Integrated Care Webinar series 2023 / 2024

Webinar:
How to ensure Integrated Care Systems focus on prevention

Monday 4 December 2023

NHS England in partnership with the Social Care Institute for Excellence (SCIE)

NHS

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Your panel today

- Sarah Price, new Director for Public Health, NHS England
- Dan Alton: GP, National Clinical Advisor in Population Health Management, NHS England (Chair)
- Priya Kumar: Transformational Clinical Lead for the Connected Care Programme, Frimley ICB and GP Partner and Health Inequalities Lead, Kumar Medical Centre
- Professor Rowan Pritchard Jones, Executive Medical Director Cheshire and Merseyside ICB.

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Focussing on prevention: a national to system level perspective

Integrated care webinar series
4 December, 11.30 am – 1.00 pm

Sarah Price

Director of Public Health, NHS England

Why ICSs should prioritise secondary prevention

1. Reduce health inequalities

- To address health inequalities, we need to do more to get upstream and prevent the causes of health inequalities

2. Reduce excess mortality

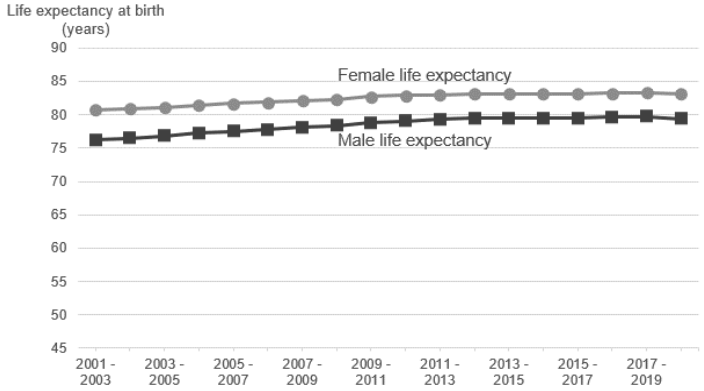
- Likely disruption to routine prevention services during the pandemic, in part, contributed to the current excess mortality we are seeing.

3. Reduce preventable admissions

- UEC crisis is complex, prevention could help reduce demand over the short to medium term

Improvements in life expectancy have stalled and the gap in life expectancy is widening

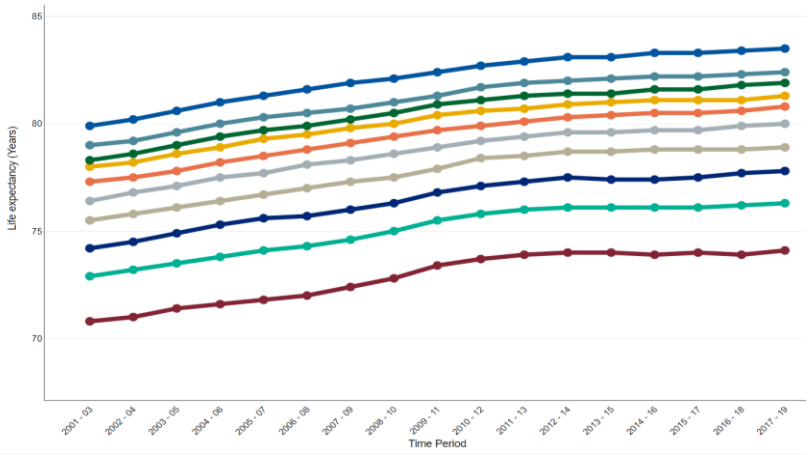
Life expectancy (LE) at birth for males and females in England 2001-03 to 2018-20



Source: ONS, 2022

- Upward trend in LE in England seen in the 20th Century has stalled and is now declining in older adults living in poorer areas.
- Following the pandemic, LE fell by 1.3 years for males and 1.0 year for females in 2020.

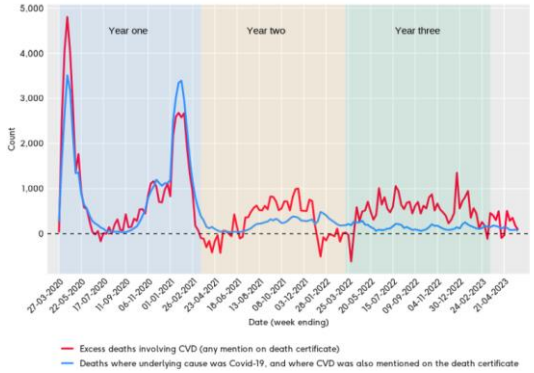
Life expectancy for males – by deprivation deciles, 2001-2019



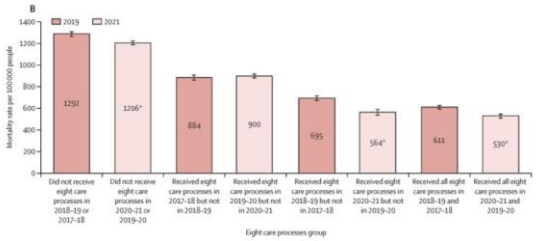
- The rise in life expectancy is slowing and the deprivation gap is widening

There is potentially a relationship between delivery of routine care processes and excess non-COVID mortality

Source: CVD Prevent



Source: British Heart Foundation



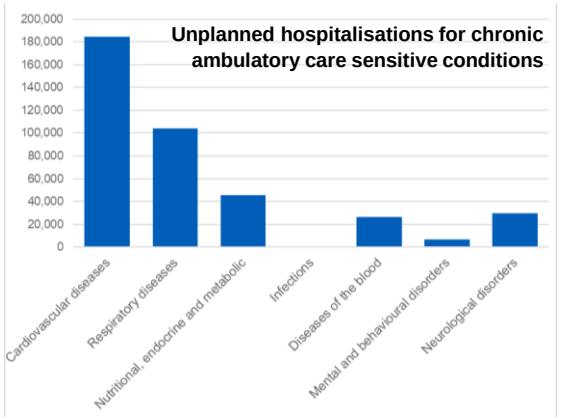
Source: Valabhji et al, 2022

- BHF analysis shows significant non-COVID excess mortality following the pandemic and a drop in routine management of hypertension over the same timeframe.
- Published data* shows an increased risk of mortality in people with diabetes who did not receive all eight care processes between July and Oct 2021 which is associated with a reduction in completion of routine diabetes care processes following the pandemic.

**Valabhji et al. Associations between reductions in routine care delivery and non-COVID-19-related mortality in people with diabetes in England during the COVID-19 pandemic: a population-based parallel cohort study. Lancet Diabetes Endocrinol. 2022 Aug;10(8):561-570. doi: 10.1016/S2213-8587(22)00131-0. Epub 2022 May 27. PMID: 35636440; PMCID: PMC9141683.*

Failure to manage preventable conditions may exacerbate pressure on operational delivery

Pressure on delivery

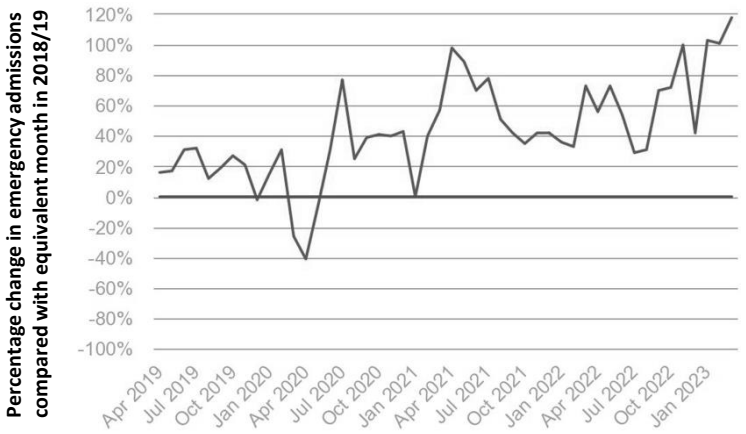


- CVD and respiratory diseases are the leading causes of emergency admissions for chronic ambulatory care sensitive conditions.
- Strong demographic bias in terms of who gets admitted to hospital.

