Transformation Partners
in Health and Care

Personalised Care in Secondary Care London

9th January 2024

SOCIAL PRESCRIBING & COMMUNITY LED PREVENTION

Personalised Care in Secondary Care in London

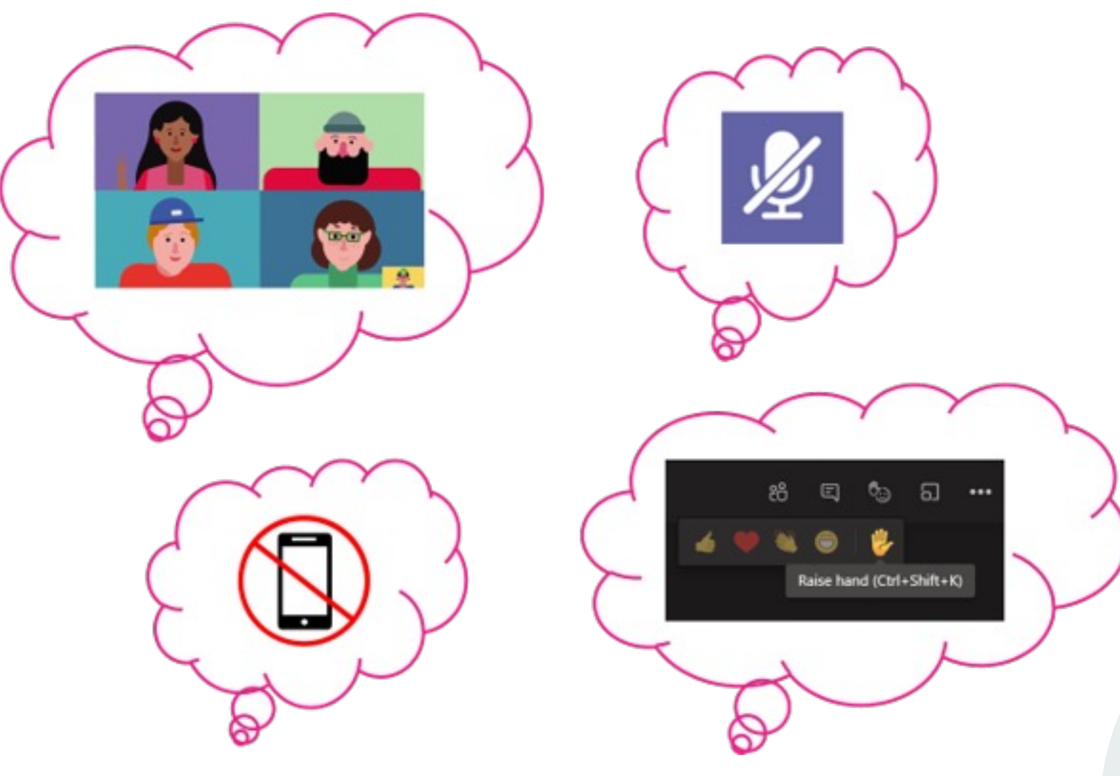
Objectives:

- To showcase where personalised care roles are being used in secondary care to tackle health inequalities in London
- To demonstrate the impact personalised care in secondary care can have on patients, communities and services
- To bring together leaders across London to connect, discuss and enable cross-sector collaboration
- To explore what we hope to achieve in secondary care & personalised care by 2025

Time	What
12:00-12:05	Welcome, introductions and housekeeping
12:05-12:15	Melissa Heightman: Why prioritise personalised care in secondary care?
12:15-12:20	Landscape of personalised care in secondary care across London
12:20-12:50	Project presentations • Barts Hospital Cardiac Community Connector project, Tara Mastracci • NWL Chronic Pain Social Prescribing service, Selena Stellman and Kalwant Sahota • CACT Social Prescribing pilots in UEC & Discharge Teams at Queen's Hospital, Deborah Browne
12:50-13:00	2025 ambition for London presented by Jane Clegg
13:00:13:25	Panel discussion: personalised care in secondary care
13:25-13:30	Reflections and close

Personalised Care in Secondary Care in London

Housekeeping



Join at slido.com using code:
#2321851

Access via this link or scan QR:
https://app.sli.do/event/dXN34b5BgNdv6UmXa61tT5

Personalised care model

Universal personalised care model:

- Health and care will be organised in a different way, creating a new relationship between patients and health and care professionals
- Giving patients a voice and ensuring they understand their health and care choices
- **Connecting patients to support and their community**
- 6 components of personalised care:

Reduced excess mortality

Reduced health inequalities

Reduced preventable admissions

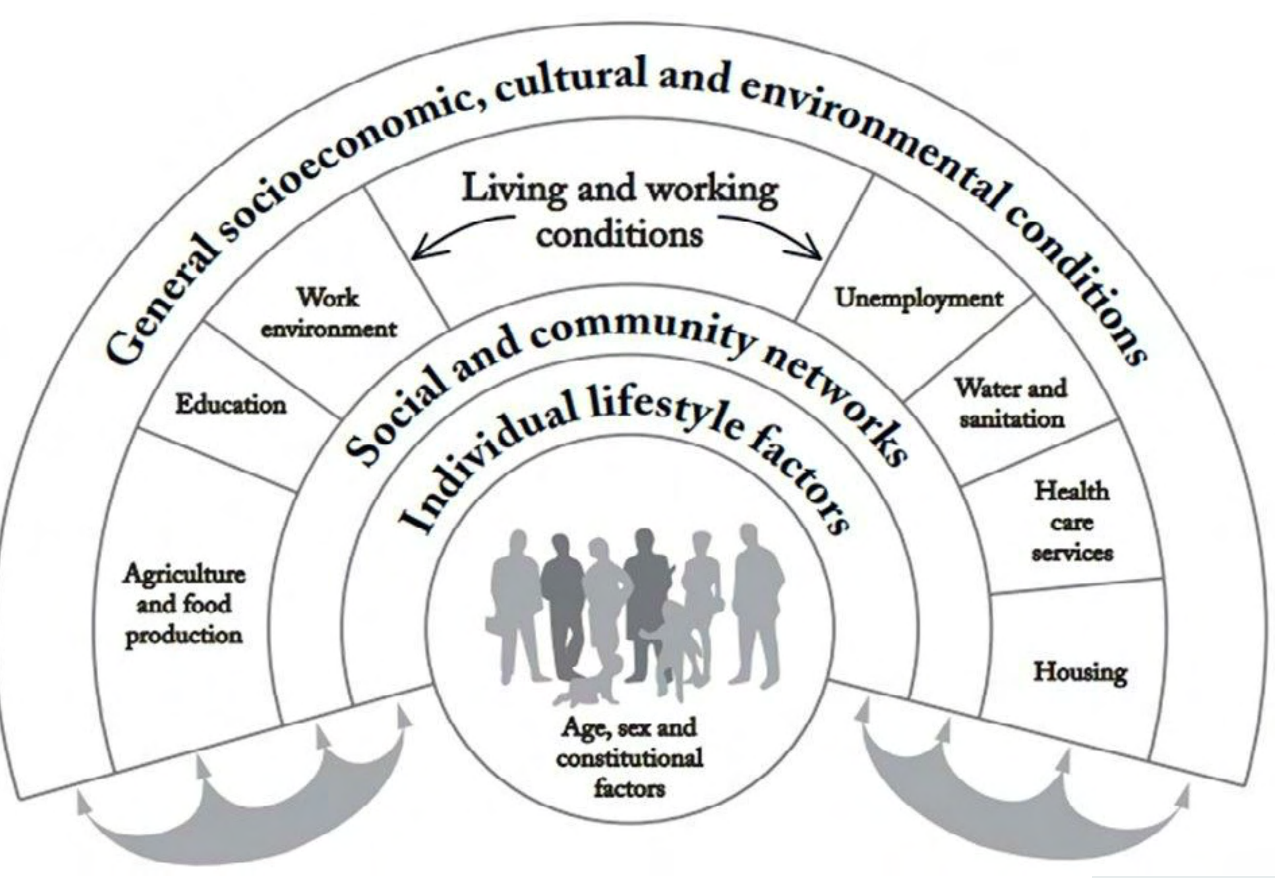
Social prescribing and personalised care

Increased capacity for clinical staff

Improved population health

Care more tailored to patients and communities

Demand is primarily driven by the wider determinants of health



Personalised care interventions support people to manage the wider determinants, thereby reducing demand for services

The diagram shows what are known as the **wider determinants of health**. These factors surround and **influence individuals**' psycho-social selves and their behaviours, **contributing to their health outcomes**.

These factors are **not distributed evenly** throughout the population, so their **impact is also unequal**. This leads to health inequalities.

These factors lead people to develop Long Term Conditions, and to hamper people's ability to manage those conditions. People with Long Term Conditions make up c.**30% of the population** and drive c**.70% of demand**.

The wider determinants are estimated to **account for up to 80% of people's health outcomes**.

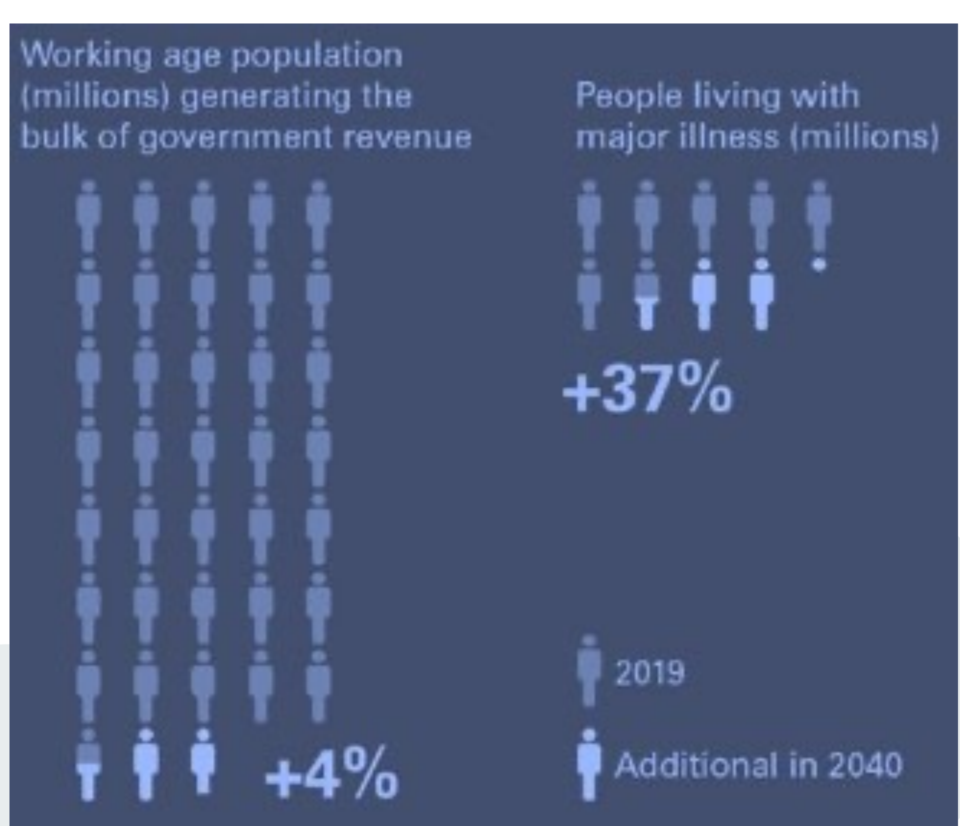
Healthcare services only contribute 20%.

Current context and system challenges

System challenges:

- People are living longer with more complex long-term conditions and co-morbidities
- The NHS is facing backlogs and long waiting times for patients to receive care/treatment
- Existing challenges across the healthcare system have been exacerbated by the COVID-19 pandemic
- Workforce are under significant stress with rising demand and limited capacity, leading to burn out, recruitment & retention issues
- Rising cost of living crisis is causing a fall in living standards, impacting physical & mental health and exacerbating existing conditions. Those with greatest health inequalities are most impacted.

Widening access to personalised care interventions at more contact points with the NHS could extend reach and bring important benefits



Analysis by the Health Foundation Suggests that the number of people living with major illness is projected to increase by 37% by 2040 (from 6.7m to 9.1m).

Why prioritise personalised care in secondary care?

- **Population health management (PHM)** → Secondary care supports many of the most high-risk/ vulnerable patients
- **Personalised care interventions** → Tackling social determinants of health will support reduced admission rates/ length of stay/ patient flow in acute hospitals
- **Community led prevention** → Pathways should promote as early diagnosis as possible to prevent and improve outcomes from long term conditions
- **Improved access, experience & outcomes, and health equity** → Enhanced opportunity to support self management of long term conditions improves outcomes and reduces NHS pressure

Personalised care roles in secondary care enable proactive targeting of ‘at risk’ groups identified through PHM and connects patients to more appropriate support in the community, tackling social determinants of health and improving health outcomes.

How to make a start from a secondary care perspective?

- Align thinking with a team/ department/ organisation that this is worth doing
- Work as an integrated care system- build relationships. **Include the voluntary sector in clinical networks and service planning**
- Understand and document the **needs of the patient cohort** in question (will vary with age and condition)
  - ➢ What is the impact on their wider life?
  - ➢ How does their wider life affect their ability to manage their illness?
- Identify **partner organisations** which could support the patients group
  - ➢ e.g. for long COVID: ENO breathe/ Age UK/ Personalised Health Budgets
- Ensure focus is not only on pharmacological or surgical treatments – remember the broader benefits of rehab and support for mental health
- What would be the right **mechanisms to access personalised care** for the range of needs?
  - ➢ Dedicated social prescriber? Think re. geography
  - ➢ Training for the team?
  - ➢ Partnering with community providers and charities – build relationships – **drive improvement together**
  - ➢ Support **integrated neighbourhood teams** (need more integrated secondary care clinical roles)
  - ➢ Monitor outcomes and patient experience – is their equity in access and outcomes?

Preventative models of care: Workstream Priorities

The Social Prescribing & Community Led Prevention Team will support London's health and care systems to scale community centred models of care which focus on addressing the wider social determinants of health and target those experiencing the greatest health inequalities

Aim

Improve access to Personalised Care across secondary care in London

Activities

- ✓ Support and scale approaches to improve access to personalised care in secondary care leading to more sustainable and integrated pathways
- ✓ Develop resources, build the evidence base and communicate the impact

As part of this workstream, the Social Prescribing & Community Led Prevention Team are committed to:

- Sharing and spreading examples of services across London that are **improving access to holistic support in secondary care**, with a particular focus on sharing approaches, models, learnings, enablers and impacts.
- Supporting frontline approaches & the transformation of services that are embedding access to **non-clinical wellbeing support in the community**.
- Improving patient experience through **better integration between local services** e.g. between primary care, secondary care, VCSE and local communities, strengthening place-based partnerships.
- Advocating for the **impact of holistic care in secondary care settings** in order to influence commissioning and funding.

Improving access to personalised care in secondary care: Activities

What we've been doing so far

- Mapping the landscape of **social prescribing & personalised care in secondary care** across London.
- Developing case studies of **innovative and exciting pilots/projects** embedding personalised care roles in secondary care. Read here!
- Providing **direct support & resources** to pilot projects in development.
- Bringing together a network as part of a **Community of Practice** to champion and support development of integrated & sustainable approaches to improve access to personalised care in secondary care across London.

