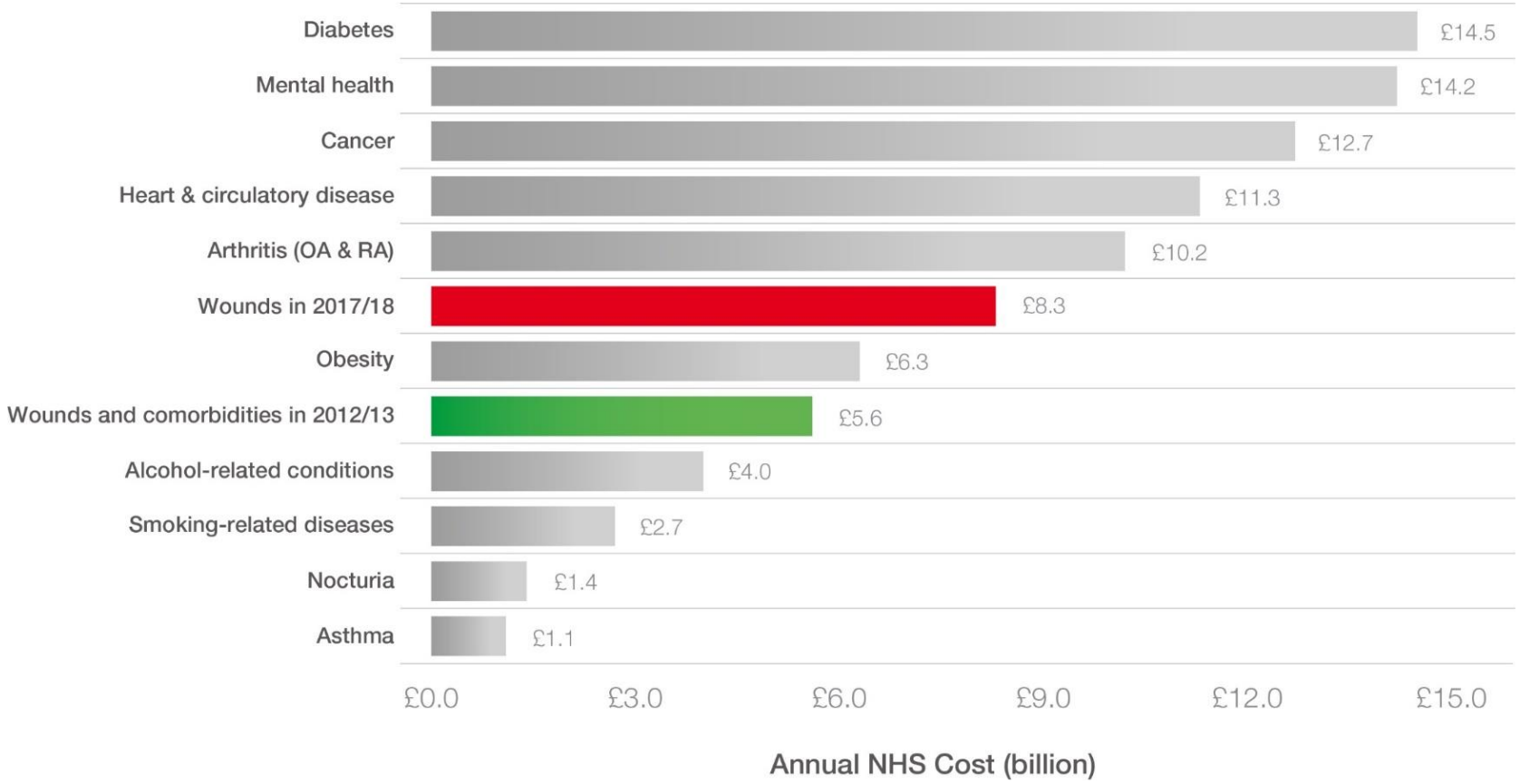
Increase in the prevalence of wounds

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

The burden of wound care is escalating

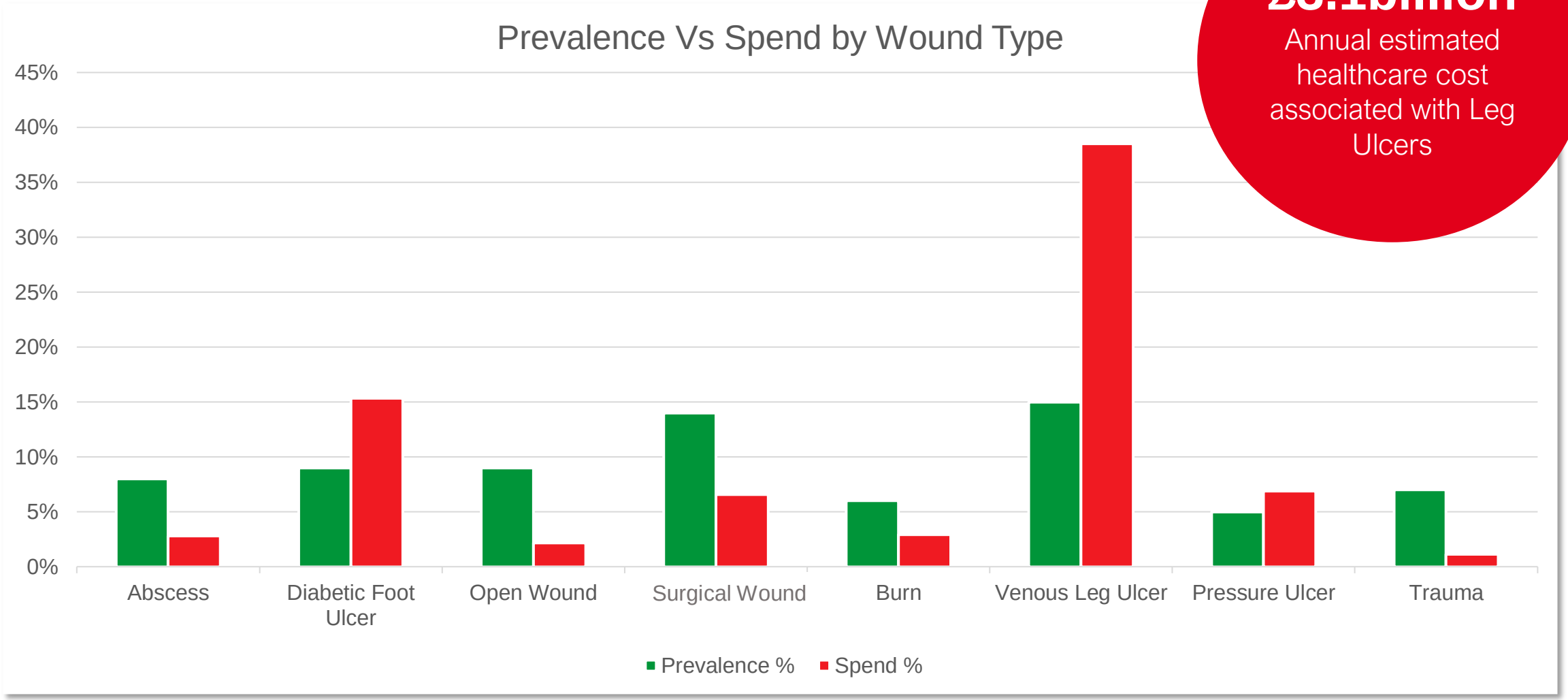
Figure 1

Burden of illness league table
Guest et al 2015



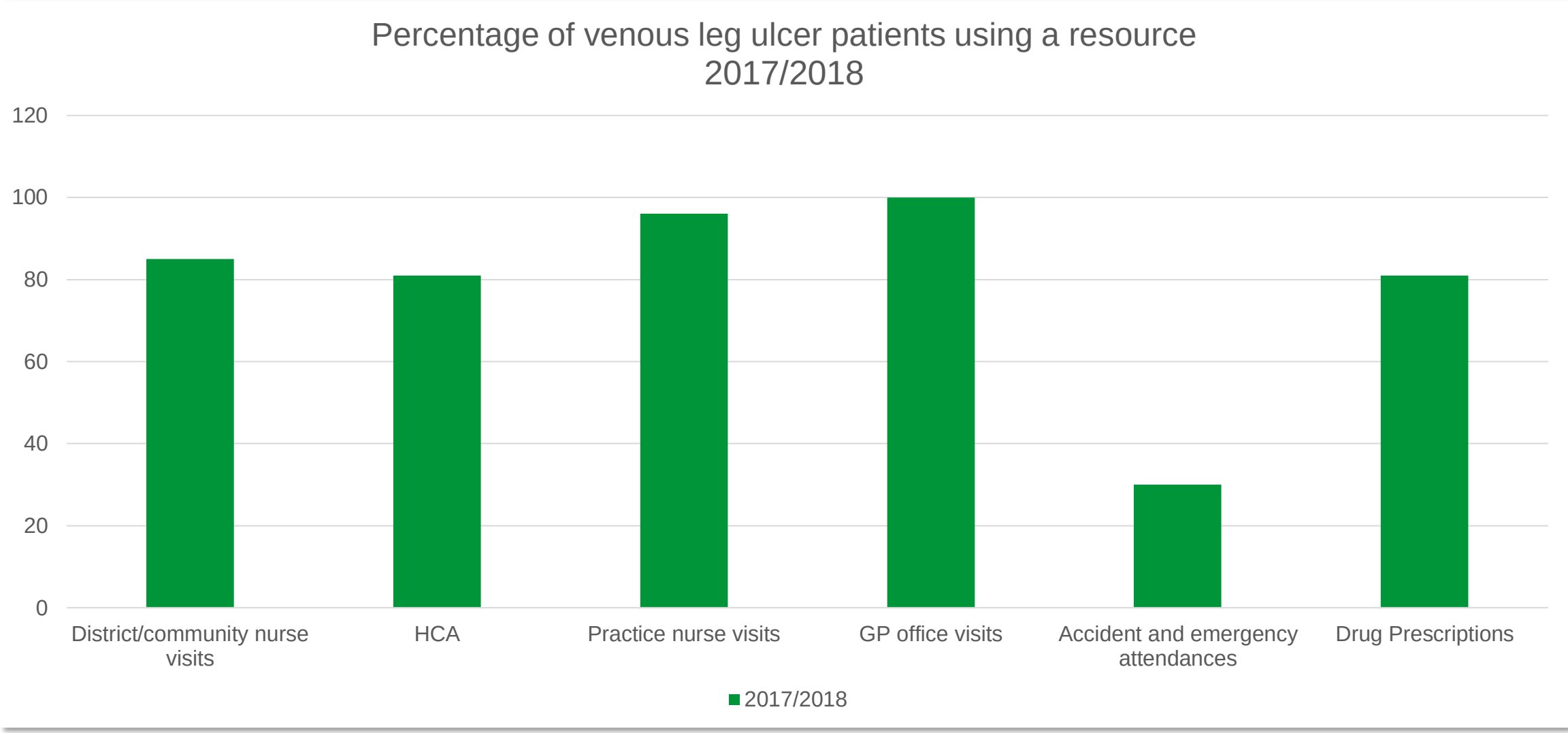
The burden of wound care is escalating

£3.1billion
Annual estimated healthcare cost associated with Leg Ulcers



Guest et al. 2020

The burden of wound care is escalating



Guest et al. 2020

Betty's Story

January 2017

NHS RightCare

NHS RightCare scenario:
The variation between standard and optimal pathways

Betty's story: Wound care

January 2017

https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/02/nhs-rightcare-bettys-story-app1.pdf

NHS RightCare

Financial information

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.

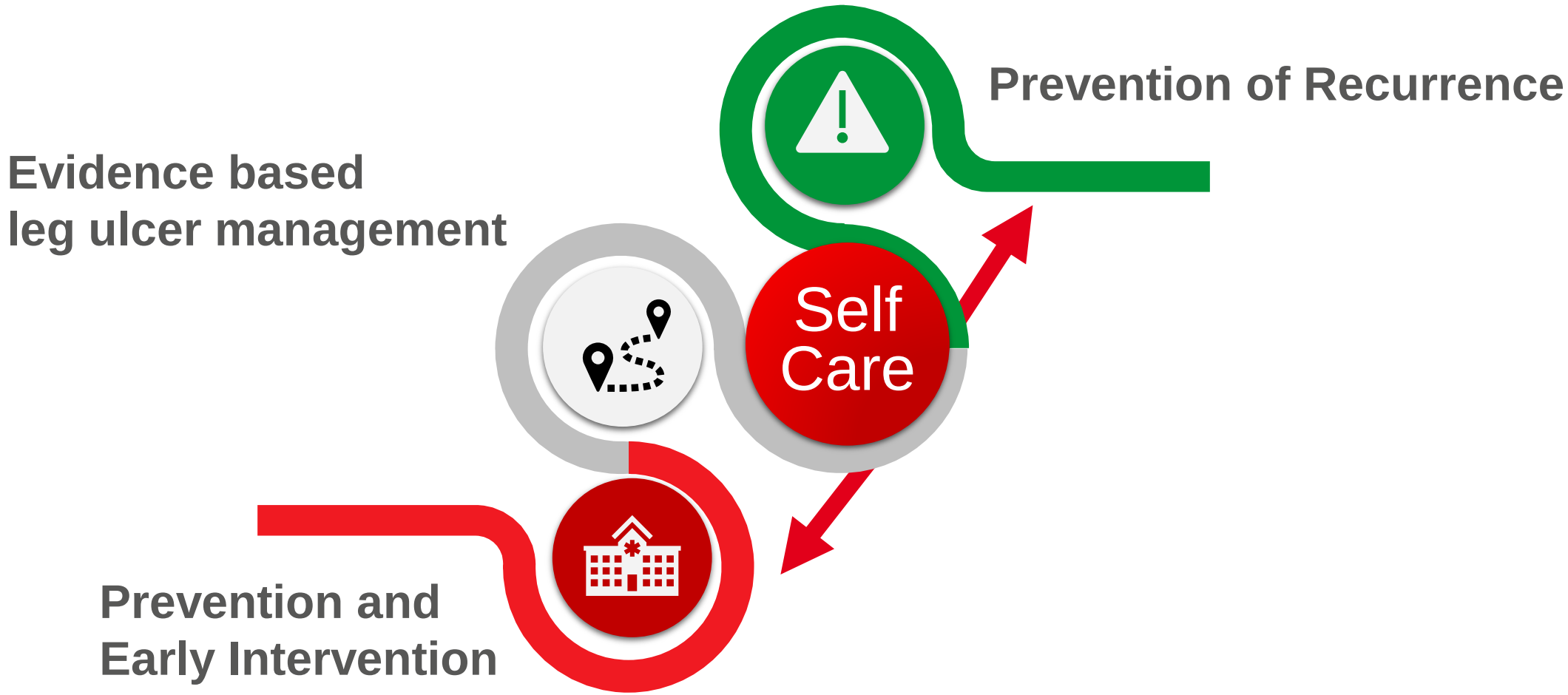
The need to optimise the patient pathway is evident:

1. NHS Long Term Plan

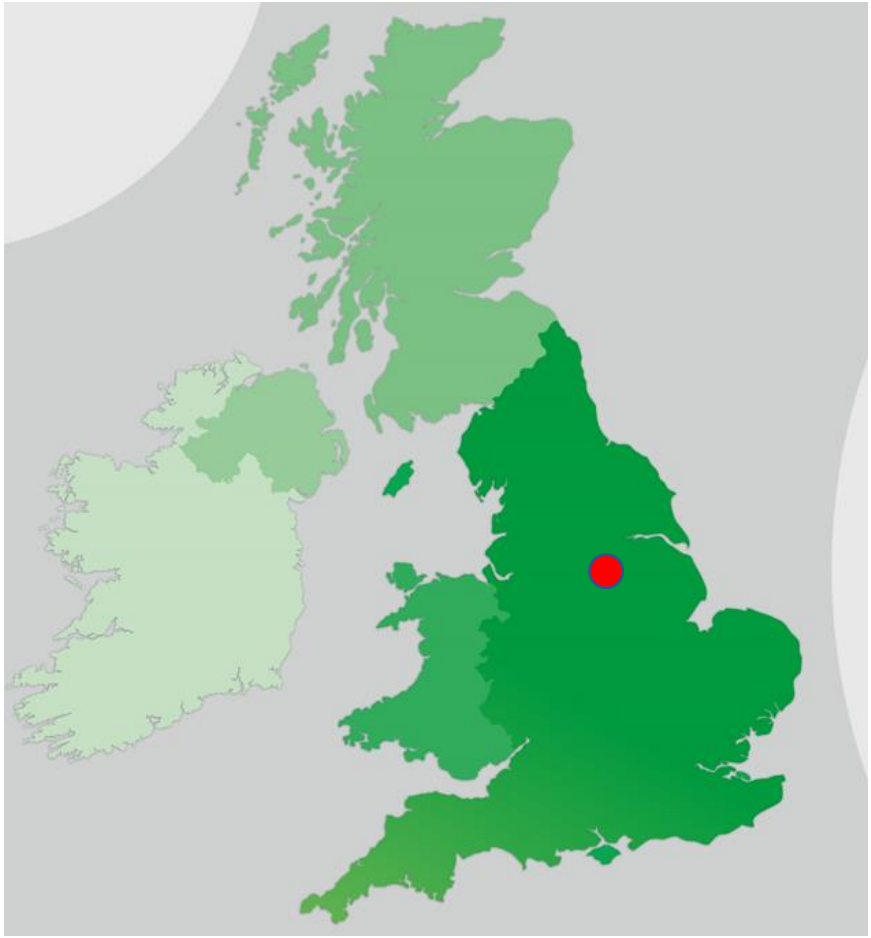
2. NHS White Paper: Integration and Innovation

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

A solution for the whole patient journey



South West Yorkshire Partnership Trust

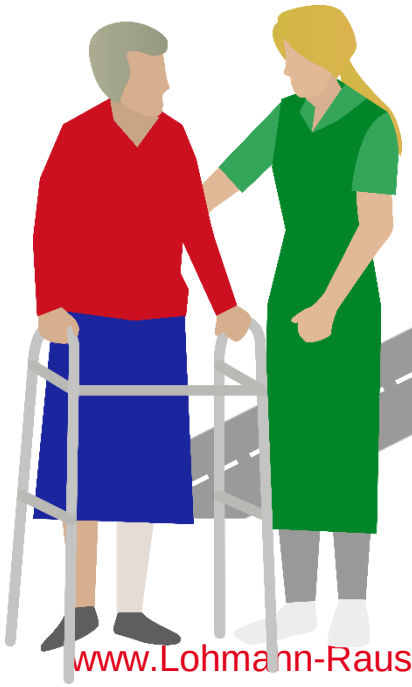


2,000
The approximate number of new patients presenting with leg ulcers at South West Yorkshire Partnership Foundation Trust in a 12-month period (2019)

Up to **1,380** may re-present to South West Yorkshire Partnership Foundation Trust with a recurring leg ulcer annually

£4.3 million
The annual approximated cost associated with treating patients with leg ulcers in South West Yorkshire Partnership Foundation Trust

Implementing a 3 step approach…



1

CLINICAL TRANSFORMATON

Atkin and Tickle (2019)

2

SERVICE EFFICIENCIES

SELF-CARE DELIVERY MODEL

3

EDUCATION AND COACHING

SQUEEZE IN

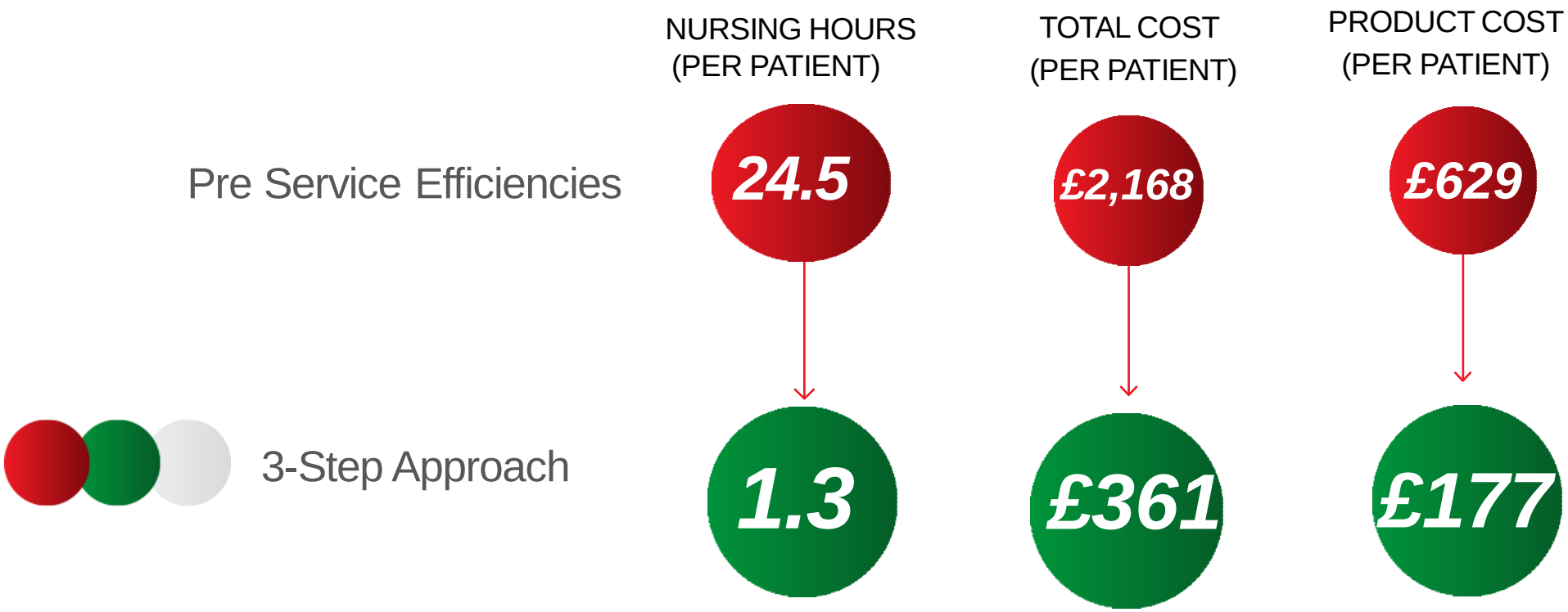
NHS South West Yorkshire Partnership NHS Foundation Trust

Based on:

1. Atkin & Tickle 2019
2. Hallas Hoyes et al 2021

The results from service model transformation

South West Yorkshire Partnership NHS Foundation Trust



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

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

National Scalability

Per 100,000 population:
(total cost release or cost avoidance)

£903,500

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

Per 100,000 population:
(product cost release or cost avoidance)

£226,000

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

Per 100,000 population:
(nursing hours)

6 FTE

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

System wide improvements:

South West Yorkshire Partnership NHS Foundation Trust

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*

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

Improved patient outcomes

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- Enabling patients to stay in employment while receiving treatment
- Patients preferred not being confined to set appointments
- Reduced financial impact due to travel
- Increased empowerment to take ownership of their care
- **Friends and Family Test: 100% rated the Leg Ulcer Service outstanding with no negative comments (1,481 respondents)**

100%
Outstanding friends and family test

Comments from patients on the self care delivery model in South West Yorkshire Partnership Trust

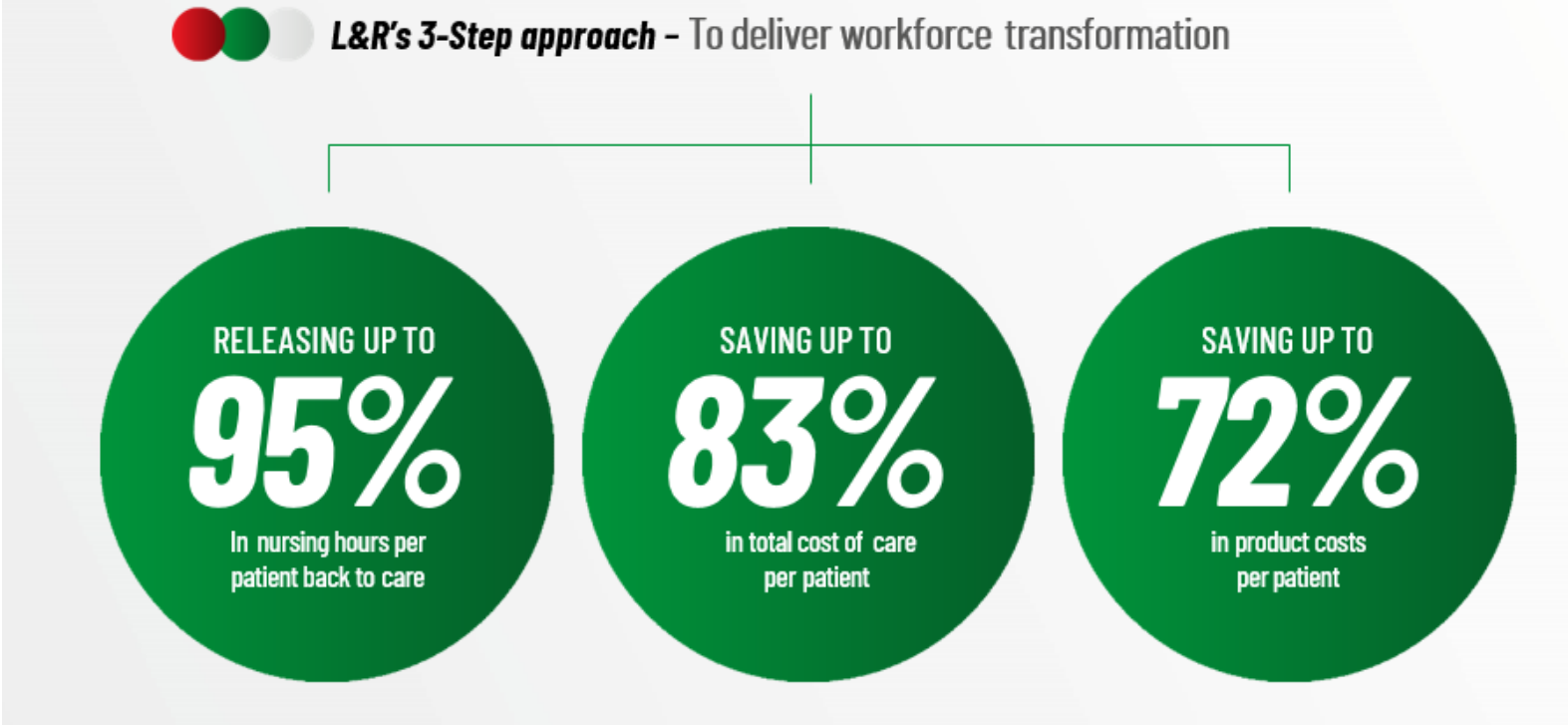
Award winning approach

HSJ Partnership Award March 2022
Most effective contribution to clinical redesign L&R Medical and SWYPT

"The project achieved impressive results with regards to the impact on workforce utilisation and patient empowerment while ensuring high standards of clinical outcomes. There is considerable potential for the approach to be rolled out rapidly and at scale across the country which is likely to result in significant savings of care hours needed as well as costs, while allowing patients to have more flexibility with regards to their care."

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.



Hallas-Hoyes et al. (2021)

References

1. Guest JF, Fuller GW, Vowden P. Cohort study evaluating the burden of wounds to the UK's National Health Service in 2017/2018: update from 2012/2013. BMJ Open 2020;10:e045253. doi:10.1136/ bmjopen-2020-045253

2. NWCSP, National Wound Care Strategy Programme (2020) Lower Limb Recommendations. Available online at: https://www.ahsnnetwork.com/app/uploads/2020/10/@NWCSP-Lower-Limb-Recommendations-13.10.20.pdf

3. NHS Right Care 2017. NHS RightCare scenario: The variation between sub-optimal and optimal pathways. Betty's at: https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/01/nhs- rightcare-bettys-story-narrative-full.pdf

4. Hallas-Hoyes et al. (2021). An advanced self-care delivery model for leg ulcer management: a service evaluation. JWC

5. Atkin, L. et al. (2019) Updated leg ulcer pathway: improving healing times and reducing costs. British Journal of Nursing, Vol 28. (20) Suppl.

6. COVID 19 - Advice in relation to Wound Care in Community Services.

7. HSJ Partnership Award 2022
   Most effective contribution to clinical redesign
   L&R Medical and South West Yorkshire Partnership NHS Trust, Tissue Viability Service

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How would you like to follow up with Rhonda post-event?

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SPEAKING NOW

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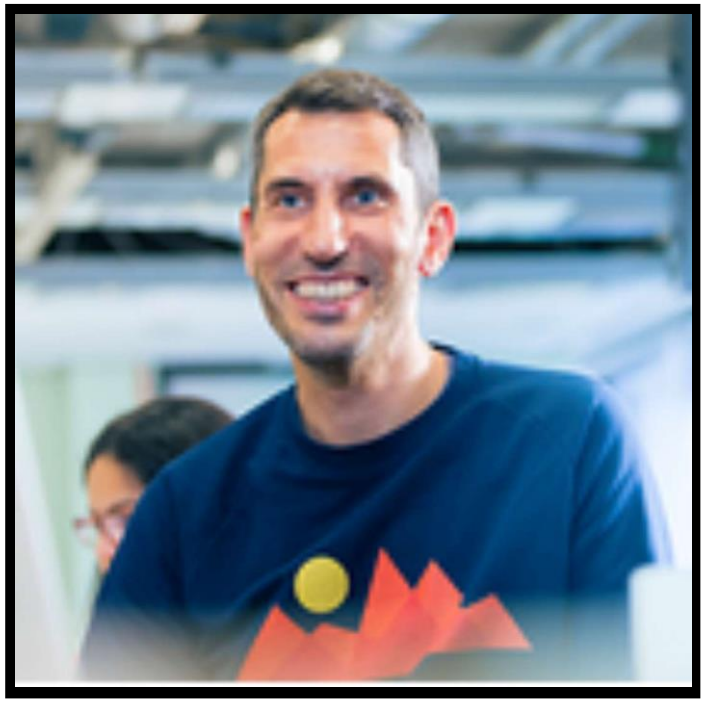


Ben Showers

Partner - **TPXimpact**

We will be discussing...

