Health Beyond the Hospital

NHS Confederation

Wednesday 28 September 2023

Event supported by

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#HealthBeyondtheHospital

Unlocking whole system value in shifting care beyond

NHS Confederation

PA

- Hilary Thomas, Partner in Healthcare and Life Sciences, PA Consulting
- Dr John Unsworth OBE, Director of Nursing
- Amanda Grantham, PA Healthcare Expert, PA Consulting

#HealthBeyondtheHospital

Unlocking whole system value to leverage interventions that enable people to remain healthier at home

Health Beyond the Hospital Conference

September 2023

Bringing Ingenuity to Life.
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Introductions

Hilary Thomas

Healthcare and Life Science Expert

PA Consulting

Amanda Grantham

Healthcare Transformation Expert

PA Consulting

Professor John Unsworth OBE

Chair of Council

Queens Nursing Institute

Healthier at home:
The next frontier of healthcare

The health and social care market is entering a new era of radical growth in preventative, personalised treatments that maximise positive health outcomes and system resilience.

Globally, medtech and pharma leaders predict they will commercialise 25 percent more hospital to home solutions in 2027 than today. This upward trend is set to continue. Market leaders are pushing the boundaries of possibility, using breakthrough technologies, science, and data to redesign care pathways that unlock new opportunities.

This shift will also free up much-needed capacity for institutions such as the NHS – improving capacity in the NHS is expected to carry a cost of **£40 billion** over

a four-year period.

Health systems reduce costs when transitioning care to the home

£347 (17%) per bed day in cost savings have been delivered by Virtual Wards.

60% reduction of social care packages for patients with well-designed reablement schemes (specifically to help patients with complex needs to recover at home after an illness or hospital admission)

£6.4 million of cumulative net savings over five years per 100,000 people attending A&E when aligned to reablement schemes.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/459414/Moving_healthcare_closer_to_home_financial_impacts.pdf

But barriers exist to realising this vision and scaling hospital at home solutions…

60% agree that physician concerns for patient safety, patient outcomes or quality of care is a significant barrier to scaling hospital to home solutions

50% agree that data privacy concerns are a significant barrier to scaling hospital to home

60% agree that they see a gap between the number of healthcare workers and growing demand

Respondents believe that only 40 percent of physicians will be motivated to transition care from the hospital to home by 2027, a small increase from 28 percent today.

Creating value for all in the shift in hospital to home, requires a focus on four key accelerators:

Complexity comes from balancing priorities, rethinking risk, meeting a host of stakeholder needs, and delivering value across the whole ecosystem.

1. Connect the ecosystem

Engage all stakeholders to collaboratively define future care pathways and solutions.

2. Differentiate through experience

Create better, safer, easier experiences for patients and professionals.

3. Deploy digital with intention

Build connected, personalised digital solutions for a wide range of stakeholders, carefully managing data.

4. Unlock whole system value

Quantify financial and outcome opportunities across the ecosystem, focusing on prevention, early intervention, and ongoing wellness.

Unlock whole system value

Redefine value to include prevention, early intervention, and ongoing wellness across the ecosystem

Three priority areas:

- Prioritise prevention and early intervention
- Find a shared understanding of value
- Explore alternative payment models and incentives

> **A cardinal rule is to reduce a physician's effort more than you reduce their payment. If you keep that rule, and give them freedom to innovate, they'll accept your solution.”**

Chris Plance, healthcare expert, PA

Bringing Ingenuity to Life.

About PA.

We believe in the power of ingenuity to build a positive human future.

As strategies, technologies, and innovation collide, we create opportunity from complexity.

Our diverse teams of experts combine innovative thinking and breakthrough technologies to progress further, faster. Our clients adapt and transform, and together we achieve enduring results.

We are over 4,000 strategists, innovators, designers, consultants, digital experts, scientists, engineers, and technologists. And we have deep expertise in consumer and manufacturing, defence and security, energy and utilities, financial services, government and public services, health and life sciences, and transport.

Our teams operate globally from offices across the UK, Ireland, US, Nordics, and Netherlands.

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Welcome to Health Beyond the Hospital conference

NHS Confederation

- Dr. Layla McCay, Director of Policy, NHS Confederation

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A strengths based approach to community transformation in Derbyshire

- Ian Lawrence - Clinical Director, Derbyshire Community

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Joined Up Care Derbyshire

Team Up Derbyshire

A Strengths Based approach to building integrated neighbourhood teams

Dr Ian Lawrence
Clinical Director for Integration & CCIO
NHS Derby & Derbyshire / Derbyshire Community Health Services
Ian.lawrence@nhs.net

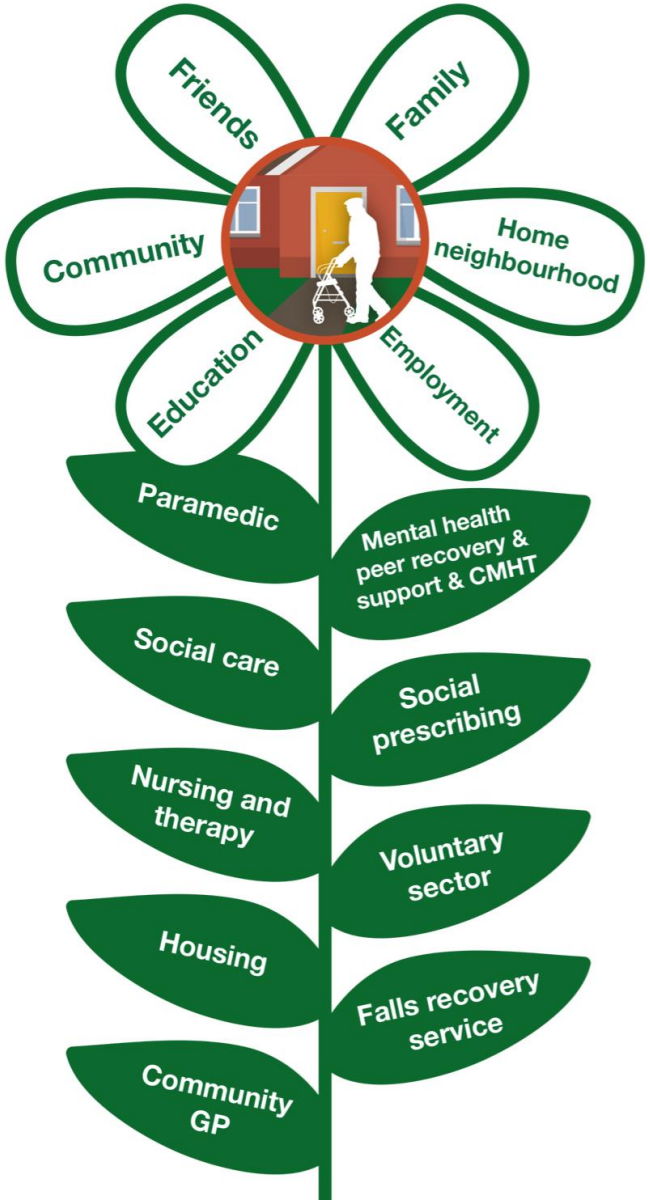
NHS
The Derbyshire VCSE sector Alliance
Derby City Council
DERBYSHIRE County Council

Take home messages

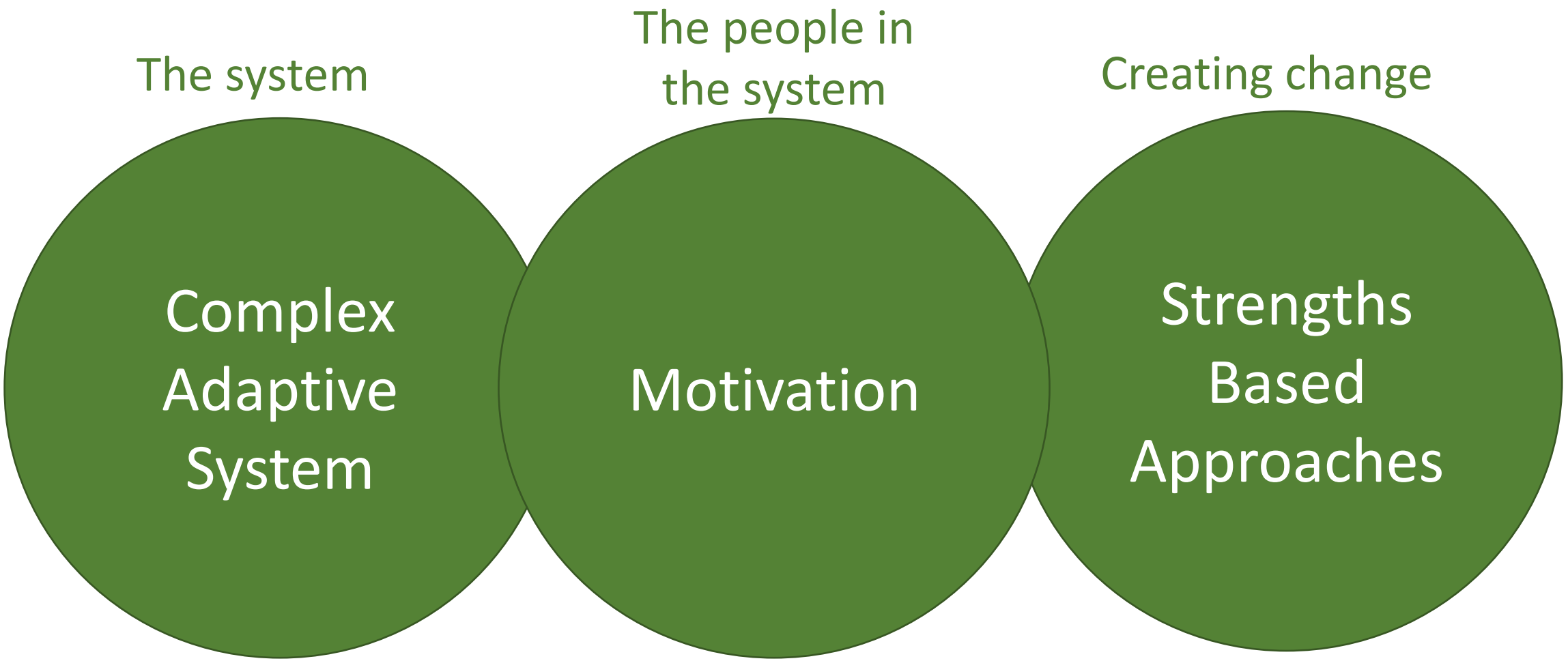
1. It’s Complex
2. Trust your people
3. It takes time

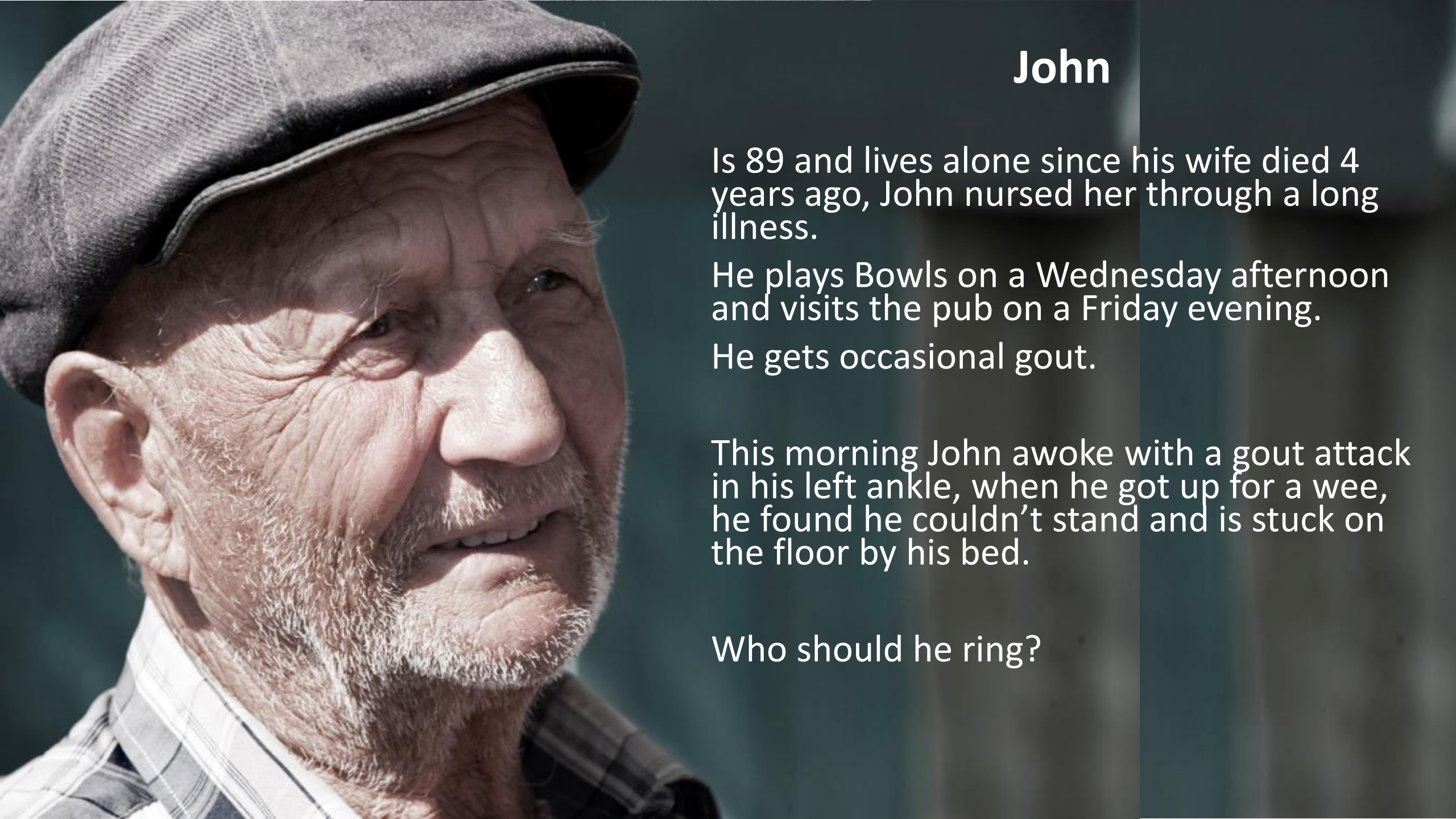
Team Up - Concept

- Work together across health and social care to see all people in a neighbourhood currently unable to leave home without support.
- Create more capacity without creating a new service by bringing together all partners.
- Build the infrastructure for future integrated working



Team Up - Approach





John

Is 89 and lives alone since his wife died 4 years ago, John nursed her through a long illness.

He plays Bowls on a Wednesday afternoon and visits the pub on a Friday evening.