Source: NHS Digital, NHS Outcomes Framework

- Prevalence of LTCs increases risk of admission and complexity of cases.
- Multi morbidity exacerbates pressure on delivery. Prevalence is higher and onset earlier in those living in more deprived areas.

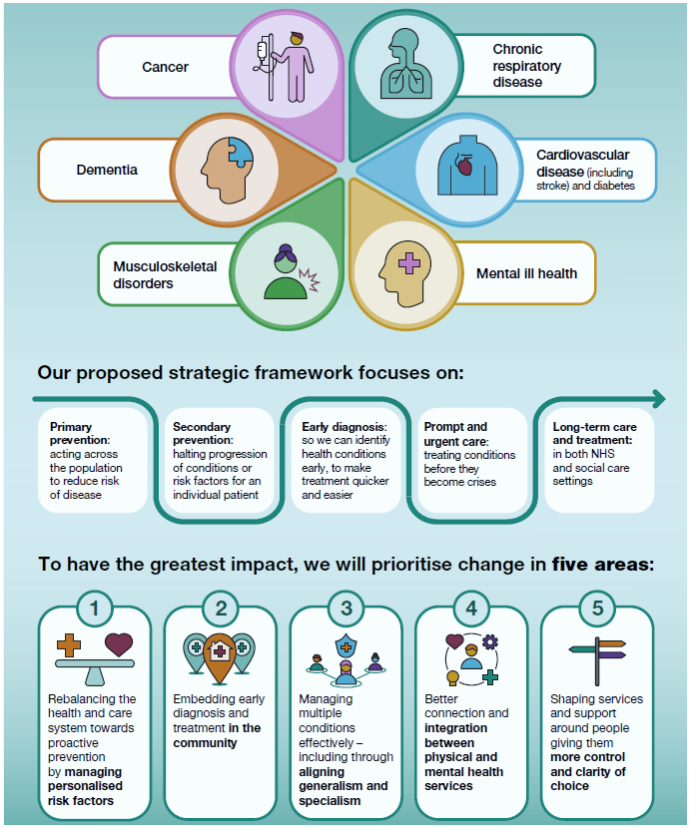
Change in emergency admissions for hypertension cases that can be managed outside hospital



- Analysis of data on ambulatory care sensitive conditions by the Nuffield Trust shows that in March 2023 emergency admissions for hypertension had increased by 118% compared with a 2018/19 baseline.

Strategic Context

Major Conditions Strategy.



Hewitt Review.

"The share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years. To deliver this the following enablers are required"

Prevention as a key priority is supported by feedback from the NHS Assembly

Growing consensus for needing three shifts in the delivery of healthcare to respond to the continuing rise of chronic ill health. (NHS@75 Report)

1. Preventing poor health

- Shift funding to evidence-based prevention measures
- Collaborate with partners to reach those at greatest risk
- Advocate for action to tackle the wider determinants of health

2. Personalisation and participation

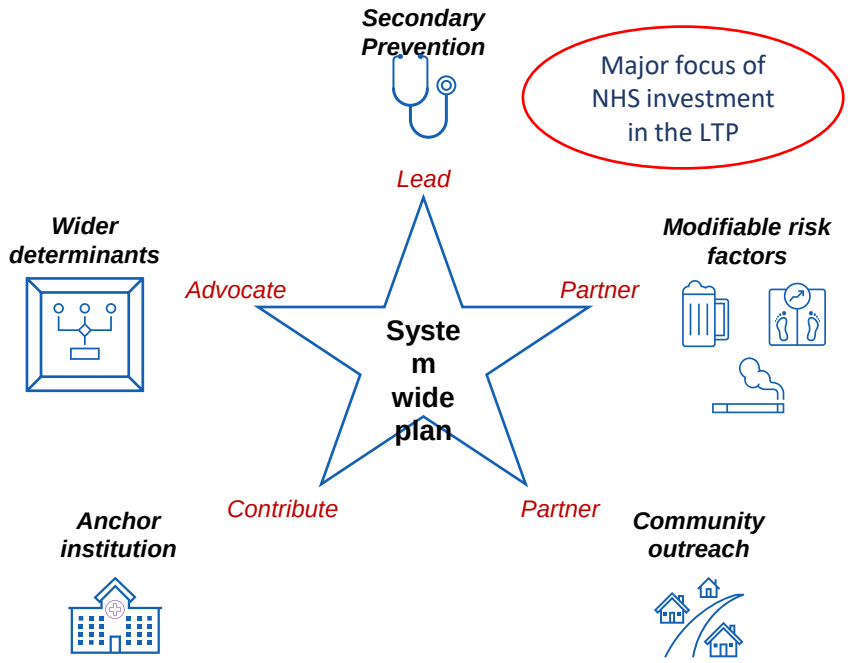
- Ensure people have control in planning their own care
- Ensure continuity of relationship with clinical team
- Prioritise patients' experience and voice, particularly marginalised groups

3. Co-ordinated care, closer to home

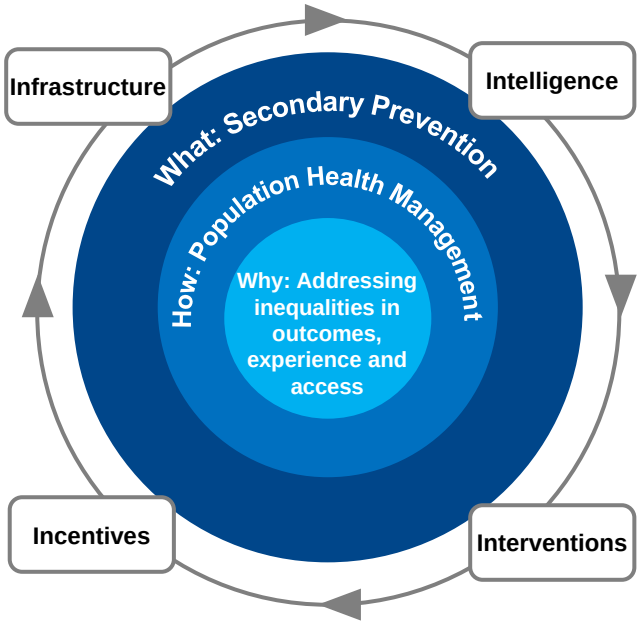
- Accelerate plans to strengthen general practice, primary care, and community care
- Better care for those with complex needs and frailty by community teams and hospital at home services,

1. The NHS is uniquely placed to lead on secondary prevention, but needs to do so in the context of the overall system strategy

- We are advocating for a stronger NHS role in prevention;
- This needs to sit alongside and align with a broader system wide strategy for prevention and tackling wider determinants;
- The NHS role in prevention:
  - i. Uniquely placed to lead action on secondary prevention – eg ABC for CVD prevention;
  - ii. Expanding role, alongside local government, to address modifiable risk factors;
  - iii. Working with local government and VCS partners to improve outreach to under-served communities;
  - iv. Advocating for and supporting action on wider determinants (but not necessarily funding);
  - v. Contributing to social and economic development as we deliver healthcare - an anchor institution.