"Improving Patient Pathways"

David Robson

Senior Service Designer - **TPXimpact**

TPXimpact

NHS
Buckinghamshire Healthcare
NHS Trust

Improving patient pathways

Creating a simple, consistent and integrated experience for all

TPXimpact

Hello! We are Dave and Ben

Ben Showers

Health partner
@benshowers

Dave Robson

Service designer
@daybydayv

We worked with wonderful people

The incredible patients and staff within Bucks who made this project possible

Ian Roddis
Interim chief digital & information officer

Julia Fish
Digital project manager

Hannah Z
Design researcher

Mo A
Technology lead

Buckinghamshire Healthcare Trust (BHT) wanted to understand the patient experience across gynae and cancer pathways - from a communications and information provision perspective.

We took a human-centred design approach

Agile and iterative.

Open and transparent.

Digitally collaborative.

What we discovered for patients

Information that patients receive can be confusing. They experience challenges with appointments, don't have visibility of their journey, and feel they are discharged without direction - not knowing risks, what to expect, or who to contact

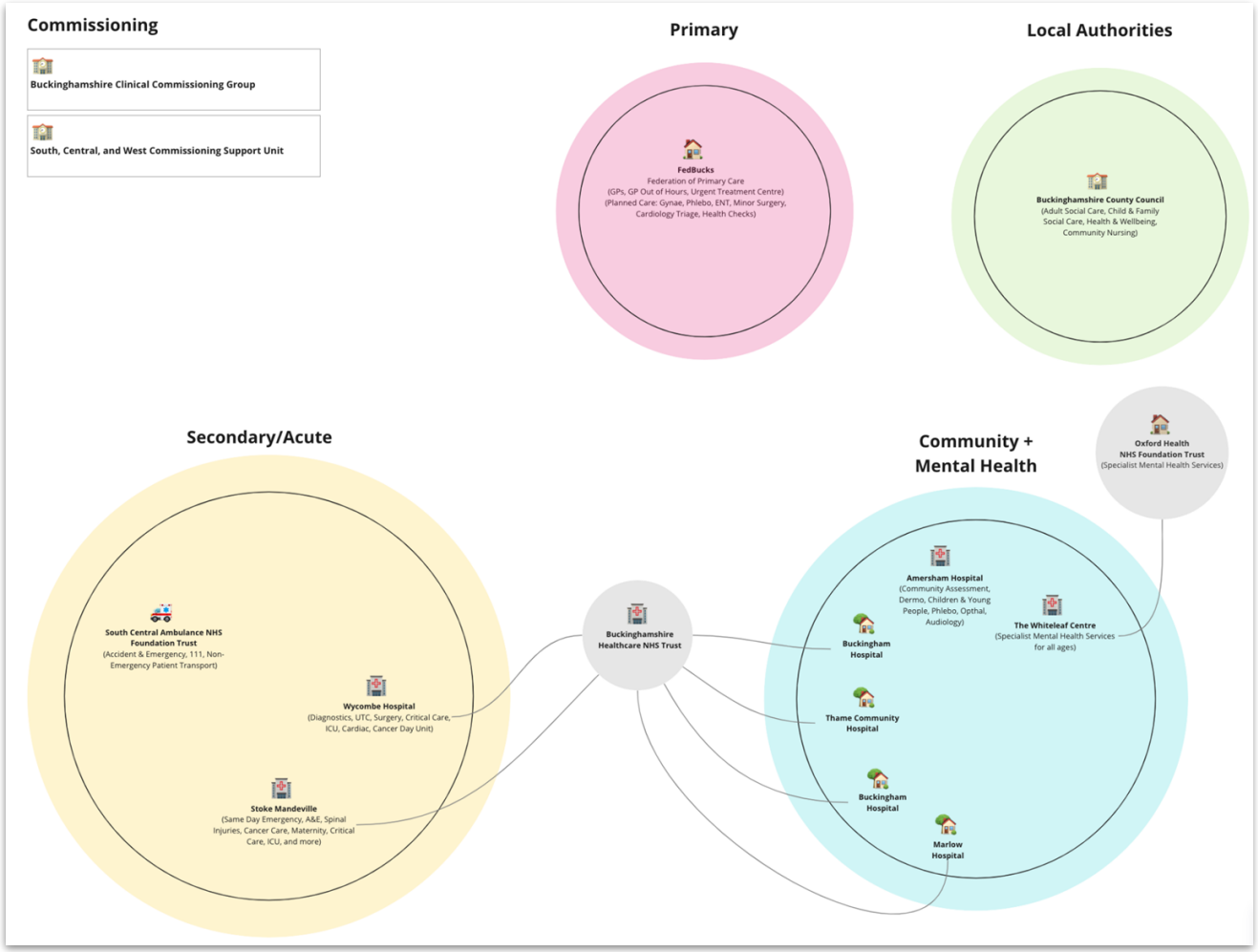
What we discovered for staff

Staff time is precious. Too much time is spent traversing a complicated tech landscape. They can't access reports, don't have a full picture of the patient's journey, and have difficulty communicating between departments and sites.

TPXimpact

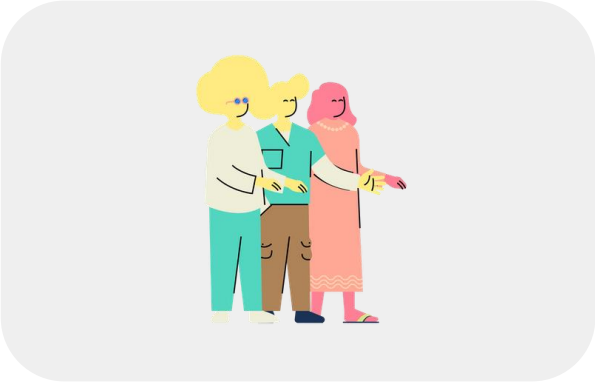
How did we get there?

We knew this would involve more than one organisation across the system

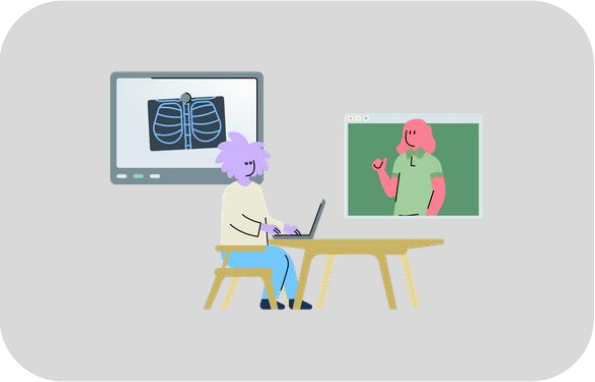


We took a full-service approach...

Patients
Cancer, Gynae, Community Groups



Clinical & Admin Staff
GPs, Consultants, Nurses, Healthcare Assistants, PX

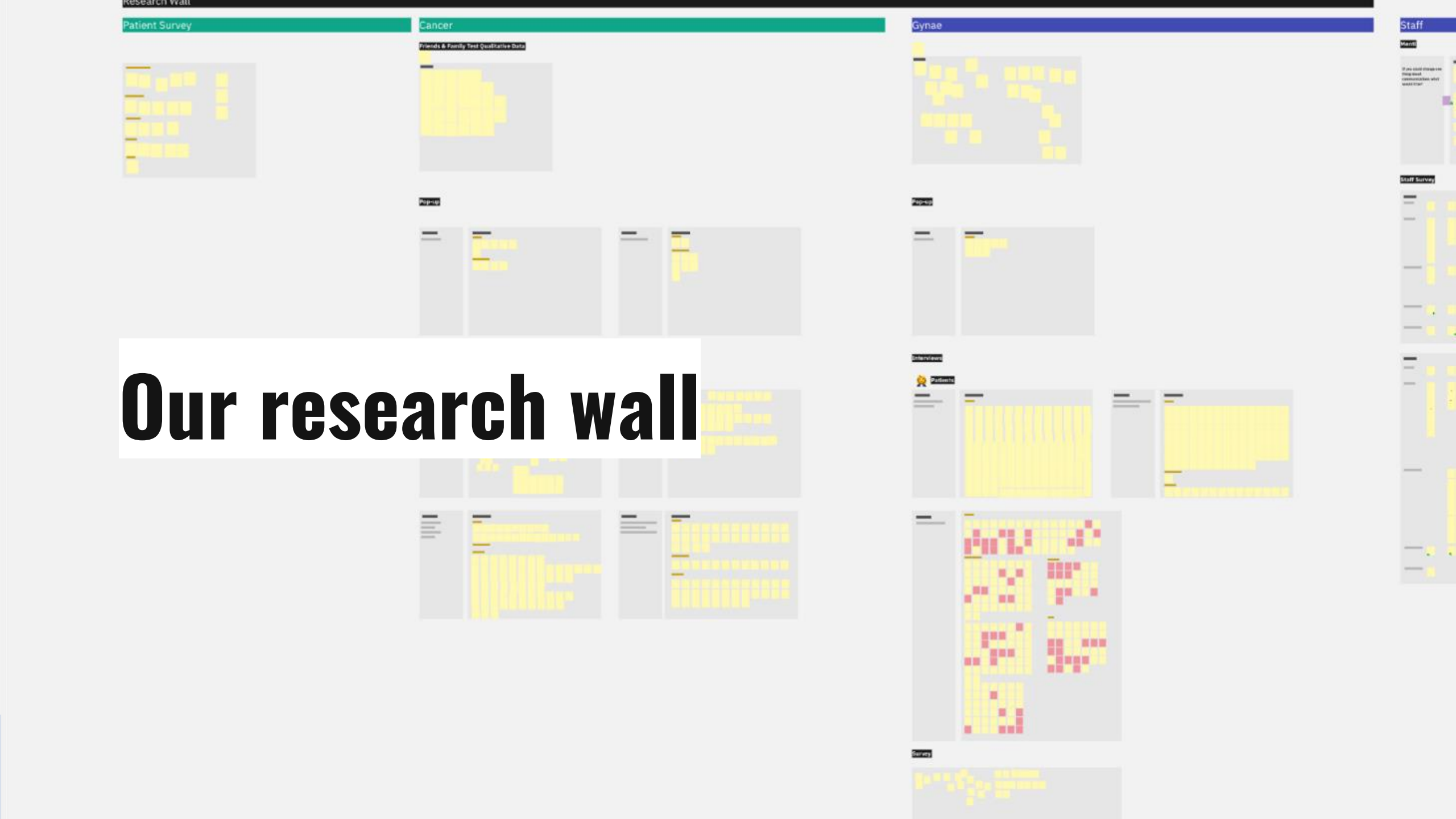


Digital Back Office
Product Managers, Digital Team

...and used a range of methods

Patients		Staff	
Friends and family data	Survey	Tech workshops	Survey
Hospital pop-up	Interviews	Clinical staff workshops	Interviews
Desk research			

Hospital pop-up


Research Wall
Patient Survey
Cancer
Friends & Family Test Qualitative Data
Pop-up
Gynae
Pop-up
Interviews
Patients
Staff
Staff Survey
Our research wall

NHS
Buckinghamshire Healthcare
NHS Trust

Patient Pathway Discovery Project

Cancer Patient Journey

Our journey map

Summary

Buckinghamshire Healthcare NHS Trust (BHT) and TPXimpact have delivered a patient pathway discovery project to understand more about the patient experience. This journey map is the synthesis of our discovery, across the cancer pathway.

Key Context

This journey map is to **help BHT understand where there are opportunities for improving the patient experience across all pathways.** We have used the Cancer pathway as just one area for our overall research.

We are fortunate to have worked with the Cancer team, who have been willing to engage, to better understand where there are opportunities to improve the patient experience across BHT.

Meet Rhonda

Rhonda is 49 years old. She lives in Bucks with her partner and dog. She enjoys being active and countryside walks

Journey Map Scenario

Rhonda lives a healthy lifestyle. She has not had much engagement with healthcare services up until this moment in time and does not have a deep knowledge of medical terminology. Recently, she hasn't been feeling herself and following inspection discovers a lump on her body.

How to use it

- Focus on understanding and addressing both patient **and staff pain points**
- Look through the pain points on this map and consider how we can address them
- This map should be an **evolving document**. Add more insight to it over time
- Consider testing and adopting the ideas shared by patients in the successes swimlane

Research considerations

This journey map is **not intended to be representative of all** cancer patient experiences. All healthcare journeys are unique and cancer journeys, especially, can be episodic and complex in nature.