What's next?

- Support secondary care to embed access to **non-clinical wellbeing support** in the community.
- Develop and share resources to support rollout of **holistic support in secondary care.**
- Develop **cross-sector partnerships** to embed personalised care approaches in acute settings.
- Support better **integration** between local services.
- A call to action for London to set an **ambition to have access to personalisation interventions in every acute trust by 2025.**

Improving access to personalised care in secondary care London Community of practice (CoP)

What?
A pan-London network to champion and support development of integrated and sustainable approaches to improve access to personalised care in secondary care across London.

Representation from secondary care personalised care roles, ICS, secondary care staff & allied health professionals, VCSE & charities, hospital trusts and specialist alliances or networks.

Activities:
- Drawing on insights, expertise and learnings, and sharing ideas
- Enabling cross sector collaboration at place and regionally
- Discussing diverse topics selected by the group, unpicking challenges and brainstorming solutions

Outcomes and learnings:
- Mapping insights into what's happening across Ldn
- Fishbone exploring how to facilitate referrals from secondary care into SP/community support

What's next for the CoP
- Developing, inputting or feeding into resources to support strategy across the system
- Building a network of champions able to advocate for impact and disseminate learnings/resources

How to get involved

Contact beth.medforth1@nhs.net

or mollie.mccormick@nhs.net

to hear more or be involved!

Transformation
Partners
in Health and Care

Learnings

Personalised care pathways in secondary care

Key findings:

- There is **not one uniform model** as there is in primary care due to the complexity of hospital & acute care settings
- There is **discrepancy** across the system on job titles, descriptions & responsibilities
- Routes of referral from secondary care into the community are challenging due to lack of **capacity and established pathways for referral**

Cohort	Referral	Personalised care roles	VCSE services
Targeted group of patients	Route of directing towards PC roles	Holistic/non-clinical roles supporting patients with social determinants of health	Voluntary, community & social enterprise sector services or organisations

HIU
At risk patients
Outpatients
CYP
Elderly
Specialisms
General (all hospital patients & staff)

Direct via a platform
Hospital dashboards/data
MDT meetings
Clinical hospital staff
Social deprivation screening tools
Self-referral

PC roles based in the community
PC roles based in hospital
PC roles based remotely
PC roles based in primary care
Core/community connectors
Care Navigators
Clinical/non-clinical/wellbeing coaches
SPLWs, HWBCs, CCs

Local community services based on patient locality (registered PCN)
Commissioned programme/portfolio of activities
Contracted community services - based on patient cohorts' needs
National services
Local community services

Miro board link
(password: CLPrevention1)

What's happening across London?

We held a brainstorming exercise in one of the CoP sessions to explore what we were aware of in terms of personalised care in secondary care across London. Find the Jamboard here.

There's lots of work happening across each of the ICS regions to expand personalised care into secondary care.

Specialisms & cohorts

- High Intensity Users (HIU) or frequent attenders of emergency services
- 'At risk' patients identified through population health data – more likely to attend emergency services
- Discharge/outpatients receiving or recently received treatment
- CYP with LTCs or CAMHS
- Elderly patients (>65 years)
- Key specialisms e.g. Mental health, cancer, CVD, chronic pain, diabetes, dermatology, renal or maternity patients
- General support e.g. SWLA services

Service models: Personalised Care (PC) roles..

- Directly based in secondary care/hospital setting
- Based in wards with patients at high risk of admissions
- Based in community as a non-clinical role or in primary care receiving referrals from secondary care
- Co-located in hospital and community
- Remotely supporting patients
- Information or support hubs based in hospitals

Referral pathways

- Direct referral via a platform into community services / voluntary sector
- Referral based on dashboards or hospital data e.g. HIU in specific departments
- Referral from the clinician directly based in hospital to PC role – similar to in primary care
- MDT meetings with all the virtual team around condition-specific patients (including PC roles) to discuss most appropriate support

Evaluation and funding in secondary care

Importance of evaluating personalised care interventions in secondary care:

- Demonstrates the impact on patients, communities and the system
- Demonstrates value to funders to secure investment
- Support sustainability and scalability of pilot projects
- To make personalised care business as usual

Evaluation methods:

- Measured outcomes / survey with patient pre and post intervention
- ONS4, EPIC, MyCaW, SF questionnaires
- Tracking rates of specific prescription medication
- Evaluation of data reports to compare patterns of reattendance at A&E/UEC
- Qualitative tracking of patient progress & case studies
- Presenting patient stories and experience

Funding model examples:

- Limited one-off funding e.g. applications through a hospital scheme
- Funding pool jointly held with local authority and match funded by public health
- ARRS or PCN funding
- Winter access funds
- NHSE funding
- Hospital or National Charity funding e.g. Barts charity, Macmillan, Barnados
- Grass roots funding e.g. engagement fund
- ICB/ICS funding e.g. health inequalities or innovation funds

Personalised care in secondary care in London

London is leading the way in embedding personalised care support into secondary care.

Children & Young People (CYP)

Barts Health NHS Trust & NHSE have funded a young person-led pilot using a social prescribing link worker based in Royal London Renal department to improve health & wellbeing of CYP living with long term conditions (LTCs) including thalassemia, sickle cell anaemia or diagnosed with medically unexplained symptoms.

High Intensity Users of A&E

A 12 month pilot aiming to provide community based alternatives to patients attending A&E & UEC services to reduce frequency of attendances in the Biborough (Royal Borough of Kensington & Chelsea & North Westminster).

Mental health & discharge

A step down service in NWL supporting mental health patients after discharge, where a social prescribing link worker meets with patients face to face and links into community support as well as attending to additional concerns or symptoms.

Cancer

Inequalities fund for 1.4 social prescribing link workers working across 8 GP surgeries in Haringey to support cancer patients through inviting those on the cancer register to the service, making home visits and supporting patients post cancer.

HIV – NICHE

A 5 year programme of research funded by NIHR to develop and evaluate a health coaching and social prescribing intervention for people living with HIV, to improve health and wellbeing and reduce socio-economic disadvantages and stigma.

Chronic pain

A 12 month pilot which compared the impacts of a social, prescribing and health coaching intervention in secondary care. A link worker based at Epsom St Pelia and a Health Coach based at St George's to tackle reasons for referrals to the chronic pain service.

Find more case study examples on our website: Personalised Care in Secondary Care case study series

Reach out to mollie.mccormick@nhs.net for contact details.

Impact of personalised care in secondary care in London

A High Intensity User service using care coordinators to support individuals with complex needs at North Middlesex University Hospital NHS Trust in NCL.

Increased wellbeing by 20-25% (Warwick Well-being Scale)

30% reduction rate in Emergency Department attendances

SWL ICB in collaboration with Merton PCNs commissioned Merton Connected to deliver Merton's boroughwide social prescribing model.
A Macmillan Community Link Worker service run by Enable supports cancer patients living in Merton, Croydon & Wandsworth.

Comparison of ONS4 scores at baseline and follow-up demonstrated:

- **statistically significant increase** in life satisfaction, in feeling life was worthwhile and in happiness
- **statistically significant decrease** in anxiety

A project in NWL aiming to improve health & wellbeing of patients with fibromyalgia and high impact chronic pain by embedding social prescribers and health coaches in the MDT, alongside primary and secondary care clinical staff.

Of 22 patients reviewed in MDT meetings, **12 referrals to secondary care were avoided** through providing access to more appropriate support in primary care or the community

Substantial improvement in average Patient Activation Measure (PAM), and average Musculoskeletal Health Questionnaire (MSKHQ) score

One patient said, "it's changed how I see myself, and now I have courage to live with the pain"

Read more here

Impact of personalised care in secondary care in London

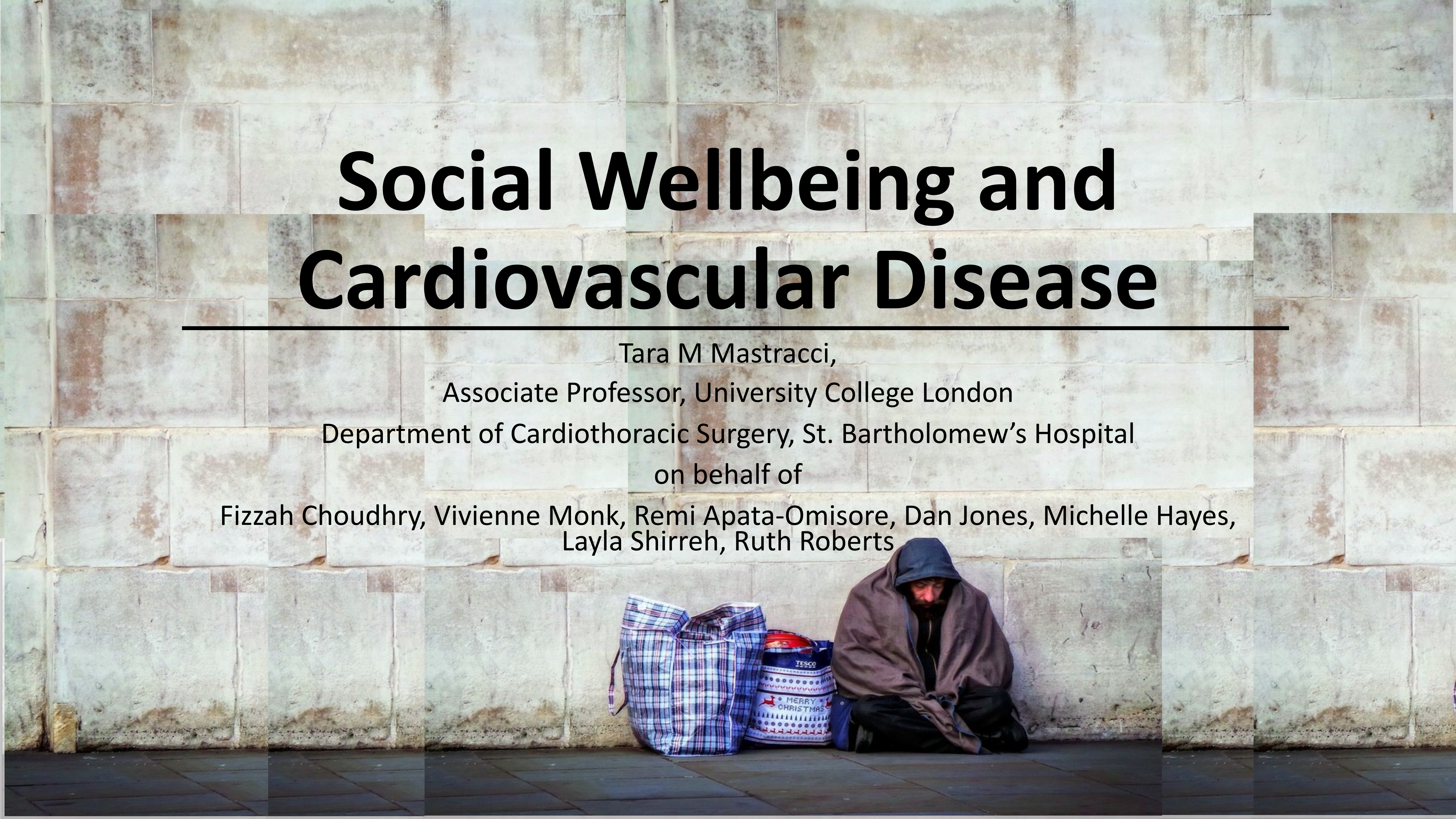
Join at slido.com using code: **#2321851**

Access via this link or scan QR:
https://app.sli.do/event/dXN34b5BgNdv6UmXa61tT5

What are the most important factors to consider when introducing personalised care roles in secondary care?

What do you think are the biggest benefits of introducing personalised care roles in secondary care to the residents of London?

Hear from a few projects already embedding personalised care interventions and the impacts!


Social Wellbeing and Cardiovascular Disease
Tara M Mastracci,
Associate Professor, University College London
Department of Cardiothoracic Surgery, St. Bartholomew's Hospital
on behalf of
Fizzah Choudhry, Vivienne Monk, Remi Apata-Omisore, Dan Jones, Michelle Hayes, Layla Shirreh, Ruth Roberts
TESCO
MERRY CHRISTMAS

Social Factors are a Cardiovascular Risk

Socioeconomic status and the 25 × 25 risk factors as determinants of premature mortality: a multicohort study and meta-analysis of 1·7 million men and women

Silvia Stringhini*, Cristian Carmeli*, Markus Jokela*, Mauricio Avendaño*, Peter Muennig, Florence Guida, Fulvio Ricceri, Angelo d'Errico, Henrique Barros, Murielle Bochud, Marc Chadeau-Hyam, Françoise Clavel-Chapelon, Giuseppe Costa, Cyrille Delpierre, Silvia Fraga, Marcel Goldberg, Graham G Giles, Vittorio Krogh, Michelle Kelly-Irving, Richard Layte, Aurélie M Lasserre, Michael G Marmot, Martin Preisig, Martin J Shipley, Peter Vollenweider, Marie Zins, Ichiro Kawachi, Andrew Steptoe, Johan P Mackenbach, Paolo Vineis†, Mika Kivimäki†, for the LIFEPATH consortium‡

Lancet 2017; 389: 1229–37
Published Online January 31, 2017
http://dx.doi.org/10.1016/S0140-6736(16)32380-7
This online publication has been corrected. The first corrected version first appeared at thelancet.com on February 27, 2017

See Comment page 1172

*These authors contributed equally to this work
†Joint last authors
‡Members are listed at end of paper

Summary

Background In 2011, WHO member states signed up to the 25×25 initiative, a plan to cut mortality due to non-communicable diseases by 25% by 2025. However, socioeconomic factors influencing non-communicable diseases have not been included in the plan. In this study, we aimed to compare the contribution of socioeconomic status to mortality and years-of-life-lost with that of the 25×25 conventional risk factors.

Methods We did a multicohort study and meta-analysis with individual-level data from 48 independent prospective cohort studies with information about socioeconomic status, indexed by occupational position, 25×25 risk factors (high alcohol intake, physical inactivity, current smoking, hypertension, diabetes, and obesity), and mortality, for a total population of 1 751 479 (54% women) from seven high-income WHO member countries. We estimated the association of socioeconomic status and the 25×25 risk factors with all-cause mortality and cause-specific mortality by calculating minimally adjusted and mutually adjusted hazard ratios [HR] and 95% CIs. We also estimated the population attributable fraction and the years of life lost due to suboptimal risk factors.

Findings During 26·6 million person-years at risk (mean follow-up 13·3 years [SD 6·4 years]), 310 277 participants died. HR for the 25×25 risk factors and mortality varied between 1·04 (95% CI 0·98–1·11) for obesity in men and 2·17 (2·06–2·29) for current smoking in men. Participants with low socioeconomic status had greater mortality compared with those with high socioeconomic status (HR 1·42, 95% CI 1·38–1·45 for men; 1·34, 1·28–1·39 for women); this association remained significant in mutually adjusted models that included the 25×25 factors (HR 1·26, 1·21–1·32, men and women combined). The population attributable fraction was highest for smoking, followed by physical inactivity then socioeconomic status. Low socioeconomic status was associated with a 2·1-year reduction in life expectancy between ages 40 and 85 years, the corresponding years-of-life-lost were 0·5 years for high alcohol intake, 0·7 years for obesity, 3·9 years for diabetes, 1·6 years for hypertension, 2·4 years for physical inactivity, and 4·8 years for current smoking.