2. Ensure strategic alignment between prevention and health inequalities



Alignment between system wide action on health inequalities and prevention is key supported by effective use of data to stratify population groups to enable effective targeting strategies

WHY Addressing health inequalities	• Improvements in healthy life expectancy have stalled; particularly amongst more deprived communities • Being driven by a higher prevalence of modifiable risk factors within certain population groups, particularly the Core20PLUS5 population
HOW Population health management	• The move towards PHM, integrated data and predictive analytics enables more effective targeting and tailoring of interventions • Enables targeting on those groups who are experiencing greatest inequity in outcomes, experience and access and those who do not traditionally engage with health services
WHAT Secondary prevention	• There is extensive evidence on secondary prevention interventions which work and deliver rapid improvements • NHSE in partnership with NICE, have developed a resource with the most impactful interventions for the prevention and management of CVD, diabetes and respiratory disease

Using a PHM approach to target secondary prevention interventions will contribute to reduced health inequalities

ICP Strategy Mission 2: Helping People Stay Well and Detecting Illness Earlier

Greater Manchester Integrated Care Partnership

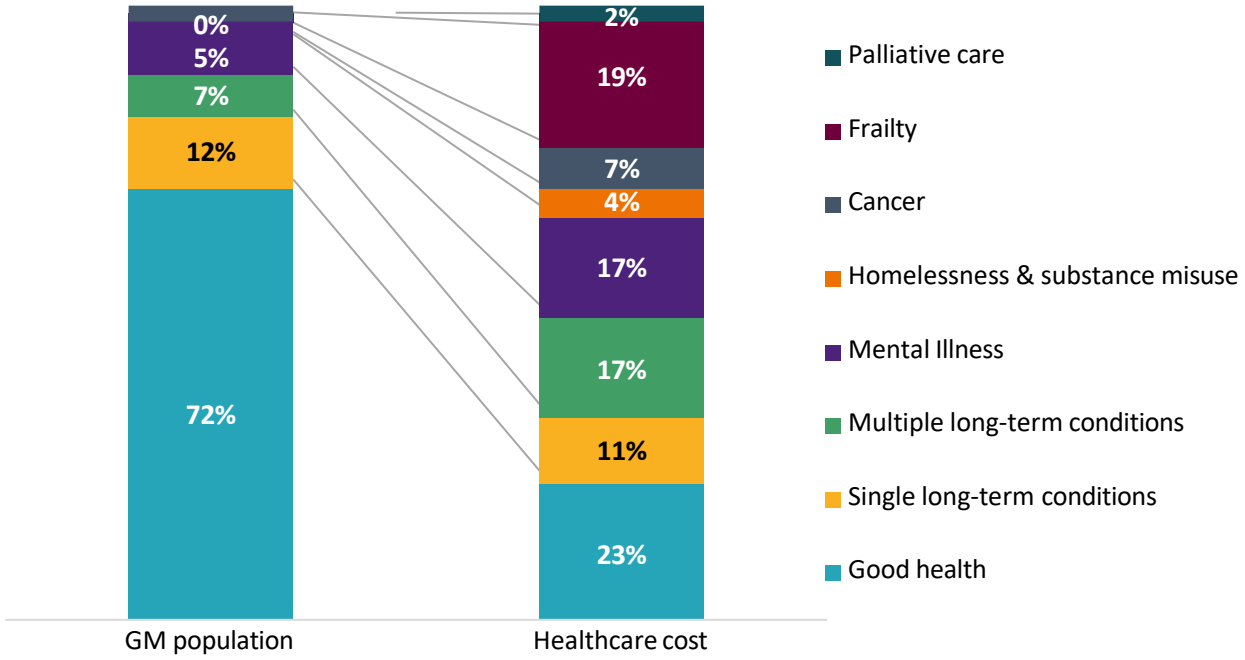
The Strategic Financial Framework is developed via a four-stage approach

	Understand baseline and "do nothing" forecast	Consider opportunities to improve health, performance and finance	Phasing and Investment	Reflect in financial framework
Population	**Understand place** • Segment population by age, condition and deprivation • Level of consumption of healthcare • Allocation growth • Spend on providers	1. Reducing the growth in prevalence and progression of ill-health 2. Optimising models of care to optimize total spend (across all settings) for each segment 3. Improving care for the most disadvantaged communities	• Identification of interventions and ROI • Non-recurrent investment to ramp up/double run services • Investment in data and digital capabilities	• Calculate the total allocation change including ICS and NHSE in the do nothing baseline • Optimise spend while improving population health and shift pattern of spend
Provider	**Understand provider** • Understand current activity and expenditure • Apply growth assumptions • Understand the underlying recurrent financial position of each trusts	1. Improve model of care to increase quality and flow (theatres, OP, discharge) 2. Pure unit labour productivity (skill mix, rota, bank/agency) 3. Procurement (drugs, medical consumables, nonclinical) 4. Estates (facilities, capital, etc) 5. Back office (IT, admin)	• Non-recurrent costs to support transformation • Any restructuring of costs to address a deficit • Investment in data and digital capabilities	• Forecast current underlying position for each provider • Understand the productivity gains that are required to address the underlying position

Those who are frail and have multiple LTCs account for 36% of total healthcare spend in GM, despite only making up 9% of the population

Population size and healthcare cost by segment

Proportion of the total population and total healthcare spend for each population segment across all ages



- The good health population segment accounts for 72% of the total GM population but only accounts for 23% of the total healthcare spend
- Conversely, those who are frail make up only 2% of the GM population but account for over 19% of the overall healthcare spend
- Those with multiple long term conditions account for 17% of all healthcare spend but are only 7% of the total GM population

Source: CF Analysis, ADSP, August 2022 – August 2023

Three population health opportunities have been identified and quantified to optimise the allocation and support health and care services in better, more efficient, ways

Opportunity:

Opportunity 1: Reducing the growth in prevalence and progression of ill health	Opportunities to reduce prevalence and progression of ill health relative to baseline trend based on targeted prevention and early detection activities
Opportunity 2: Optimising models of care	Opportunities to change models of care to deliver more consistent proactive care to support effective population health management
Opportunity 3: Improving care for the most disadvantaged communities	Opportunities to improve health and address and reduce disparities in care for people in deprived socioeconomic groups

Quantified opportunities map to primary, secondary, and Social Determinant focussed interventions

For the purposes of initial investment quantification – opportunities one has been aligned with primary intervention, opportunity two with secondary interventions, and opportunity three with Social Determinants of Health interventions

Opportunity 1: Reducing the growth in prevalence and progression of ill health

Opportunities to reduce prevalence and progression of ill health relative to baseline trend based on targeted prevention and early detection activities

→ Primary Prevention intervention across five key areas:
- Smoking
- Obesity
- Diet
- Exercise
- Alcohol Dependency

Opportunity 2: Optimising models of care

Opportunities to change models of care to deliver more consistent proactive care to support effective population health management

→ Secondary intervention, targeting 5 specific patient cohorts:
- Cardiovascular Disease
- Diabetes
- Respiratory Conditions
- Frailty
- Serious Mental Illness

Opportunity 3: Improving care for the most disadvantaged communities

Opportunities to improve health and address and reduce disparities in care for people in deprived socioeconomic groups

→ Interventions targeting 4 social determinants of health areas:
- Housing
- Food Insecurity
- Transport
- Substance Misuse

Key areas for potential avoided cost have been identified across Multiple Long Term Conditions, Mental Illness, Homelessness and Frailty populations in GM