	Sharing symptoms with a doctor			Referral and testing				
Step. The key activities that Rhonda is involved in throughout the journey.	Rhonda has been feeling fatigued for a while and finds a lump on her body. She's worried	Rhonda calls her GP and attends an appointment later that day	Rhonda's GP refers her for tests at the hospital. She is told to expect to hear from the hospital within 3 weeks	Rhonda waits more than three weeks to hear from the hospital, so chases via email and phone before receiving a letter confirming details of her appointment	Rhonda isn't sure what the various tests are and how to prepare for them. She looks for information online and tries to contact the hospital for more information	Rhonda attends the hospital for her appointment. She's not sure where to go or what is going to happen. She's come alone	Rhonda spends the next few hours undergoing various diagnostic tests at the hospital. It's a long day	At the end of the day, Rhonda has an appointment with the consultant and a Macmillan nurse where she is given an initial diagnosis
Feelings and needs. What Rhonda is feeling as she progresses throughout the journey. Includes real quotes from patients.	**"It's uncomfortable to verbally say to someone that I have a lump. My go-to would always be digital."**			**"I never received communication for today's appointment, only word of mouth."**		**"It feels like you're wetting yourself (MRI) - nobody told me this."**		**"After they said you have cancer, I didn't really hear the rest of the words."**
Positives. Interactions or parts of the patient experience that are good.						Patients have found setting **realistic expectations in advance** helpful - such as the **number and type of diagnostic tests** to expect on a given visit	Patients have found setting **realistic expectations in advance** helpful - such as **actual waiting times**	
Pain points. Challenges the patient experiences on their journey. Includes real quotes from patients.	Patients have expressed difficulty in accessing GP services in the first place "I can't communicate with my GP unless I go through Patient Access. It's a nonsense, I just want a consultation."	Information on referral letters - when to contact, who to contact - is not always accurate, causing patients to be distressed and contact the hospital. Letters can be late, too "I was not given a date. I had to call them and follow up to say I haven't heard. It felt like a blur." "Sent late. Appointment nearly missed."		Appointments aren't working for patients - there are double bookings, lack of available times, bookings with short notice, poor communications, and inefficient locations "Expected to be in two places at once." "I couldn't make appointments because letters came late."	Language and information in communications is confusing and unhelpful for patients. It doesn't always make sense and they can misinterpret it "I had an appointment come through for radiotherapy. I saw the word radio and thought I have cancer, but it was for an MRI scan."	From the information provided, it's difficult for patients to prepare emotionally and logistically for diagnostic testing "I was not prepared for the biopsy. I had no idea. It was much more invasive than I had expected."	Waiting for expected communications, such as diagnostic results, is distressing. Patients feel left in the dark and contact the hospital "During the wait I felt nervous, scared." "The waiting is the biggest thing. Would have liked regular check-ins."	Receiving upsetting news of a cancer diagnosis is a tough moment and patients have found anything other than face-to-face to be upsetting "Telephone consultation - poor delivery of upsetting messages." "Due to nature of treatment I feel results should be face to face."
Staff. Which staff roles are involved at different stages.	General Practitioner, Admin Team			Admin Team, Clinical Team				
Activities. The main activities staff are delivering at this stage of the service.	**Booking appointments, holding initial appointments, and sending referrals**			**Receiving referrals, triaging referrals, booking appointments, and conducting diagnostic tests**				
System pain points. Challenges the staff experience while	**Lack of system understanding, speed, and reliability** eRS and triage software runs slowly for GPs and Admin teams. Systems can sometimes crash.	**Lack of systems management & consistency** Multiple different systems require logging into separately. Multiple different systems spanning multiple hospitals		**It's difficult to get information about the patient #1** The general feeling amongst admin teams are that they are expending huge effort doing "detective work" across multiple systems to understand all information on the		**DocGen referral can cause delays** Consultant letters often remain on DocGen unapproved. This prevents them from advancing the patient journey. Multiple		

Cross-pathway insights

Patients don't have clear visibility whilst waiting. They find this - and timelines not being met - distressing

Patients feel they are discharged without direction: not knowing risks, what to expect, or who to contact

The lack of integration between primary and secondary care causes challenges for patients and staff alike

Clinical teams can't access patient results across departments, services, and geographical boundaries

TPXimpact

Journey maps should not be the end outcome.

It should be driving change.

We created an opportunity backlog to help drive delivery against the insights

Insight is...	We believe...	Will...	Outcomes...
Once treatment is finished, patients feel they are discharged without direction. They do their best but feel unguided and don't know what to keep an eye on	Providing better guidance for post-treatment life, recovery, and what to look out for	Help patients to safely manage their health following discharge and reduce their demand on healthcare services	Reduced avoidable admissions Increased patient safety Reduce patient calls Increased admin capacity Increased clinical capacity


Sharing symptoms with a doctor
Referral and testing

We thought these things went well

1 - WHAT WENT WELL

Using mixed research methods

2 - WHAT WENT WELL

Taking a universal synthesis approach

3 - WHAT WENT WELL

Including patients beyond research

4 - WHAT WENT WELL

Setting up teams to deliver

If we could go back, we would change our approach

1 - WHAT WE WOULD CHANGE

Taken a systems-convening approach

2 - WHAT WE WOULD CHANGE

Engage even more clinical teams

3 - WHAT WE WOULD CHANGE

Setup long-term relationships and participation

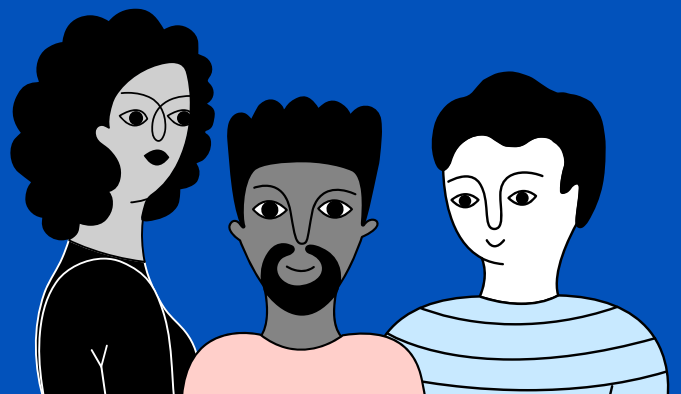
TPXimpact

All the project outputs are open to the public.

Speak to us if you would like to hear more, ask questions, or seek advice!

THANK YOU

TPXimpact



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How would you like to follow up with Ben and Dave post-event?

ⓘ Start presenting to display the poll results on this slide.

The Integrated Care Summit North 2023

Headlined by: Content Guru

The Integrated Care Summit North

SPEAKING NOW

Martina Lagu Yanga

Head of Medical Education and Training -
Epsom and St Helier University Hospitals NHS Trust

I will be discussing...

"Delivering education and training for whole systems integrated frailty care pathways"

NHS
Epsom and St Helier University Hospitals NHS Trust

Developing evidence based education framework for frailty practitioners within Sutton integrated care system

Martina Lagu Yanga
Dr Mohamed Elokl

Integrated Care Summit North 16th May 2023

Outline

- Innovation in evidence-based education for frailty practitioners within Sutton integrated care system
- Frailty awareness and management
- The frailty framework core capabilities
- Soft skills, simulation training and focused study days
- Whole system stakeholder engagement
- Developing and supporting learners and educators

The need for frailty education and training in Sutton

- Changing demographics and healthcare landscape
- Actions from Sutton whole system frailty stakeholder engagement and launch Sept 2022
- To support the NHS People Plan
- Integral to new approaches to workforce design/planning - from profession focus to skills and competency focus
- To develop and support multi-disciplinary and inter-professional learning throughout the patient journey
- To develop and support healthcare educators to ensure sustainable future workforce supply

The People Plan

Overall outcome

- ✓ More people
- ✓ Working differently
- ✓ In a compassionate and inclusive culture

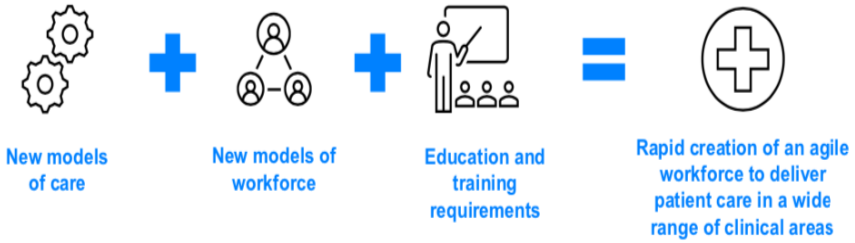
. . . to support the delivery of the NHS Long Term Plan

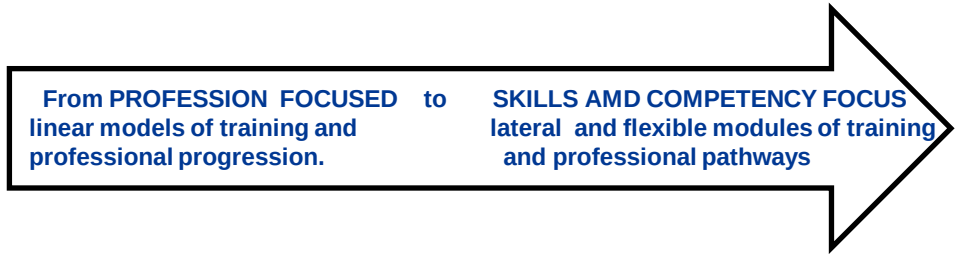
Pillars	Themes for action in 2020/21
Looking after our people	We are safe, and physically and mentally healthy and well
	We work flexibly
Belonging in the NHS	We are open and inclusive, and staff have a voice
	Leaders are compassionate and inclusive at all levels
New ways of working and delivering care	Making the most of the skills in our teams
	Educating and training our people for the future
Growing for the future	Expanding and developing our workforce
	Recruiting and retaining our people

Source: Prof Sheona McLeod (HEE): Epsom and St Helier Medical Education Away Day 29 Sep 2022

A new approach to workforce design/planning

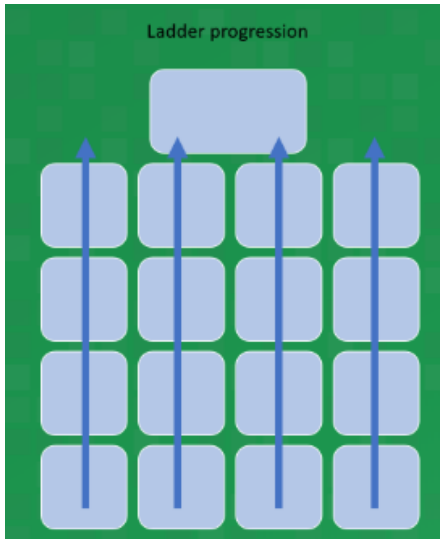
Health Education England

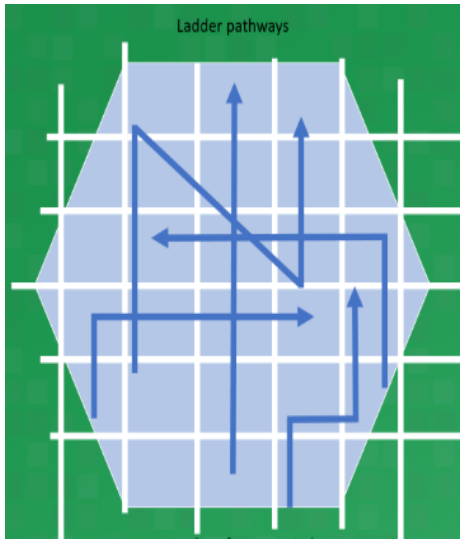




A clinically led workforce planning approach, using activity to determine capability requirement and shape skill mix redesign.. Enables a **skills and competency based, rather than professional role and title** based approach to planning and deployment.

During COVID, early integration of the E&T workstream into the service planning for the clinical workforce led to planned training of staff.





Strategic priorities that underpin the Educator Workforce Strategy

Source: NHS Educator Workforce Strategy 2023

Strategic priorities for education in integrated care systems

Priority 1

Key consideration in integrated workforce and service planning

Priority 2

Support the implementation of Integrated Care Board workforce plans

Priority 3

Introducing career frameworks for educators of all professions

What is frailty?

- *Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves (* British Geriatric Society, 2014)
- Manifests in loss of resilience: people don't bounce back quickly after a physical or mental illness, an accident or other stressful event (NHS England)
- A dynamic state of reduced resilience and increased vulnerability.
- Impact: increased risk of mortality, increased risk of institutionalisation, prolonged hospital stay, increased hospital readmission rate.

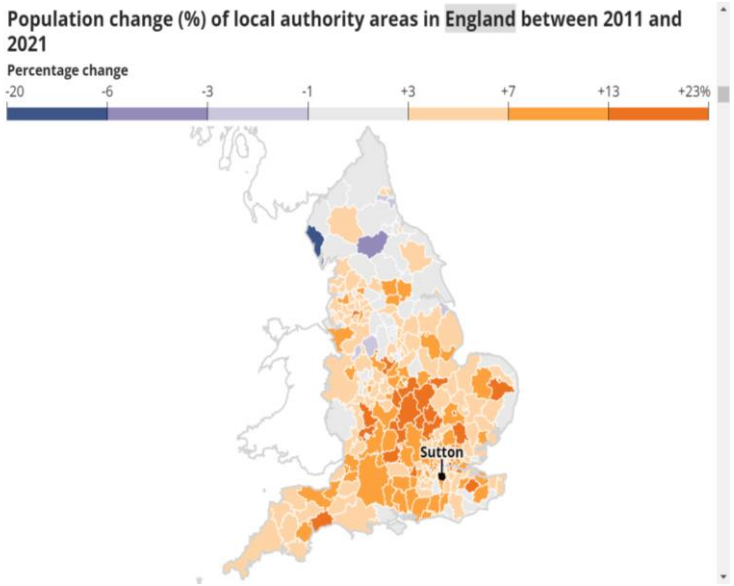
Common presentations of frailty

- Delirium
- Falls
- Immobility
- Incontinence
- Polypharmacy

I
A
M
Frailty
aware

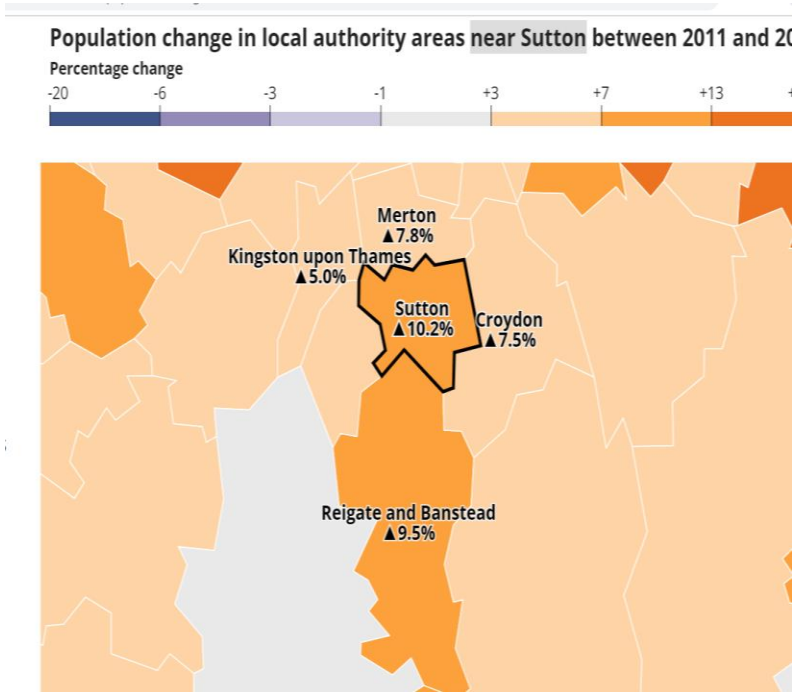
- **I**dentify : CFS
- **A**ssess : 5M
- **M**anage : MDT