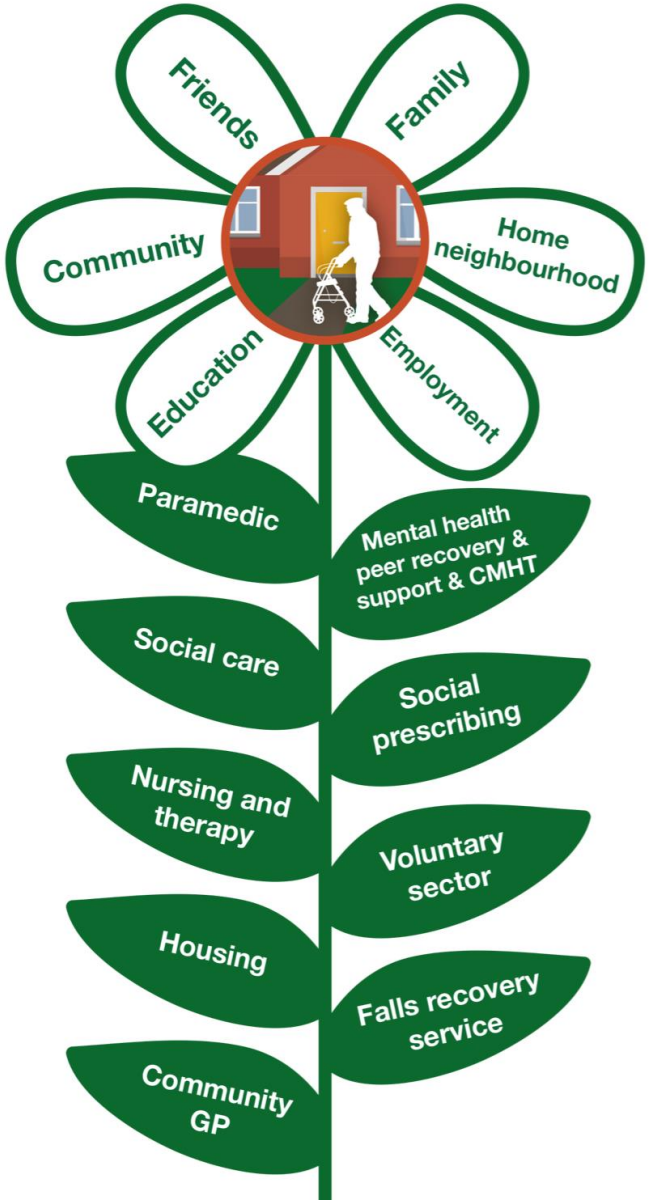
He gets occasional gout.

This morning John awoke with a gout attack in his left ankle, when he got up for a wee, he found he couldn’t stand and is stuck on the floor by his bed.

Who should he ring?

The Derby & Derbyshire health & care Community

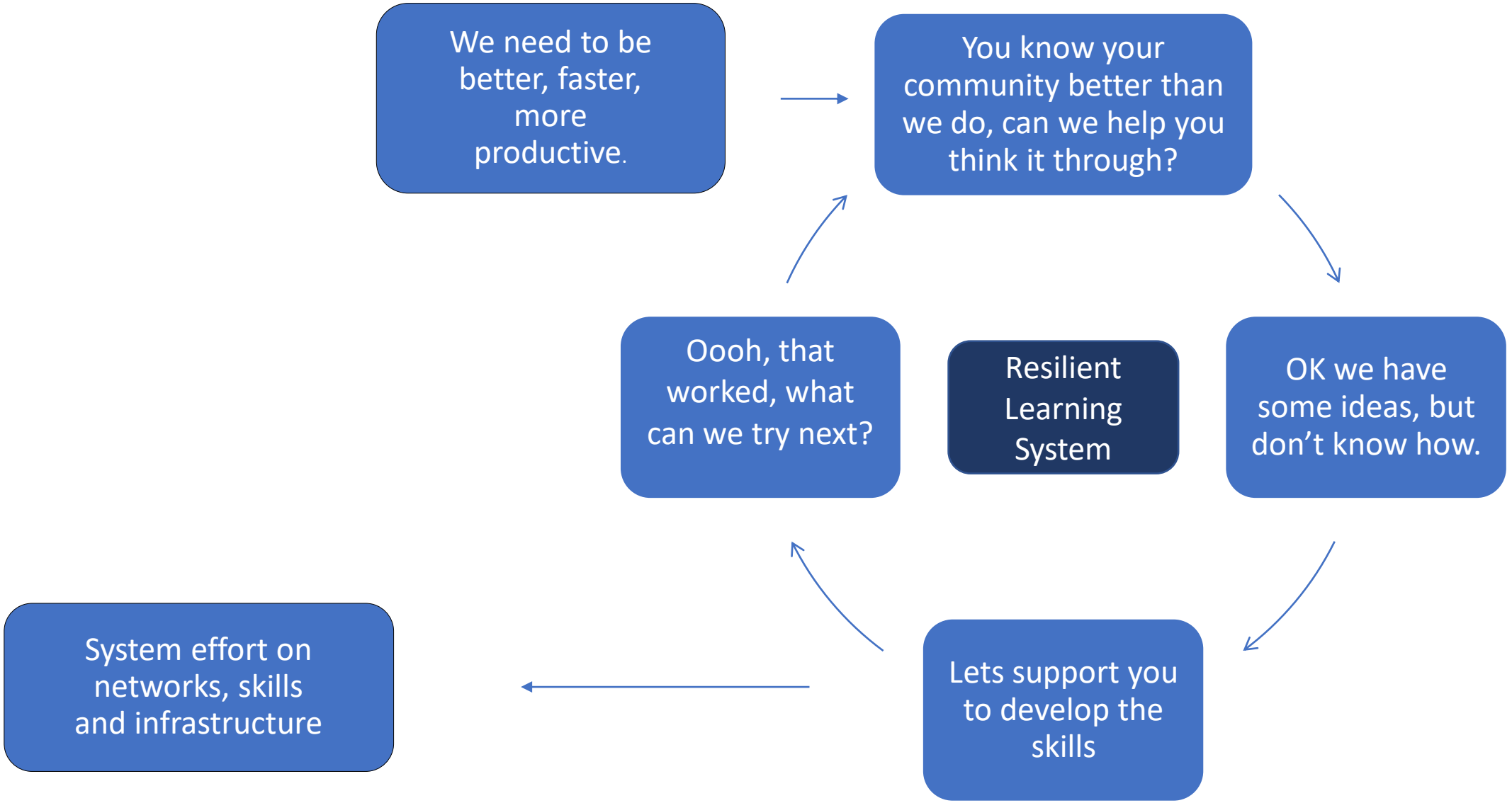
- 114 GP practices providing **6 million** appointments a year
- **1.2 million** nursing & therapy home visits a year
- 325 care homes with nearly **9000** residents
- 270 home care providers with **10,000** care workers supporting 11,500 residents
- Over **2000** registered charitable organisations
- 204 community pharmacies
- 91 funeral homes
- Etc. etc…



How do you transform all that?

Deficit based Approaches

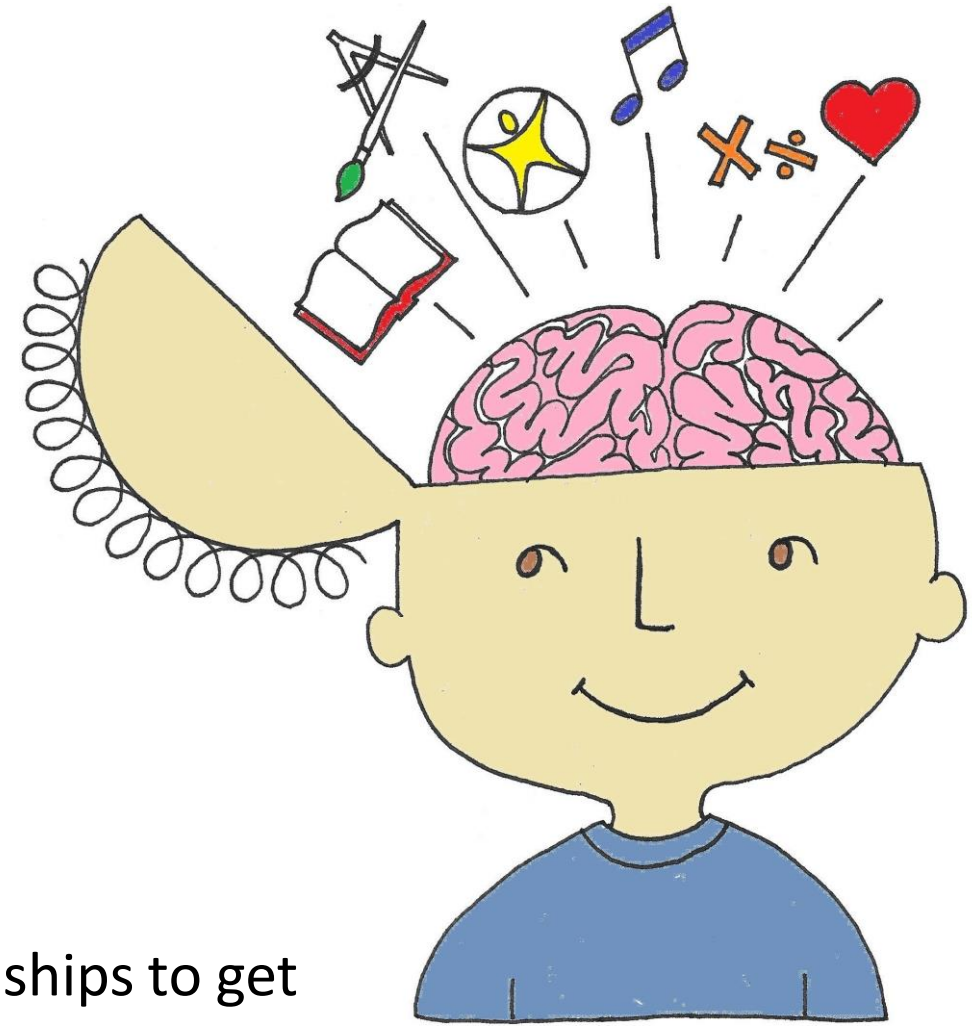
Strengths based Approaches



Intrinsic motivation

(Daniel Pink)

- **A sense of purpose**
  - Working together in and with our community…
- **Mastery**
  - **…**We can solve the daily problems we face
- **Autonomy**
  - …and we have the tools, permission and relationships to get on with it!



Team Up

Urgent Community Response

We asked PCNs to…

1. Set up a home visiting service
2. It must have a dedicated GP available
3. It must be ready to integrate with Community Health services, short term Adult Social Care and falls recovery services
4. And you must engage with our learning network (Team Up Learning in Practice - TULiP)

TULiP

(Team Up Learning in Practice)

- Learning
- Support
- Peer review
- Governance
- Consistency
- Planning

Set up your service to a max running cost of £10.06 pp
Claim back what you spend

Modelling in the background to create a programme budget to grow in line with anticipated recruitment.

Team Up Community Transformation Programme

Team Up Programmes.

Urgent Community Response
- Rapid Nursing & Therapy
- Rapid and short term adult social care
- Falls recovery services
- Local Access Points

Enhanced Health in Care Homes
- EHCH DES (med reviews, care plans, MDTs, linked GPs)
- Care home Engagement
- Managing deterioration
- Digitisation

GP Home visiting services
- PCN infrastructure
- Community GPs
- Local Access Points

Anticipatory care
- PHM approaches & data
- PCN engagement
- Falls prevention

Joint projects & infrastructure

Digital
- IG complexity
- integrated infrastructure
- Hardware
- Software
- Support
- Data collection, reporting and use.

Workforce
- Planning, recruitment
- Training and development
- HR processes in an integrated team

Central Access Point
- With Urgent & Emergency care
- Central clinical resource in DHU
- DoS development

Legal and regulatory
- CQC
- Indemnity
- Finance
- Contracting

Developing Networks

Strengths based approaches:
- To patient/citizen support
- To service improvement

Frailty Pathways
- Front door
- Discharge
- Geriatricians in community
- Virtual ward

Community Mental Health
- Dementia and delirium
- Living Well programme
- Referral pathways

12 Home Visiting Services - July 2023

24,259

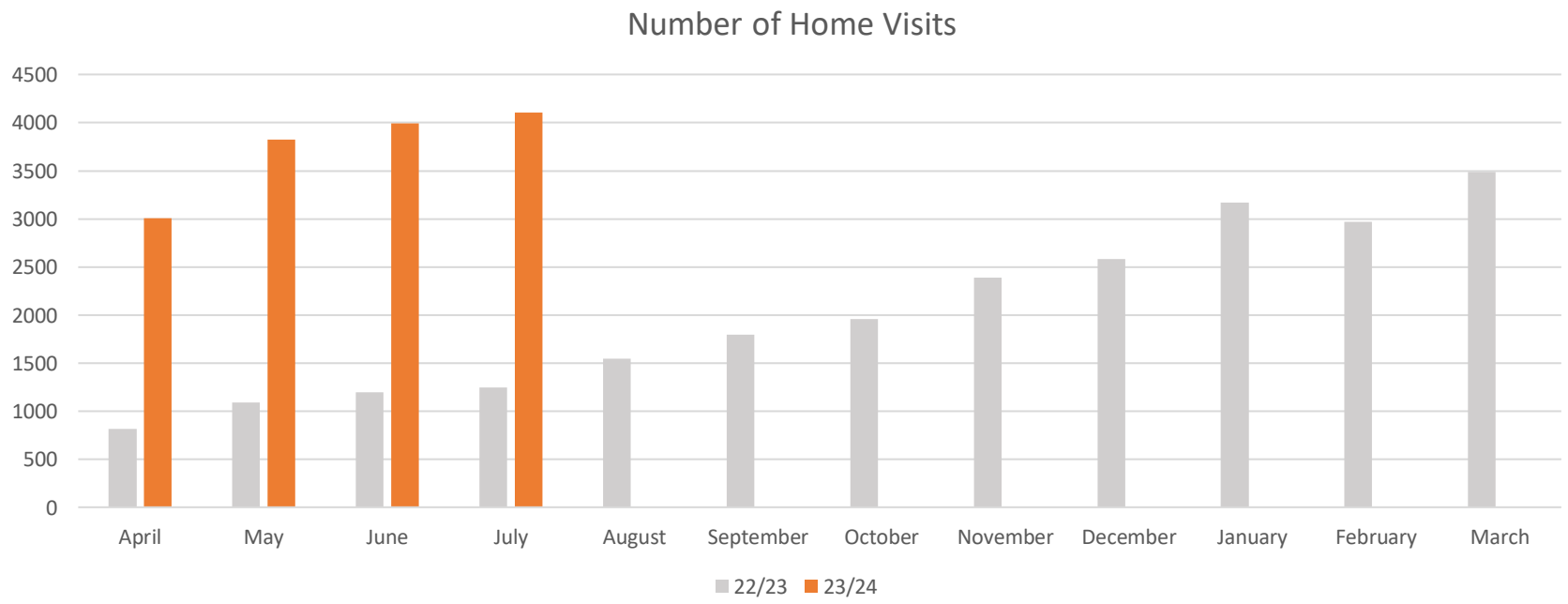
Total Home visiting service visits Apr22- Mar 23