Priority areas determined across GM

£ Total Opportunity

Total Optimising Models of Care Opportunity

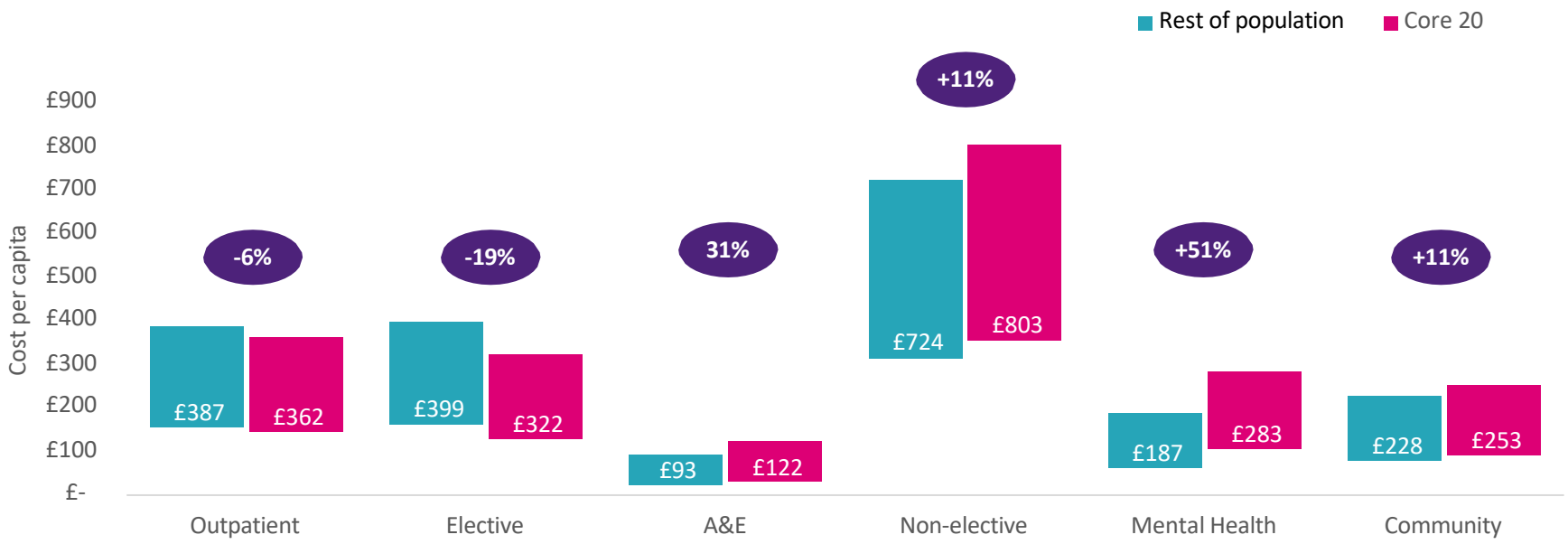
Age	1 Good health Pop: 76% Opportunity: 2%	2 Single LTCs Pop: 10% Opportunity: 1%	3 Multiple LTCs Pop: 6% Opportunity: 14%	4 Mental Illness Pop: 6% Opportunity: 43%	5 Homelessness Pop: <1% Opportunity: 12%	6 Cancer Pop: 1% Opportunity: 1%	7 Frailty Pop: 1% Opportunity: 24%	8 Palliative care Pop: <1% Opportunity: 4%
0-17 Pop: 17% Saving: 8%	Size: 402k £5m	Size: 22.3k £776k	Size: 15.1k £3m	Size: 71.4k £16m	Size: 380 £1m	Size: 180 -	Size: 3.71k £1m	Size: 8 -
18-64 Pop: 74% Saving 60%	Size: 1.43m £2m	Size: 154k -	Size: 197k £18m	Size: 188k £118m	Size: 13.7k £38m	Size: 27K £3m	Size: 17.9k £21m	Size: 520 £7m
65+ Pop: 9% Saving 32%	Size: 139k -	Size: 56.8k £2m	Size: 205k £28m	Size: 43.4k £13m	Size: 2.47k £230k	Size: 40K £1m	Size: 34.3k £59m	Size: 785k £9m

Source: ADSP

Opportunity three analyses and quantifies the inequalities between the most disadvantaged populations and the general population

Spend per capita (£) for GM's Core20 and the rest of the population

Spend per capita (£) for most cost effective adjusted Core20 and the rest of the population across GM and %difference



Source: CF analysis, ADSP August 2022 – August 2023

Opportunities

Current

- Financial challenges, but ICS and ICP provide a vehicle for joint working;
- New NHS lifestyle interventions + LTP funding for in-hospital stop smoking services;
- Opt-out approaches proving successful in EDs (HIV etc);
- New ways to engage patients in their own homes – eg home blood pressure monitoring, COPD@home.

Future Direction?

- Increase ICS spend on prevention – let's not polarise the debate?
- Redouble focus on interventions with the strongest evidence base (eg CVD ABC).
- More integration across pathways (eg between GP and secondary) to address multi-morbidity?
- Targeting underserved groups and aligning prevention opportunities.

CONNECTED CARE

2022

Using a Population Health Management Approach to tackle Health Inequalities in Slough

Presenter: Dr Priya Kumar, GP and Health Inequalities Lead, KMC
Transformational Clinical Lead Connected Care, Frimley ICB

4th December 2023

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It's all about the people








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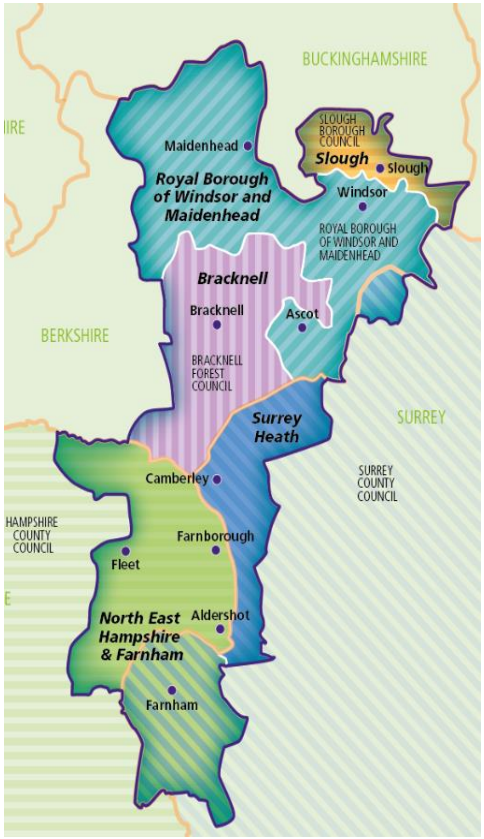
Frimley Today



Demographics

Population - 800,000

x100K

3% of the population live in the most deprived areas of England, while the region also includes large affluent areas.

Population increase by 2036

6.4%

(about 47,000 people with largest increases in the over 60's and 13-18 age group)

16.8%

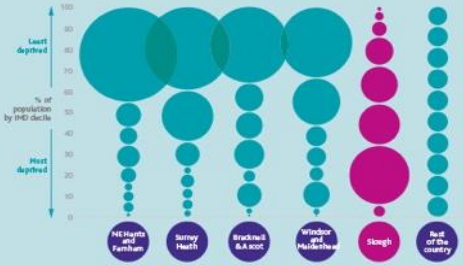
(13.5%)

Deprivation

People that live in recognised areas of deprivation will often have poorer outcomes.

Most of our population do not live in an area of deprivation. Over 30% are in the 10% least deprived in society.

All areas contain pockets of deprivation but they can be less visible due to nearby affluence. In Slough there are more people living in deprivation.

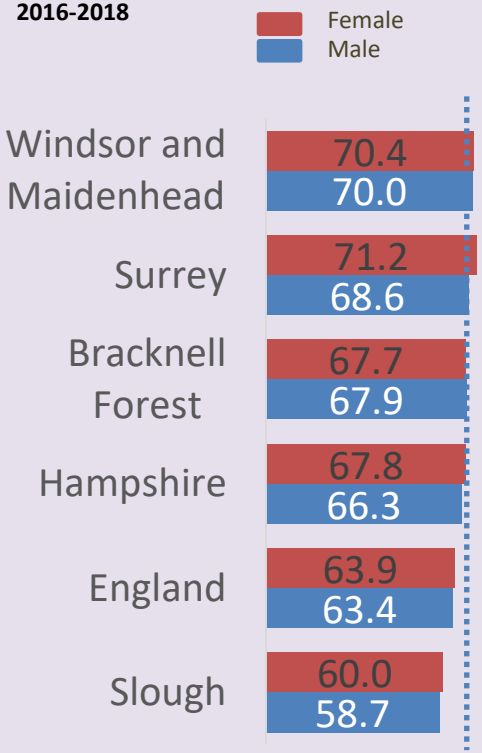


People living in areas of deprivation have a greater prevalence of Long term conditions such as Diabetes, Hypertension and Obesity.