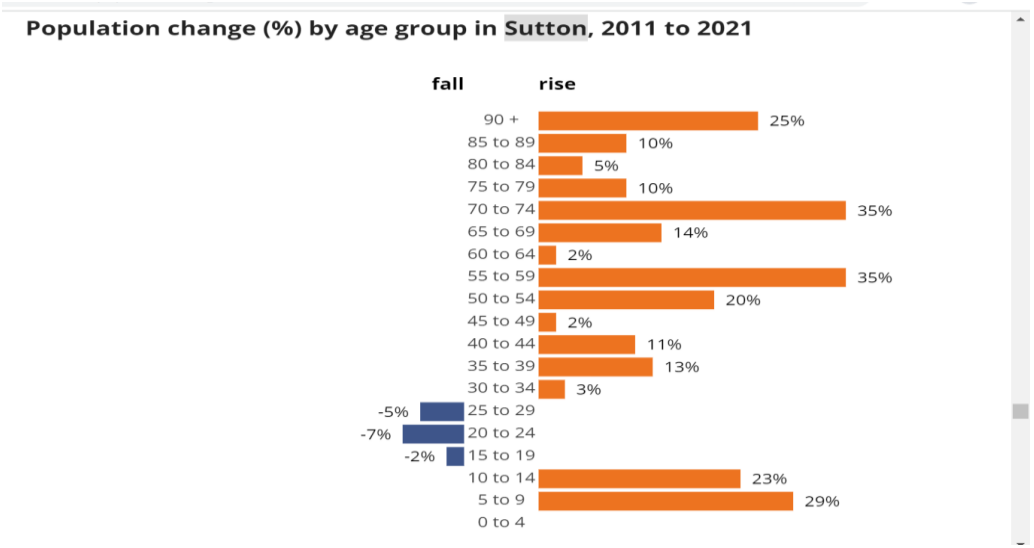
- **A**wareness
- **S**kills
- **K**nowledge



- England and wales **59,597,300**
- **Sutton** 209,600
- Over age 65 represent 18 % of total population in England

- Frailty :
- *10% ⊃ 65 years*
- *Up to 50% ⊃ 85 years.*





Don't call me frail…

By focusing on the important things to improve older people's care and wellbeing we can help to make **the term 'frailty'**

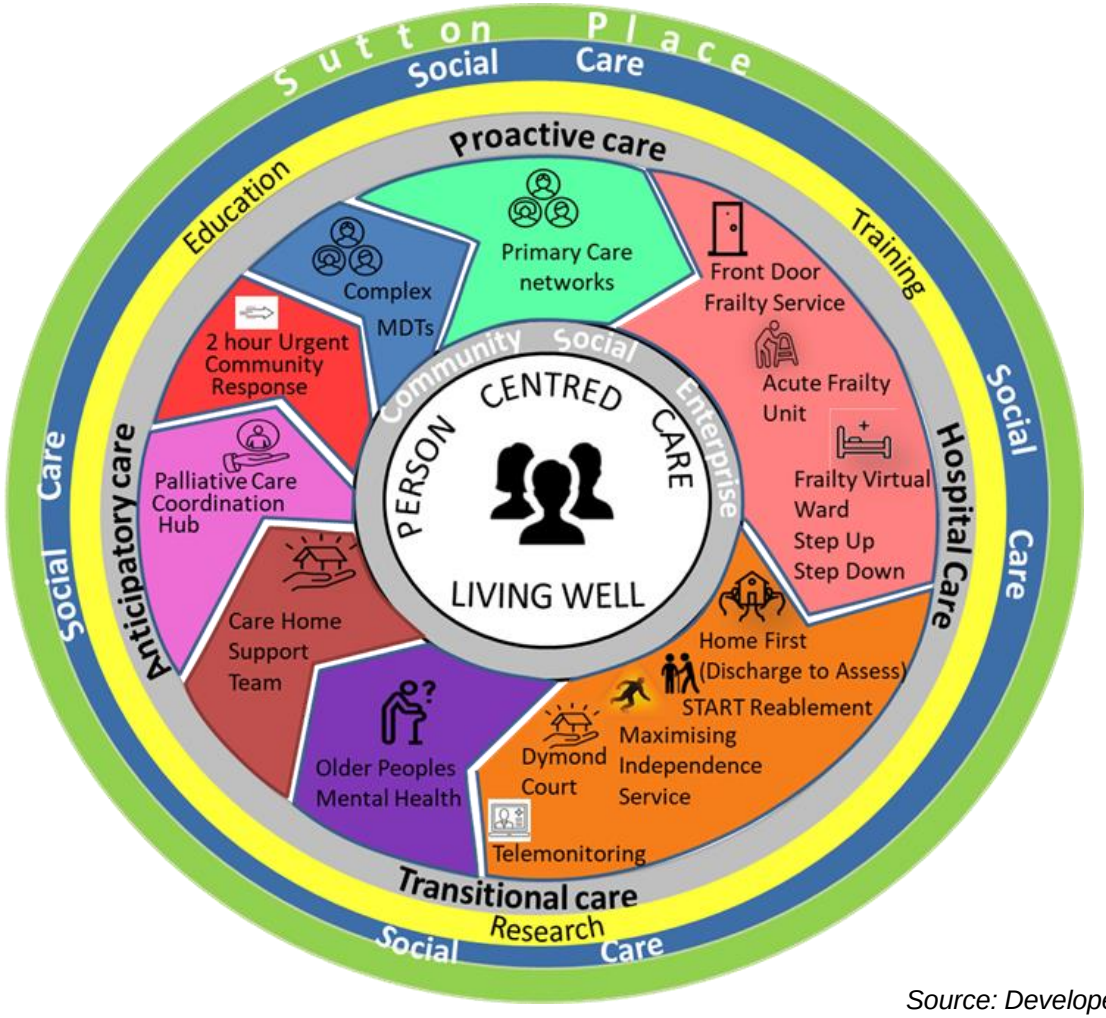
- **A passport to the kind of support that makes a real difference to persons' health and lives.**

- **Signpost** multidisciplinary **services** to deliver better health for older people.

  - **Age UK Published on 24 July 2015**
  - ***Baroness Sally Greengross : Frailty framework***

Frailty Wheel

Innovation in evidence-based frailty awareness, practice and education



Source: Developed by Sutton Health and Care, St Helier Hospital and Sutton ICB - Sutton Whole Systems Frailty Stakeholder Engagement Sept 2022

Education Framework

1. E-learning on core capabilities
2. Hybrid lectures and workshops on topical issues, cases and soft skills
3. Simulation training for handover
4. Focused study days

E-learning

Core curriculum grid

In line with the Frailty framework of core capabilities

Tier 1: Those that require general awareness of frailty.

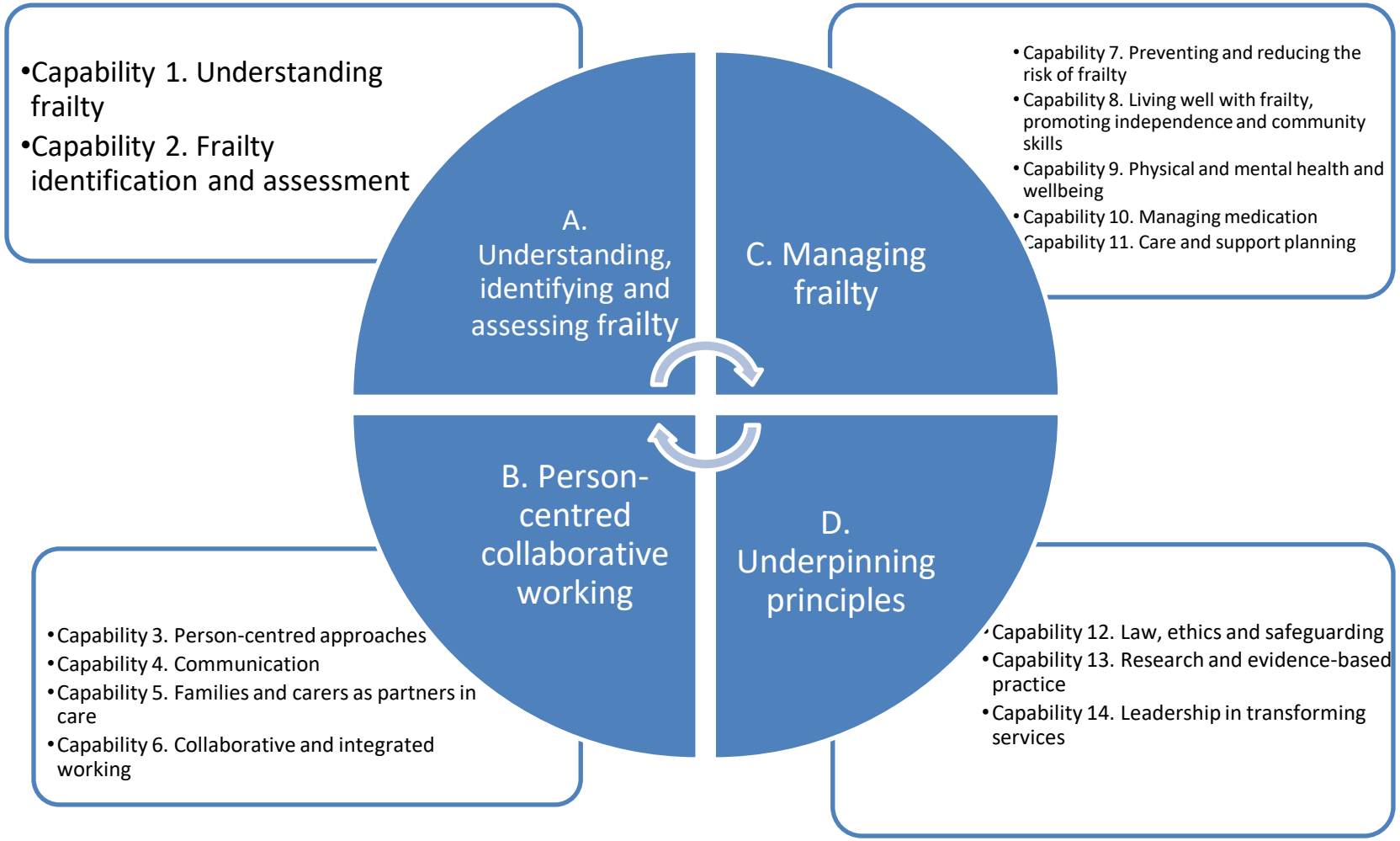
Tier 2: Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

Tier 3: Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty

Domains

A. Understanding, identifying and assessing frailty
B. Person-centred collaborative working
C. Managing frailty
D. Underpinning principles

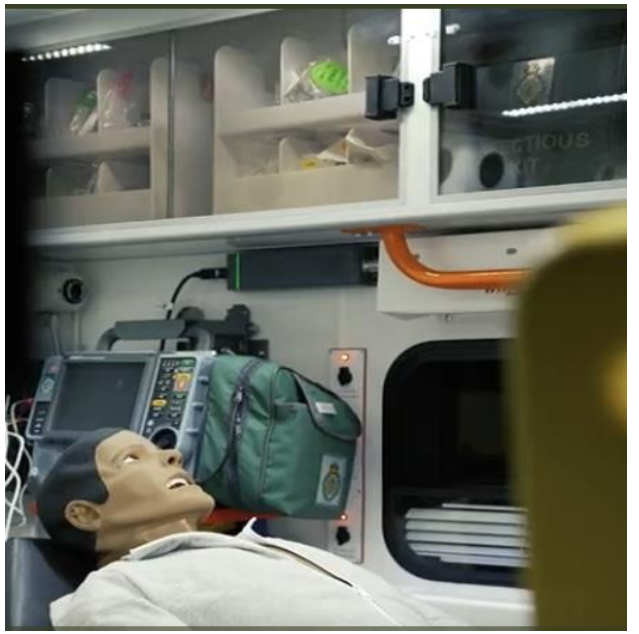
https://www.skillsforhealth.org.uk/info-hub/frailty-2018/



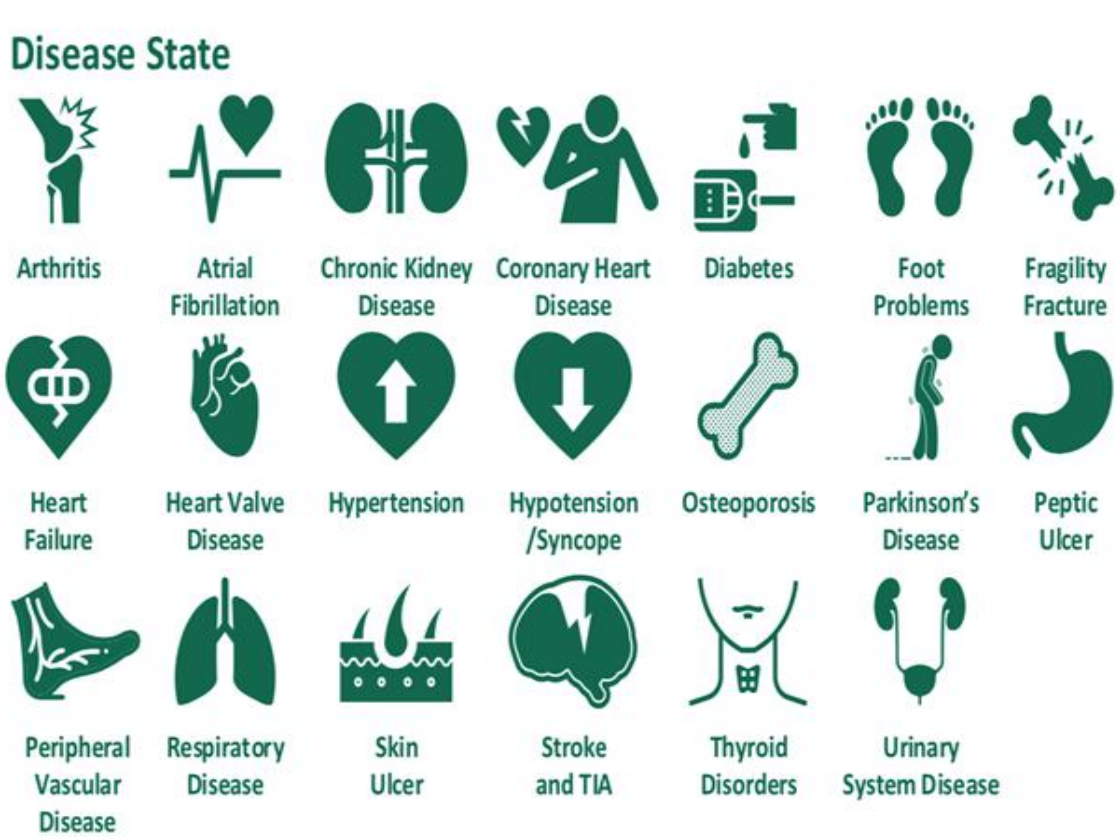
https://www.skillsforhealth.org.uk/info-hub/frailty-2018/

Simulation training

in collaboration with Ambulance Service



Focused study days



Challenges

- Non homogenous groups of frailty practitioners with variable training needs
- Lack of integrated education board across ICS to drive development of education and training
- Digital literacy, cognitive capacity of patients and ability to access/upload digital information.