14,930

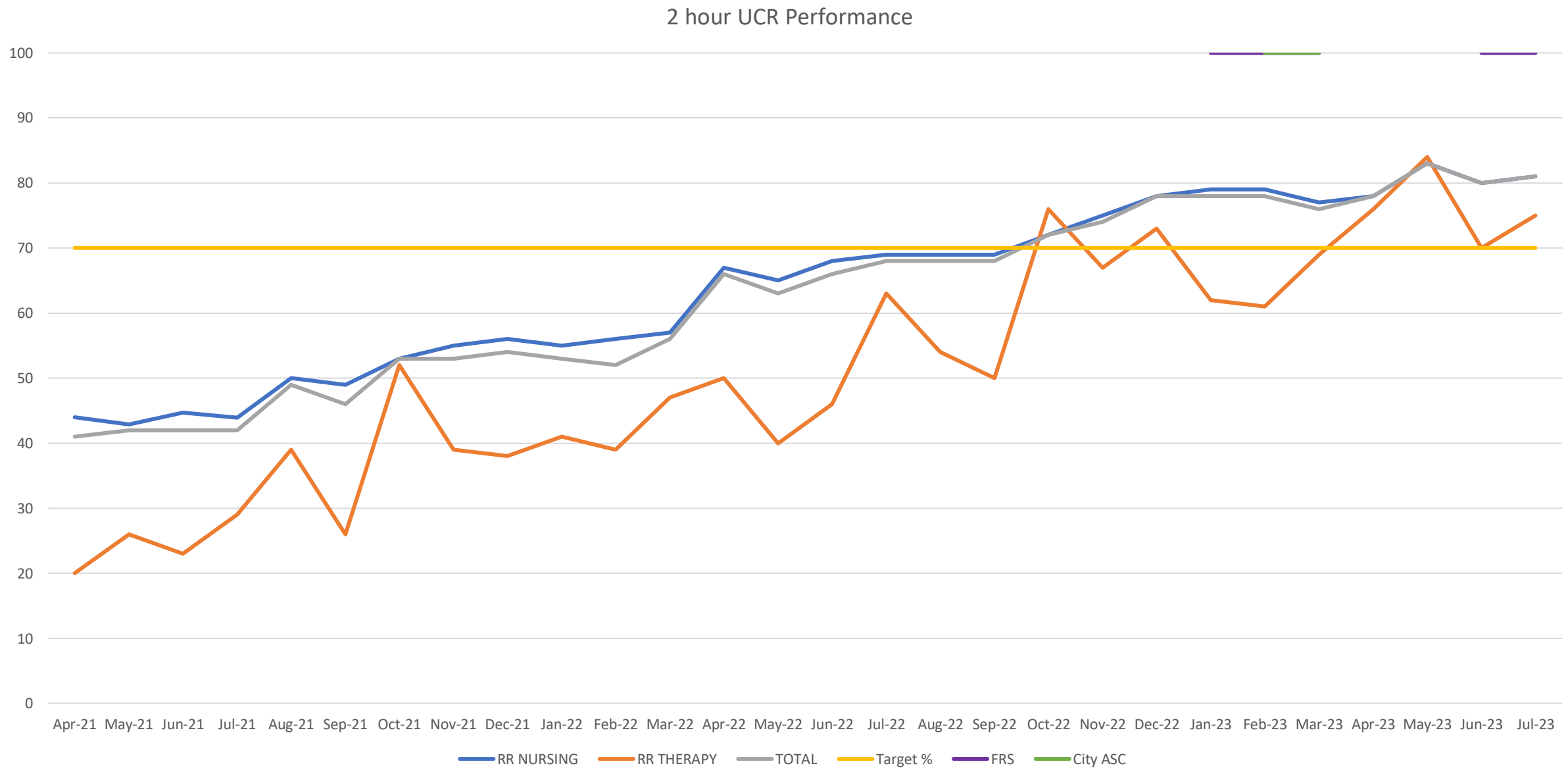
Number of home visits since April 2023

4,107

Number of home visits for the month of July 2023



UCR 2-hour reporting-July2023



Data source: DCHS

Evaluation…

Ageing Well Outcomes

1. Reduce total time spent in a bedded facility
   - hospital or care home - for those with frailty over a year.
2. Increase participation in decision making-
   this includes confidence in:
   - ability to cope with own health
   - role as participant in care (involved in discussions, planning)
   - healthcare professionals.
   - treated with dignity and respect
   - coordination of care and discharge to place of choice.
3. Improved carer experience
4. Improved staff experience
5. Cost effective/ Equitable/ Sustainable

More Integrated??

Can you measure Integration?

“I’m profoundly deaf. The main problem is that I can’t make voice calls on the telephone. […] I don’t know how many times I’ve told them I can’t take a phone call, and how many times they write to me to tell me to ring a number.” – Service user

“It’s like swimming through treacle…” - Carer

Can you measure Integration?

“There’s that element that you’re all working together, everyone feels absolutely part of the same team and delivering on the same objectives and are equal partners in some of that.” – Staff member

“What this is telling me, that I hadn’t previously realised, is that you can’t do personalisation without integration”
- Community Trust NED

For over 65 years….

Compared to previous 12 months from November…

↓ **2,875 A/E attendance**

(Type 1 & 2)

↓ **1,712 EMAS cat 3 responses**

↓**1,303** reduction of those with a **length of stay 1 &2 days.**

From April 2022 to August 2023…

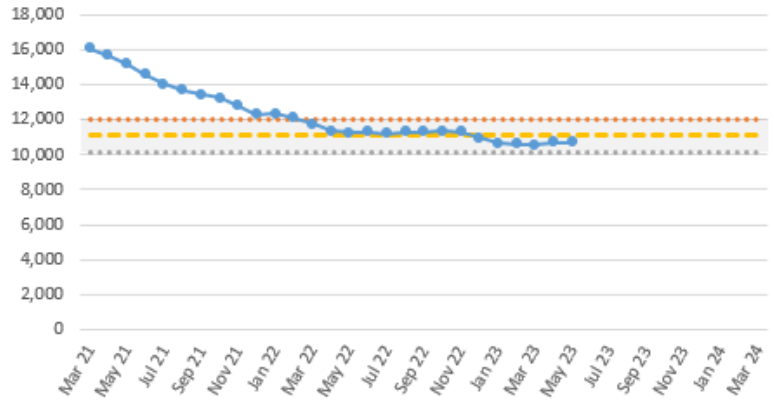
Over 10,000 people needing a **UCR Rapid Nursing and therapy 2 hour** response

Nearly 44,000 home visits

EMAS cat 3 response

Derbyshire ICB, EMAS Cat 3 response (See & Treat/ See, Treat & Convey) for over 65 years Rolling 12 month trend

Source: ECDS (AW Dashboard v2.3)6

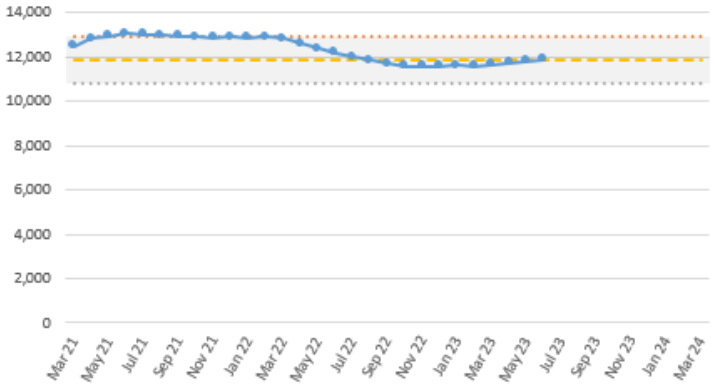


EMAS cat 3 response (see & treat/ see, treat and convey) (data to May 23 only) **has now plateaued**

Length of Stay (LOS)

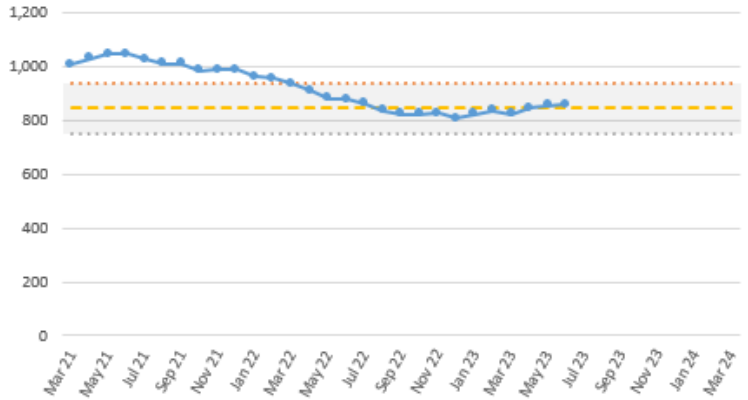
Derbyshire ICS- non elective inpatient discharges >65 years, LOS 1&2 days Rolling 12 month trend

Source: Ageing Well Dashboard v2.6)



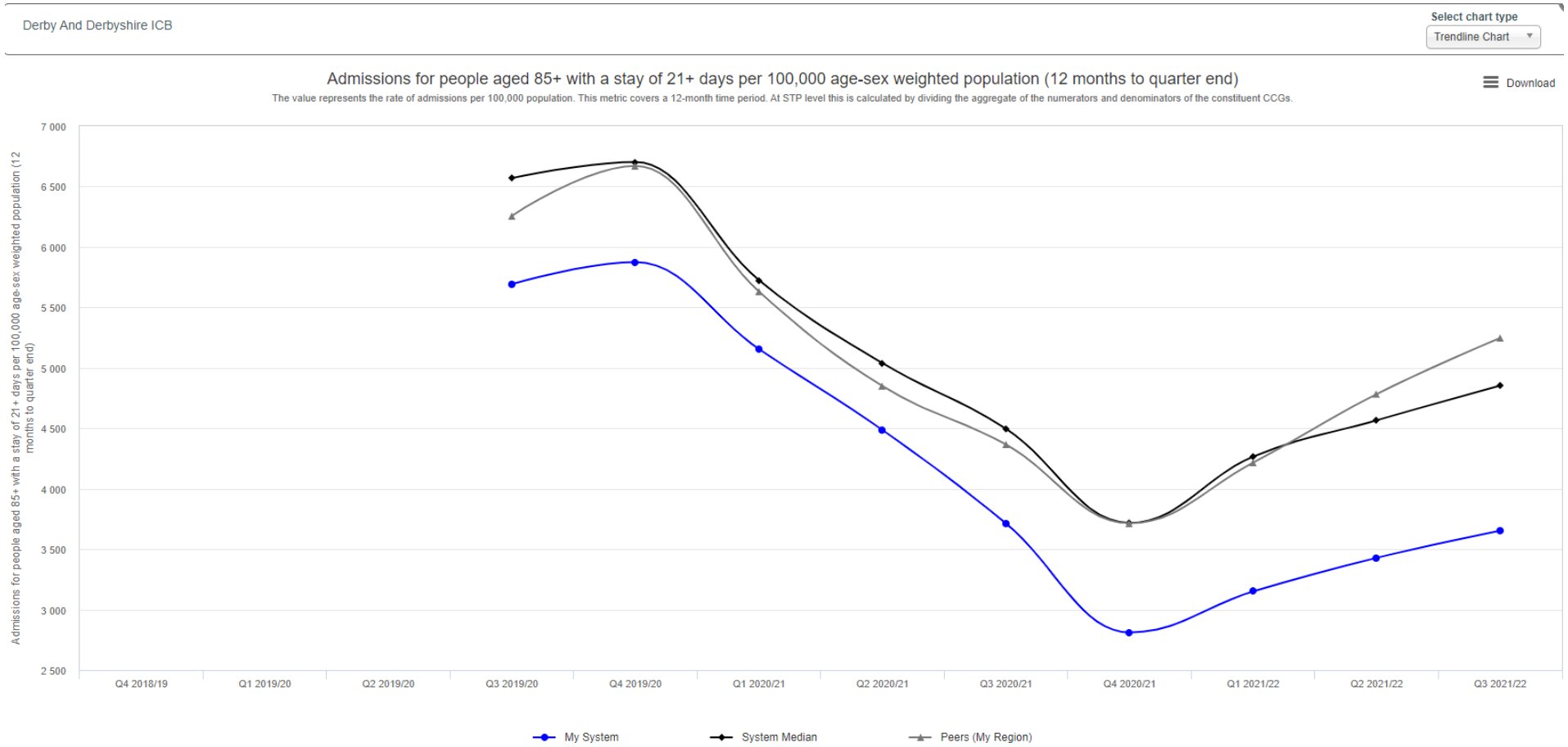
Derbyshire ICS- Readmissions within 7 days >65 years, LOS 1&2 days Rolling 12 month trend

Source: Ageing Well Dashboard v 2.6



LOS 1&2 days remains **stable** currently in addition those discharged within 1-2 day are not being readmitted

Data Source: NECS Derbyshire BI, AW Measures 2.6

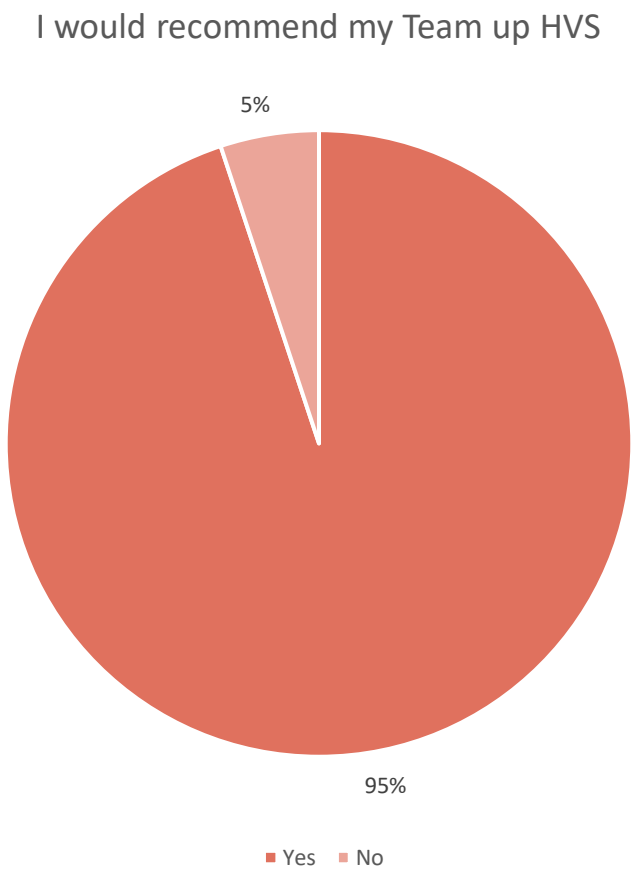


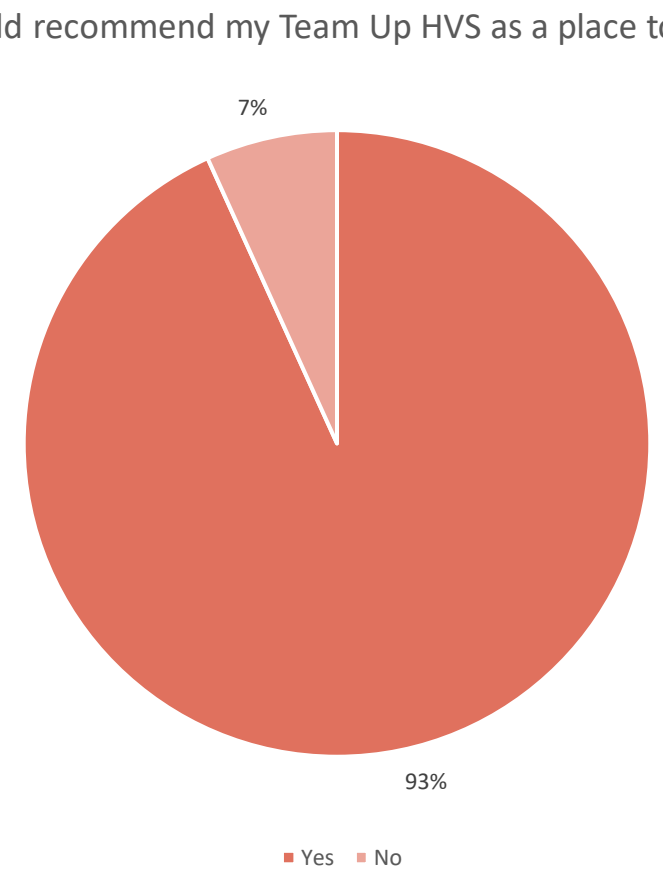
Admission over 85 years with a stay over 21 days

The same trend can be seen with this older age group. We look favourable compared to both the national and regional position, but the trend can be seen to be increasing again

Source: NHS Model Health System Dashboard

When asked about the Home Visiting Service….