Interpretation Socioeconomic circumstances, in addition to the 25×25 factors, should be targeted by local and global health strategies and health risk surveillance to reduce mortality.

Funding European Commission, Swiss State Secretariat for Education, Swiss National Science Foundation, the Medical Research Council, NordForsk, Portuguese Foundation for Science and Technology.

Copyright © The Author(s). Published by Elsevier Ltd. This is an Open Access article under the CC BY license.

Introduction

The 2013–20 World Health Organization (WHO) Global Action Plan for the Prevention and Control of Non-Communicable Diseases (NCDs) targets seven major risk factors, comprising the harmful use of alcohol, insufficient physical activity, current tobacco use, raised blood pressure, intake of salt or sodium, diabetes, and obesity (referred to as the 25×25 risk factors), with the overall aim of reducing premature mortality from non-communicable diseases by 25% by 2025.[1] Similarly, the Global Burden of Disease (GBD) Collaboration, the largest study monitoring health changes globally, performs an annual risk assessment of the burden of disease and injury attributable to 67 risk factors in 21 world-regions.[2] Despite the fact that low socioeconomic status is one of the strongest predictors of morbidity and premature mortality worldwide,[3-6] poor socioeconomic circumstances are not considered modifiable risk factors in these important global health strategies.

Socioeconomic circumstances and their consequences are modifiable by policies at the local, national, and international levels,[7-9] as are risk factors targeted by existing global health strategies. Evidence also suggests that the burden of most 25×25 risk factors is concentrated in lower socioeconomic groups worldwide.[10,11] Interventions to reduce premature mortality attributable to

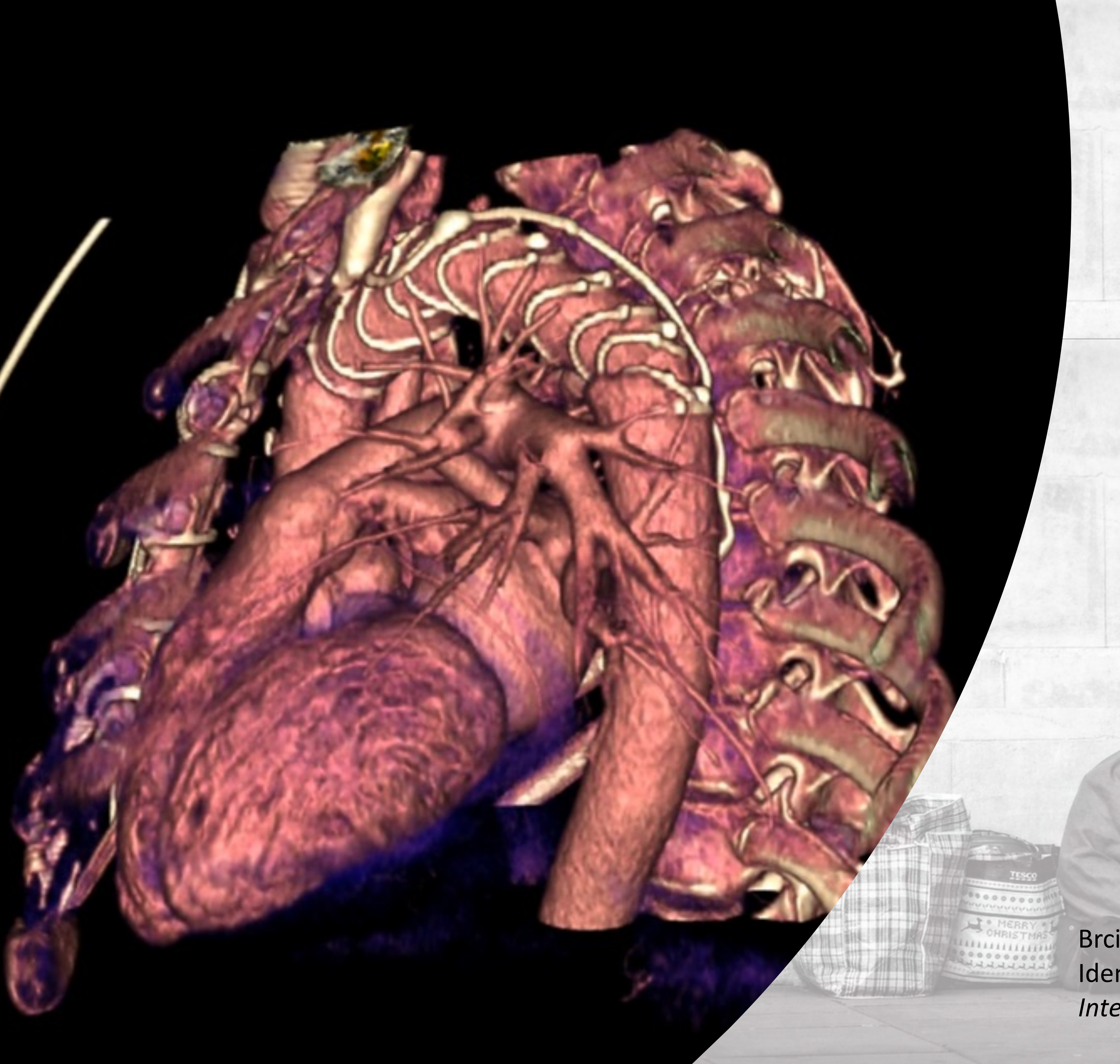
Institute of Social and Preventive Medicine and Departments of Psychiatry and Internal Medicine, Lausanne University Hospital, Lausanne, Switzerland (S Stringhini PhD, C Carmeli PhD, Prof M Bochud PhD, A M Lasserre MD, Prof M Preisig MD, Prof P Vollenweider MD); Institute of Behavioural Sciences, University of Helsinki, Helsinki, Finland (M Jokela PhD); Department of Global Health and Social Medicine, King's College London, London, UK (M Avendaño PhD); Harvard T H Chan School of Public Health, Boston MA, USA (M Avendaño, Prof I Kawachi PhD); Global Research Analytics for Population Health, Health Policy and Management, Columbia University, New York, NY, USA (Prof P Muennig MD); MRC-PHE Centre for Environment and Health, School of Public Health, Department of Epidemiology and Biostatistics, Imperial College London, London, UK (F Guida PhD, M Chadeau-Hyam PhD, Prof P Vineis PhD); Epidemiology Unit, ASL TO3 Piedmont Region, Grugliasco,

Risk factor	Deaths	Participants	Time at risk (years)	HR (95% CI)
Low SES (reference high SES)				
Men	87 716	619 402	9 835 775	1·42 (1·38–1·45)
Women	48 791	592 157	9 538 159	1·34 (1·28–1·39)
Current smoking (reference never smoking)				
Men	37 238	276 686	3 150 820	2·17 (2·06–2·29)
Women	46 447	423 861	5 271 704	2·02 (1·91–2·14)
Diabetes				
Men	39 655	262 745	3 089 811	1·69 (1·56–1·83)
Women	38 162	325 540	3 749 493	1·88 (1·73–2·03)
Physical inactivity				
Men	39 794	259 265	3 029 468	1·60 (1·50–1·70)
Women	45 353	398 992	4 941 600	1·58 (1·48–1·67)
High alcohol intake (reference moderate alcohol intake)				
Men	33 151	235 245	2 808 575	1·50 (1·38–1·64)
Women	37 864	363 666	4 649 162	1·69 (1·49–1·92)
Hypertension				
Men	41 034	273 190	3 184 326	1·30 (1·24–1·36)
Women	44 340	391 681	4 752 337	1·28 (1·21–1·36)
Obesity (reference normal BMI)				
Men	131 882	636 779	17 632 210	1·04 (0·98–1·11)
Women	136 680	815 005	22 310 188	1·17 (1·10–1·24)

0·5 1·0 1·5 2·0 1·5

***Figure 3:* Pooled hazard ratios of socioeconomic status and 25 × 25 risk factors for mortality**
HRs are adjusted for age, marital status, and race or ethnicity. SES=socioeconomic status. BMI=body-mass index.

Stringhini et al, Lancet 2017



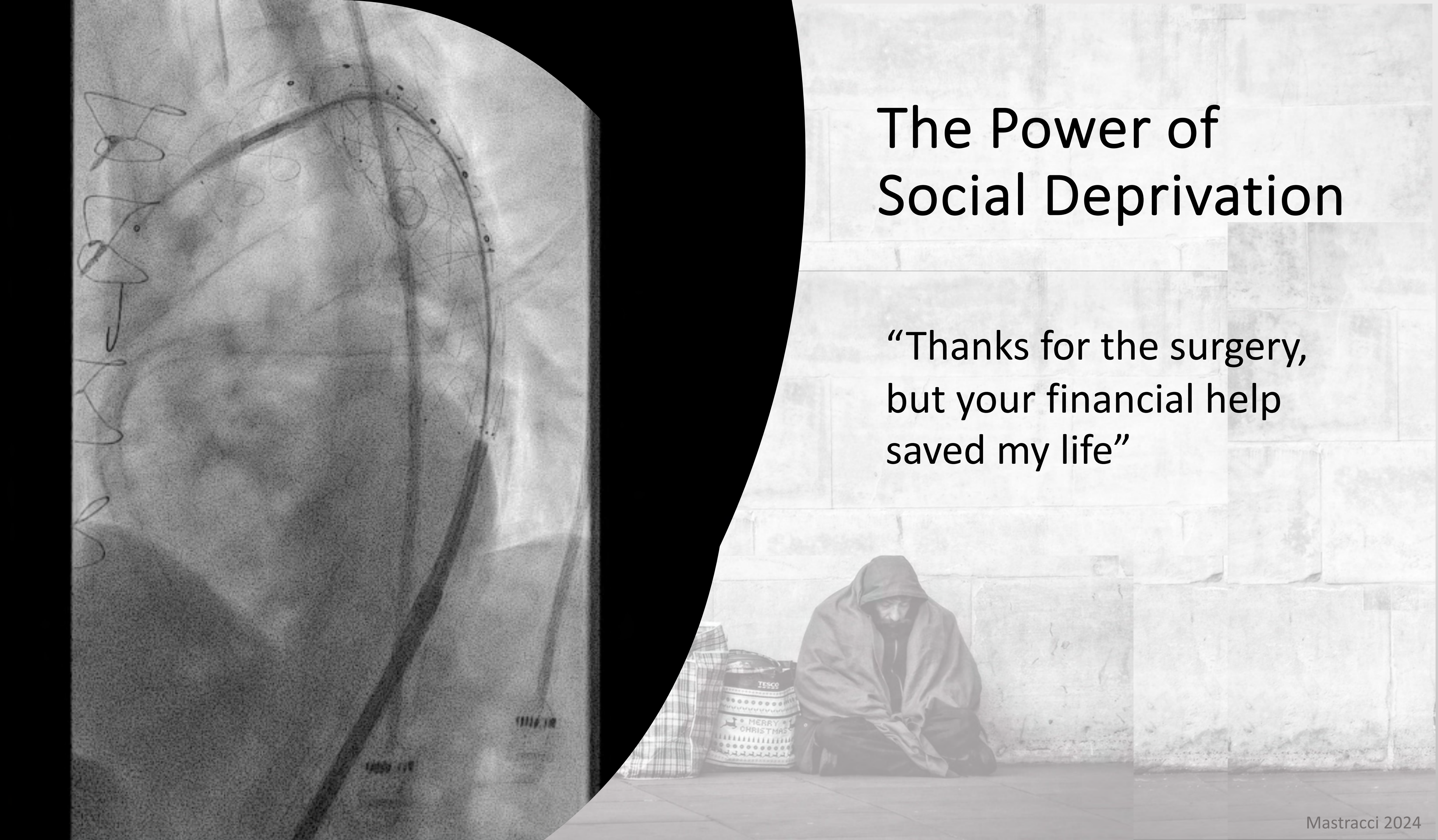
The Power of Social Deprivation

"Do you have difficulty making ends meet at the end of the month"

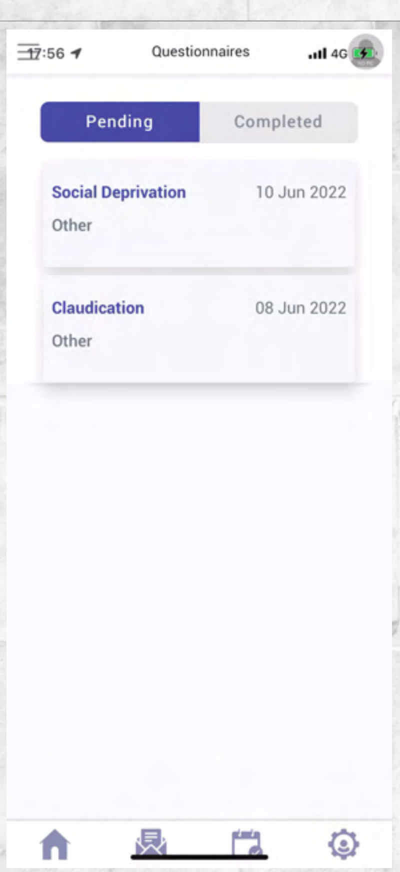
Brcic, V., Eberdt, C. & Kaczorowski, J. Development of a Tool to Identify Poverty in a Family Practice Setting: A Pilot Study. *International Journal of Family Medicine* **2011**, 1–7 (2011).