Stakeholder engagement

- Sutton whole system stakeholder engagement
- Survey of frailty practitioners and stakeholders
- Educator sessions to help develop curriculum
- Train the trainer workshops
- Leadership training
- Blended advanced communications skills workshops

Training needs assessment survey

- 77 individuals surveyed within Sutton ICS including physicians, GPs, nurses, carers, social care
- 35 respondents
- 22 have completed Tier 1-3 training
- 18 would like to become frailty champions
- 24 would like to become frailty trainers

Frailty Champions and Trainers programme

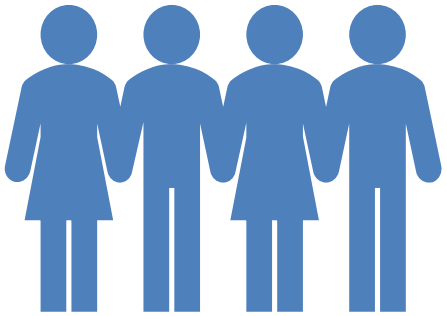
Overall goals

1. Provide general awareness of frailty
2. Equip Health and social care staff with the knowledge, skills and support needed for MDT management and decision making when they deal with older people living with frailty in different care settings.

Learning outcomes

1. Understand the concept of frailty
2. The ability to confidently identify and assess Frailty
3. Actively participate in MDT management for frailty.
4. Work with older people living with frailty, families and carers in a collaborative way in an integrated care system.
5. Develop the necessary knowledge and skills to deal with the Frailty syndromes
    1. Delirium
    2. Falls
    3. Polypharmacy
    4. Reduced Mobility
    5. Recent Incontinence

What happens next?



Frailty champion

1. 4 (full day) face to face training workshops
2. E.learning Tier 1 and Tier 2

Frailty Trainer

1. The frailty champion
2. Train the Trainer
3. Ongoing CPD

NHS
Epsom and St Helier University Hospitals NHS Trust

Developing evidence based education framework for frailty practitioners within Sutton integrated care system

Contacts:
martina.yanga@nhs.net
m.elokl@nhs.net

Headlined by: Content Guru

UP NEXT...

publicis sapient

The Integrated Care Summit North

SPEAKING NOW

Jack Chilcott

Healthcare Transformation Director,
Customer Experience & Innovation - **Publicis Sapient**

Case Study - Publicis Sapient

Jack Chilcott | Healthcare Transformation Director

Patient engagement for improved outcomes at the heart of long-term conditions care.

How might we integrate to deliver this at scale?

publicis
sapient

The needs of the patient come first

“The best interest of the patient is the only interest to be considered.”

Integrated, multi-specialty group practice

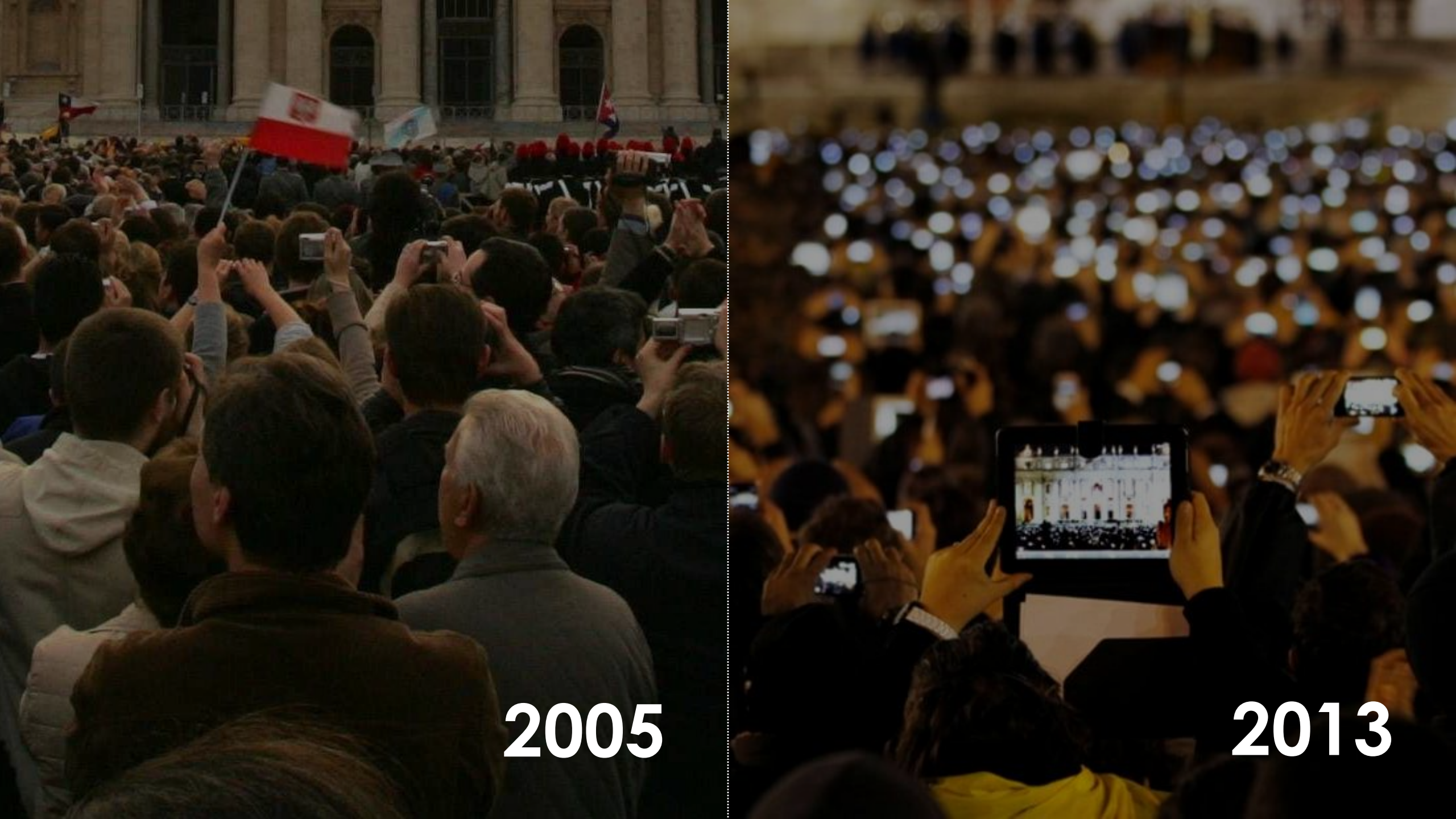
“So that the sick may have the benefit of advancing knowledge, a union of forces is necessary.”

Systems and process engineering

Early adopters of germ theory in practice.
Designed one of the first holistic medical records.

Not for profit, for the betterment of human care

“The success of the Clinic, past, present and future, must be measured by its contributions to the general good of humanity."


2005
2013

£7 in every £10

of total health and social care expenditure

50% of all GP appointments

41% of A&E visits that could be prevented

70% of all hospital bed stays

Poor mental health and quality of life.

The system wasn't created with LTC needs in mind…

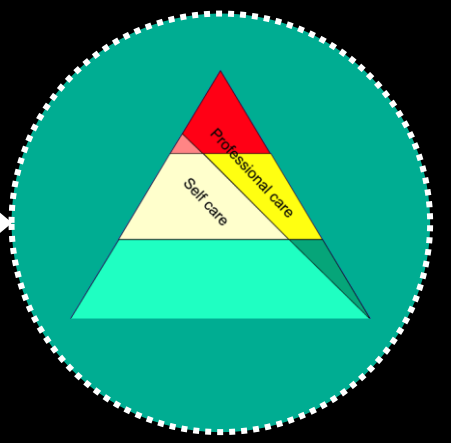
"every system is perfectly designed to get the results it gets".

Past

Present

How?

Future



HDRUK

Health Data Research UK

Discover-NOW

Health Data Research Hub for Real World Evidence

Fresh Start

A remote 12-week enhanced PCN delivered service for people with type-2 diabetes

Population of North West London

~1.8m

People with type-2 diabetes

~145k

8%

People at high-risk of CV complications

~75k

51%

Aafiya

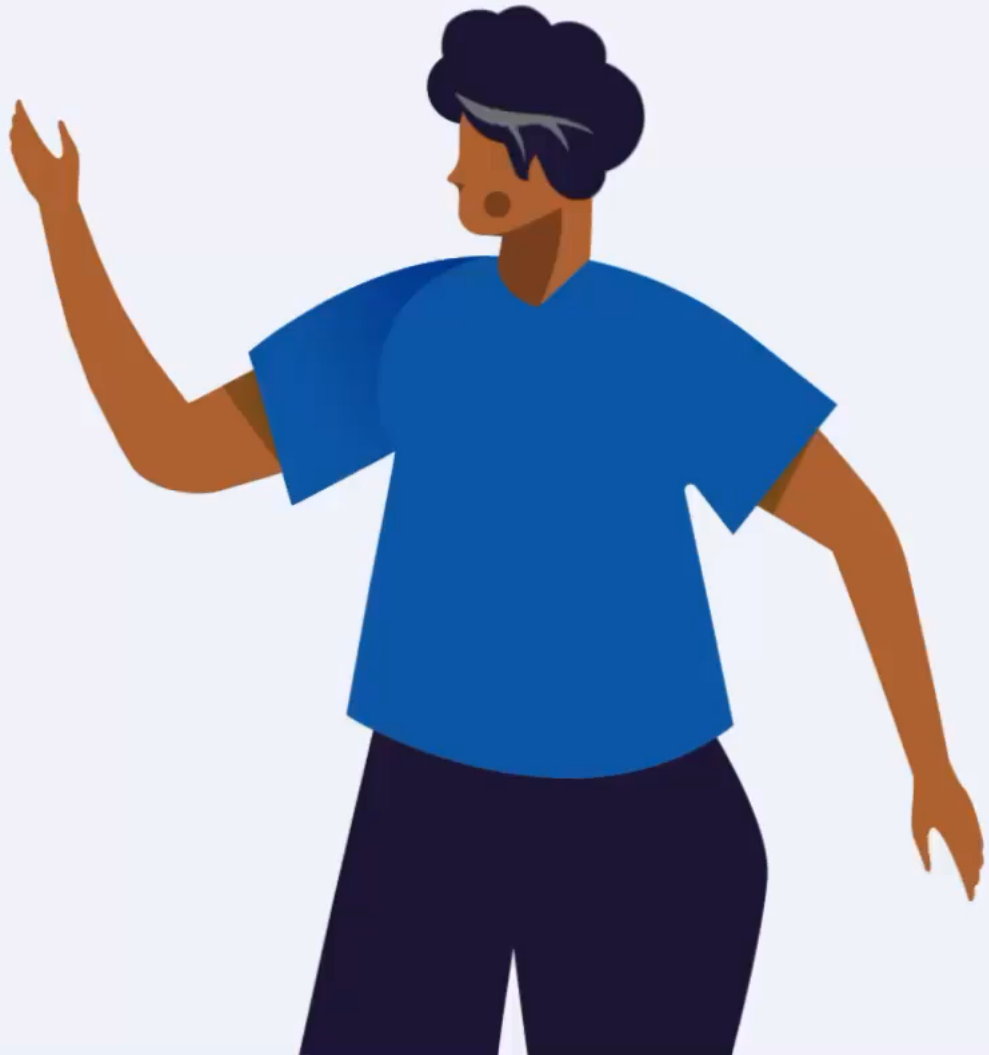
What do we know about Aafiya?

- 45 year old
- T2DM diagnosis 7 years ago
- Speaks relatively little English
- Little engagement with her diabetes due to work

- metformin, gliclazide, empagliflozin
- HbA1c **77**
- BP **141/95**
- Urine ACR **130**

What don't we know about Aafiya?

- Her family and social situation
- How food plays a role in her life
- Her mental wellbeing
- Her true clinical understanding of her diabetes risks

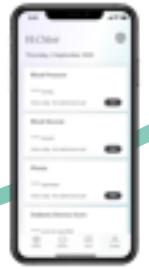


Building Aafiya's health engagement over 12 weeks

Receives an invitation text from her GP about the service and a follow-up call from one of the practice staff to enroll her

Enrolls into service, is supported through onboarding and collects devices from her local GP

Downloads and signs into patient remote reporting app with unique code



Uses devices and app to capture

- *Blood pressure*
- *Blood glucose levels*
- *Weight*
- *Diabetes Distress Scale scores*
- *Photos of food*
- *Step count*

Attends 3 x virtual group consultations (VGCs), discusses her progress and remote reporting data with other patients and her care

Receives twice weekly emails related to the VGCs

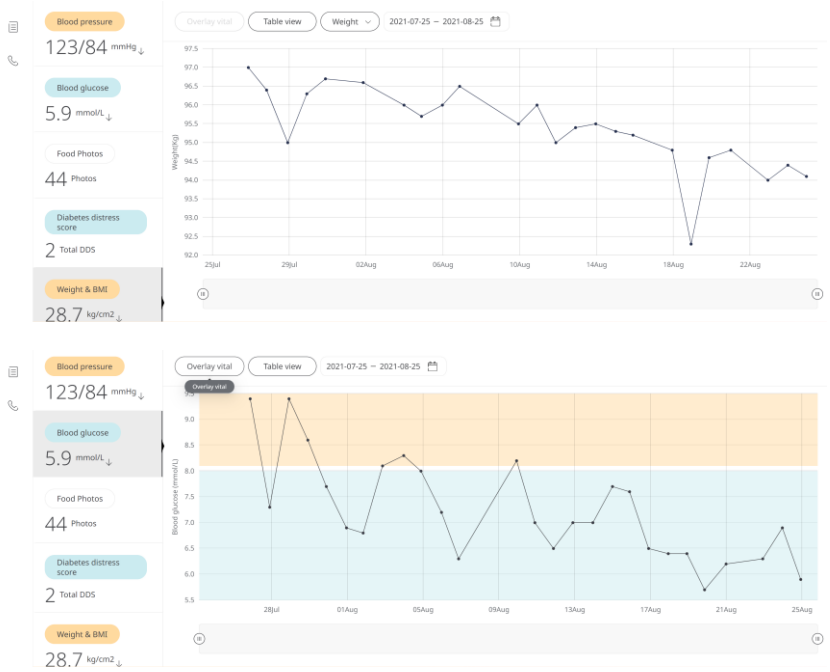
In-app digital education also available on-demand

Attends follow-up with her GP to discuss best next steps

How is Aafiya doing now?

- Entering remote data daily
- Attended VGCs with her husband, happy to share remote data on screen, highly motivating for other attendees
- Feels more confident to self-manage, understands her diabetes for the first time
- 130,000 steps per week
- Weight improving
- Blood glucose improving
- Blood pressure improving

7 week snapshot



5

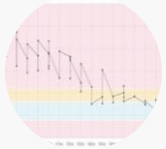
PCNs delivering all, or partial, enhanced service components

118

patients enrolled as part of real-world delivery model matched control feasibility study (publication submission stage)

Imperial College London

Empower patients



"Seeing my sugar levels in the app made me realise how what I eat affects them."

Improve care relationships

"It's good to hear how other patients are doing, and what we can do to improve our health."

Build trust

"I don't normally think these kinds of things work, but now I think differently."