Take home messages

1. It’s Complex
   - Acknowledge it, understand it, don’t make it worse.
   - Do whatever you can to create certainty. Vision, finance, infrastructure…

2. Trust your people
   - They are the ones who will make the change (or not!).
   - Building learning networks into the governance mitigates the risks

3. It takes time
   - Transformation is emergent and considered and chaotic and exciting.
   - Hold your nerve, the research backs you up.

‘George’ was introduced to Charlotte, a Team Up Local Area Coordinator.

He had been diagnosed with Colitis and had increasing levels of anxiety. He had not left his home in three years and was feeling isolated from his family. He had started talking of taking his own life.

Charlotte and George spent time getting to know each other. George felt the biggest barrier to going out was the fear of being incontinent in public. Over five months, they made small steps together, they found incontinence products to help make George feel more comfortable and he started to get out of the house, starting with small walks out of the front door.

George is now attending the community ‘Coffee and Company’ group independently and has started going back to a social group he had not visited for three years.

George is no longer ‘housebound’ and now has the confidence to do his own shopping and has reconnected with his family.

Case study kindly provided by **Derby City HVS**

“My mental wellbeing had been rapidly deteriorating just before Christmas. I was connected to Charlotte just at the right time as I had virtually given up the idea of trying to cope. Now with Charlotte’s support, my future is looking a lot brighter and the person I once was is slowly returning”

Photo for illustrative purposes only

James Sanderson

Director of Community Health and Personalised Care, NHS England

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Community Health Services

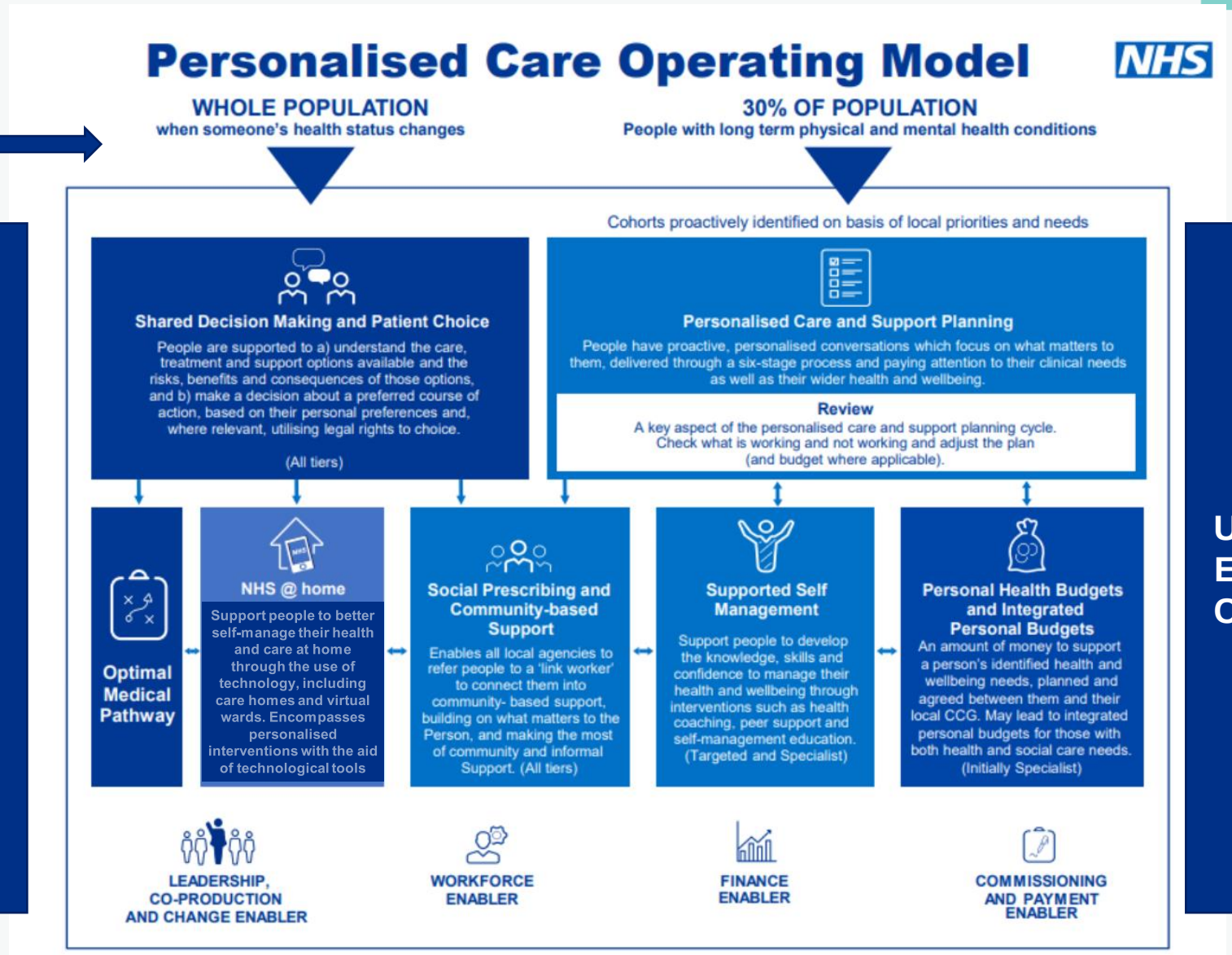
James Sanderson
Director of Community Health and Personalised Care
NHS England

Actions over the next 3 years to build a universal community services offer

Recover	Respond	Support
Steps to recover community services	Developing an integrated response service	To strengthen the hands of the people we serve
Continued expansion of the Comprehensive Model of Personalised Care		
• Address waiting list challenges including MSK and SaLT • Continuing to boost out of hospital care through supporting recovery plans of Urgent and Emergency Care, Elective and Primary Care Access • Empowering professionals and reducing GP demand through expanding direct access into services • Consolidating enhanced health in care homes (EHCH) framework including supporting care homes with highest unwarranted variation in secondary care use. • Improved offer for Palliative End of Life Care	• Winter approaches implemented as BAU to avoid regular reinvention and support ongoing improvement • Support and appraise single point of access for urgent and integrated care to support health professionals and patients • All areas consistently meeting or exceeding 70% 2hr urgent community response (UCR) standard • Ensure 10,000 virtual ward ‘beds’ are in place ahead of winter to provide care for more people in their homes • Acute Respiratory Infection hubs in all local areas that would benefit • Community-based falls response service in all systems for people who have fallen at home, including care homes	• Tailored support for those with multi-morbidities through development of NHS @home and Proactive Care offers • Targeted and proactive support to high-frequency users to improve quality of care and reduce unwarranted health care utilisation • Improve self-care approaches to strengthen the hands of the people we serve and consolidate personal budget, shared decision making and social prescribing • Continuing to unify NHSE’s approach to population health, inequalities and personalised care
Enablers	• Digital infrastructure and transformation • Strategic co-production • Workforce	• Public NHS offer • Aligned system incentives

Prevention

Population Health Management



Fuller – Integrated Neighbourhood Teams

Thank You

@JamesCSanderson

company/nhsengland

england.nhs.uk

Supporting high intensity users

NHS Confederation

- Jonathan Hammond-Williams, Head of Safeguarding, South Western Ambulance Service

#HealthBeyondtheHospital

Ageing: supporting people to live well for longer

NHS Confederation

- Chair: Professor Adam Gordon - President of British Geriatric Society (need adding to speaker matrix)
- Annette Bradley (CEO, MA Training), Jo Creed (MA Training)
- Sophie Green, Neighbourhoods Project Manager, City and Hackney
- Ruthe Isden (Head of Health Influencing, Age UK)

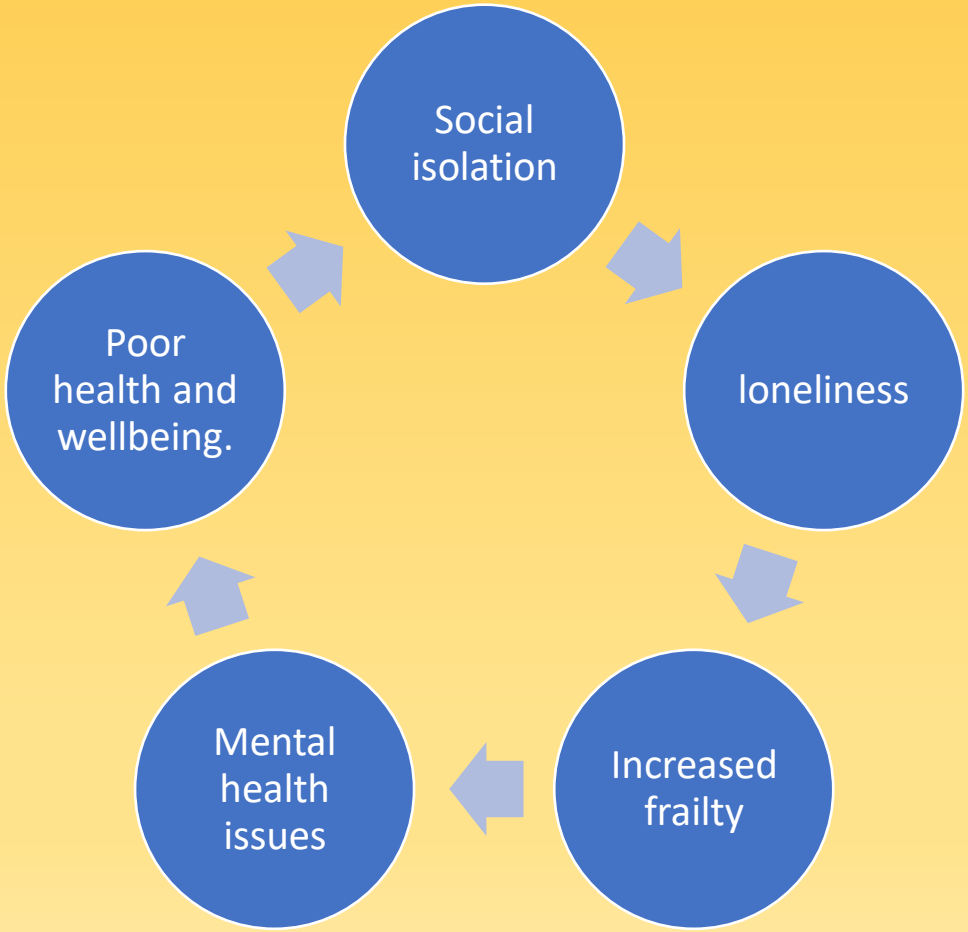
#HealthBeyondtheHospital

How the Aligned Care Approach helps our older patients with complex needs and long-term conditions live well for longer.

Jo Creed

Annette Bradley

Very often the problem people appear to have is not the real problem



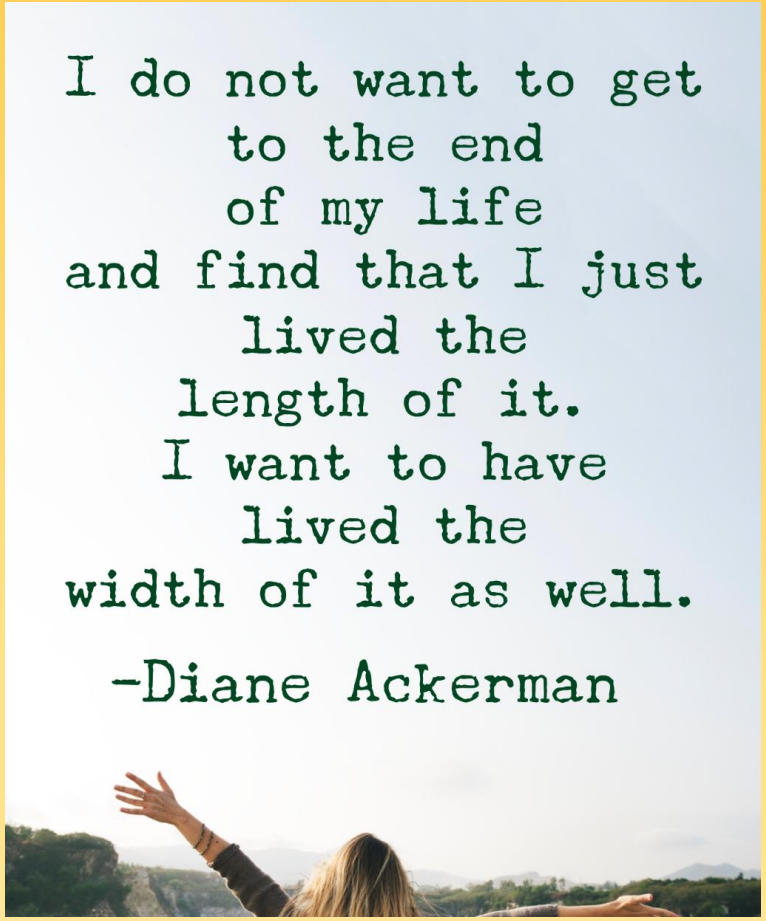
Soft signs - examples

- Comments- *"It's my age" " I am too old to be useful" "I don't want to be a burden on my family."*
- *Losing a loved one.*
- *Losing weight- not eating*
- *Appearing more unkempt.*
- *Not holding a conversation as they used to.*

The Aligned Care Programme

The Aligned Care Programme

Please come and have a chat with us later for some demonstrations of the approach



The Aligned Care Programme

Neighbourhoods

City & Hackney Living Better Together

The Neighbourhoods Programme And Proactive Care

Sophie Green

We will discuss how a Neighbourhoods approach can help people live well and examples of how this is being delivered through Proactive Care.