The Power of Social Deprivation

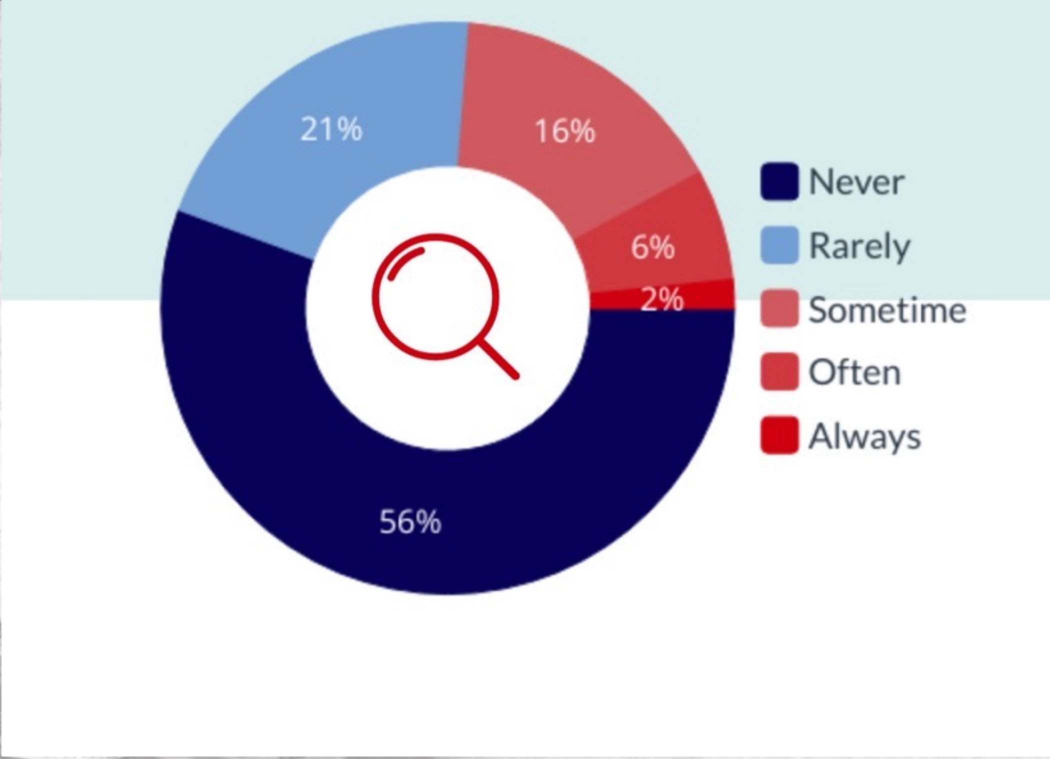
"Thanks for the surgery, but your financial help saved my life"



Barts Experience:
Proof of Concept: Screening



- Digital questionnaire sent to patients with aortic dissection and pre op cardiac surgery in our practice



Mastracci, Das 2023: Credit to Ortus

Well Newham Cardiology Wellbeing Study

TM Mastracci, M Khanji, R Patel, S Waite, Y Hawkings

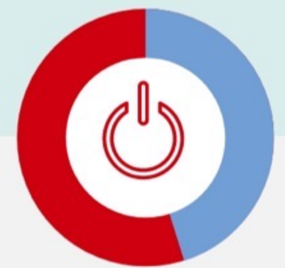
Barts Social Welfare Screening Tool

	Questionnaire Item	Possible responses	Reference source
1	Do you have difficulty making ends meet at the end of the month?	Yes/No/ I don't want to answer	Brcic, V., Eberdt, C. & Kaczorowski, J. Development of a Tool to Identify Poverty in a Family Practice Setting: A Pilot Study. International Journal of Family Medicine 2011, 1–7 (2011).
2	Do you ever have to miss a meal because you don't have food?	Yes/No/ I don't want to answer	
3	In the past 2 months, have you been living in stable housing that you own, rent, or stay in as part of a household?	Yes/No/ I don't want to answer	Chhabra, M. et al. Screening for Housing Instability: Providers' Reflections on Addressing a Social Determinant of Health. J GEN INTERN MED 34, 1213–1219 (2019).
4	If you were in trouble or felt alone, do you have family or friends you can rely on for support?	Yes/No/ I don't want to answer	Escalante, E., Golden, R. L. & Mason, D. J. Social Isolation and Loneliness: Imperatives for Health Care in a Post-COVID World. JAMA 325, 520 (2021).
5	Do you ever feel unsafe?	Yes/No/ I don't want to answer	
6	Do your personal health issues impact your role as a carer	Yes/No/ I don't want to answer	Focus group, Barts CVD patients 2023
7	(Optional if any flags in the first 6 items) Do you want to talk to someone who may be able to help?	Yes/No/ I don't want to answer	Consultation, Lewisham Social Prescribing Team

Mastracci 2024

Newham Cardiology Pilot Project

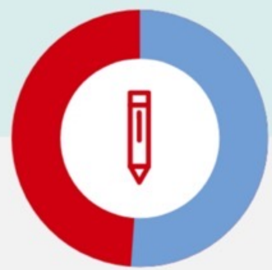
Engaged with digital tool



45%

of patients registered with ORTUS when prompted before their clinic appointment

Completed screening questionnaire



50%

of patients who registered went on to complete questionnaire.

Flagged a concern

56%

of patients who completed the questionnaire flagged for concerns about social deprivation

Financial Deprivation

68%

reported financial distress or hardship

- 150 patients at outpatient cardiology clinic in Newham
- Proved: We need a human interface to make this work!

Mastracci, Khanji 2023

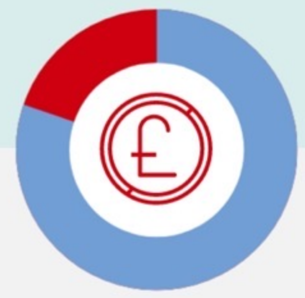
Renal Disease Social Prescriber

Engaged Social Prescriber

100%

of 100 patients starting dialysis since August 2023 had a triage meeting with the social prescriber

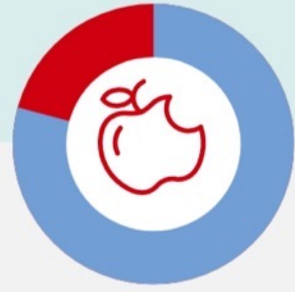
Completed screening questionnaire



80%

of screened patients need some onward referral to support services

Flagged a concern

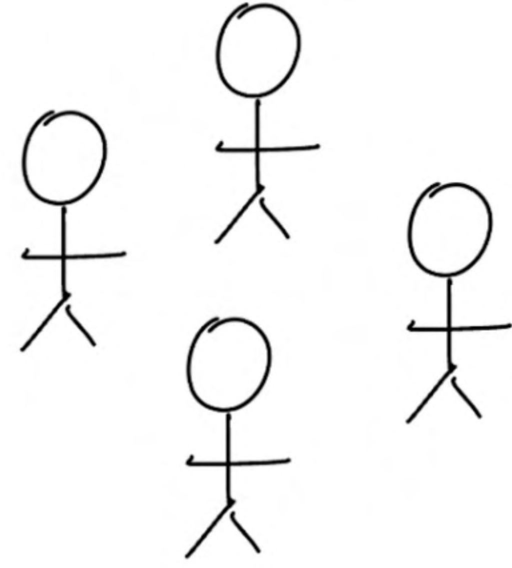


10%

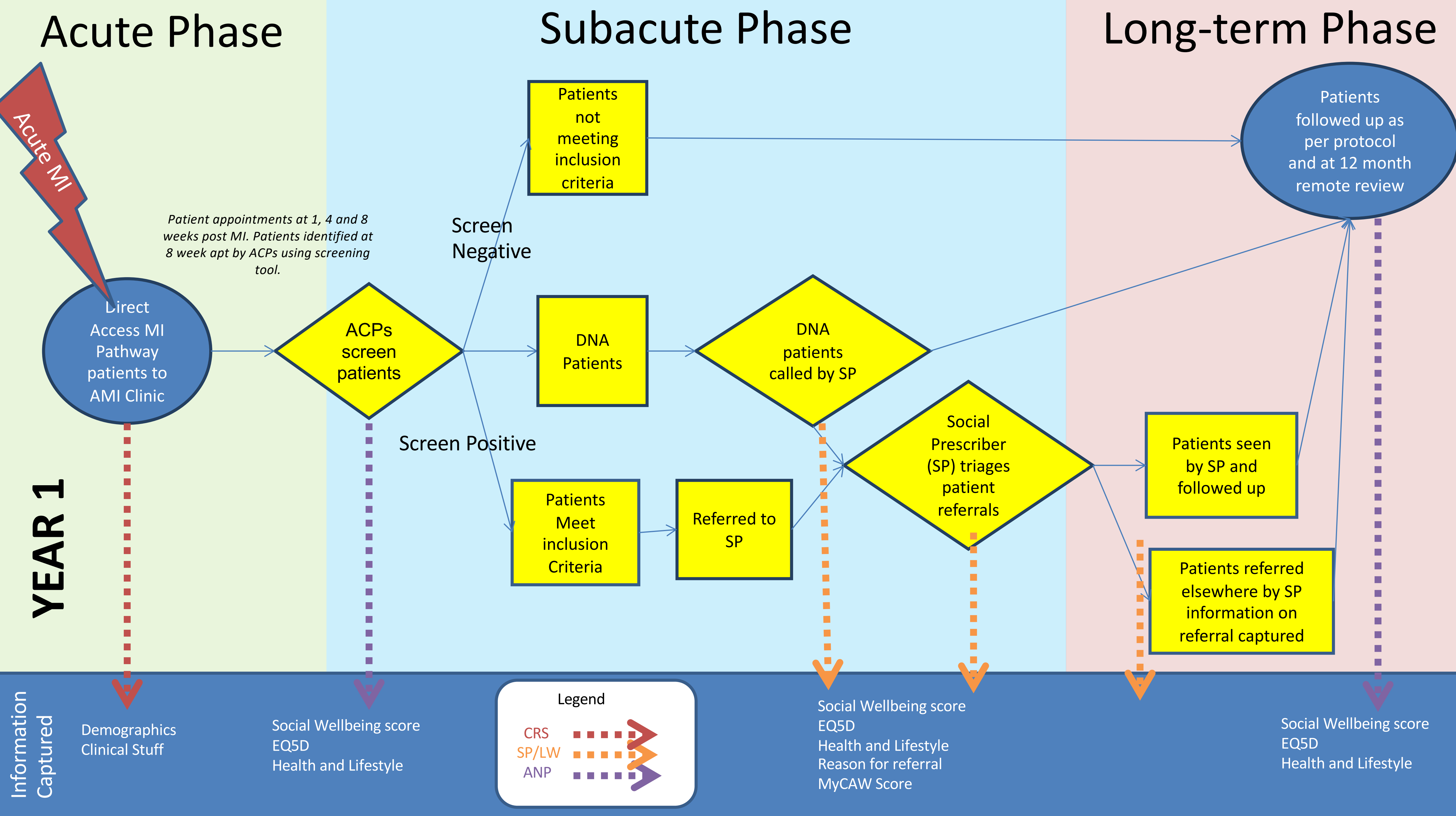
of patients need referral to a food bank.

- 150 patients starting dialysis at RLH since August 2023
- The pathway needs People!

Screening for social wellbeing in the Acute MI/CABG pathway



Patients who have
acute MI (heart attack)
or who need CABG
(heart surgery)


Acute Phase
Subacute Phase
Long-term Phase
Acute MI
Patient appointments at 1, 4 and 8 weeks post MI. Patients identified at 8 week apt by ACPs using screening tool.
Direct Access MI Pathway patients to AMI Clinic
ACPs screen patients
Screen Negative
Screen Positive
Patients not meeting inclusion criteria
DNA Patients
DNA patients called by SP
Patients Meet inclusion Criteria
Referred to SP
Social Prescriber (SP) triages patient referrals
Patients followed up as per protocol and at 12 month remote review
Patients seen by SP and followed up
Patients referred elsewhere by SP information on referral captured
YEAR 1
Information Captured
Demographics
Clinical Stuff
Social Wellbeing score
EQ5D
Health and Lifestyle
Legend
CRS
SP/LW
ANP
Social Wellbeing score
EQ5D
Health and Lifestyle
Reason for referral
MyCAW Score
Social Wellbeing score
EQ5D
Health and Lifestyle