RegisterDescription	Prevalence DSR Quintile 1-2	Prevalence DSR Quintile 3-5	Prevalence DSR Quintile 1-2 vs 3-5
Diabetes	10.5 %	5.3 %	1.98
Mental health	1.3 %	0.7 %	1.84
COPD	2.2 %	1.2 %	1.83
PAD	0.7 %	0.4 %	1.75
Learning disability	0.6 %	0.4 %	1.72
Heart Failure Lvsd	0.5 %	0.3 %	1.61
Non-Diabetic Hyperglycaemia	7.0 %	4.5 %	1.55

Healthy life expectancy at birth (years)

2016-2018



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Connected Care System Insights

Choose toolkit → Define population → Choose report → **View insights**

Core 20 Plus 5

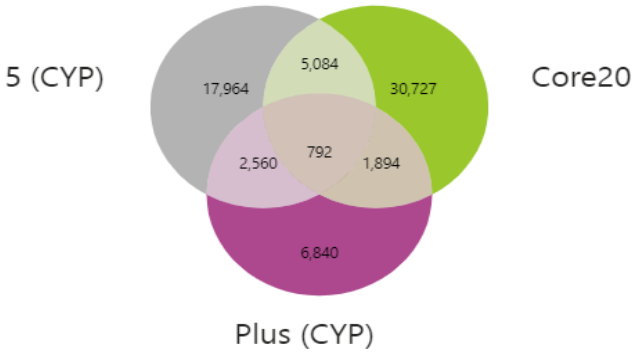
5 Edit Population | List of Patients

780,128 Population size

Overview - CYP | Overview - Adults | Breakdown of cohort size | Clinical Outcomes | Prevalence of conditions | Achievement of checks | Activity

How big is the Core20Plus CYP population?

47,897	175,560	27.28 %
Core20Plus Cohort	All CYP (Under 18s)	% of population



Select column to show in Venn

Target population	Cohort size	% of Core 20 Plus 5 cohort	% of total population
5 (CYP)	26,400	40.08%	15.04 %
Core20	38,497	58.45%	21.93 %
Plus (CYP)	12,086	18.35%	6.88 %
Total	**65,861**	**100.00%**	**37.51 %**

Info:
← 5 group here includes ***entire population*** with relevant conditions, ***including*** those outside Core20Plus population.

Table to the right shows the cohort with clinicial conditions ***within*** Core20Plus cohort→

Choose Plus groups: Multiple selections

Breakdown of the Core20Plus target population

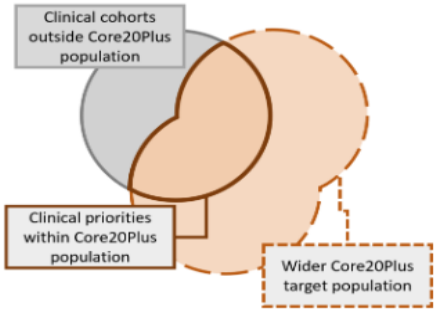
RegisterType	% Prevalence	# Prevalence
Core20		**38,497**
Deprivation Decile 1	0.0%	54
Deprivation Decile 2	3.0%	5,289
Deprivation Decile 3	7.3%	12,753
Deprivation Decile 4	11.6%	20,401
Plus (CYP)		**12,086**
Learning Disability	0.4%	634
Lives in Household with Carer	6.6%	11,662
Young Carers	0.1%	233
Total		**47,897**

Clinical cohorts within the Core20Plus target population

RegisterType	% Prevalence	# Prevalence
5 (CYP)		**16,218**
Asthma	3.0%	2,813
Dental Issues	2.5%	2,383
Epilepsy	0.3%	305
Mental Health and Neurodivergence	12.6%	12,013
Type 2 Diabetes	0.0%	7
Total		**16,218**

Find out more about the Core20Plus5 (Children and Young People) approach here:
NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people

Venn diagram key



Include Secondary Opt Outs: (•) No ( ) Yes

Show low numbers: (•) No ( ) Yes

Date accessed: 14/09/2023 | Data refreshed: 13/09/2023 05:25:32 PM | User: shariqa.akbar@bks.gnpoph.com

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Frimley Health and Care

Reducing Health Inequalities in our most deprived populations in Slough

The Aim:
The overall aim of this indicator is to empower people in our most deprived communities to make positive changes to help themselves

Rationale for intervention:

- Enable opportunities to support patients to identify issues and for practice teams to build trust with this patient group from a social perspective
- Provide health education
- Understand barriers to access that these patients experience to improve future experiences and overall health outcomes
- Empower our social prescribers within primary care
- Further strengthen the strong partnerships within Slough

Cohort description: Residents living in decile 1-3 with 2- 3 chronic Conditions (hypertension and / or obesity and / or diabetes)

DiPCARE-Q

We would like you to answer the following questions dealing with your personal finances, social environment and general health. Please mark with an X the answer that best applies to your own situation.

		Question	Yes	No
Material deprivation index	1	During the last 12 months, have you had trouble paying your household bills (taxes, insurance, telephone, electricity, credit cards, etc.)?		
	2	During the last 12 months, have you had to ask your immediate family for money to cover your basic day-to-day needs?		
	3	During the last 12 months, has a member of your household not sought treatment (dentist, doctor, buying medication) because you didn't have enough money?		
	4	During the last 12 months, have you feared being evicted from or losing your home?		
	5	During the last 12 months, have you not bought clothes even though you or a member of your household needed them?		
	6	During the last 12 months, have you not bought furniture or household goods even though you or a member of your household needed them?		
	7	During the last month, has there been an occasion when your household did not have enough to eat?		
	8	Are you currently finding it very difficult to pay back money (to the bank, family, friend etc.)?		
		Number of questions answered Yes		
Social deprivation index	9	During the last 12 months, have you gone on holiday?		
	10	During the last 3 months, have you spent an evening in the company of close family members or friends?		
	11	During the last 3 months, have you been to the cinema, the theatre, a concert or a sports event?		
	12	During the last month, have you been able to access the internet (at home, at work, at a library, at an internet café, etc.)?		
	13	If you're in difficulty, is there someone outside your household to whom you can turn for material help (money, food, accommodation)?		
		Number of questions answered No		
Health deprivation index	14	Do you currently suffer from a physical disability that has a major impact on your day-to-day life?		
	15	Do you currently suffer from mental health issues or problems that have a major impact on your day-to-day life?		
	16	Do you currently have problems linked to alcohol consumption, drug-taking, gambling etc.?		
		Number of questions answered Yes		

Citation: Vaucher P, Bischoff T, Diserens EA, Herzig L, Meystre-Agustoni G, Panese F,Favrat B, Sass C, Bodenmann P. Detecting and measuring deprivation in primary care: development, reliability and validity of a self-reported questionnaire: the DiPCare-Q. BMJ Open. 2012 Feb 3;2(1):e00069

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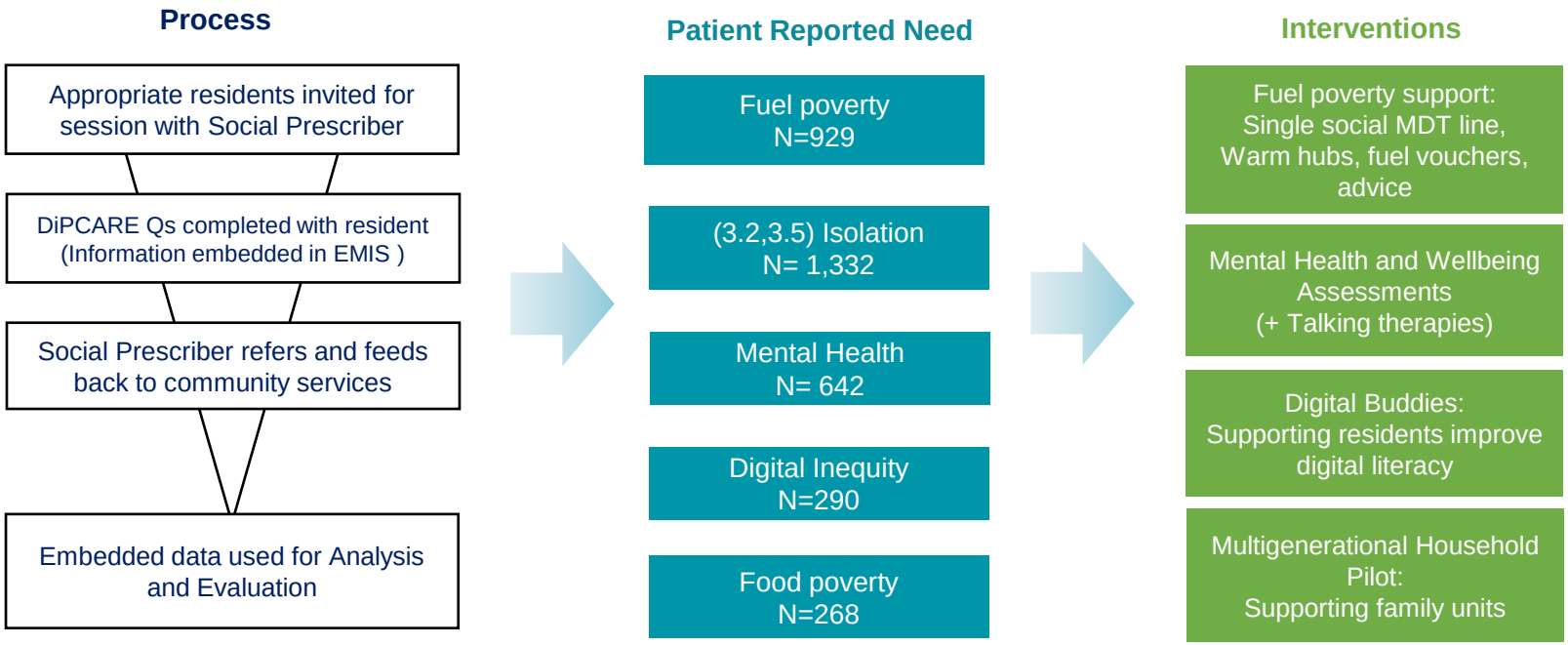
Process, Outcomes & Interventions