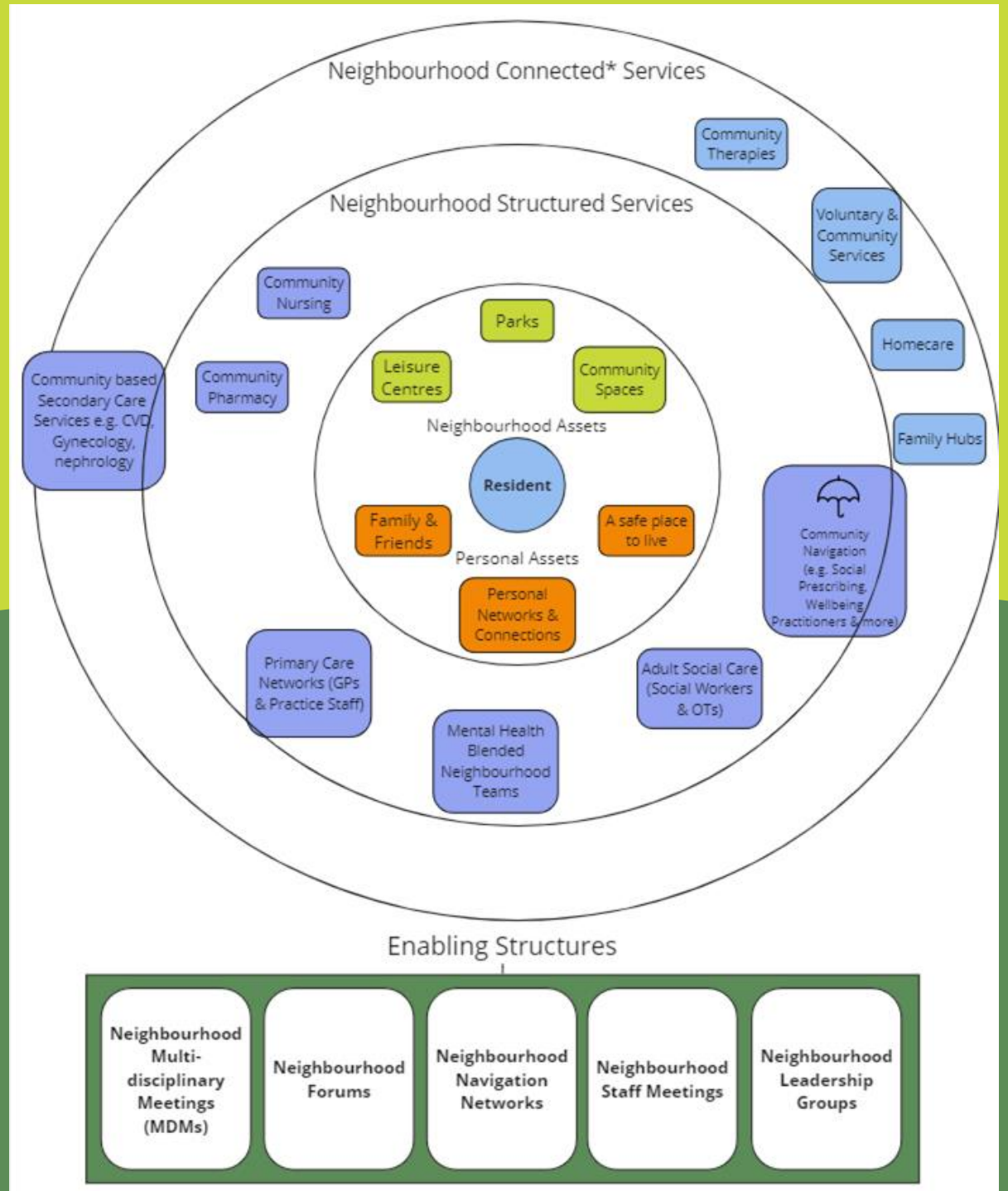
The Original Vision: case for change 2018

One size/approach doesn't fit all - Neighbourhoods allow targeted approaches and to target highest need

Evidence from Safeguarding Adult Reviews – Neighbourhood Teams can create trust, collaboration and improved communication

Importance of work to improve population health – Neighbourhoods offer a framework to promote and deliver prevention work at a local level

Fuller Stocktake 2022


Neighbourhood Connected* Services
Community Therapies
Neighbourhood Structured Services
Voluntary & Community Services
Community Nursing
Parks
Homecare
Community based Secondary Care Services e.g. CVD, Gynecology, nephrology
Community Pharmacy
Leisure Centres
Community Spaces
Family Hubs
Neighbourhood Assets
Resident
Family & Friends
A safe place to live
Personal Assets
Community Navigation (e.g. Social Prescribing, Wellbeing Practitioners & more)
Personal Networks & Connections
Primary Care Networks (GPs & Practice Staff)
Adult Social Care (Social Workers & OTs)
Mental Health Blended Neighbourhood Teams
Enabling Structures
Neighbourhood Multi-disciplinary Meetings (MDMs)
Neighbourhood Forums
Neighbourhood Navigation Networks
Neighbourhood Staff Meetings
Neighbourhood Leadership Groups

How we can support the workforce: Organisational Development (OD) pilots

City and Hackney OD/Transformation/Quality Improvement (QI)/Culture leads coproduction of a programme of work with the following areas of focus:

- Embedding Anti Racism (principles and case studies from Women's Health, frailty awareness and cardio-vascular disease prevention)
- Inclusive Recruitment
- Embedding Making Every Contact Count in Neighbourhoods
- Resident led QI Neighbourhood Resident Advisor Programme
- Neighbourhood Staff Meetings and Leadership Groups
- Getting to know your Neighbourhood Pilot- an induction to your Neighbourhood through the eyes of volunteers in community settings
- Shared competency framework
- Co-production of a shared Neighbourhoods Resource Pack

Proactive Care Pathway

A City and Hackney Neighbourhood model for Proactive Care

Proactive Care is an approach that **helps people to live well and independently for longer, through the provision of proactive care in the community for people living with moderate frailty and long term conditions** who may have underlying risk factors such as unhealthy lifestyles, behavioural risks, social isolation or poor housing.

Each Neighbourhood funded to deliver the Critical Pathway:

- Support for Care Coordinators (inclusive recruitment and a range of development)
- Volunteer Centre Hackney case finding pathway
- Dedicated line management and supervision

In addition **a devolved budget (approximately 20k per Neighbourhood) allowed each Neighbourhood to implement local enhancements** to meet their local needs, decided through Neighbourhood Forums:

- A frailty aware Neighbourhood : Cohort awareness training using an anti racist approach
- Mini budgets for barriers/enablers pilot. Delivery of mini budgets from £50 - £500 to solve individual issues and longer term analysis of the spending to inform future service planning.

Case Study

67 year old Caribbean Man
Clinical Frailty Score: 4, long term conditions: small vessel disease, osteoarthritis, type 2 Diabetes, left ventricular systolic dysfunction, cervical spondylosis, hypertension

Type of contact: Invited to pathway via letter, followed up with a telephone call to book initial appointment
Time from letter to initial appointment: 3 weeks (4 days between follow up call and initial appointment)
Contact: 1 initial and 4 follow up sessions

What matters to the resident?
The resident identified several outcomes they wanted to work on. Resolving a long-standing issue of damp in his home, improving his financial situation as he was struggling with the cost of living on a small pension and improving his physical health by losing weight

The Care Coordinator supported the resident to identify the appropriate department to contact regarding the damp and helped the resident plan a timeline for contacting them and escalating his concerns. The Care Coordinator supported the resident to complete a self-assessment benefits calculator and when it was identified he was eligible for additional benefits linked the resident with the Hackney Money hub for support making a claim

Using their knowledge of the PCN and GP practice the Care Coordinator helped the resident sign up to a weekly weight loss group run at the practice
The resident was very pleased to find he was eligible for more benefits and appreciated the opportunity to plan an approach to working towards his outcomes with the Care Coordinator

Thank you

Sadie King- Neighbourhoods Programme Lead - s.king33@nhs.net
Sophie Green- Neighbourhoods Project Manager - sophie.green3@nhs.net

Neighbourhoods

Breakout session: How can we achieve full integration when delivering virtual wards

NHS Confederation

- John Rochford, Deputy Chief Medical Officer for Central London Community Healthcare NHS Trust (CLCH).
- Nicola Lorena, Transformation Manager - Virtual Wards, Central London Community Healthcare NHS Trust
- Erin Gallagher, Nurse Consultant - Frailty, Central London Community Healthcare NHS Trust

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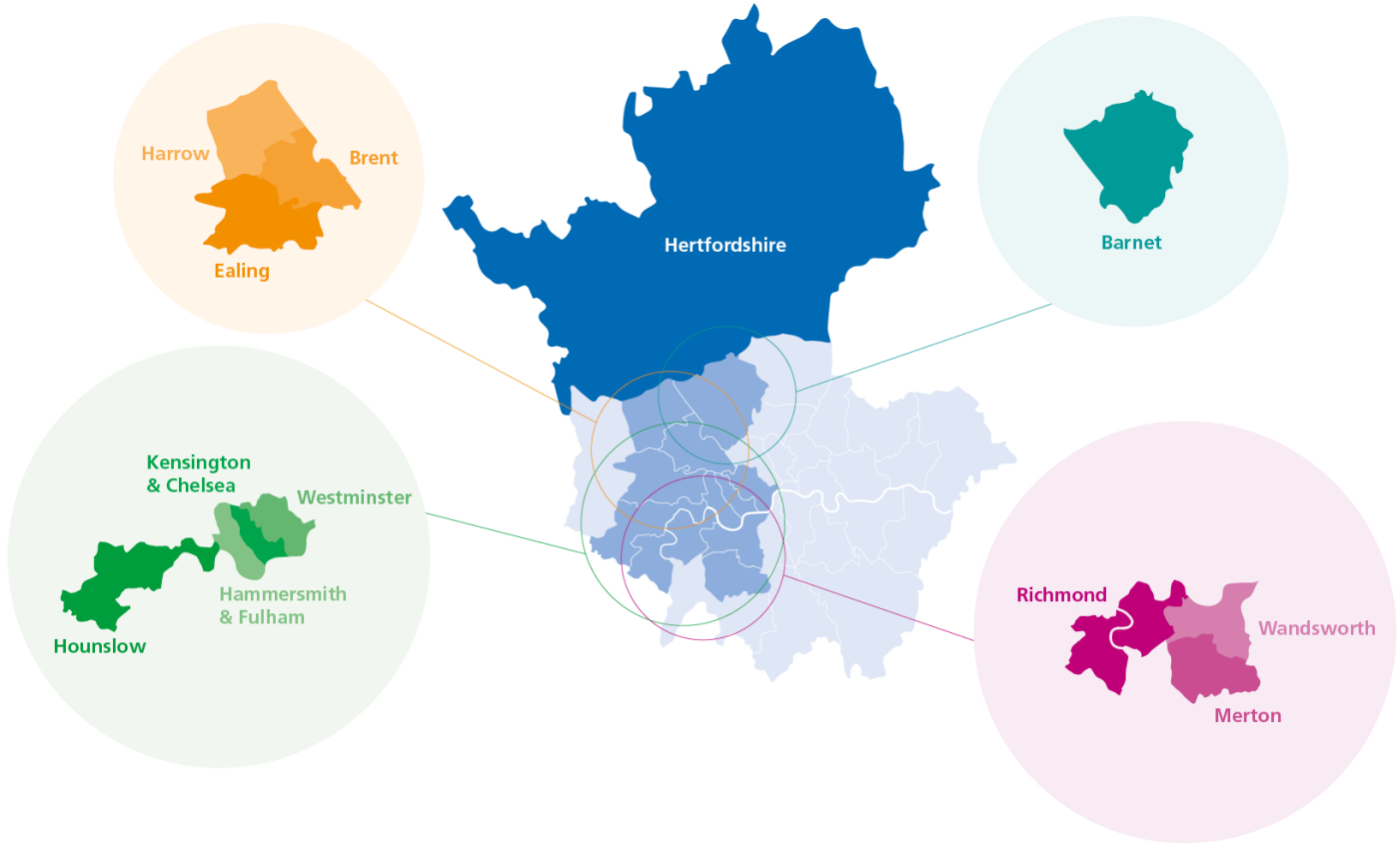
Achieving integration in CLCH Virtual Wards

NHS
Central London Community Healthcare
NHS Trust

John Rochford
Erin Gallagher
Nicola Lorena



Outline of session

Experience of integration in developing Virtual wards in CLCH (30 mins)

- Introducing CLCH
- Context of Virtual wards and role of Community health providers
- Integration approach – “Inside out approach”
- Case Study 1 – South West London “Innovation alongside integration”
- Case Study 2 – South and West Hertfordshire “Going slow to go fast”
- Conclusion

Discussion with panel (25 mins)

Where we work

NHS
Central London Community Healthcare
NHS Trust

We deliver services in **11** London boroughs and Hertfordshire

Across **650+** sites

84

Primary Care Networks (PCNs)

GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups

4

Integrated Care Systems (ICSs)

Partnerships of organisations that come together to plan and deliver joined up health and care services to improve the lives of people in their area

11

Place Based Partnerships

Collaborative arrangements that have been formed across the country by the organisations responsible for arranging and delivering health and care services in a local area

A year in numbers

NHS
Central London Community Healthcare
NHS Trust

Our key facts and figures from 2021-22

2,000,000

CLCH cares for over 2,000,000 people across London and Hertfordshire

45

volunteers supporting patient care

99.3%

of patients felt our staff treated them with dignity and respect

1,232,478

visits to people in their own home

36,289

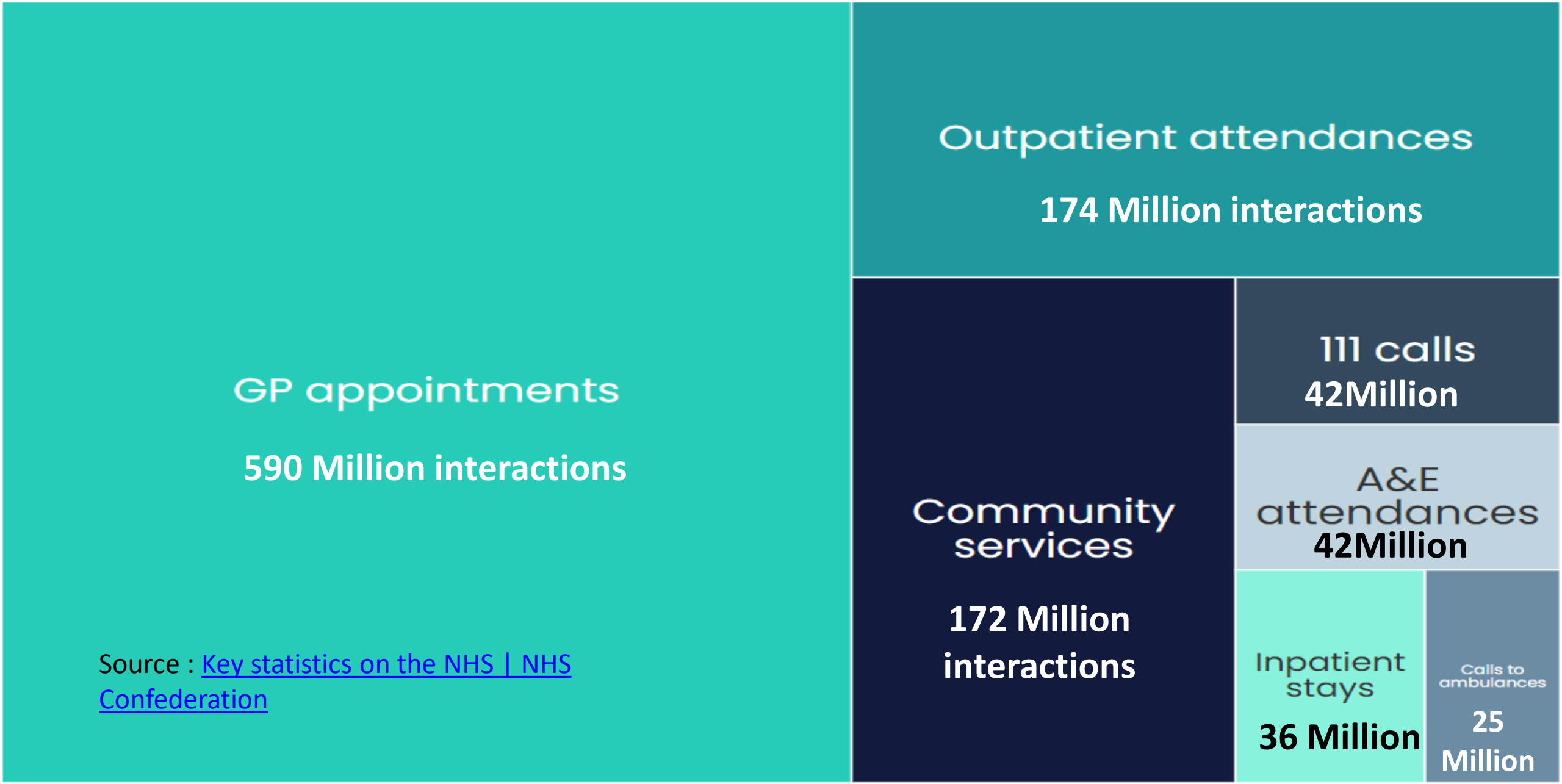
emergency visits within 2 hours (rapid response)