Acute MI

Direct Access MI Pathway patients to AMI Clinic

ACPs screen patients

Screen Negative

Screen Positive

Patients not meeting inclusion criteria

DNA Patients

Patients Meet inclusion Criteria

Referred to SP

DNA patients called by SP

Social Prescriber (SP) triages patient referrals

TH and N Patients seen by SP and sent to BBBC

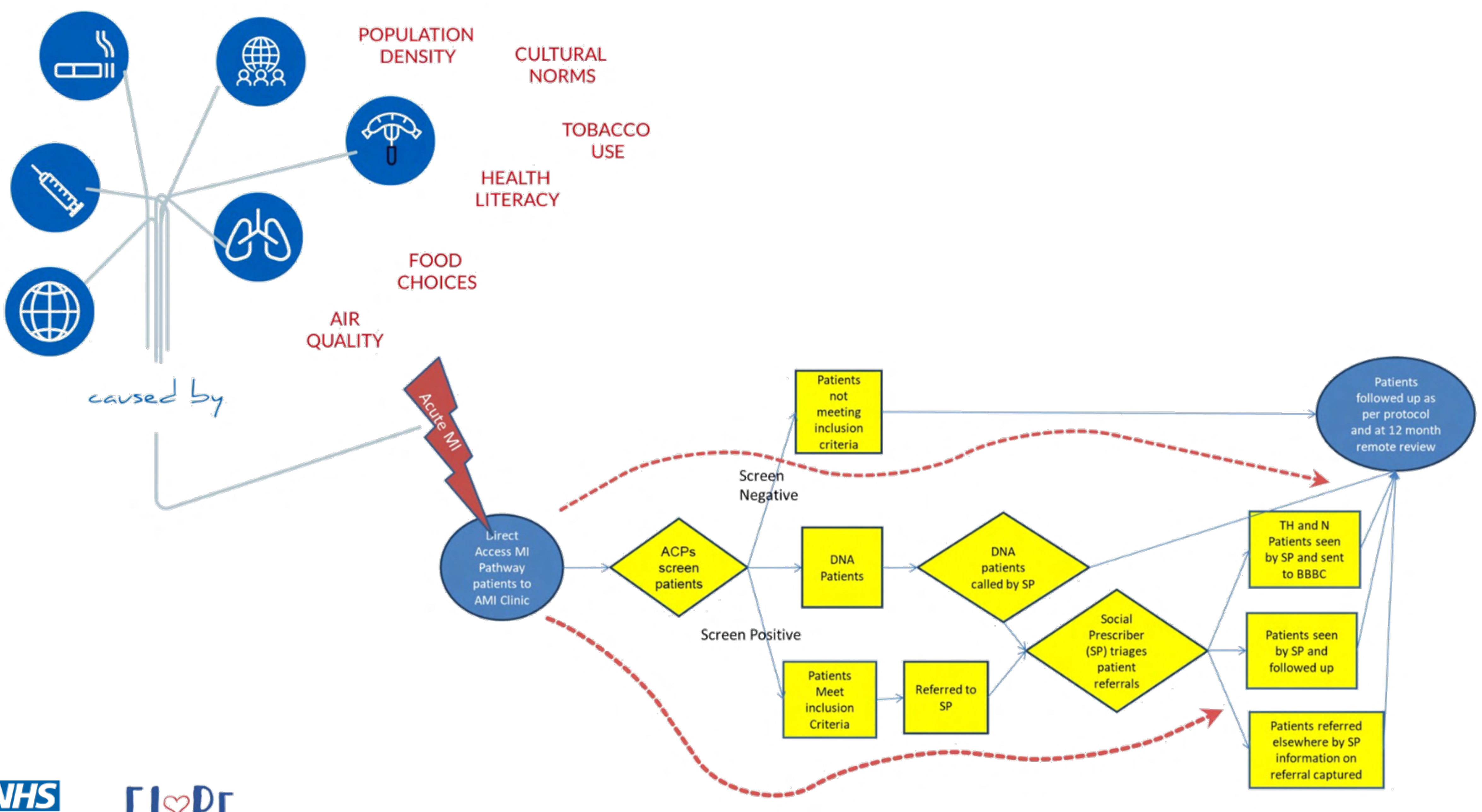
Patients seen by SP and followed up

Patients referred elsewhere by SP information on referral captured

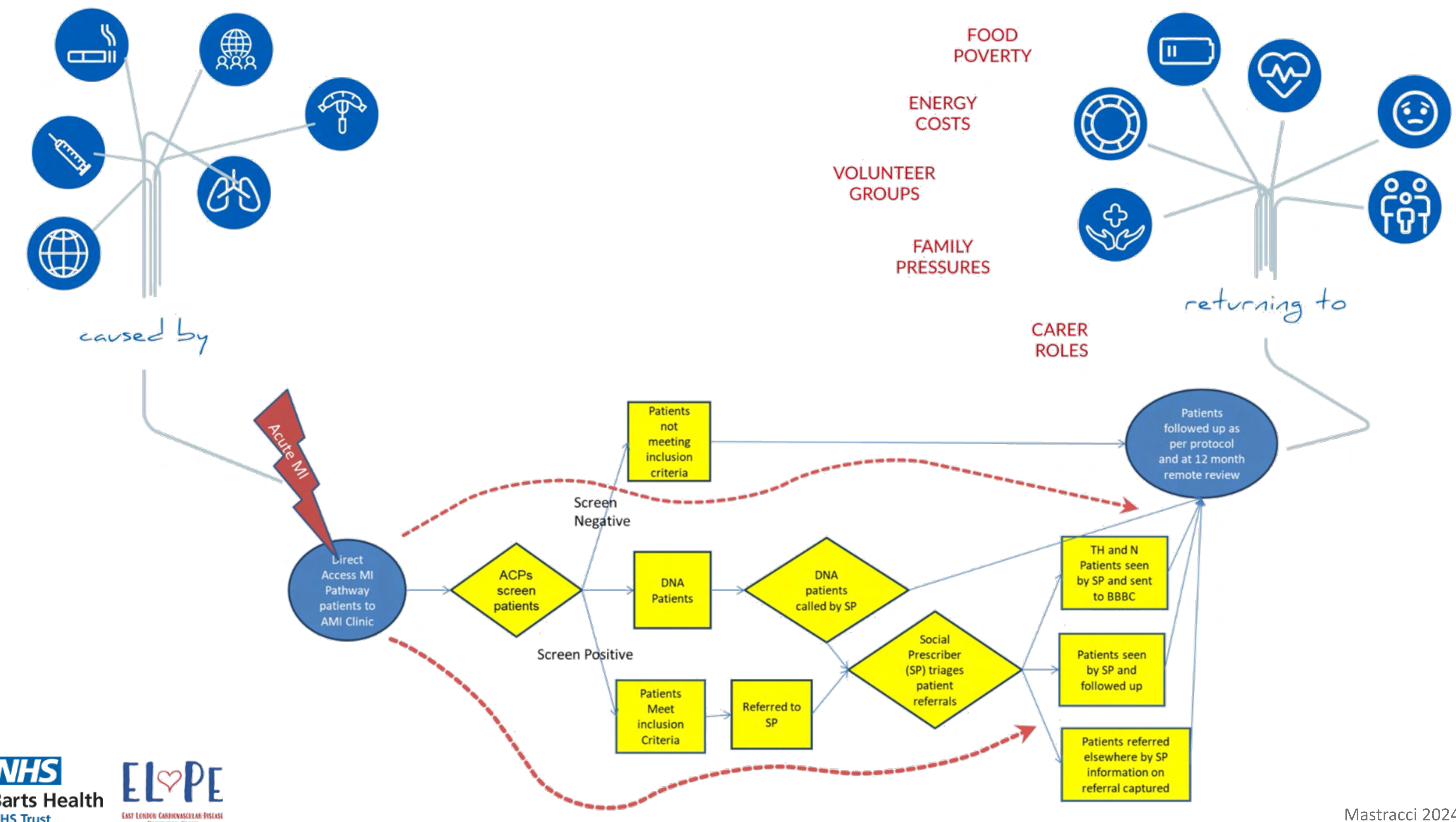
Patients followed up as per protocol and at 12 month remote review

psychology support

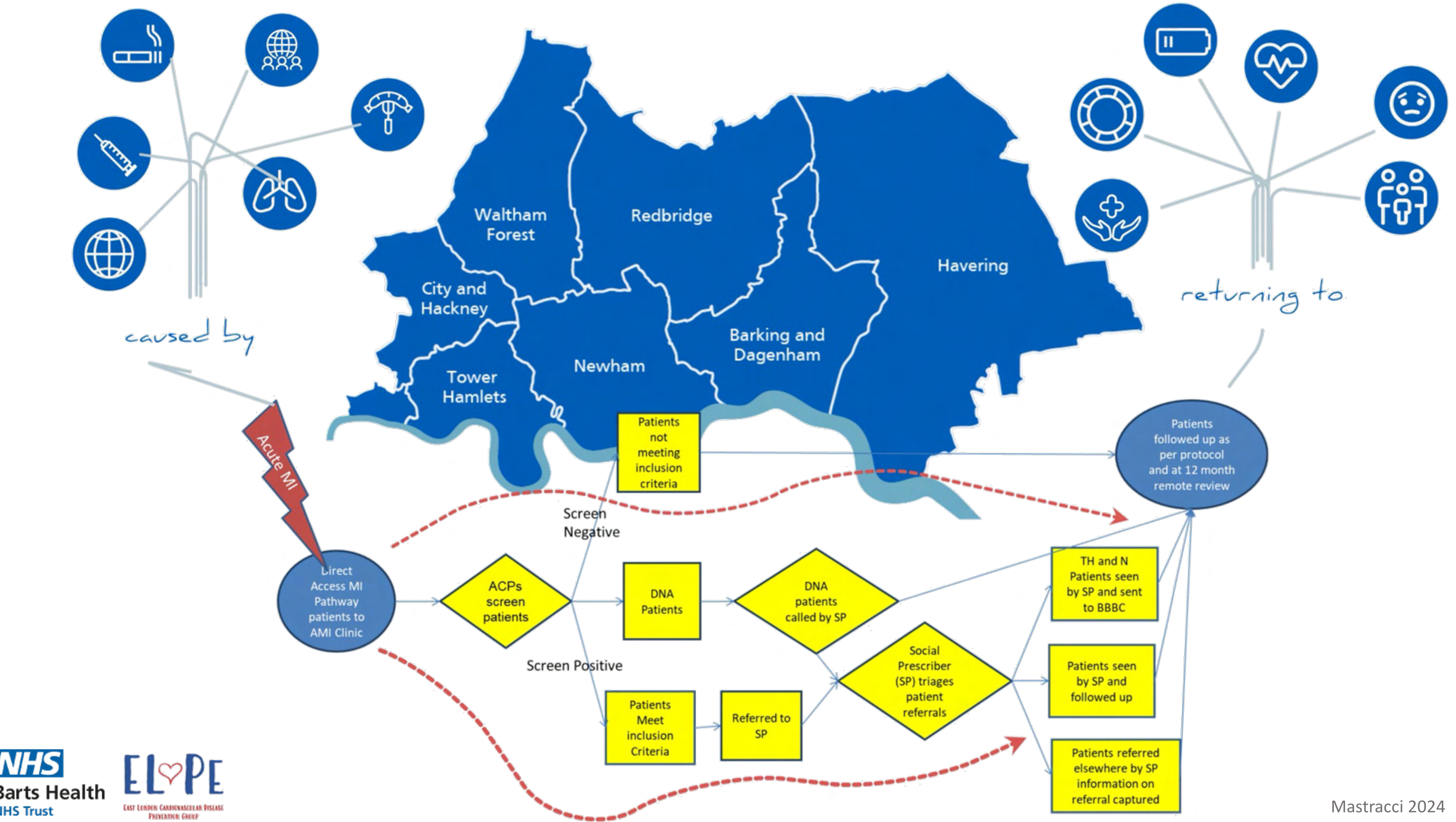
safeguarding



Mastracci 2024



caused by
FOOD POVERTY
ENERGY COSTS
VOLUNTEER GROUPS
FAMILY PRESSURES
CARER ROLES
returning to
Acute MI
Direct Access MI Pathway patients to AMI Clinic
ACPs screen patients
Screen Negative
Screen Positive
Patients not meeting inclusion criteria
DNA Patients
Patients Meet inclusion Criteria
Referred to SP
DNA patients called by SP
Social Prescriber (SP) triages patient referrals
TH and N Patients seen by SP and sent to BBBC
Patients seen by SP and followed up
Patients referred elsewhere by SP information on referral captured
Patients followed up as per protocol and at 12 month remote review
NHS Barts Health NHS Trust
ELoPE
East London Cardiovascular Disease Prevention Group
Mastracci 2024



caused by
returning to
Waltham Forest
Redbridge
Havering
City and Hackney
Barking and Dagenham
Newham
Tower Hamlets
Acute MI
Patients not meeting inclusion criteria
Patients followed up as per protocol and at 12 month remote review
Screen Negative
Direct Access MI Pathway patients to AMI Clinic
ACPs screen patients
DNA Patients
DNA patients called by SP
TH and N Patients seen by SP and sent to BBBC
Social Prescriber (SP) triages patient referrals
Patients seen by SP and followed up
Screen Positive
Patients Meet inclusion Criteria
Referred to SP
Patients referred elsewhere by SP information on referral captured
NHS
Barts Health
NHS Trust
ELPE
East London Cardiovascular Disease Prevention Group
Mastracci 2024

NHS
Barts Health
NHS Trust

ELoPE
East London Cardiovascular Disease Prevention Group

The simple question…

These days some people are having difficulty meeting their basic needs and in some cases we may be able to help.

- **Do you have difficulty making ends meet / meeting basic needs at the end of the month ?**
  - This may include difficulty putting food on the table, finding a place to sleep at night, feeling safe in your home, having a job, or fulfilling your role as carer?
  - Yes/No/Prefer not to talk about it
- **Do you want help?**
  - Yes/No

Outcomes for the Project

Understand burden of deprivation

Use classification system to assess the care pathway (and any inequity in care)

Understand the needs of the community

Hopefully demonstrate improved outcomes.

Outcomes

Process Driven

- Number of patients screened
- Number of patients who screen positive
- Number of patients who want help
- Number of sessions with the SP
- Number of onward referrals
- Type of onward referrals
- Number of referrals back to PCN

Clinically Relevant

- DNA to future clinics
- Attendance at cardiac rehab
- Readmission
- Second cardiac event
- Patient wellbeing (improvement)
- Patient satisfaction

Financially Relevant

- DNA to clinic appts
- Attendance at GPs
- Attendance at A&E
- Compliance with medications

PROJECT ROADMAP

	2022	2023	2024	2025

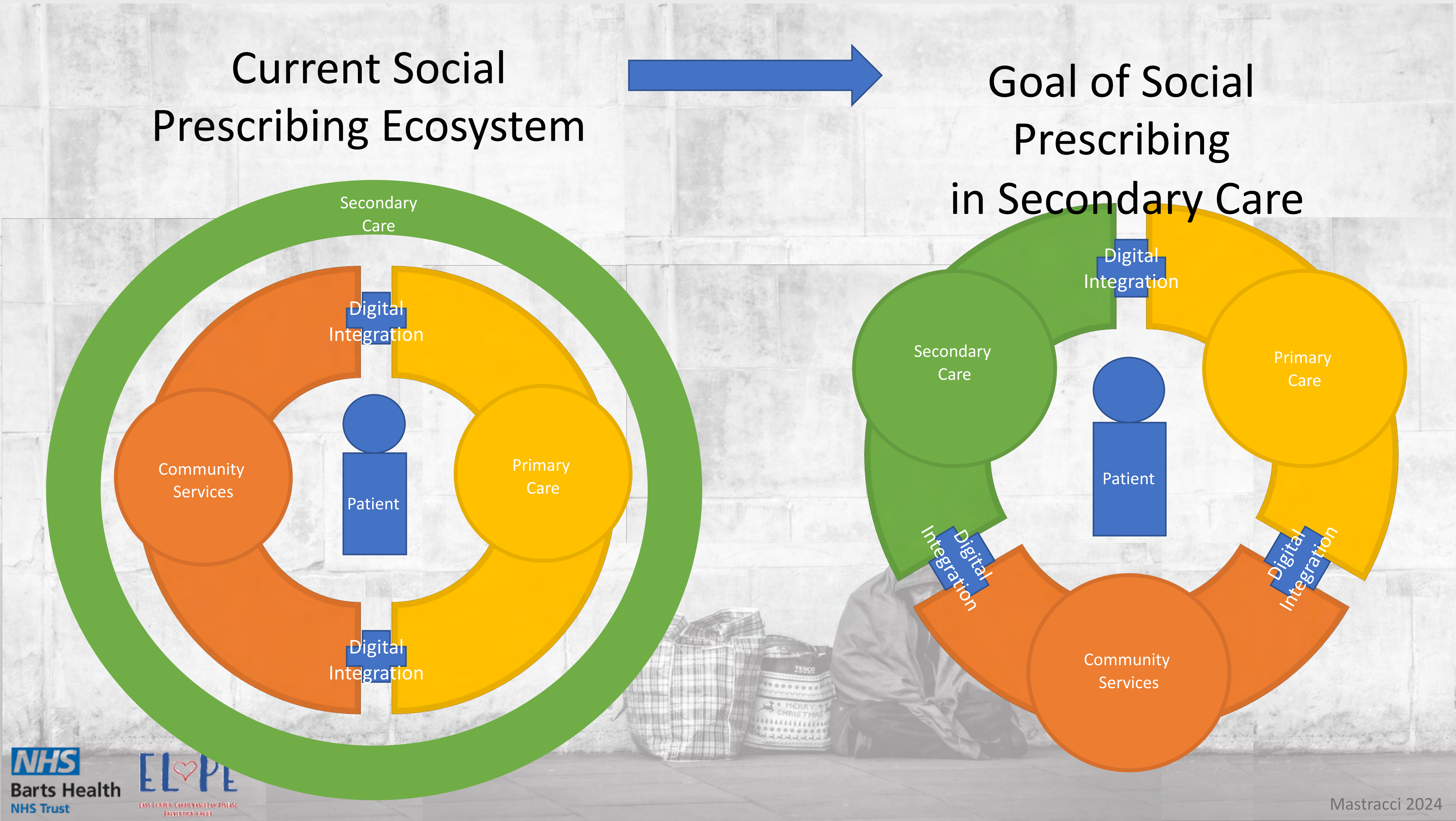
Planning
- Research & Design (Pilots)
- Community Engagement
- S2B Development
- Funding First Round
- Funding 2nd Round

Barts Heart Centre Service
- SP hired
- ANP/Pharm training
- Psychology Co-Design
- Project Live

Bromley By Bow Involvement
- Participate in Co-Design
- Services Provided

Evaluation
- PDSA parameters set
- Data Collection and Analysis

Mastracci 2024


Current Social Prescribing Ecosystem
Goal of Social Prescribing in Secondary Care
Secondary Care
Digital Integration
Community Services
Patient
Primary Care
Digital Integration
Secondary Care
Digital Integration
Primary Care
Patient
Digital Integration
Digital Integration
Community Services
NHS
Barts Health
NHS Trust
Mastracci 2024