*Quotes from pre-launch pilot feedback

Cohort: Type-2 Diabetes at high risk of CV complications

12 weeks

1 Identify

2 Contact

MJOG PATIENT MESSAGING SERVICES

accuRx

3 Onboard

Virtual Group Consultations

Patient app self-monitoring

Digital education

4 Listen

5 Support

6 Empower

1 Setting goals

2 Lifestyle changes

3 Staying motivated

Patient reported blood pressure, blood glucose levels, weight, DDS PROM, photos of meals, step count

Twice-weekly emails and on-demand content

7 Re-assess

End-of service pathways

Improved review / virtual MDTs

Cohort: Type-2 Diabetes at high risk of CV complications

12 weeks

1 Identify

2 Contact

3 Onboard

4 Listen

5 Support

6 Empower

7 Re-assess

Virtual Group Consultations

Setting goals

Lifestyle changes

Staying motivated

End-of service pathways

Patient app self-monitoring

Patient reported blood pressure, blood glucose levels, weight, DDS PROM, photos of meals, step count

Improved review / virtual MDTs

Digital education

Twice-weekly emails and on-demand content

PCN remote LTC care operating model

People
PCN skill-mix delivery model with aligned purpose, flexible service roles, rotas and targets

Processes & finances
Training and implementation funding, enhanced services specification, Standard Operating Procedures, and EPR embedded protocols

Technology & data
Iteration of existing T2D S1 and EMIS templates, remote monitoring dashboard, PCN shared instance IT infrastructure and licencing

Cohort: Other LTCs?

? days / weeks

1 Identify	2 Contact	3 Onboard	4 Listen	5 Support	6 Empower	7 Re-assess
EPR embedded risk stratification	Patient messaging system	Virtual group consultations	VGC structure & topics			Offboarding & referral pathways
Risk strat criteria variables & fidelity	Message content	Remote patient monitoring	Remote monitoring metrics	Email / app content & topics	Additional Support Groups	Virtual MDTs
Relevant pathway touchpoint		Digital education		Clinical protocols & guidelines		Escalation SOPs
			Translation technology			Enhanced reviews

PCN remote LTC care operating model

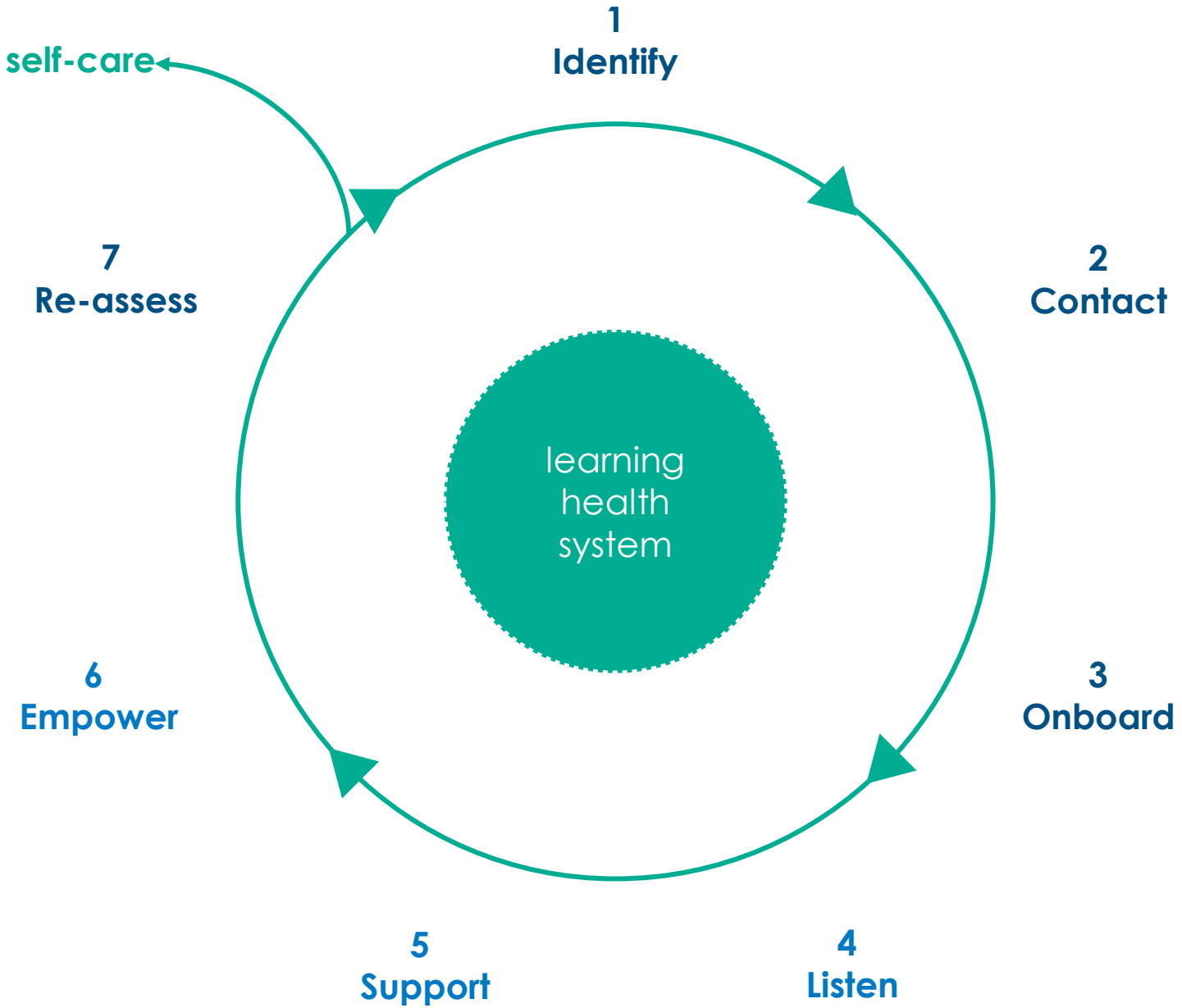
People
PCN skill-mix delivery model with aligned purpose, flexible service roles, rotas and targets

Process
Training, implementation funding, enhanced services specification, Standard Operating Procedures, and EPR embedded protocols

Technology & data
Iteration of existing T2D S1 and EMIS templates, remote monitoring dashboard, PCN shared instance IT infrastructure and licencing

New capabilities to re-configure according to population health needs…

…that use real-world data and the latest guidelines to define what those are.

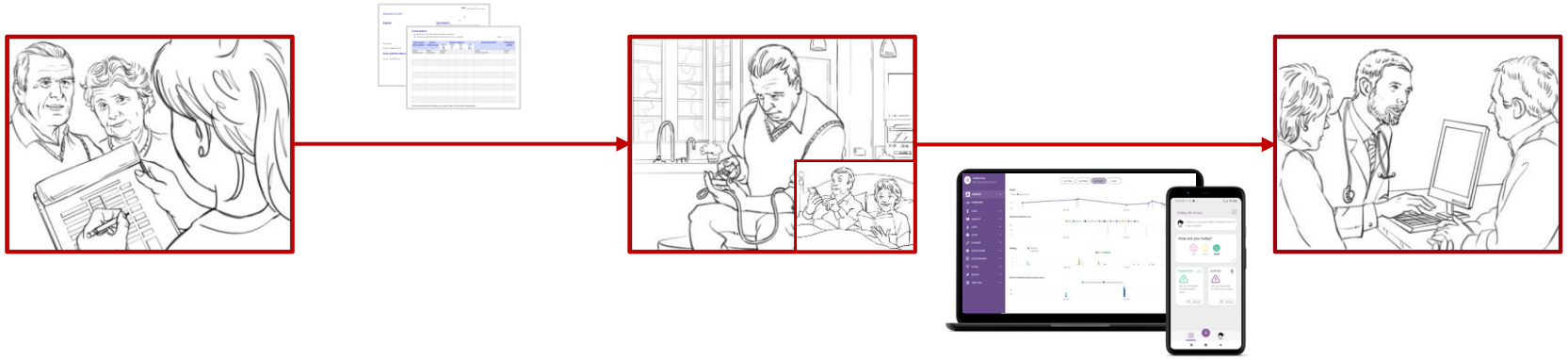


Cohort: HF post-event secondary care discharge

30 days

1 Identify	2 Contact	3 Onboard	4 Listen	5 Support	6 Empower	7 Re-assess
	Relevant pathway touchpoint	Personalised care plan				Offboarding & referral pathways
		Remote patient monitoring	Remote monitoring metrics	Adherence support	Wearable integration	
		Digital education		Clinical protocols & guidelines		Escalation SOPs
						Enhanced reviews

We applied this model and thinking to secondary care heart failure re-admission in Italy.



What worked well

- Shared objectives aligned early
- Environment and data access
- Skill-mix and co-creation approach
- Agile, iterative ways of working with CRG check-points

What we could have done better

- Involve secondary care specialists earlier in the process
- PR and comms – communicate the process continuously

Continuous improvement…

- Continue to scale / share this kind of thinking and work at an ICS level?
- Automate (for a model):
  - Patient booking
  - EPR embedded guideline updates
  - Patient onboarding
  - Suggested VGC groupings?
- Integrate (for a model):
  - remote monitoring data into EPRs
  - with secondary care
  - more deeply with mental health
  - co-morbid conditions? e.g. T2D & HF
  - translation technology
- Shift to upstream prevention (e.g. pre-diabetes)

thank you.

slido

How would you like to follow up with Jack post-event?

ⓘ Start presenting to display the poll results on this slide.

THE INTEGRATED CARE SUMMIT NORTH 2023

Headlined by: CONTENT GURU Engagement Made Easy

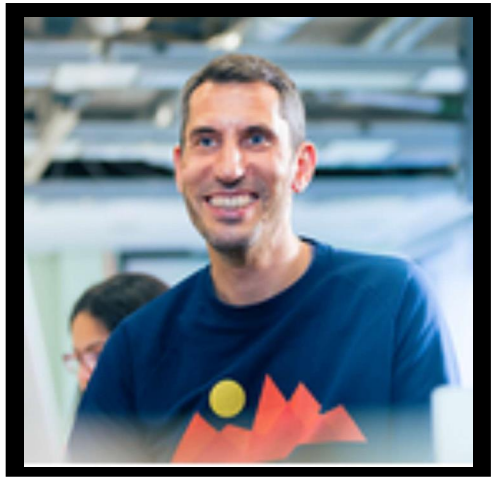
The Integrated Care Summit North

CONVENZIS

Q&A PANEL

Rhonda Bradder

Regional Commercial Manager - **L&R Medical UK**



Ben Showers

Partner - **TPXimpact**

David Robson

Senior Service Designer - **TPXimpact**

Martina Lagu Yanga

Head of Medical Education and Training - **Epsom and St Helier University Hospitals NHS Trust**

Jack Chilcott

Healthcare Transformation Director, Customer Experience & Innovation - **Publicis Sapient**

Networking and Lunch

The Integrated Care Summit North

Chairs Afternoon Address

Dr Gurnak Singh Dosanjh

GP and ICB Clinical Lead for **Home First**
Leicester, Leicestershire and Rutland ICB

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SPEAKING NOW

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We will be discussing...

"Boston Neighbourhood Team: Empowering our community to drive change through grass roots integration"

Neil Baker

Specialist Neighbourhood Practitioner - **Lincolnshire Community Health Services NHS Trust**

Jenny Streather

Primary Care Network OT - **Boston Primary Care Network**

BOSTON NEIGHBOURHOOD TEAM

EMPOWERING OUR COMMUNITY TO DRIVE CHANGE THROUGH GRASS ROOTS INTEGRATION

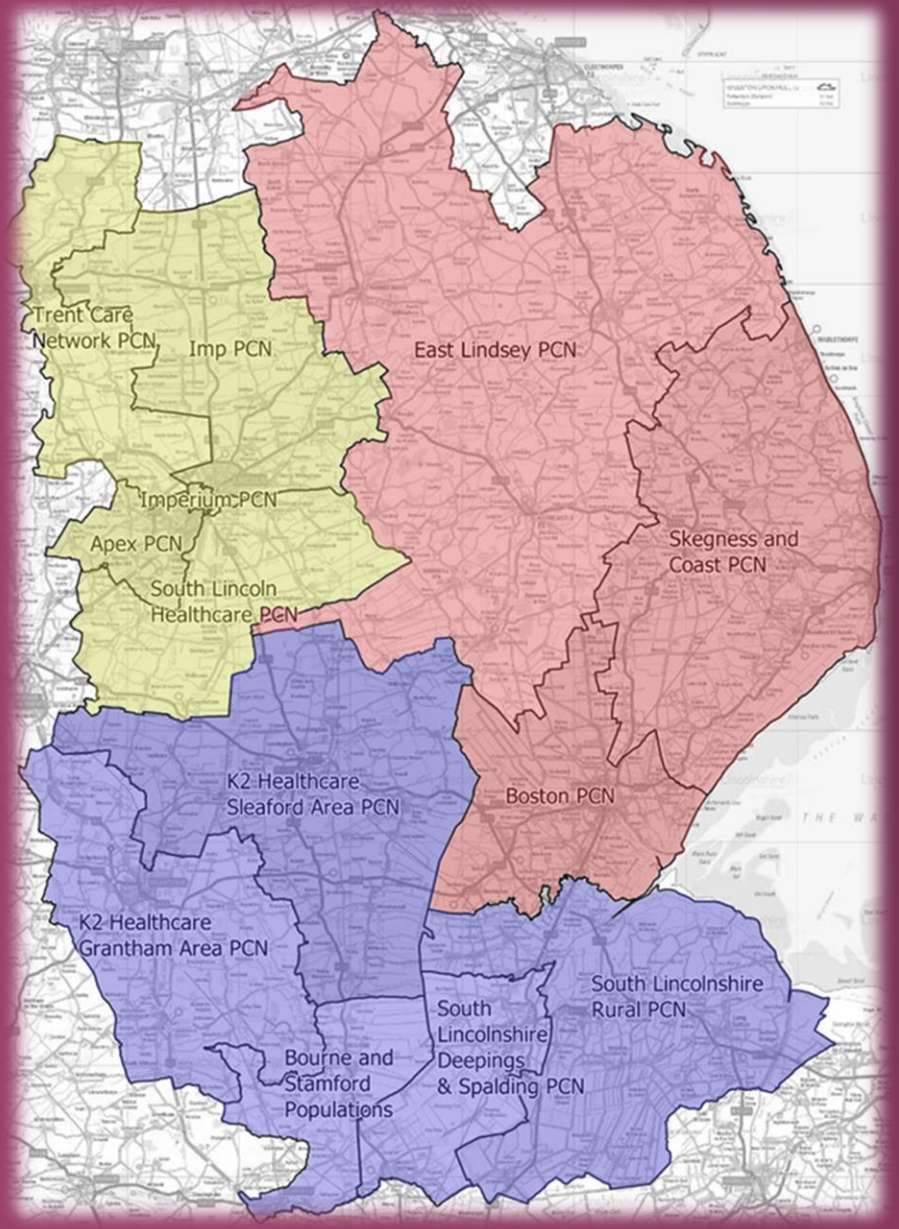
NEIL BAKER

SPECIALIST NEIGHBOURHOOD PRACTITIONER

JENNY STREATHER

LEAD PCN OCCUPATIONAL THERAPIST

Neighbourhood Working Lincolnshire



East Lincolnshire – Late 2018 – 100 day challenge

- Looking at a reduction in A&E admissions
- High intensity users
- Supporting patients ‘falling’ through services

Healthcare and Adult social care sat together with housing in a central shared space

Concept proved to be effective

Specialist Neighbourhood Practitioners recruited to create a core Neighbourhood team

Neighbourhood Lead

Strategic

Specialist Neighbourhood Practitioner

Clinical

Neighbourhood Project Manager

Strategic

Neighbourhood Coordinator

Clinical admin

Community Stakeholders

Original Team Aims

To tackle repeat admissions to A&E / Secondary care

High intensity users of Services

To Join services together

And then…….