72,184

days for patients in our inpatient beds

97%

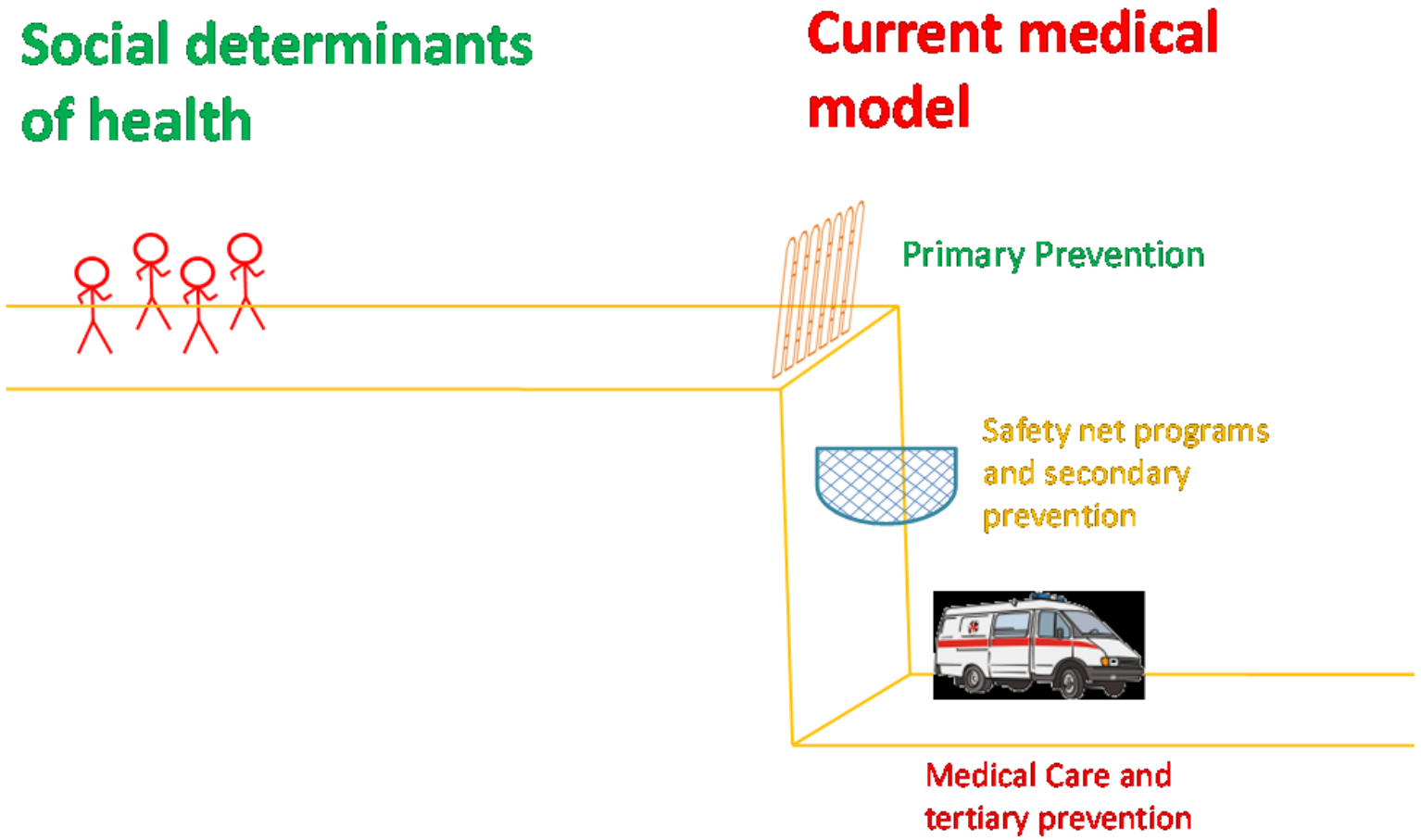
of patients felt our staff took time to get to know them



Source : [Key statistics on the NHS | NHS Confederation]

Over 50% of budget is for acute services, whilst these services deliver 26% of interactions

Community providing acute care in home setting



Community services and primary care see both top and bottom of cliff.

Virtual wards are in the unique position to strengthen the safety net and the fence. They support growing preference for patients to receive acute care at home.

What are Virtual Wards?

Virtual wards are an approach to providing technology enabled, hospital level care safely and efficiently in a patient's home.

The remit encompasses providing a safe and supported alternative to hospital admission, or an earlier discharge from hospital.

There are three core criteria:

1. Patient would otherwise be in an acute hospital bed
2. Patient requires daily review from a consultant level practitioner
3. Care is enabled by technology

Bed capacity for virtual wards will address the anticipated increase in acute bed requirement in the next decade, not lead to a reduction in the number of acute beds.

Virtual ward models

What different virtual ward models can look like

VIRTUAL WARDS

Mostly remote

Based on technology-enabled remote monitoring and self-management, with minimal face-to-face provision

What

- Personalised and digitally-enabled remote monitoring, with supported self-management and escalation pathways

How

- Digital remote monitoring service, or suitable digital alternatives
- Early deterioration detection and recognition to trigger clinical input and responses from MDTs
- Patient and carer enablement to self-monitor with escalation routes

Who

Use case: ARI virtual ward

- Adults with confirmed or suspected acute respiratory infections, who are stable or improving and are not living with moderate or severe frailty, but need ongoing monitoring

Mostly face-to-face

Based on a blended model of technology enablement with face-to-face provision (Hospital at Home)

- Hybrid service model that blends digital monitoring and face-to-face care to support patients with acute needs

- Digital remote monitoring and relevant service enablement
- Care assessments, intervention planning and face-to-face support with senior clinical oversight and MDT support
- Delivering acute-level interventions (i.e. screening, diagnostics, prescription and medicines reconciliation, IV therapies)

Use case: frailty Hospital-at-Home

- Adults aged 65 and over who have been clinically assessed to be frail and are experiencing an episode that requires acute intervention

The benefits seen in existing virtual wards including Hospital at Home services

Click to download a catalogue of evidence, covering different themes, pathways and countries

Research and studies are providing strong evidence for the benefits of virtual wards.
* The data below is based on observations from single site analyses relating to frailty.

Patient choice and preferences

>99% Over 99% of patients on existing virtual wards would recommend the service *

Treatment and care in a more comfortable home environment.
Keeping patients in a place where they would prefer to be cared for in future
23% of patients treated in a virtual ward achieved a more independent social care outcome than they would have in an acute setting.*

Reducing health inequality

Development of virtual wards offers opportunities to address healthcare inequalities in target areas including COPD and frailty.

Patient wellbeing and safety

5x Patients are five times less likely to acquire an infection * when treated on a virtual ward compared to an acute setting

8x Patients are eight times less likely to experience functional decline * whilst in a virtual ward compared to equivalent treatment in an acute setting

Avoiding potential harms in a hospital setting, such as falls and delirium

More holistic assessment in home circumstances

Capacity and productivity

2.5x Two and a half times fewer patients treated on a virtual ward are readmitted * to frailty beds than the national acute benchmark

Frees up physical beds for other patients who require an in-patient admission

Improves integration between hospital and community services

Improved staff experience and opportunities

Enabled by technology including remote monitoring

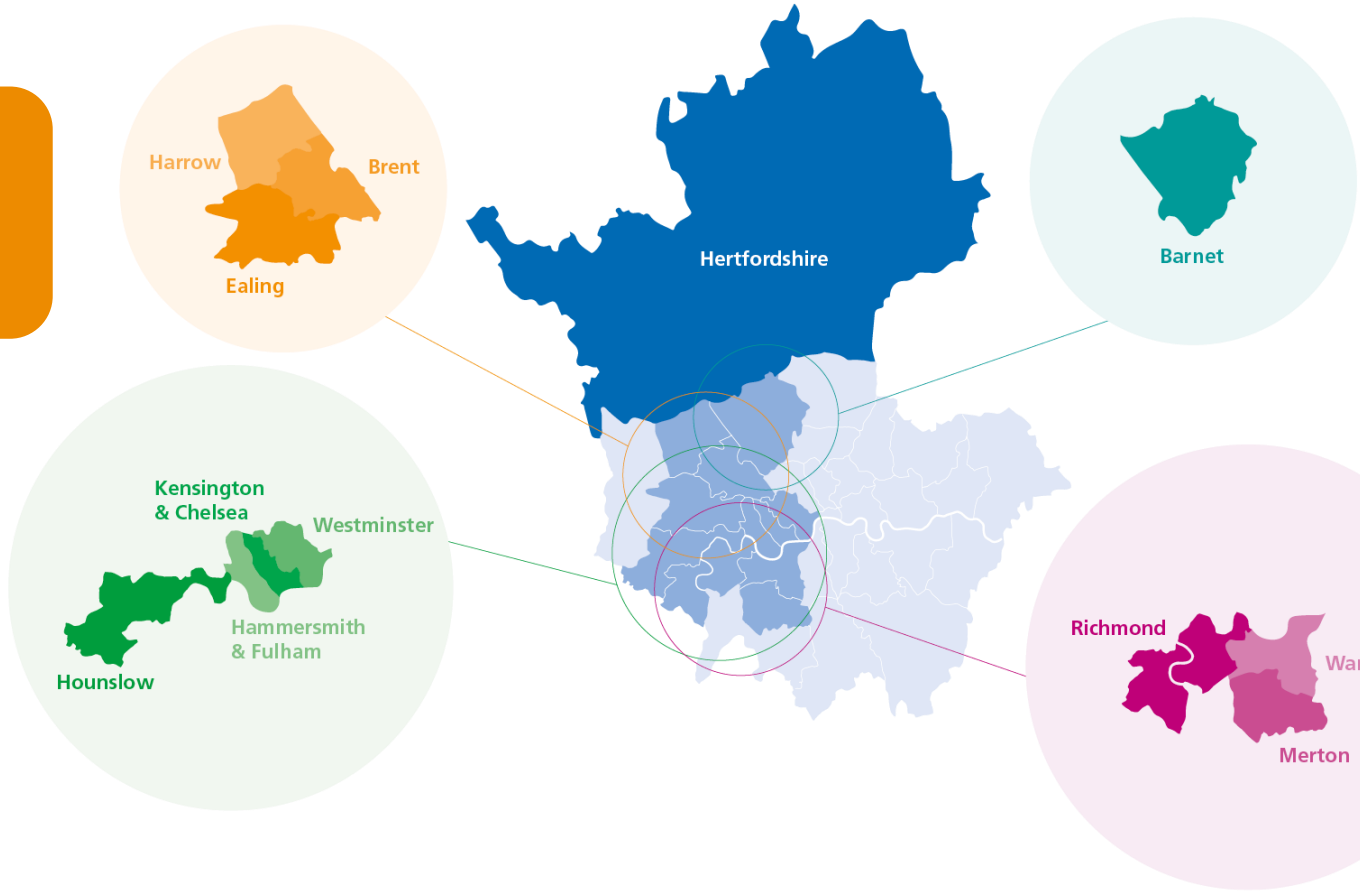
Produced in partnership by GIRFT and the NHS England Virtual Ward programme

Virtual wards in CLCH

South and West Hertfordshire
CLCH lead provider
Frailty Virtual Ward

South and West Hertfordshire
Collaboration with West Herts Hospital NHS Trust
COPD Virtual Ward
Heart Failure Virtual Ward
Acute Respiratory Infection Virtual Ward

Harrow and Brent
Frailty Virtual Ward



Barnet
Delirium Virtual Ward
Frailty Virtual Ward

Wandsworth and Merton
Frailty Virtual Ward
Technology enabled Virtual Ward

Impact (175 beds) Dec 2021- Aug 2023

Frailty **764** patients	**HF** **347** patients	**COPD** 314 patients	**Delirium** 55 patients	**ARI** 190 patients
4.1 bed days saved per patient	**3.7** bed days saved per patient	**2.2** bed days saved per patient	**4** bed days saved per patient	2.4 Bed days saved per patient

5783 Acute bed days saved through virtual wards

Experience

Patients have a positive experience

Overall experience of virtual wards 8.3/10

Rating of feeling safe 96%

“I think the team did a brilliant, job its good service. One thing I like is they come with everything equipped, something to check for blood pressure, check bloods, check if any infections so on the whole that little package identifies anything that can be done right then and there. “

Informal carers feel reassured by care

“Massively reassuring, better than being in hospital. My mother was constantly monitored by the doctors and nurses, even twice a day...It was an unbelievable service”

Staff have a positive experience

Overall experience of working in virtual wards 8.6/10

“ I’m really enjoying this role, as we are definitely making a difference. I find this work mentally stimulating”


Falls services
Medical devices
Ambulance Service
Hospices
Single point of access
SDEC
Specialist Community teams
Early discharge
Clinical Systems Application
Data Analysts
Remote Monitoring providers
Social services
Microbiologists
Cardiologist
Community Mental Health teams
Virtual Wards stakeholders
Discharge Coordinators
Population Health Analysts
Respiratory Consultants
Remote Monitoring Hub
Medical Assessment Unit
Community Rehabilitation
Acute Geriatrician
Community Nurses
Voluntary Sector
Therapy services
Reablement care
Front door teams
Family & friends
Information Governance
Palliative Care Services
Primary Care Networks
Complex Care Services
Point of care providers
Integrated Care Board
Acute medical wards
Flow Manager
Urgent Community response
Psychiatrists
Community Diagnostic hubs
Paramedics
Case Management services
Patients
Discharge to assess
Care Homes
Out of hours GP
Primary Care
Carer Networks

NHS Confederation

“What is needed for integration?”

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“What hampers integration?"