Governance - Health Inequalities Board

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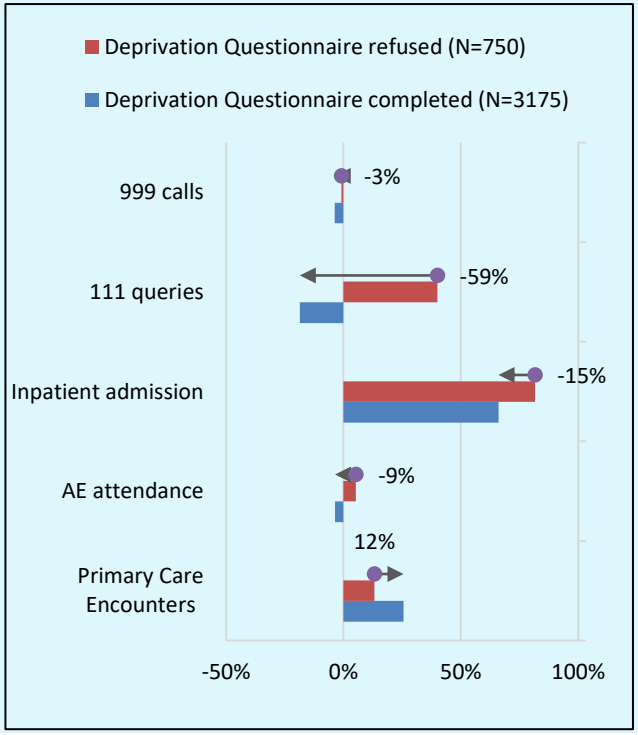
Value + Outcome



There has been a Net Reduction of:

- 3% in 999 calls
- 59% in 111 queries
- 15% in Inpatient Admissions
- 9% in AE attendances

There has been a Net increase of:

- 12 % in Primary Care Encounters

Achievement of health checks completed

	Mar-22	Apr-23	% Change
DQ completed	65.53%	72.86%	7.33%
DQ eligible but not completed	58.62%	64.45%	5.83%

Achievement of Treatment targets for health checks

	Mar-22	Apr-23	% Change
DQ completed	79.18%	79.65%	0.47%
DQ eligible but not completed	76.63%	76.77%	0.14%

Key Insights

Patients who have completed the questionnaire have had a greater increase in their achievement of health checks and their treatment targets compared to those who have not.

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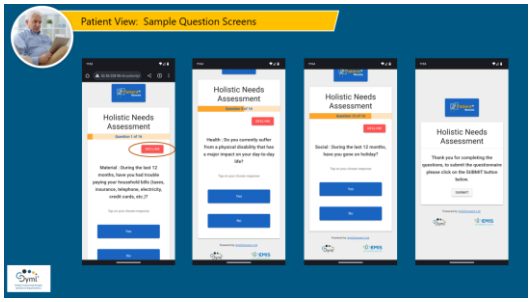
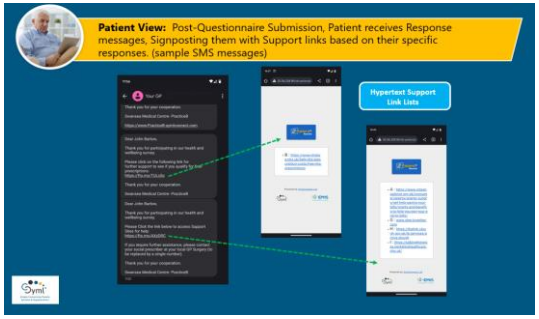
Scaling of the Holistic Needs Assessment (DipCare-Q)

- Digitalisation of the holistic needs assessment (16 questions - DipCare-Q)
- Automated text response with support depending on the answers
- Increasing capacity within the social prescribing teams for those that are digitally capable
- Identifying those residents who potentially have digital inequity concerns through analytic dashboards
- Scaling the offer through digital to reach out to as many residents as possible





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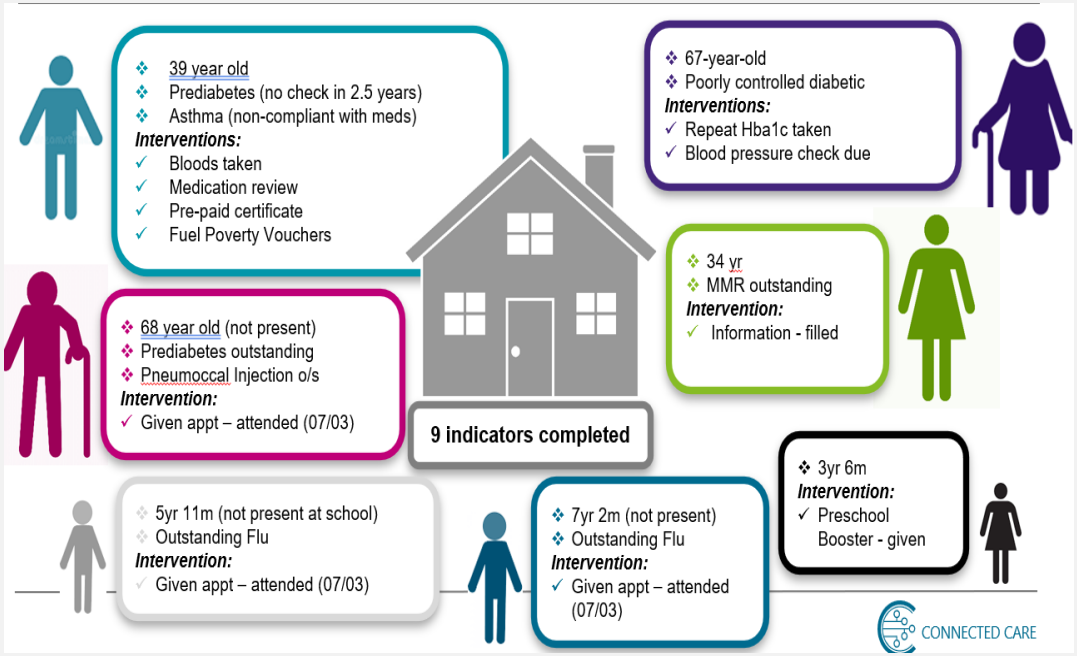
Multigenerational Household Pilot

Findings from the initial Pilot



Key insights

Background

- Slough – Nationally has the highest number of multigenerational households in the country and highest in our ICS
- Engagement with multigenerational households crucial during pandemic and vaccination programme

Objectives

- Addressing the wider determinants of health - social prescribers as part of the team
- Treating the family as a unit – changing health behaviours with the peer support of the family
- Improving uptake of NHS health checks, QoF indicators, immunisations, screening for cervical and breast screening
- Educating appropriate use of urgent care services
- Primary Care - productivity and efficiently
- Better engagement with the family as a whole.