Social Prescribing in Secondary Care at Barts Trust

	RENAL DISEASE HEALTH AND WELLBEING COACH	HEART CENTRE COMMUNITY CONNECTOR	CHILDREN & YP SOCIAL PRESCRIBER	DIABETES SOCIAL PRESCRIBER	NEWHAM A&E SOCIAL PRESCRIBER	CARDIAC REHAB SOCIAL PRESCRIBER
FUNDING	Confirmed Barts Charity	Confirmed NHSE	Confirmed Barts	Confirmed NHSE	Confirmed Barts Charity	Pending NHSE
PEOPLE	In Post	Appointed	In Post	In Post	In advert	Awaiting Funding
SITE	RLH	SBH	RLH	Cross Site	NH	Tower Hamlets
DURATION	1 year pilot	1 year pilot	1 year pilot + 1 year extended	0.8 FTE 1 year pilot	0.8 FTE 1 year pilot	1 year pilot

Mastracci 2024

Personalised Care in Secondary Care

Personalised approach to supporting people with chronic and persistent pain

9 January 2024

Selena Stellman and Kalwant Sahota

Experiences of patients with chronic pain

- Complex medical, physical, and psychosocial needs, often on background of emotional or childhood trauma
- High users of primary, secondary and OOH services
- Poor experience of care
  - Fragmented care under multiple specialists
  - Short GP appointments and lack of continuity
  - Lack of GP knowledge and confidence managing chronic pain
- Inefficient use of services and resources
  - Over-investigation
  - Inappropriate unnecessary analgesia prescriptions
  - Inappropriate and unnecessary referrals to secondary care

Based on findings from pre-pilot survey of 26 patients with chronic pain in primary care, conducted Feb-March 2021

Pilot Model

Person with chronic pain identified by GP/HCP

→ Person invited for conversation about their pain and given information to plan for conversation

→ Initial longer GP appointment focusing on:
- What matters to patient (patient led)
- Pain journey
- Understanding of their pain and diagnosis
- Patient-identified needs (e.g. referrals, specialist input, information provision)
- Goal setting

→ GP works with patient to identify and signpost to resources, services and communities

→ Complex patients discussed in monthly MDT → Follow up appointment 6-8 weeks to review goals, progress, MDT outcome

→ Referral on to relevant services or third parties suggested following MDT

Patient continues to access usual GP services/OOH services/etc. as usually would

MDT

Meeting every 4-6 weeks, on Teams

- Explore diagnosis, support options, resources, referrals
- Primary care: GP, social prescriber, health coach, primary care pharmacist
- Secondary care: consultant pain specialist, physiotherapist/ESP, health psychologist
- Opportunity for joint consultations with GP and MDT members
- *Ad hoc* support for queries, building relationships

Benefits to patients

- Improved MSK-HQ score (MSK and non-MSK symptoms, wellbeing)
- Improved Patient Activation Measure score (understanding & confidence managing symptoms)
- Patient management more consistent with NICE guidelines
- Support from ARRS roles for non-medical needs

"Being validated, not having my worries dismissed, being listened to and feeling like the doctor really cared about me and my pain"

"Having time to discuss my condition and symptoms thoroughly rather than feeling rushed to pick one or two bigger symptoms"

"Follow up appointments were really helpful as we would pick up where we left off and then talk about how the previous months went during the build up to the follow up appointment"

Benefits for clinician and team

- Clinician: upskilling, improved job satisfaction, variety, opportunity to develop special interest, reduced burn out
- GP team: Greater awareness, diagnosis, confidence managing chronic pain
- Improved team relationships and MDT working for chronic pain patients but others patient groups too
- Opportunity for HCPs to discuss patients with GPwSI/MDT → reduced inappropriate investigations, prescribing, referrals

Benefits for system

- Substantial improvement in average Patient Activation Measure (PAM), and Musculoskeletal Health Questionnaire (MSKHQ) score from 48 to 53
- If extrapolated to all patients:
  - Reduction in three GP appointments per patient per year ➔demand savings of £345 per patient per year for primary & secondary care
- Reduced use duty GP appointments, A&E attendances and unplanned admissions, and referrals to secondary care (MSK and non-MSK)
- Increased use MDT and ARRS roles
- Improved prescribing in line with NICE, and aiming for reduced opioid use

Nadia’s story – Personalised approach to pain

My name Nadia I was diagnosed with fibromyalgia, which had taken a while to get and I had suffered with pain for years. I also had a history of mental health issues and found it difficult to leave my house and often never spoke to a soul for days and days….

Outcomes – for patients, practitioners, and system

- Reduction in GP appointments
- Fewer hospital admissions
- Shift from reactive to more planned/ structured care
- Improved patient experience of care
- Improved health and wellbeing
- Reduced number and severity of reported exacerbations
- £ efficiencies

"Every step along the way I was wholly supported, my experiences, worries, concerns were validated and my progress, however small, praised. The support I got working towards my goals helped me in so many ways."

Nadia’s PCN has defined pain and mental health as a local population health priority- they are supporting workforce development, including the additional roles within the practice.
Nadia is proactively identified invited for a care planning conversation by her GP, looking at what is important to her- identifying walking and getting out of the house as a priority. By the 3rd session with a health coaching Nadia was walking outside with less pain and walking aids and improved mood. Over the summer Nadia was even able to try kayaking and canoeing. She felt strong and able to cope with life’s challenges

Nadia understanding of her condition and confidence in managing exacerbation and breathing techniques improves. She is introduced to local support groups, leisure centre and better understands her condition.

Social Prescribing Link Worker/health and Wellbeing Coach refers to goals in the digital personalised care and support plan and identifies online peer support and staged goals towards exercise and increasing wellbeing.

Reflective Practice and Training

Reflective Practice Sessions

- 12 sessions so far, attended by multiple healthcare professionals across NWL
- Six weekly virtual lunchtime session for anyone working in the pain field
- Aim: to share insights, key themes, learning, resources and discuss key challenges and identify solutions

Health coaching training

- 2 half days for clinical and non-clinical staff

Why set up a Community of Practice (CoP)

"The most important single change in the NHS …would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end."

Berwick Report, Aug 2013

Our Purpose

What are we trying to achieve and why do we need a learning network approach?

1. What could only happen through and with this specific group of people that you couldn’t do on your own?
2. Why are we doing this?
3. What might the purpose of our network be?
4. How might we go about achieving this?
5. Who might we want to involve?

For extra information please see Attached our newsletter from the day!

Community of Practice

for a Personalised Approach to Pain Management

Further information

- Dr Benjamin Ellis benjamin.ellis@nhs.net
- Dr Selena Stellman selena.stellman@hs.net
- Kalwant Sahota kalwant.Sahota@nhs.net

Virtual Hospital Team

October – November 2023

Principal Partner

www.cact.org.uk

Summary Outcomes

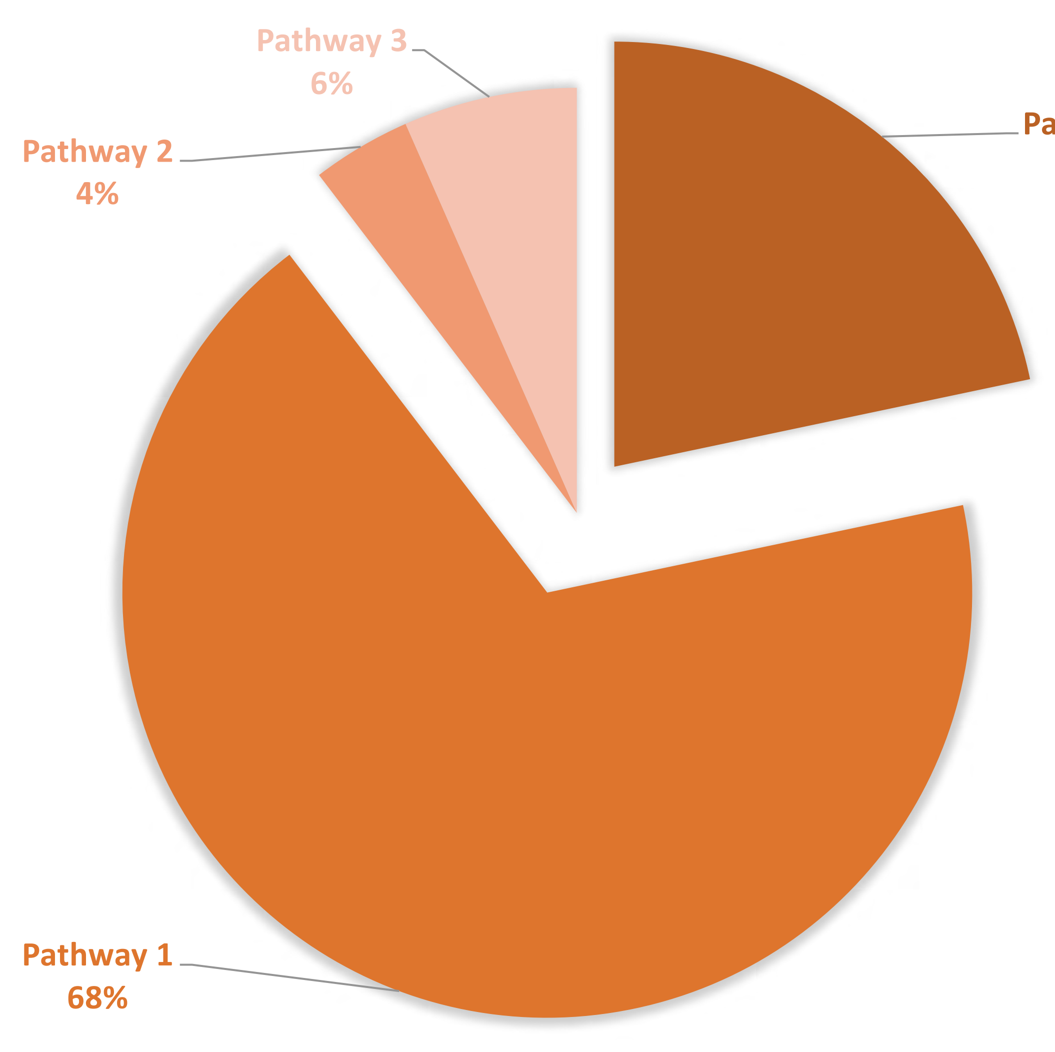
- LWVHT have received a 192 referrals so far.
  - Whilst majority of these referrals come from the QEH Discharge Team, referrals are also received from other services (Social Service) and other local hospitals and step-down accommodation as well.

- 100% of food shopping referrals are met within the estimated discharge date.
  - Food shopping is delivered to the patient on ward or at their usual residence using a key safe to gain access.

- Temporary key safe installation, allows for patients to be discharged within hours of completing the installation.
  - Installing temporary key safe depends on type of accommodation and whether landlord permission is required. These are used whilst waiting for a permanent one to be fitted.

- 100% of furniture moves completed by the CACT Team, are completed within two days of receiving a referral.
  - Expected delivery date of the medical equipment poses a secondary barrier. More time, a furniture move can be arranged and carried out however this will not make a significant impact on the discharge date unless the medical equipment is ordered and delivered to the client's home on time.

Additional Data: July to November



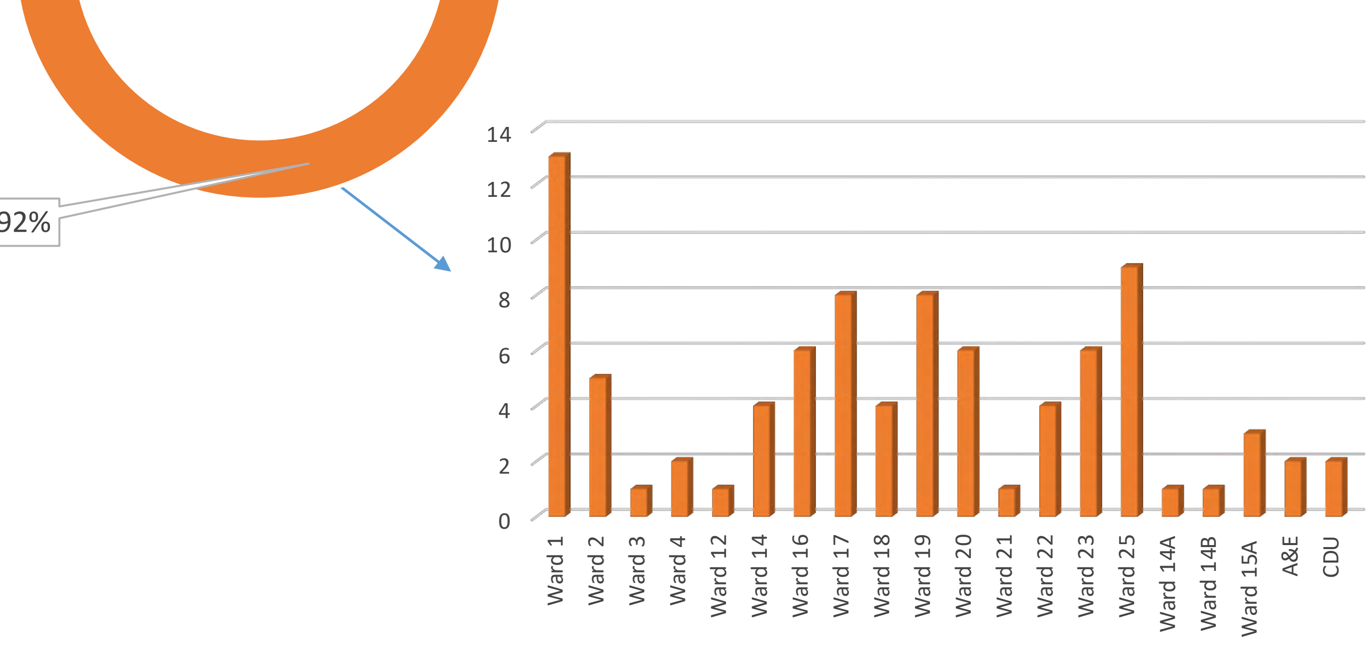
Most clients that are referred to Live Well are discharged on pathway 1. This means they are discharged with the support of medical equipment or a reablement package or a continued or upgraded care package.

Additional Data: July to November

- Queen Elizabeth Hospital
- Newham
- Charlton Park Care Home
- Princess Royal University Hospital
- Langton Way
- Lewisham Hospital
- King's College Hospital

1%
1%
1%
2%
2%
1%

Although this service is based at Queen Elizabeth Hospital, the referral we receive are not limited to just hospital but also local step-down accommodation and care homes too.



CASE STUDIES – OUTCOMES

Information	Referral Turn around
A A client with diabetes was unable to get his medication prescribed for long-term as they were not registered at a GP practice. The client was immediately registered to one of their local GP, supported by a Care coordinator, within the week and now can access their insulin regularly.	Depending on the surgery usually, it can take a client up to a fortnight to register to a GP in Greenwich and get a subsequent appointment. We can utilise are current connections with all GPs in Greenwich, to book and register new clients quickly.
B An elderly client had lost their keys and had left their front door ajar for an entire year. The LWVDT contacted a local locksmith. They installed a key safe and exchanged a new lock on the front door. One set of keys were left in the key safe, and another were handed back to the client with the key safe details. The client was able to return to a property that was safe and secure.	While many locksmiths take between 2-3 working days for callout, we were able to contact a company who was able to change the locks within the day.
C A client needed a new bed in order be discharged from hospital. By highlighting the urgency and need for a bed, LWVDT were able to fast track the response time of the ESS application- on a non-urgent basis this would have been two weeks. The bed was delivered to the client's property within 4 days.	The turnaround for ESS application is 4-6 weeks. When escalated, it took 4 days to get the bed delivered to client's home.