NHS Confederation

slido

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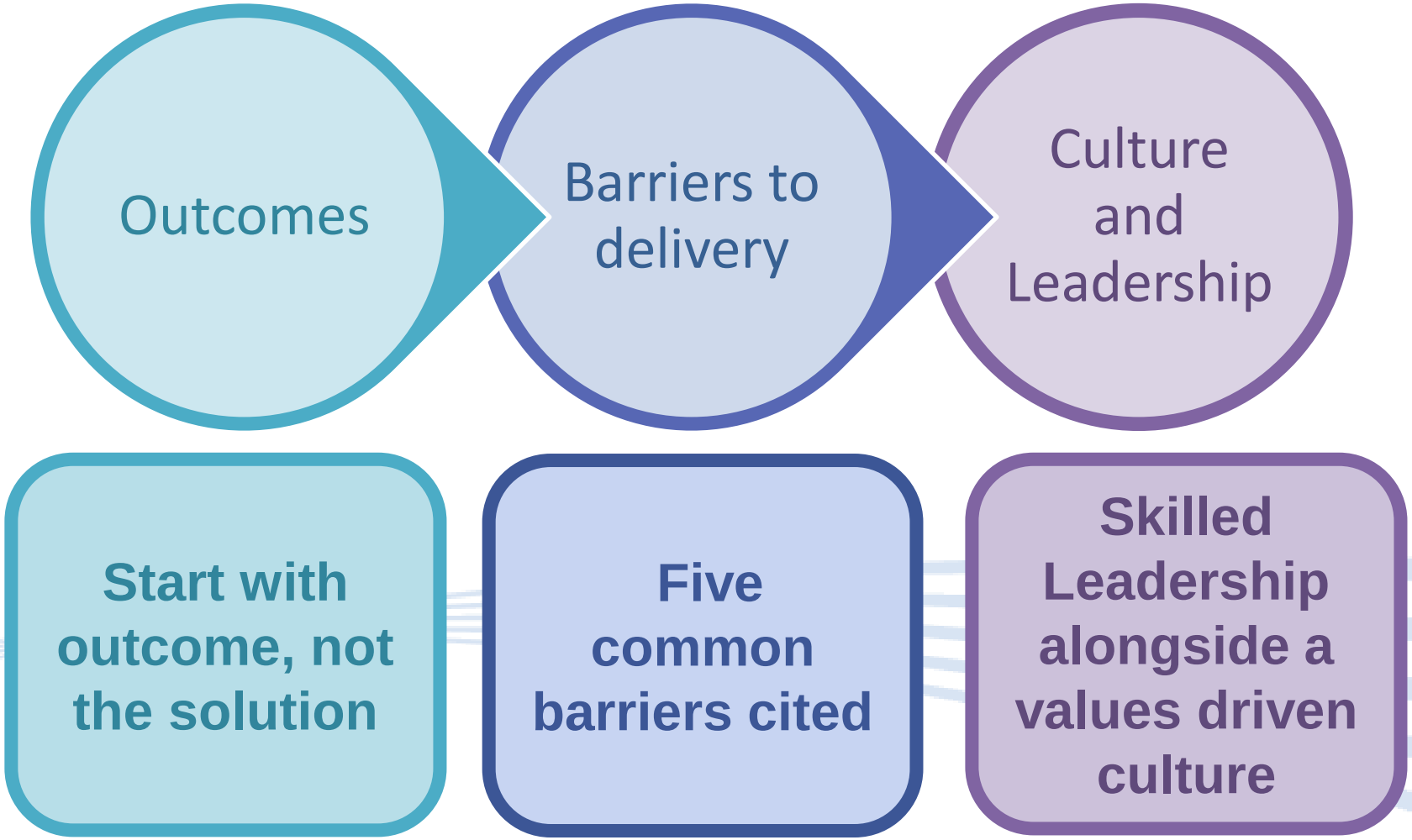
"Inside Out" model

Integration is the result, not the main driver



From Integration at Place toolkit from NHS Providers and Newton Europe (2022)
www.integrationatplace.org

Outcomes

1. **Have a specific focus on a clear goal (and vision): to achieve for people**
2. **Evidence of what patient/population outcomes could be improved and agree them**
3. **Measure the success: how much could it be improved realistically** e.g lived experience, Population health management, outcomes (comparing what is known against the new approach)

Barriers to delivery

1. **Workforce pressures: 'going slow to go fast'**
2. **Competing demands and incentives:**
   Based on evidence
   The Twin Track Approach: balance short term imperatives & long-term change
   Plan for resolving disputes
   Build alignment & principles and maintain, even when times are tough
   Be clear on investments and benefits
3. **Navigating governance and moving beyond a focus on structure**
   'Keep it simple and get started'
   Set up governance structure early with clear accountabilities: tweak and iterate
   Keep management arrangement simple for clarity
   Embed governance into existing structures without adding to it
   Focus on outcomes not processes
4. **Lack of joined up data and insight at place**
5. **Historical ways of working and behaviours**

Culture and Leadership

1. **Leadership alignment and shared ambition**
2. **Learning:**

a. Build:
    i. A shared belief
    ii. Clarity of purpose
    iii. Joint ownership
    iv. Visible leadership
    v. Culture of outcome-based performance
    vi. A strong programme identity

b. Maintain commitment of the vision and outcomes
c. Assume the best in colleagues and gather feedback to support adaptation
d. Celebrate success

South West London Division
"Innovation alongside integration"

Outcomes

✓

Specific focus to reduce hospital pressure due to pandemic.

Vision shared with acute hospital – staff and COO

Adapted an existing service to provide a new model

Measured outcomes and success and fed back regularly

Barriers to delivery

Bring all staff on whole patient journey, involve them in decisions & listen

Pressure to fund other services

Hand-off of patient

Simple, accountable governance with clear management structure

Joined-up data - access

Old ways of working on all sides

Tech not providing expected results

Geographies and politics

Culture and Leadership

✓

Collaboration and trust post-pandemic was high

Visible leadership

Regular feedback to all teams on patient outcomes

A clear definition and identity 'easy to describe'

Maintained vision

Sought feedback from all

Celebrated success

Learned from mistakes

✗

Joint ownership was not strong due to acute pressures

South and West Hertfordshire
"Going slow to go fast"

Outcomes

Shared vision

Whole patient journey considered

Impact on systems: reduce reliance on social care, primary care and acute e.g. self-management: tech and personalised care

National guidelines as the central direction to bring change on an agreed trajectory

Barriers to delivery

Workforce: training and other service impact

Competing demands: External pressures, services in community, bed pressures

Lack of joined up systems: different systems – HIE updates are not live and difficult to navigate

Other partners trusted and respected partners as informal work done previously

Culture and Leadership

Shared vision

Trust and respect across teams Safe space during workshops to aid open discussions

Understanding of each other's priorities

Being honest and open about restrictions and barriers

Continued to meet as a group, Lessons learned workshops and reflection

Simple governance

Experiences in other CLCH divisions

Outcomes

✓

Agreed shared approach across all providers in an ICS

✗

Simple models were favoured, complex patient cohorts were not focussed on initially

Barriers to delivery

Historical ways of working and behaviours overshadowed innovation and integration
"Not curious"

Clinical governance has been challenging to agree

Competing demands

Wanting ownership not integration

Culture and Leadership

✗

Integration and cohesion of VW portfolio across ICS not consistent

No clear or consistent leadership respected across all partners

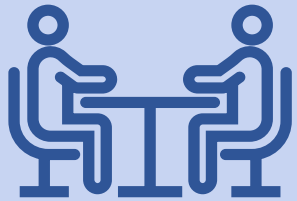
Core principles for integration in virtual wards?

Agreed understanding

Treat all as equal partners

Honest communication

Genuine trust and respect



"What do you do when barriers to delivery stall integration? "

NHS Confederation

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Healthy homes and neighbourhoods: lessons from Australia

NHS Confederation

- Chair - James Maddocks, International Policy Advisor, NHS Confederation
- Professor John Eastwood, Clinical Director, HHAN Initiative
- Dr Niamh Lennox-Chhugani, Chief Executive, International Foundation for Integrated Care (IFIC)

#HealthBeyondtheHospital

International Foundation for Integrated Care

Making Integrated Community care a reality – international lessons

Dr Niamh Lennox-Chhugani, Chief Executive, IFIC

Sept 2023

HHN model - Family-Centred Care Coordination

- **Wrap-around model**
- **Family Group Conferencing**
- **Family Partnership**
- **Shared-care planning**

- **Clinical review**
- **Patient reported outcomes**
- **Health Pathways**

HHN model - Key Features

- All agencies as partners
- Planning and steering committee
- Must be Family Focused
- Must have “all family needs” in scope
- Must be longitudinal with no discharge of families or “passing the parcel”
- Place-based work and then expand

Read more about the model and its impact:
https://ijic.org/articles/10.5334/ijic.6421

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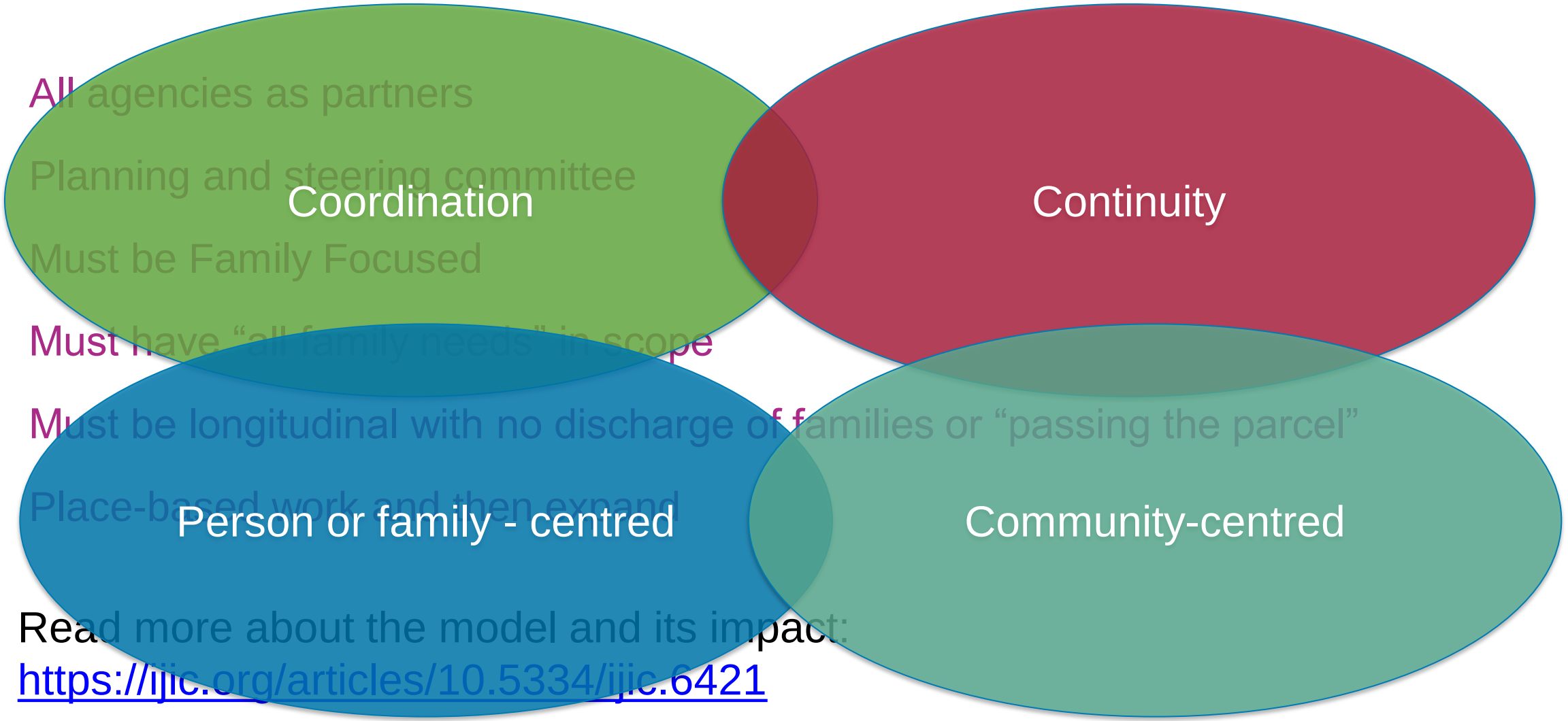


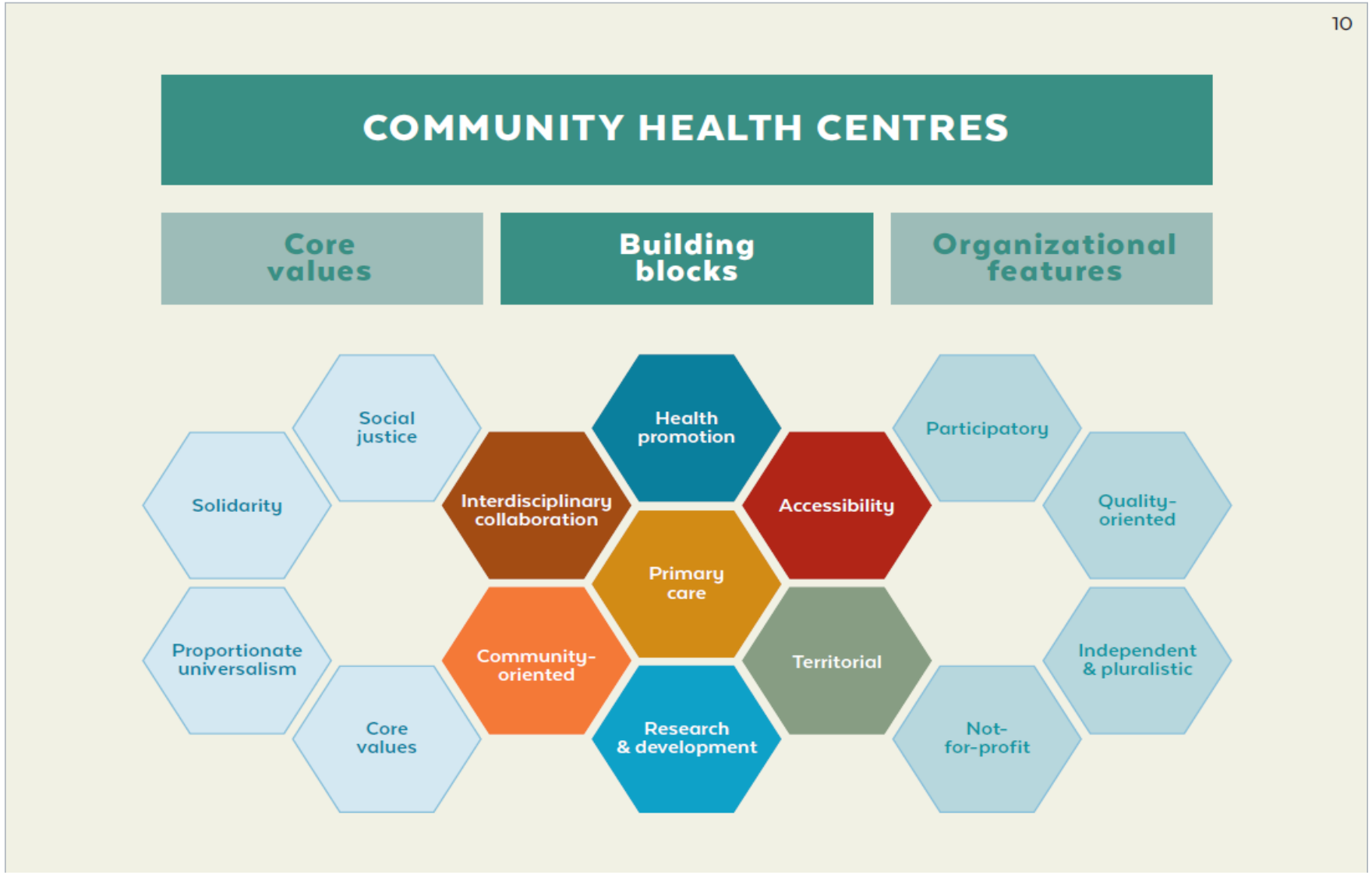
Read more about the model and its impact:
https://ijic.org/articles/10.5334/ijic.6421

TransForm Integrated Community Care

https://transform-integratedcommunitycare.com/strategy/

ICC points towards a paradigm shift at the citizen, community and system level. Lived experience, a shared vision on the common goals of a local community, distributed power and collective learning are its cornerstones.