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Multigenerational Household Pilot

Summary

441 households (4,023 residents) identified in Slough using the following criteria:

- Multigenerational households with more than 5 residents in decile 1-4
- Households with a less than 30% achievement in QOF indicators (range from 15%-23%)
- Includes the Core20PLUS5 cohort
- Includes learning disabilities and their carers

Next steps

- Engage Health and Social members of the team
- Integration with community developers service, housing, benefits, fuel vouchers, citizen bureau, mental health
- Extrapolating to ICS level. We can identify 1,414 households (with 11,249 residents) that meet this criteria

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Multigenerational Household Pilot Interim Results

SLOUGH PRACTICES	Count of Households	Sum of Est. Household Size	Average of Achievement as of 31st Mar 23 (Baseline)	Average of Latest achievement of indicators (Aug 23)
A	33	279	21%	69%
B	63	525	23%	67%
C	53	372	19%	69%
D	58	477	23%	50%
E	54	449	21%	33%
F	177	1,444	21%	45%
G	62	463	21%	52%
H	37	276	18%	62%
I	96	841	19%	56%
J	69	572	23%	52%
K	8	66	20%	45%
L	57	480	18%	45%
M	41	307	15%	50%
N	49	354	22%	47%
O	32	277	22%	66%
Grand Total	889	7,182	21%	52%

Improvement in 889 households by 31% up to August 23 across the whole of Slough.
Scheme started in June 23. These are households in the decile 1-4.

Source: Connected Care

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% ACHIEVEMENT OF HEALTH CHECKS ACHIEVED (YTD) COMPARED TO THE PREVIOUS YEAR

Total Population (ICB): (All health checks except Dementia)

Place / Locality name	Current YTD	Previous YTD	Difference
Slough	42.9 %	39.4 %	3.54 %
NEHF	42.1 %	40.0 %	2.05 %
RBWM	39.3 %	37.3 %	1.97 %
Bracknell Forest	36.2 %	36.5 %	-0.30 %
Surrey Heath	37.7 %	38.8 %	-1.09 %
Total	**40.3 %**	**38.7 %**	**1.68 %**

Total Population in Deciles 1-4: (All health checks except Dementia)

Place / Locality name	Current YTD	Previous YTD	Difference
Slough	43.6 %	39.5 %	4.09 %
RBWM	39.4 %	36.5 %	2.91 %
NEHF	43.3 %	42.4 %	0.87 %
Bracknell Forest	36.2 %	35.9 %	0.37 %
Surrey Heath	37.3 %	37.2 %	0.14 %
Total	**42.8 %**	**39.7 %**	**3.11 %**

Total Population (ICB): (LD and SMI health checks)

Place / Locality name	Current YTD	Previous YTD	Difference
Slough	51.1 %	43.0 %	8.03 %
RBWM	37.0 %	34.2 %	2.79 %
Bracknell Forest	35.6 %	34.1 %	1.49 %
NEHF	38.7 %	40.2 %	-1.42 %
Surrey Heath	32.8 %	36.5 %	-3.71 %
Total	**40.8 %**	**38.5 %**	**2.26 %**

- Compared to the other places in System, Slough has seen a greater improvement in QOF health check achievement compared to the previous financial year.
- There has been a greater % improvement in the deprived populations in Slough.
- LD and SMI health checks has had a much greater increase compared to the previous year, with Slough having the greatest achievement in the System.

Source: Connected Care

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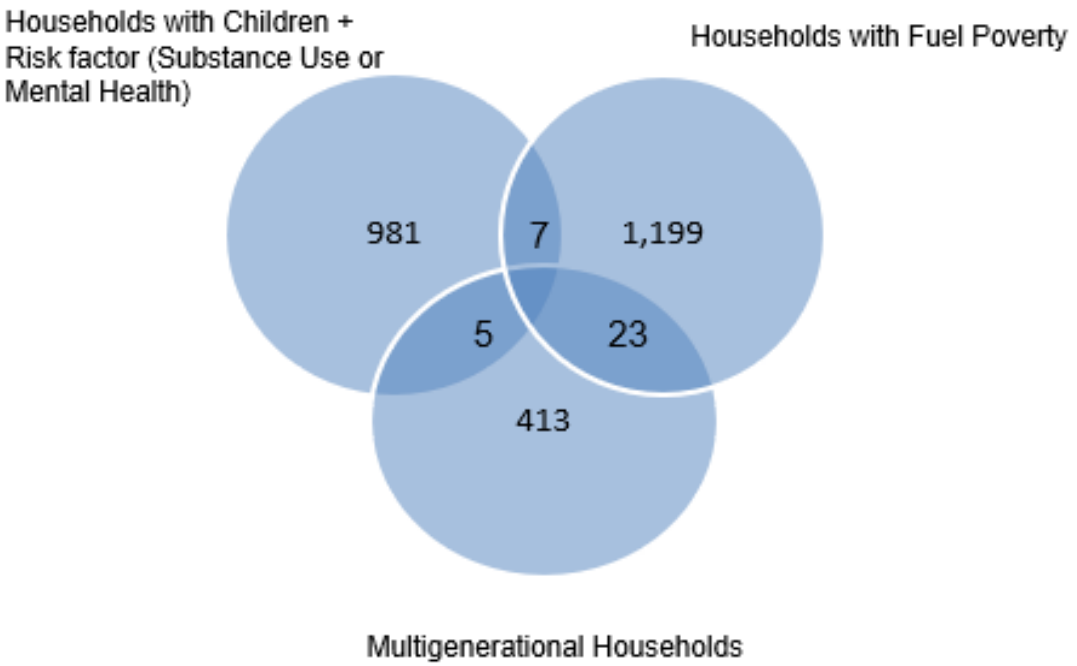
Household level approach

Venn Diagram of different Household level app



Key insights

Summary
Criteria for household level searches and total numbers:

- Number of Households which includes children and where one or members of the household has substance use issues or Mental Health issues: 993
- Number of Households have either report fuel poverty issues or live in a household with an EPC rating of F and G (poor insulation): 1,229
- Number of Multigenerational Households for targeting: 441
- **Next Steps:**
- Full evaluation of MGH project in March 2024
- Create a social MDT team around the 993 households wth children -including early help, mental health, safeguarding, health, council, citizens bureau, drugs and alcohol services and schools.

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Graphnet
Integrating Care

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Targeted Fuel Poverty Interventions in Cheshire and Merseyside

Prof. Rowan Pritchard Jones, Executive Medical Director

NHS Cheshire and Merseyside ICB

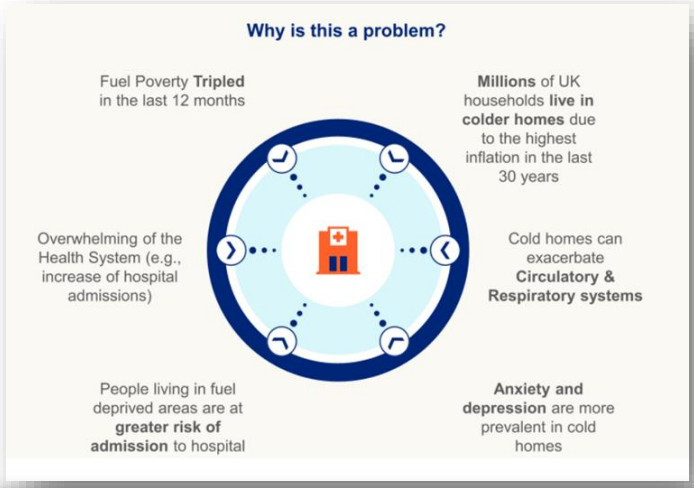
Fuel Poverty in Cheshire and Merseyside

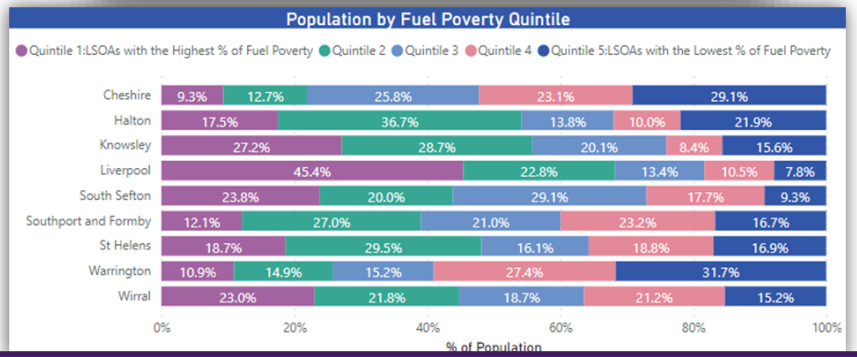
Cheshire and Merseyside
Health and Care Partnership

Why Fuel poverty interventions?