Covid

NATIONAL DRIVERS FOR NEIGHBOURHOOD WORKING

- Clinical treatment and access represent only 25 per cent of a population's health
- £7 out of every £10 of health and care spending in England is spent on long term conditions. Prevention needs to be a priority!
- Loneliness increases someone's likelihood of mortality by 26 per cent, equivalent to smoking 15 cigarettes a day.
- The Marmot Review and Marmot Review 10 Years On have shown the impact of health inequality with the higher levels of deprivation lower life expectancy.
- The 2018 Care Quality Commission Local System Reviews - voluntary, community and social enterprise (VCSE) sector is underutilised in the planning and delivery of care and are often not included as full partners .
- Moving out of COVID provide opportunities not barriers to improve integration

Whole communities are key to integration!

- Boston Population 75,757
- Boston has the highest proportion of males/females aged 30-34 in Lincolnshire
- 5.4% unemployment
- <u>Lower rates of salaried and hourly pay compared to locally and nationally</u>
- 5.9% of the population are in the least deprived quintile. 23.5% of the population are in the most deprived quintile. Highest ranking deprivation domain, education, skills and training.
- There is a significantly high population growth of the European population over the past 10 years
- Boston has lower life expectancy (80.7 years) than Lincolnshire (81.6 years). Premature mortality is higher in Boston than Lincolnshire
- 54% of Boston residents have a disability or long-term health condition (MSK and Mental Health)
- Higher rates of Depression and Dementia Diagnosis

Recognition of the wider determinants of health and social inequality in Boston

So What ?

NEIGHBORHOOD CORE STRUCTURE

ORGANISATIONAL AGNOSTIC

NEIGHBORHOOD LEAD (LCHS)

SPECIALIST NEIGHBORHOOD PRACTITIONER (LCHS)

NEIGHBORHOOD COORDINATOR (ICB)

INTEGRATED PLACE BASED TEAM (LPFT)

SENIOR MENTAL HEALTH PRACTITIONER

2 X MENTAL HEALTH PRACTITIONERS

SENIOR MENTAL HEALTH SUPPORT WORKER

MENTAL HEALTH PEER SUPPORT WORKER

WELLBEING PRACTITIONER

NEIGHBORHOOD TEAM ADMIN

PRIMARY CARE NETWORK

LEAD OCCUPATIONAL THERAPIST

CARE HOME CARE COORDINATORS

LEAD PHARMACIST

2 X MENTAL HEALTH PRACTITIONER (ARSS)

SOCIAL PRESCRIBERS (PCN/LCVS)

HEALTH INCLUSION OFFICER

OLDER ADULTS SERVICE (GP BASED)

CANCER CARE COORDINATORS

COMMUNITY CONNECTOR (ST BARNABAS/THE PARISH OF BOSTON)

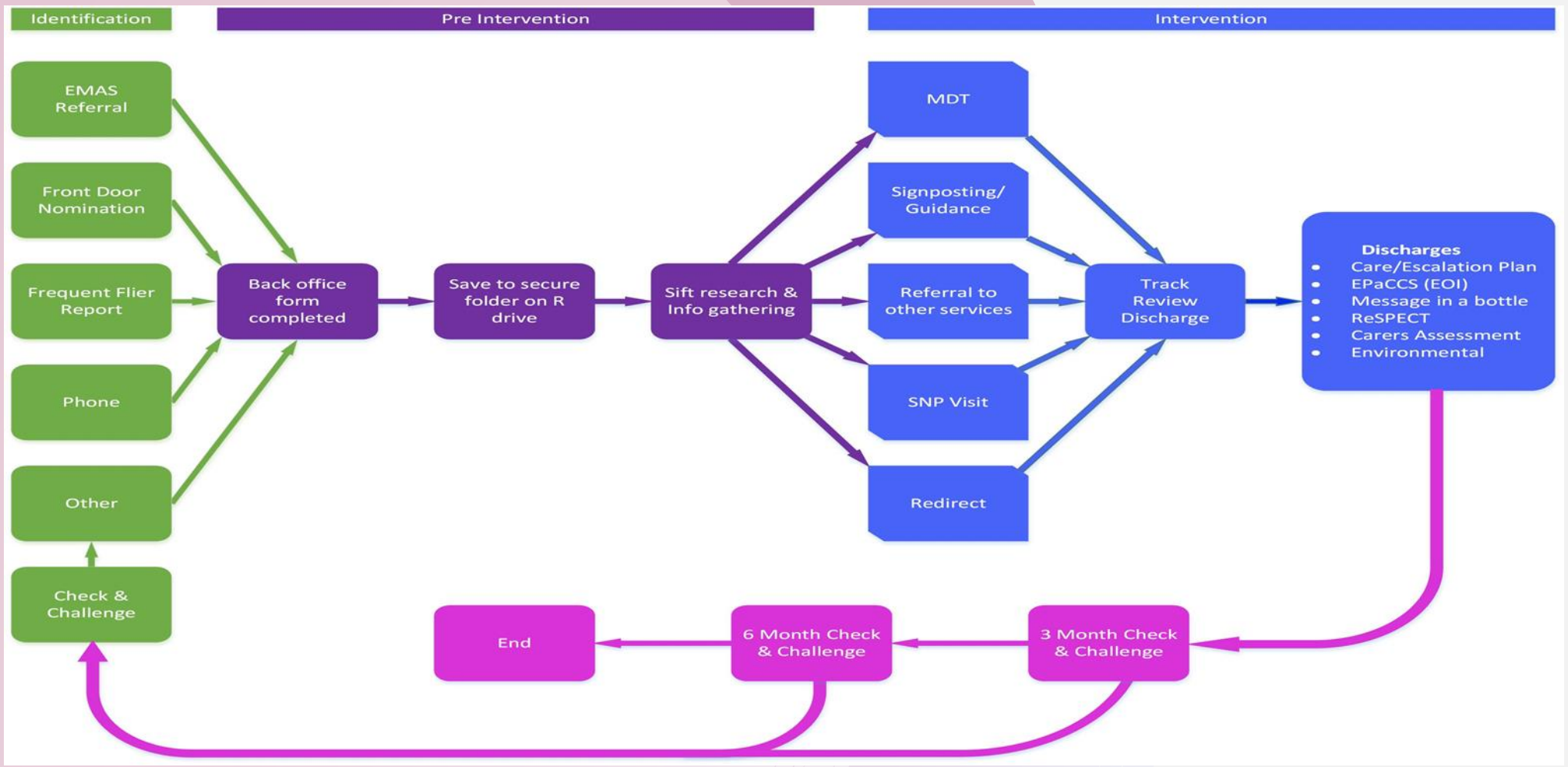
PROJECT SUPPORT OFFICER

(LCHS – Lincolnshire Community Health Service) (LPFT – Lincolnshire Partnership Foundation Trust) (Lincolnshire Community Voluntary Service) (ARSS – Additional Role

LCC Adult Social Care
Lincolnshire Housing Partnership
Lincolnshire Partnership NHS Foundation Trust
Longhurst Housing
Lincolnshire Police
Centrepoint
Framework
Community Nurses (LCHS)
Specialist Community Services (LCHS)
Lincolnshire Fire & Rescue
East Midlands Ambulance Service
Age UK
Wellbeing
East Lindsey District Council
Lincolnshire Integrated Care Board
Shine
United Lincolnshire Hospitals NHS Trust
Macmillan
St Barnabas
GP surgeries
Restore Church
Lincolnshire Rural Support Network
We are With You
Steps 2 Change (LPFT)
Carers First

The team process

How we get nominations



TOP TIPS FOR REFERRALS

You have exhausted all options and need help with an issue/problem and there are still unmet needs

A person is complex in terms of their circumstances: physical/mental health, social & financial

The person may be at risk of admission/readmission to hospital

The person is a frequent user of services

The person has had significant deterioration in their health and wellbeing

59 YEAR OLD MALE

MENTAL & PHYSICAL HEALTH CONCERNS

SOCIAL NEEDS

RECENT BEREAVEMENT

12 MONTHS PRIOR TO INTERVENTION

125 X PHONE CALLS TO OOH / 111

59 X AMBULANCE ATTENDANCES

5 X ATTENDANCES TO A&E

5 X ADMISSIONS TO HOSPITALS OF STAYS LONGER THEN 5 DAYS

Services working independently

GP

MH Service

EMAS

INITIAL HOLISTIC ASSESSMENT

WHAT'S IMPORTANT TO AND FOR

PH ASSESSMENT

MH ASSESSMENT

SOCIAL NEEDS ASSESSMENT

JOINING UP SERVICES

BEREAVEMENT SUPPORT

ADULT SOCIAL CARE

HOUSING

WELLBEING

CARE PLAN CREATION WITH EMAS

FOLLOW UP AND THROUGH

NEIGHBOURHOOD WORKING LINCOLNSHIRE

12 MONTHS POST INTERVENTION

10 X OOH /111 CALLS

3 X AMBULANCES ATTENDED

2 X ATTENDANCES TO A&E

2 DAY STAY IN HOSPITAL

24 MONTHS POST INTERVENTION

5 X CALLS TO OOH/111

1 X AMBULANCE ATTENDED

1 X A&E ATTENDANCE

1 X DAY STAY IN HOSPITAL

81 YEAR OLD MALE

LIVES ALONE

HOUSING ASSOCIATION PROPERTY

MODERATE FRAILTY - ALZHEIMER'S DEMENTIA AND MULTIPLE CO MORBIDITIES, HOARDING.

MULTIPLE DNA APPOINTMENTS AT GP, 5 ADMISSIONS /ATTENDANCES TO A&E IN 1 YEAR, VISITS FROM PROFESSIONALS TO HOME WHO RECOGNISED LEVEL OF HOARDING (STAGE 9)

AUGUST 2022 RADIOGRAPHER AT HOSPITAL RAISED A CONCERN TO GP SURGERY “NOT CONFUSED” CONCERNED ABOUT SOILED CLOTHING. VISITS FROM SURGERY CLINICIAN.

EMAS SAFEGUARDING CONCERN RECEIVED DIRECT TO NEIGHBOURHOOD TEAM. ADMITTED TO HOSPITAL FOLLOWING LONG LIE ON FLOOR OF PROPERTY (3 DAYS).

HOUSING OFFICER AND GP SURGERY BROUGHT A CONCERN TO MDT AROUND HOARDING AND RISKS

INITIAL JOINT VISITS WITH SPECIALIST NURSE, SOCIAL WORKER AND OT.

IDENTIFIED COGNITIVE IMPAIRMENT AND LIMITATIONS IN CAPACITY WHEN MAKING DECISIONS ABOUT SAFETY.

REFERRAL TO HORDING 1:1 WORKER.

LIAISED WITH SECONDARY CARE RE PREVIOUS CAPACITY ASSESSMENTS – VERY GOOD AT MASKING.

REFERRAL TO OLDER ADULTS MENTAL HEALTH – JOINT VISIT WITH OLDER ADULTS MENTAL HEALTH NURSE.

PROVISION OF FOOD PARCELS FROM LOCAL ORGANISATIONS.

MEETING WITH HOUSING TO ASCERTAIN A PLAN .

JOINT VISIT WITH HOUSING AND HOARDING SUPPORT WORKER FOLLOWED.

PLAN MADE WITH PATIENT TO BEGIN CLEARING PROPERTY.

ADMISSION TO HOSPITAL FOLLOWING FURTHER LONG LIE ON THE FLOOR (3 DAYS). DID NOT USE CARE LINE ALARM OR MOBILE PHONE.

NHT CONTACTED SECONDARY CARE OT AND ADVISED NOT TO DISCHARGE UNTIL ALTERNATIVE ACCOMMODATION SOURCED (SOURCED WITHIN 24 HOURS).

FAMILY MOVED BASIC FURNITURE FOR LIVING.

USED LOCAL SUPPORT MONIES TO PURCHASE FOOD, MICROWAVE, KETTLE.

FURTHER FOLLOW UPS TO SUPPORT INTEGRATION INTO COMMUNITY AND EQUIPMENT NEEDS IDENTIFIED.

OUTCOME

CONTINUES TO ENGAGE IN ACTIVITIES THAT ARE IMPORTANT TO HIM.

NO DESIRE TO RETURN TO OLD PROPERTY.

NO FURTHER HOARDING.

NO FURTHER ADMISSIONS TO HOSPIT
(5MONTHS).

NOMINATIONS

DIRECT REREFERRALS – HOWEVER NO WRONG DOOR LEADS TO SIGNPOSTING = NO REFERRAL

2019 (OCT- DEC) - 25

2020 – 430

2021 – 483

2022 – 555

2023 - 208

Boston Networking Event

2021 – Fydell House Boston

35 x Organisations

160 x professionals

2022 –Boston Gliderdrome

75 x Organisations

300 x professionals

NEIGHBOURHOOD WORKING LINCOLNSHIRE

BOSTON NEIGHBOURHOOD TEAM

EMPOWERING OUR COMMUNITY TO DRIVE CHANGE THROUGH GRASS ROOTS INTEGRATION

THANKYOU

Neil.Baker4@nhs.net

Jenny.Streather@nhs.net

https://vimeo.com/825093134

The Integrated Care Summit North

Q&A PANEL

Neil Baker

Specialist Neighbourhood Practitioner - **Lincolnshire Community Health Services NHS Trust**

Jenny Streather

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Dr Hatim Abdulhussein

National Clinical Lead for AI and Digital Workforce and Medical Director
NHS England and Kent Surrey Sussex Academic Health Science Network

Panel Discussion

Abigail Knight

Strategic Programme Lead – Integrated Child & Family Health Consultant in Public Health MFPH - Barnardo's

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Would you like to receive future updates on the Integrated care conference series?

ⓘ Start presenting to display the poll results on this slide.

Drinks Reception, Networking and End of Day

THANKS FOR ATTENDING

The Integrated Care Summit North

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REGISTER FOR THE NEXT INTEGRATED CARE SUMMIT HERE!