Community health centres – Belgium and Canada



An example from Belgium

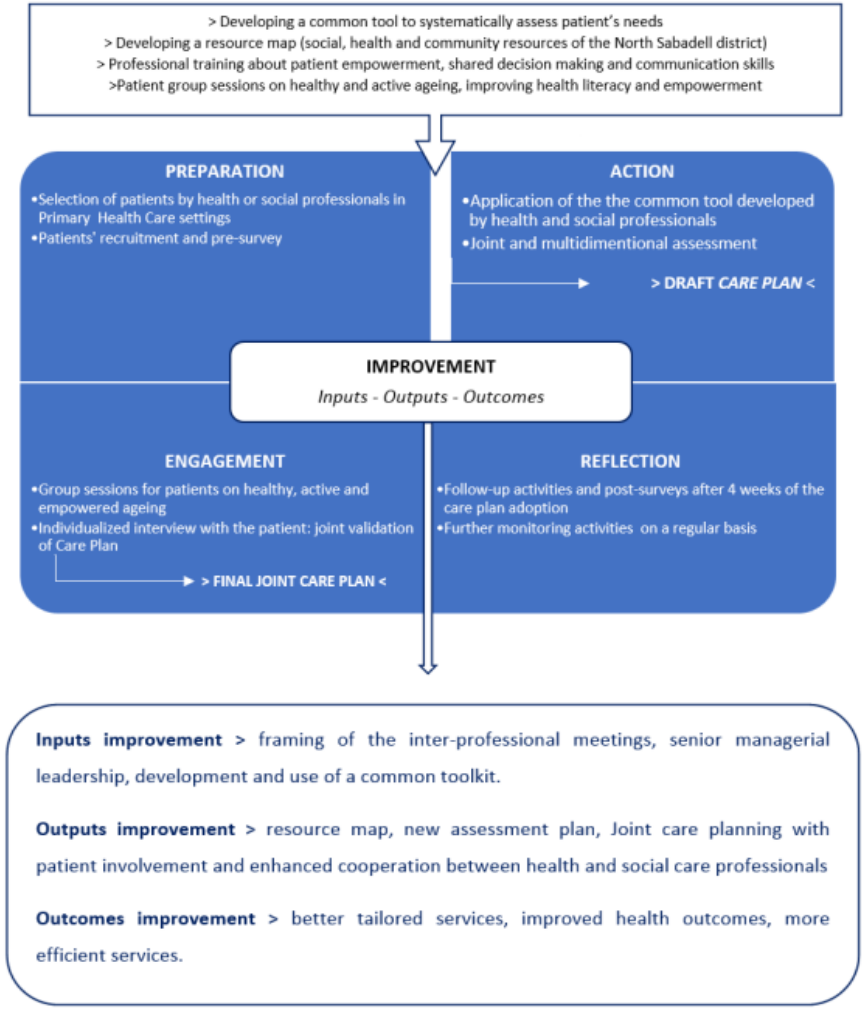
CHC Nieuw Gent

CHC Nieuw Gent was founded in 2000 under the impetus of the Department of Family Medicine and Primary Health Care of Ghent University. It has 31 full-time equivalents (42 employees) from **multiple disciplines** including **care coordinators**, and serves circa 4400 patients, with the potential to add 500 patients within the current capacity.

All team members are implementing **goal-oriented care** by being engaged in developing so called a “chronic care plan”. This label is used to describe a process **involving the patient**, which consists of a conversation and the **co-creation of a care plan**, as well as a consultation within the health care team.

Low income and poor housing conditions in the area are huge problems, so the centre is aware that they **cannot be approached and solved by one organization**. But even if there is a coalition of different agencies, the challenge is to define the role of the CHC, which usually focuses on spreading information and empowering the population.

Sabadell social and healthcare integration (Catalunya)



Inputs improvement > framing of the inter-professional meetings, senior managerial leadership, development and use of a common toolkit.

Outputs improvement > resource map, new assessment plan, Joint care planning with patient involvement and enhanced cooperation between health and social care professionals

Outcomes improvement > better tailored services, improved health outcomes, more efficient services.

In **Sabadell**, a city of 208,000 inhabitants, located 30 km north of Barcelona, AQuAS (Agència de Qualitat i Avaluació Sanitàries de Catalunya) are working on an initiative to deliver more patient-centred, prevention-oriented, efficient and safe integrated care, which is focused on integrating Primary Health Care service with Sabadell City Council's Basic Social Services for 65+ citizens with complex health care and social needs.

The team are taking a multilevel approach involving both healthcare and social care professionals to work together on three key objectives:

- Adopting a common tool for the joint multidisciplinary assessment and care planning of 65+ citizens with complex health care and social needs;
- Formalising regular meeting spaces between health and social professionals towards improved coordination between health and social care;
- Improving patient empowerment, capabilities of self-managing health and wellbeing by means of group sessions on active and healthy ageing and a greater involvement in community resources available for elderly people.

Primary mechanisms for community based care integration

Integrated information

Inter-disciplinary team working

Partnering with patients and informal carers

Primary mechanisms for community based care integration

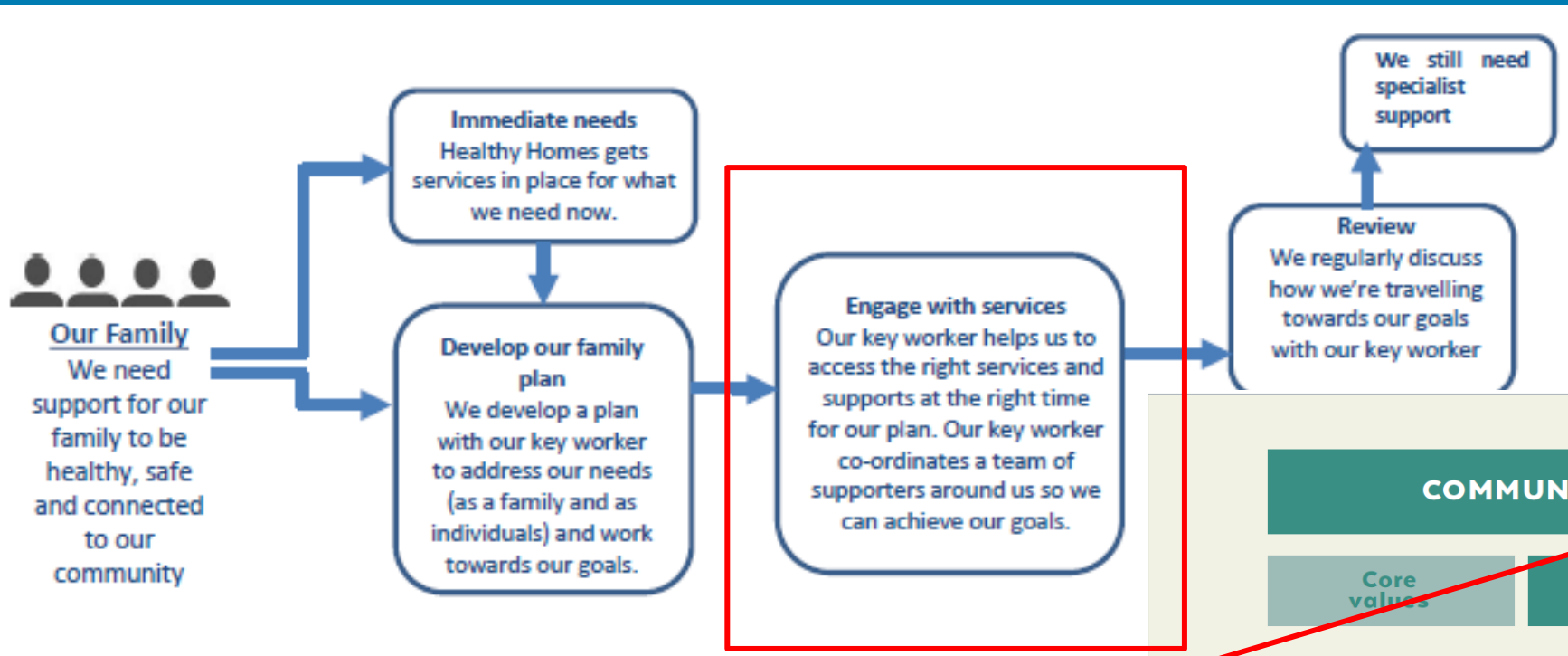
Integrated information

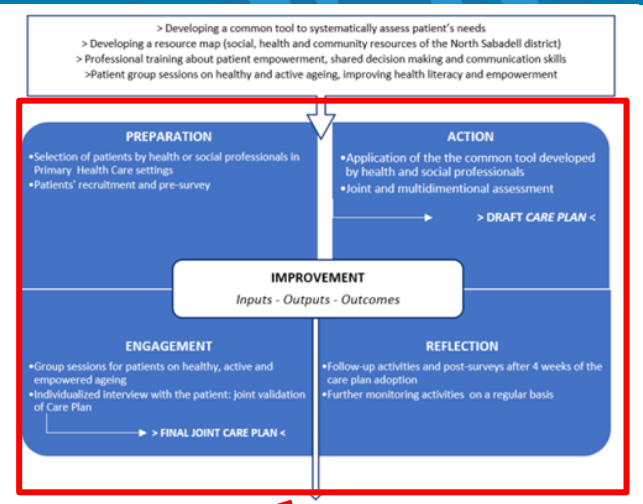
Inter-disciplinary team working

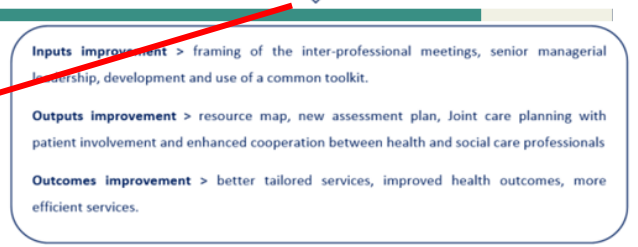
Partnering with patients and informal carers

Inter-disciplinary team working

In the HHN, CHC and Sabadell initiatives







Inter-disciplinary team working are key mechanisms in all

Definition

Interdisciplinary team implies a **greater degree of collaboration** between team members. The interdisciplinary team involves an effort to integrate and translate, at least to some degree, themes and schemes shared by several professions and other interested actors. **The interdisciplinary team is a structured entity with a common goal and a common decision-making process.** Thus, the interdisciplinary team is based on an integration of the knowledge and expertise of each member, so that solutions to complex problems can be proposed in a flexible and open-minded way.

Based on D'Amour D, Ferrada-Videla M, San Martin Rodriguez L, and Beaulieu M-D, 2005, The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks, Journal of Interprofessional Care, 19:sup1, 116-131

Overlapping terms

Multi-disciplinary teams

Members of more than one profession working independently or in parallel on the same project, coordinating their work but not necessarily meeting.

Interprofessional collaboration

An active and ongoing partnership between professionals from diverse backgrounds with distinctive professional cultures and possibly representing different organizations or sectors working together in providing services for the benefit of healthcare users.

Dimensions of IDT working

Team goals

Team roles and responsibilities

Team inter-dependence

Team identity

Team commitment

Integration of work practices

Xyrichis A, Reeves S, and Zwarenstein M, 2018, Examining the nature of interprofessional practice: An initial framework validation and creation of the Interprofessional Activity Classification Tool (InterPACT), Journal of Interprofessional Care, 32:4, 416-425, DOI: 10.1080/13561820.2017.1408576)

Competencies or behaviours for IDT working

Knowledge of the team

- Understanding roles
- Making referrals

Communication

- Sharing information
- Communicating effectively

Shared decision-making

- Including patients in decision-making
- Collective clinical decision-making

O'Donnell D, O'Donoghue G, Ní Shé E, O'Shea M, and Donnelly S, 2022, Developing competence in interprofessional collaboration within integrated care teams for older people in the Republic of Ireland: A starter kit, Journal of Interprofessional Care

What could be different quickly?
The multi-disciplinary team meeting

Inter-disciplinary knowledge creation

"The ongoing regeneration of the team's communicative infrastructure that supports the expression of tacit knowledge ***requires considerable time and energy on the part of the individuals***. In the long term, we might speculate that the process of creating new knowledge through dialogical exchange could interfere with teams' efficiency to deliver care." (Quinlan 2009:628)

Quinlan E. The 'actualities' of knowledge work: an institutional ethnography of multi-disciplinary primary health care teams. Sociol Health Illn. 2009 Jul;31(5):625-41.

Some practical tools

SUSTAIN

Sustainable tailored integrated care for older people in Europe

START ROADMAP

2. ABOUT THE ROADMAP

SUSTAIN partners worked in close collaboration with health and social care staff in 13 sites across 7 countries in Europe.

This has involved working closely in a multilevel participatory process with local authorities, managers, professional, but also users and their carers to improve integrated care for older people. Initiatives involved five different areas of care: home nursing services, transitional care, dementia care, primary care, and rehabilitative care.

These experiences have been captured in the roadmap which aims to bridge the gaps between research, practice and health systems policy that impedes far too often the scaling up of innovations across Europe and transfer to other settings.

While the Roadmap is designed principally as an improvement aid to support improving integrated care for older persons living at home, it also helps readers who may not know where their site or service is in terms of the important elements of an effective integrated care service'. The roadmap suggests that integrated care teams assess their progress to date again by focusing on improving those areas (or initiating those areas) that would appear to be furthest away from best practice.

The roadmap is set up as five books.

BOOK 1 Designing Integrated Care Services: is a guide for planning services and outlines the key design features required for integrated care so that these can be understood and assessed in terms of the capabilities required.

BOOK 2 Setting up Integrated Care: is a "how to" guide to managing change that supports key decision makers in the process of implementation of integrated care including monitoring, evaluation and quality improvement.

BOOK 3 Improving integrated care: aims to support those sites, which have already initiated the process of implementation and want to improve integration. This booklet captures the experiences of SUSTAIN in the steps and tools that were of greatest use and what the lessons learned were including various tools to analyse and capitalize on motivations for change.

BOOK 4 Context of Integrated Care: examines how to develop an enabling environment. This means how to develop a coalition towards integrated care, building the support for change, and developing collaborative capacity.

BOOK 5 Resources: contains all the references of each books, advocacy, assessment tool book 1, casestories and factsheets of the casestories.

Enjoy!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