- Work commissioned in 2022 to develop a fuel poverty dashboard in CIPHA (Combined Intelligence for Population Health Action)
- Funding was allocated through the Innovation for Health Inequalities Programme (InHIP)
- Multi stakeholder steering group established to lead the project

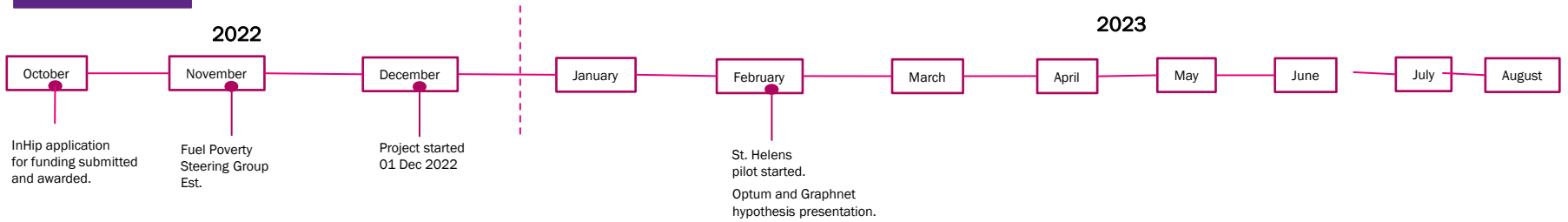
Aim: Use data to proactively identify those most at risk of poor health as a result of fuel poverty and target them with a holistic package of support from health, care, housing and wellbeing services.



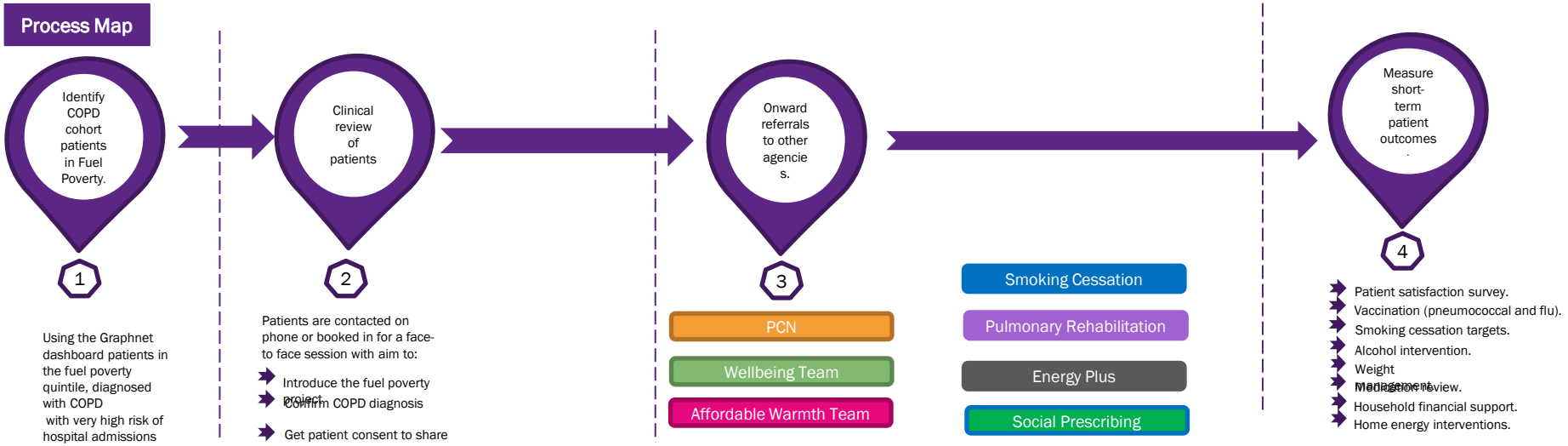


Trailblazer Project

Project Timeline



Process Map



Patient Impact – COPD Projects

St Helens Warm Homes for Lungs Project

- 159 patients contacted by the COPD Team
- 100% (159) referrals to Wellbeing Team.
- 100% (159) referrals to Affordable Warmth Team.
- 11% (18) referrals to Pulmonary Rehabilitation (PR) Team.
- 13% (20) patients were onboarded to COPD Telehealth Service.
- 84% (133) patients received £500 payments from household support fund: **£66,500 allocated in total.**
- 64% (101) patients sent feedback forms and 26% (26) returned.

They have made life easier.

Before, I was not using heating but its better now.

These nurses are most helpful at reducing stress levels.

Knowsley

- 29 of 43 Patients reviewed to date
- 18 referrals to home energy support
- 11 referrals to Pulmonary Rehab
- 8 Inhaler changes
- 28 Vaccine advice
- 4 Psychology referrals
- 5 Social prescribing referrals

Couldn't fault this clinic, answered a lot of my questions

Helpful is an understatement. Feel more confident in myself, has trust and faith in service

St Helens WarmHomes for Lungs Project Report

Meet Jo

- Dual diagnosis of COPD with primary condition pulmonary fibrosis.
- Require high flow oxygen 24 hours per day.
- Living in a cold home, can't afford rising energy bills.
- Self-managing a deteriorating condition.
- Needs a bespoke ramp, struggling to get out of the house in his scooter.
- Wife and son feel isolated, stressed and anxious.
- Having to choose between heating his home or using his oxygen.

Household Improvement

- Provision of replacement boiler.
- Risk assessment of home including storage of the oxygen , ventilation, fire breakers, care of the concentrator .
- Complete application for household support fund.
- Installation of bespoke ramp that could not be provided by the social services.

WarmHomes for Lungs

- Referred to Affordable Warmth Team for household assessment.
- Referred for an OT assessment for a stair lift and ramp assessment.
- Assisted to register on the Priority Services Register with energy provider.
- Medication review - introduced oxygen saturation probe, oxygen concentrator and provision of a fan for fan therapy.
- Household health education approach around his deteriorating condition including DNAR support.
- Advanced care planning discussion including end of life and SR1.
- Refused referral to pulmonary rehabilitation and well-being service.
- Wife referred to St Helens carer society for support.

Patient Outcome

- **Better self-management** of condition.
- **Financial savings** because of new prescription oxygen concentrator for 8 hours and then using more cylinder in the day .
- **Safer home** reduced fire and harm risk.
- **£500 household warmth fund** paid towards improvements. This fund will also be paid again in October 2023 for preparation for winter.

Next Steps

Consolidate the learning and embed the approach

Learning to date

- Build trust through consistent communication to engage harder to reach groups.
- Build on existing service offers: this isn't a new service; it's connecting existing service in a different way.
- Focus on small numbers to start; test, learn and adjust.

Roll out and spread the approach:

- Encourage and support other Places and PCNs to adopt the approach.
- Use data to identify other priority population groups.

Evaluation

- Short term: Case studies; activity data; patient and staff feedback.
- Medium term: small number of patients, pre-post intervention
- Long term: Real-World Intervention Causal Evaluation (RICE) tool using a control group

Thank you

Further details can be found at our Cheshire and Merseyside Fuel Poverty Implementation Toolkit:
https://www.healthinnovationnwc.nhs.uk/tackling-fuel-poverty

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Poll 1

How much would you say this webinar has increased your understanding of ICSs and prevention?

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Poll 2

Has much would you say this ICS webinar met your expectations?

More Information and Contacting Us

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Integrated Care Webinar

series 2023 / 2024

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