Additional Outcomes

Live Well is deeply embedded in Greenwich and has links into may organisations both statutory and Community voluntary Sector. Knowing who to contact at short notice and bring them to the table for a brief and effective meeting to resolve issues has been valuable.

- RM – Live Well convened a MDT around a vulnerable patient who is currently a high intensity user, a complex case and is at risk in the Community. This involved Social Work, Hospital Discharge, and VIA. Identified a gap. Complex Case team, Live Well, hospital Discharge and VIA now working in collaboration to support longer term.

- Key Safes – Recognised an issue with key safes. Organised a meeting with the relevant protagonist which resulted in Live Well purchasing 6 temporary Key safes for emergency use. We have since used key safe as a temporary measure to allow for the permanent key safe to be installed.

- Medical Equipment – The delivery of the medical equipment supplied to NRS has posed another issue. Whist making space for the equipment is a barrier we can overcome, the delay in the delivery becomes another external challenge. This has been escalated to Oxleas as a barrier to facilitating a smooth discharge for the patient.

99

Total Number of Referrals

Number by Referred by

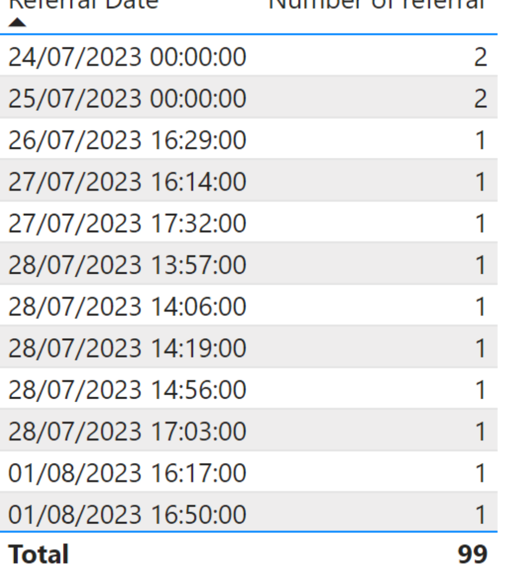
Referred by

UTC -GP
UTC -Nurse
UTC Drivers
UTC - Other S...
Self Referral

0
50

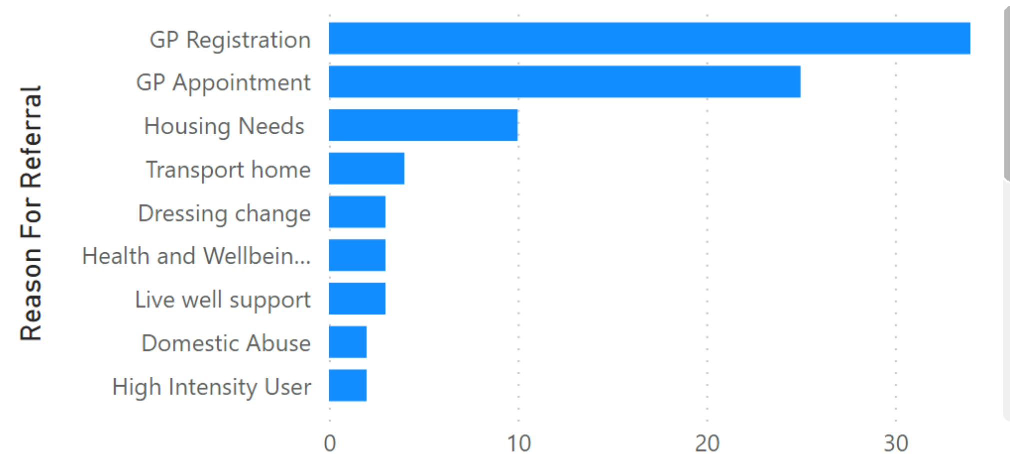
Number

Number of Patients by GP Surgery



Referral Date	Number of referral
24/07/2023 00:00:00	2
25/07/2023 00:00:00	2
26/07/2023 16:29:00	1
27/07/2023 16:14:00	1
27/07/2023 17:32:00	1
28/07/2023 13:57:00	1
28/07/2023 14:06:00	1
28/07/2023 14:19:00	1
28/07/2023 14:56:00	1
28/07/2023 17:03:00	1
01/08/2023 16:17:00	1
01/08/2023 16:50:00	1
Total	**99**

Number by Reason For Referral



Outcome Notes
A face to face appointment has been booked with the GP at Glyndon Medical Centre. Date: 27/07/2023 (Thursday) Time: 11am
Appointment booked with GP for Saturday morning. Patient is aware as still in waiting room.
Appointment made
Appointment made for dressing change
Appointment made for Friday morning

Ongoing support
Bexley - VCS/Social Prescribing
Greenwich - Care Coordination
Greenwich -Live Well Coaching -
Greenwich -Live Well Coaching -Living in his car.
Greenwich -Live Well Coaching -Supporting client to find appropriate employment. Is thinking about DV support
Lewisham - VCS/Social Prescribing
Live Well
Live well, looking for a job.
Signposted to Live Well Coach
Southwark - VCS/ Social Prescribing

Thank You

Principal Partner

www.cact.org.uk

Ambition for London

A Call to Action for London!

Every Hospital Trust in London has access to personalised care roles* by March 2025.

Access to personalised care interventions in every acute trust will:

- Bridge the gap between primary and secondary care services to allow integrated care for patients
- Build and strengthen partnerships between NHS, local authority, VCSE and communities
- Enable effective coproduction with communities, tailoring secondary care services to patient and community needs
- Address non-clinical, wider determinants of health that create barriers to access secondary care services
- Improve education and awareness of services and risk factors of poor health, supporting people to take greater control of their own health/condition
- Increase trust and patient experience of healthcare services through empowering patients as equal partners in their care
- Enable access to the 'right care, right time, right place', increasing capacity for clinical staff
- Coordinate care around patient needs, improving experience and outcomes
- Reduce health inequalities through using population health data and proactive approaches to support those in greatest need
- Improve workforce retention by improving patient experience and outcomes.

*e.g. Social Prescribing Link Workers, Health & Wellbeing Coaches, Care Coordinators

A Call to Action for London!

Every Hospital Trust in London has access to personalised care roles* by March 2025.

What London needs to make this happen?

- ✓ London-wide commitment to the ambition
- ✓ A personalised care lead in all Acute, Community, Mental Health & Specialist Trusts to act as the point of contact for the ICS
- ✓ Champions across primary & secondary care to advocate and influence on this agenda
- ✓ Personalised care & MECC embedded in training & education for all clinical staff
- ✓ Patient voice and lived experience to coproduce and shape personalised care interventions
- ✓ Cross-sector collaboration and partnership to take a whole-systems approach to deliver end to end patient care
- ✓ More consistent funding & investment in personalised care and prevention across primary and secondary care
- ✓ Clear guidance, policy and strategy for personalised care in secondary care

We all have a small part to play in driving forward this agenda!

What can you do at local, regional or system level to achieve this goal?

Create your own ambition statement for expanding personalised care provision in secondary care.

Share in slido!

*e.g. Social Prescribing Link Workers, Health & Wellbeing Coaches, Care Coordinators

Panel discussion: Personalised Care in Secondary Care

Chris Streather

Regional Medical Director & CCIO,
Medical & Digital Transformation Directorate
NHS England London

Jane Clegg

Regional Chief Nurse, London
SRO for Personalisation NHS England London

Melissa Heightman

Respiratory Consultant UCLH and National Speciality Advisor, Long COVID Program, NHSE

Selena Stellman

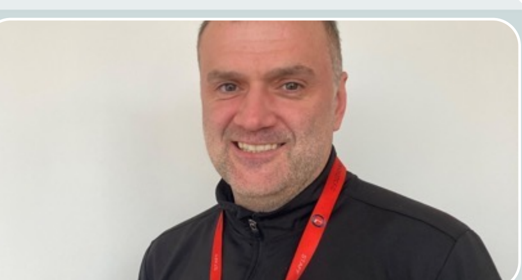
GP lead for MSK and Personalised Care
NHS NWL Personalised Care Team

Tara Mastracci

Vascular Surgeon and lead for social prescribing for the Barts East London Cardiovascular disease prevention group

Deborah Browne

Head of Health Improvement, Charlton Athletic Community Trust (CACT)



Steve Hicks

Operations Manager,
Charlton Athletic Community Trust (CACT)

Reflections & next steps

What’s next for London?

Every Hospital Trust in London has access to personalised care roles* by March 2025.

We all have a small part to play in driving forward this agenda!

- Join the Secondary Care Community of Practice if you’re interested to connect with others across London who are passionate about **secondary care personalised care and prevention**
  - ❑ Reach out to beth.medforth1@nhs.net or mollie.mccormick@nhs.net to be involved
- Champion & advocate for personalised care interventions in secondary care in your teams and networks – get others behind both your ambition and the London ambition.

Thanks for joining

- Share your ambition statements in Slido
- Look out for the slides, recording and themes from the panel discussion which will be shared in the next couple weeks
- Fill out this short feedback form

*e.g. Social Prescribing Link Workers, Health & Wellbeing Coaches, Care Coordinators

Value of Personalised Care in Secondary Care

Holistic support and personalised care can help to **reduce the demand and capacity burden** for secondary care staff, support **cost savings for the NHS** and **improve access, outcomes and experience of services**.

Evidence suggests that access to more holistic, personalised care can have a positive impact on:

Patient outcomes:

Improvements in mental health, social connections & in overall wellbeing, in turn improves clinical outcomes.

The NAPC found that Social Prescribing & Care Coordination support led to **increased activation, less hospital admissions, less falls, less GP contacts.**

Economic outcomes:

Evaluations of Social Prescribing demonstrate a favourable SROI & studies reported a link to **reduced secondary care use**.

Personalised care addressing social determinants can help prevent **problematic polypharmacy** exacerbated by the socioeconomic gradient saving **the NHS ~£1 billion on medicine related admissions** (see slide 11 in appendix).

Demand & capacity:

People from the most deprived areas & most impacted by health inequalities are more likely to be in poor health & **most likely to attend A&E more frequently.**

A study in 2017 from the University of Westminster illustrated Social Prescribing led to a **24% fall in A&E attendance.**

Population health:

Personalised Care improves integration of health & social care systems in the community and proactively targets groups facing higher levels of health inequalities, thereby improving population health.

A prediabetes support group set up in Waltham Forest, used Social Prescribing to engage & tailor support for people from Black & South Asian backgrounds.

NHSE are encouraging expansion of personalised care support in secondary care. Find out more about current policy, context and background in next slide.

Policy highlights and current context

2022:

August: NHS sets out package of measures to boost capacity ahead of winter:

→ Next steps in increasing capacity and operational resilience in UEC ahead of winter – publication ref: PR1929

- *We will **maximise recruitment of new staff in primary care** across the winter, including **care coordinators and social prescribing link workers***

September: Winter pressure new letter to systems

- Permanent contracts to ARRS-recruited staff can be offered as these staff groups will be treated as the **core general practice cost base** beyond 23/24
- *We encourage PCNs to continue to recruit, making full use of their ARRS entitlement to improve access to care and support for patients, with the knowledge that support for these staff will continue*

Changes to the DES contract:

- Aims of increasing roles that PCNs can recruit into, support PCN capacity, and ease PCN workload
- Increasing the ARRS maximum reimbursement rates for 2022/23 to account for the **Agenda for Change uplift**

October: NHSE published

- A letter to systems setting out further recommendations regarding winter resilience plans
- Guidance to Supporting High Frequency Users (HFU) through proactive personalised care, delivered by Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Coordinators
- A short video which also outlines how one system is using social prescribing to help High Frequency Users in Dudley
- Guidance for local health and care systems on Implementing patient initiated follow-up (PIFU) – giving patients and their carers the flexibility to arrange their follow-up appointments as and when they need them

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."

2023/24:

January: Delivery plan for recovering urgent & emergency care services

- Commitment to increasing workforce and capacity
- *We will expand new services in the community, as up to **20% of emergency admissions can be avoided with the right care in place***
- *Hospitals will be appropriate for some seriously ill patients but are often not the best place for many people whose **needs are better met in a different way***

July: NHSE published letter to the system on *'Delivering operational resilience across the NHS this winter'*

- A letter to ICBs, NHS trusts and PCNs setting out a national approach to winter planning
- Highlights importance of integrated & partnership working at place **across all parts of the system** and **improving the primary-secondary care interface**
- Importance of **proactive care for those most at risk of hospital admission**

Why prioritise personalised care in secondary care?

42% of the burden of poor health and early death in England is attributable to modifiable risk factors

Rise in life expectancy is slowing and the deprivation gap is widening

- Life expectancy fell by 1.3 years for males & 1.0 year for females in 2020
- There is a 10 year gap between the most and least deprived

Growing evidence of the preventative impact of lifestyle interventions on multi-morbidity

In March 2023 emergency admissions for hypertension had increased by 118% compared with a 2018/19 baseline.
Lifestyle interventions and personalised care leads to reduced incidence of LTCs.

Non-Covid excess mortality is primarily driven by CVD & diabetes which are preventable & manageable

145,000 excess deaths between March 2020 and July 2023. Managing preventative LTCs will reduce pressure on delivery

Hewitt Review stated that total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years

ICSs have a statutory requirement to help tackle health inequalities.

NHS @75th report emphasises the need for a shift in delivery of healthcare towards:

1. Preventing poor health
2. Personalisation and participation
3. Coordinated care closer to home

NHS is uniquely placed to lead on prevention and personalised care roles are enablers of integrated care (Fuller Stocktake)

The NHS is an anchor institution which can work with local community and institutional partners to plan and coordinate local services.

Opportunity and aims

- Social prescribing and other personalised care ARRS roles are not well supported outside of primary care.
- There is no London wide strategy to scale personalised care roles across acute settings.
- Many projects are in early development and as such lack thorough evaluations, impact data and funding to sustain.
- Acute and secondary care services face challenges: high demand compared to capacity, workforce pressures and securing funding to sustain personalised care interventions.

- Personalised care roles can help to address wider social determinants of health, which improves patient experience and outcomes.
- Using personalised care roles effectively in secondary care enables proactive targeting of ‘at risk’ groups with inequality in access, experience or outcomes to reduce health inequalities, helping to improve population health and prevention.
- Acute pressures could be reduced through identifying underlying causes of readmission/reattendance and providing more holistic support to patients and workforce, utilising assets in the community.
- The expansion of personalised care roles improves integrated care across London through enabling an interface between integrated neighbourhood teams (including VCSE, primary care & secondary care).

Aims

- Support secondary care to embed access to non-clinical wellbeing support in the community.
- Develop and share resources to support rollout of holistic support in secondary care.
- Develop cross-sector partnerships to embed personalised care approaches in acute settings.
- Support better integration between local services.

Why prioritise personalised care in secondary care

How can personalised care roles support challenges in secondary care?

- People with complex conditions need more complex interventions, taking into account the 'whole person' and wider determinants
- Utilising assets in the community, reducing demand for healthcare services and releasing capacity for clinical staff
- Combatting health inequalities requires a collaborative approach and leadership across primary and secondary care as part of 'integrated neighbourhood teams'
- Provides an interface between primary care, secondary care and community services, enabling greater partnership working and integrated care
- Personalised care roles in secondary care enable proactive targeting of 'at risk' groups identified through population health management

Personalised care roles in secondary care will help to improve access, outcomes, and experience of secondary care services.

Service and funding models

Personalised Care roles based in Primary care / community	
Benefits	**Risks**
Funding primarily drawn down from ARRS but can be topped up by additional sources.	Capacity of roles in primary care to manage increased caseloads and resistance from primary care.
Staff already trained and experienced with awareness of local community support/VCSE organisations	Establishing referral pathways to local SP service or PCN

Personalised Care roles based in Secondary care	
Benefits	**Risks**
Easier to demonstrate the value and educate & upskill secondary care staff.	Limited space to meet with patients – hospital setting may not be suitable.
Immediate face to face with patients avoids access issues.	Acute services support patients across a **large footprint –** challenge of awareness of all services

Funding model examples:

- Limited one-off funding e.g. applications through a hospital scheme
- Funding pool jointly held with local authority and match funded by public health
- ARRS or PCN funding
- Winter access funds
- NHSE funding
- Hospital or National Charity funding e.g. Barts charity, Macmillan, Barnados
- Grass roots funding e.g. engagement fund
- ICB/ICS funding e.g. health inequalities or innovation funds

Challenges & Enablers

Challenges	Enablers / recommendations
Sourcing & sustaining funding in secondary care: challenges with short term pilots	Increased funding to sustain longer term projects and allow time to develop trust from healthcare professionals
Limited time available for pilots to demonstrate an impact: limited data/evidence demonstrating impact or best practice	Allocating sufficient budget for thorough evaluations and having strong IT infrastructure for cross-system data sharing
Lack of trust in a new service/pilot means fewer referrals	Increased funding to sustain longer term projects and allow time to develop trust from healthcare professionals
Lack of awareness around the benefits/value of personalised care and education around social determinants for secondary care staff	Bespoke training for secondary care staff and having a lead clinician involved
Funding for the voluntary sector to support increased number of referrals from secondary care	Invest more in VCSE services e.g. through Community Chest models of funding: shared investment funds joining up money from NHS, local authorities and other sources
Discrepancy across system on role titles and descriptions means harder to promote role value	Sharing learnings to develop a more uniformed approach across secondary care
Limited resource and lack of capacity of personalised care roles to manage demand	Focus on recruitment of specialist or hybrid personalised care roles that can receive referrals from secondary care
Lack of networks to connect & best practice examples for shared learning	Peer support networks at ICS or borough level for personalised care roles in secondary care as well as the existing Pan Ldn CoP
Access to shared platforms and data sharing between secondary, primary care and VCSE	Developing and strengthening IT infrastructure across ICSs to improve data sharing & continuity of care for patients
Resistance from primary care and community due to burden of increased referrals	Reframing the communication and relationships between primary & secondary care to emphasise collaboration around a common goal
Space to meet patients: outside of hospital setting is preferable	Emphasising the value of embedding personalised care roles in hospitals and continuing conversations around optimising NHS estate

Resources shared in the webinar

Exciting projects/initiatives:

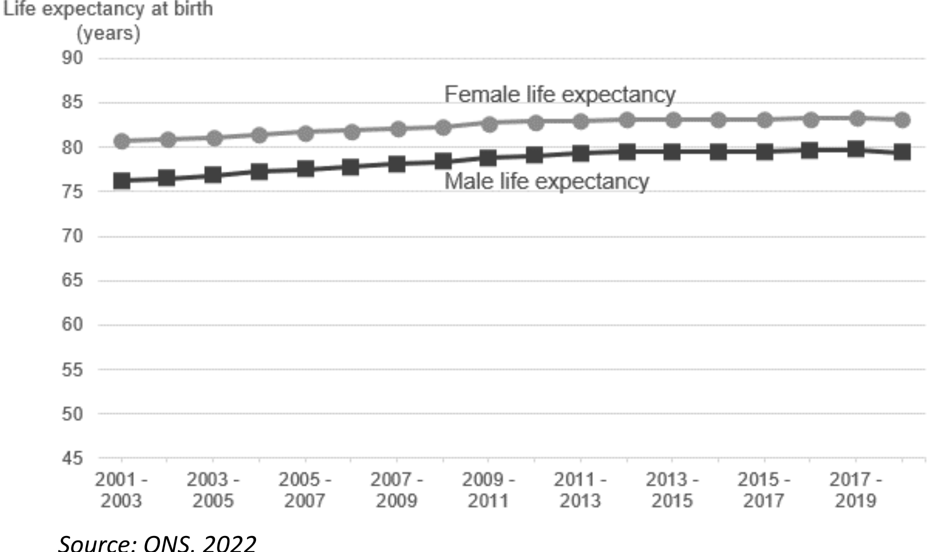
- Mental Health Integrated Network Teams (MINT) (westlondon.nhs.uk)
- English National Opera (ENO) Breathe programme – short video
- Wellbeing West London - a directory of support services across Hammersmith, Fulham, Ealing and Hounslow
- Education sessions lead to reduction in waiting lists for people with long-term pain - Swansea Bay University Health Board (nhs.wales)
- Connecting the dots: tackling mental health inequalities in Wales (senedd.wales)

Useful resources:

- TPHC Personalised Care in Secondary Care case studies

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

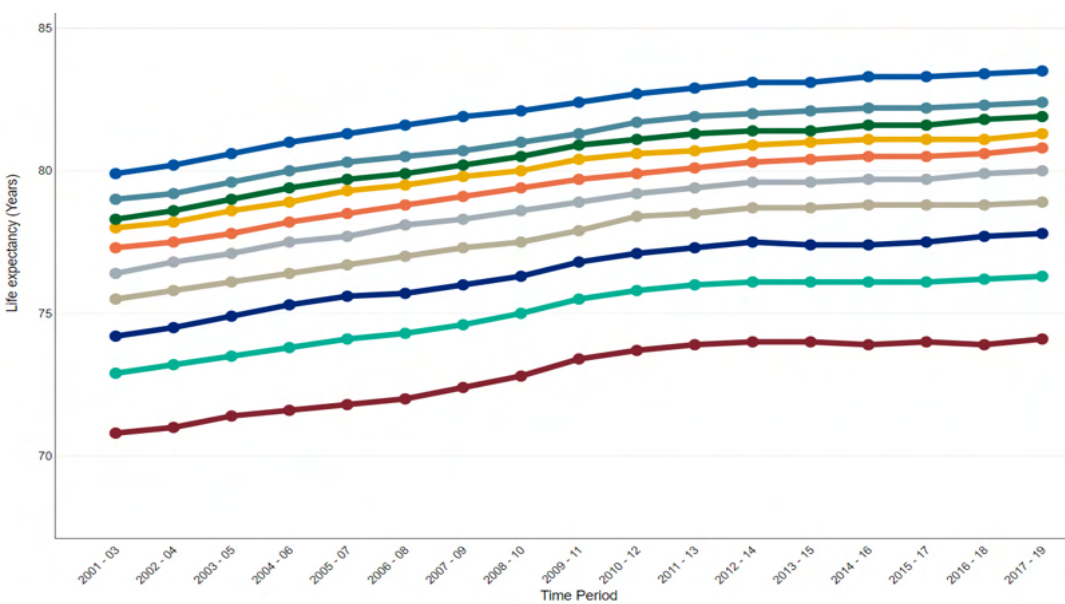
Life expectancy (LE) at birth for males and females in England 2001-03 to 2018-20



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.

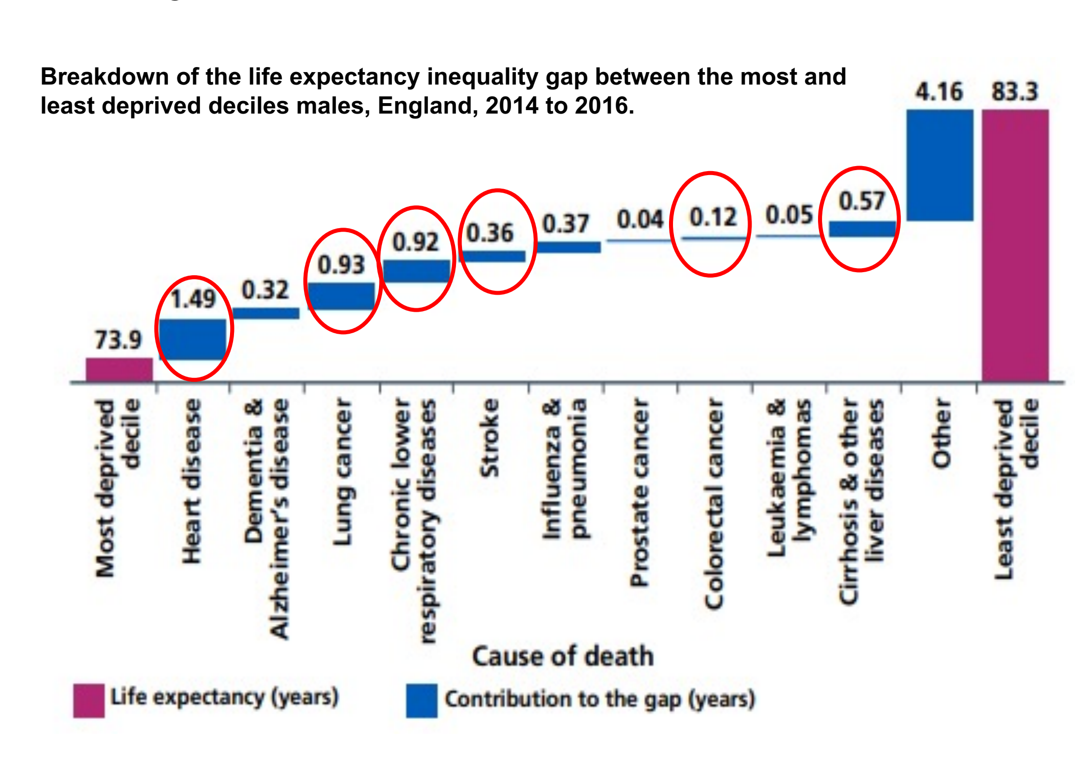
Life expectancy for males – by deprivation deciles, 2001-2019



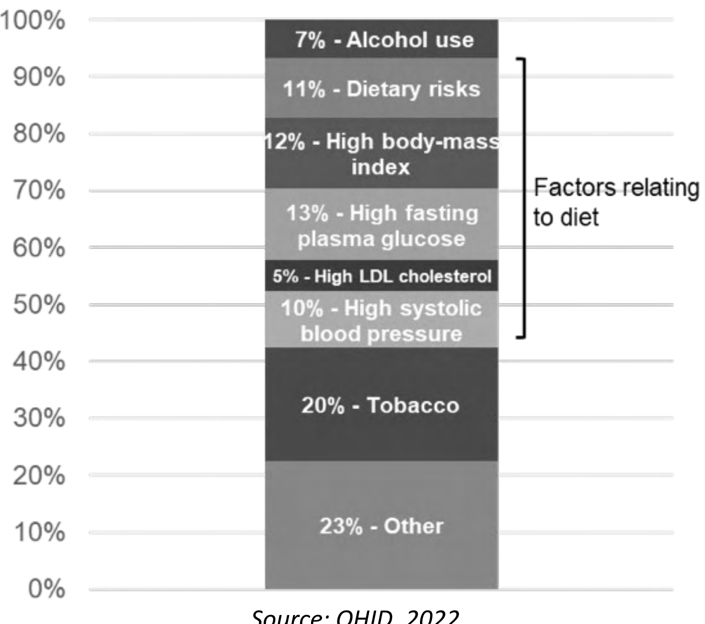
- The rise in life expectancy is slowing and the deprivation gap is widening

There is a 10 year gap in life expectancy between the most and least deprived driven by modifiable risk factors

- The life expectancy gap is driven by preventable and manageable disease



- 42% of the burden of poor health and early death in England is attributable to modifiable risk factors.



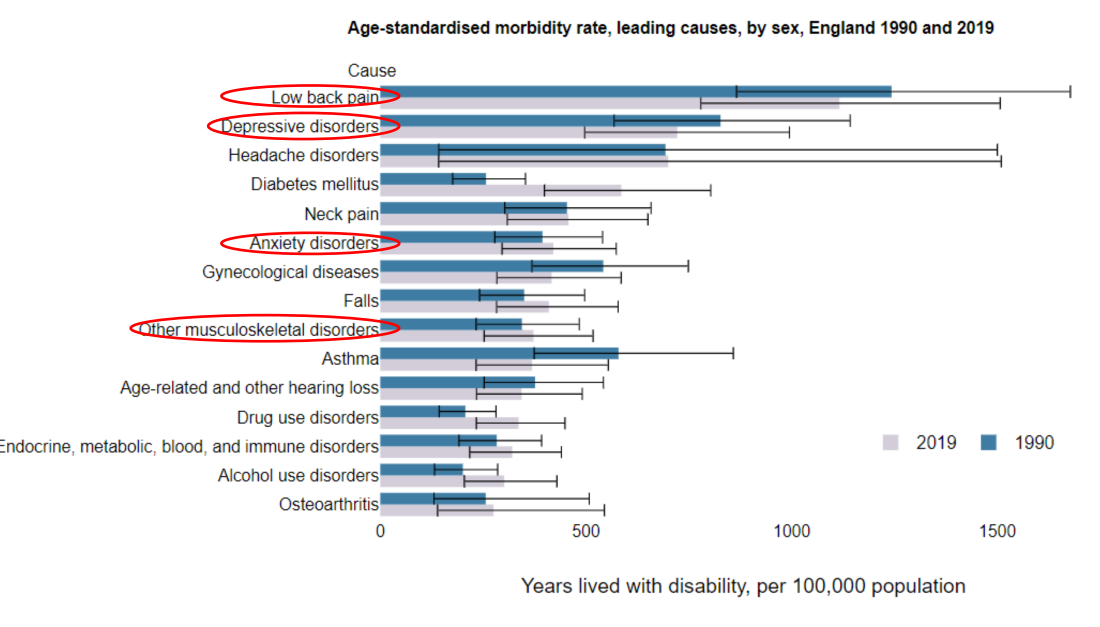
Source: OHID, 2022

Disparities in healthy life expectancy are even more acute

- Healthy life expectancy (HLE - the average years of life lived in good health) is not improving in England.
- Stark disparities in the number of years people can expect to live in good health between deprivation groups.

Expectations of life spent in good and poorer states of health for females in the most and least deprived areas in England

- There are good public policy reasons to refocus our longer-term efforts on tackling morbidity and not just mortality.



Source: Global Burden of Disease 2019