Integrated Care Webinar series 2020/21

The opportunities for systems to improve patient outcomes using digital and data

5 March 2021

NHS England & Improvement System Transformation, in partnership with the Social Care Institute for Excellence (SCIE)
Your speakers today

• Dr Shera Chok - GP, Tower Hamlets, Co-founder and Chair, The Shuri Network, Deputy Chief Medical Officer, NHS Digital and National Clinical Advisor, System Transformation, NHS England and Improvement [CHAIR]
• Dr Karen Kirkham MBBS DRCOG - National Clinical Advisor System Development and Population Health Management NHS England and Improvement, ICS Clinical Lead Dorset, Assistant Clinical Chair Dorset CCG
• Dr John Robson, Reader QMUL, Clinical Lead for the Clinical Effectiveness Group; North East London ICS
• Stephen Slough, Chief Information Officer – Dorset CCG, Chief Information Officer Dorset HealthCare, Chief Information Officer Dorset County Hospital, Portfolio for Director Digitally Transformed Dorset
• Heather Case – Head of DiiS, Dorset CCG
• Dr Simone Yule BSc MB Bch DRCOG - Clinical Director The VALE Network, Clinical Lead Dorset PHM, National Clinical Advisor PHM
Population based transformation and improvement
Prepared for Integrated care webinar March 2021

Dr Karen Kirkham NHSE/I

NHS England and NHS Improvement
Integrated Care Systems have four main objectives:
1. improving population health and healthcare
2. tackling unequal outcomes and access
3. enhancing productivity and value for money and
4. helping the NHS to support broader social and economic development.

Transforming services and pathways across care settings will require an improvement approach rooted in population and person centred need and addressing inequity – an approach which traverses organisational boundaries and clinical pathways.

Research indicates that integration efforts are not yielding improvements in patient outcomes that we want to see because the attitudes towards new care models from commissioners are driven by short-termism, despite the evidence that time and flexibility is needed to see improvements. (1, 2)

As part of implementing and transforming Integrated Care Systems we need to ensure there is a clear and evidential connection from the practical changes that are required; provider collaboration, the financial framework, commissioning, governance and accountability – to enabling a more coherent, smarter and integrated approach to meeting the current and future needs of local communities.

Over the last 3 years, ICSs have found that population health management approaches - which focus on using data and predicted analytics to join up services and deliver proactive personalised care for complex at risk groups - puts the citizen at the heart of the debate and builds consensus on maximising use of local resources and assets to have the biggest impact on health outcomes.

Central to this bottom up transformation is joined up data across an ICS

PHM uses integrated data and analytics as the foundation for understanding how to transform the health and care system to prevent future risk.

- Risk drivers to ill-health and hospitalisation (the intersectionality of physical, behavioural, psychological, socio-economic risks)
- And Demand and financial risk placed on different parts of the service currently and projections for the future

This enables local transformation – of pathways, workforce models and working practice, payment and contracting mechanisms, governance and form – to be **evidently reflective of the current and future needs of local communities**

**What are the barriers to shift our collective resources to proactively support this cohort?**

**How can we scale this to a cohort?**

**How do we overcome these barriers at scale?**
We believe this can be driven through a data driven whole system learning approach anchored in current and future population need

- Adapting governance at system and place to enable shared learning, spread and sustainability
- Developing a sustainable approach to alliance contracting for population segments
- Review of system support and enabling functions to sustain focus on continuous improvement across population segments

- Developing a clear approach to measuring and tracking outcomes for population segment ensuring this forms part of overall system oversight and governance model and outcomes framework
- Clear plan to learn and adapt from implementation using QI methodology

- Developing sustainable blended payment for population segment which outlines fixed, outcomes-based and risk share elements across responsible providers
- Outline integrated workforce model for population segment across responsible providers which includes healthcare professionals, social care, VCSE and carers involved in person centred care

- Whole population segmentation and stratification to understand the risks to physical, mental and socio-economic well-being, drivers of ill-health, hospitalisation, unwarranted outcomes and inequalities
- Analyse whole population health and care utilisation by providers and population segments
- Define short medium long term outcomes aligned to population segments

- Projecting these segments forward to understand how cost and risk will change over time for these groups.
- Estimates can then be made for where the biggest improvements in care and prevention can be made.
- Agreeing priority population cohorts where tactical service redesign will improve short and long term outcomes and mitigate future demand and financial risk

- Multi-disciplinary design across primary, community, secondary care partners, VCSE, social care and public supported by system analytical and clinical transformation teams
- Adopting logic model approach to understanding partner inputs (e.g. workforce), activities, outcomes focusing on proactive assessment and ongoing care-coordination
- Citizen and community engagement through holistic care design and preventative care

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Key planks of work

**Policy**
- Co-design, testing and delivery of
- System integration metrics; 21/22 SOF, refresh through system testing, 22/23 SOF
- National integration index – a new patient experience measure of integrated, anticipatory and personalised care – pilot, options appraisal and procurement/mobilisation
- ICS Support Services market strategy

**Support**
- Wave two – 12 systems, 14, places, 50 PCNs
- Wave three – 24 systems, 24 places, 100 PCNs
- Place partnerships PHM support
- PHM programme evaluation
- Regional capability support to Improvement Hubs
- Health System Support Framework

**Data, analytics and digital**

**Primary Care, NHS@Home, Health Inequalities and Personalised Care**

**Place partnerships and provider development**

**Commissioning and system/place functions transformation**

**Financial framework, aligned payments and incentives**

**Oversight, metrics and outcomes**

**People and workforce development**

**Improvement support, clinical priorities, model system**

**Spread**
- Academy
- Engagement
- CSU and AHSNs

**Partners**
Data should drive decisions across all parts of a system

**Decisions**

- **Planning and strategy** – understanding the burden of inequality and need, how this drives service utilisation and overall wellbeing and how demographic and demand pressures are likely to shape provision and risk between organisations
- **Commissioning** based on outcomes for population segments and future need and demand profile
- **Research and evaluation** – undertaking longitudinal studies to identify preventative interventions and understanding the impact of new care models on experience, outcomes and utilisation.

**Data**

- Overview of clinical and socio-demographic risk factors distribution, with comparisons across provider catchments and geographic footprints
- Projections of key drivers of demand and utilisation, including health inequalities
- Data showing the current utilisation and cost of pathways and care settings by provider group and modelling to indicate likely impact of new interventions and care models
- Financial modelling to create service, pathway and population based blended payment models
- De-identified person level historic data (synthetic dataset) to run research trials

**System**

- Operational management of patient flow and service activity supporting demand management and capacity planning short, medium and long term (command centre)
- Population health and health inequalities – understanding drivers of disproportionate and unwarranted health outcomes and the new and emerging needs of different population groups
- Tactical commissioning and contracting for service specifications and care models within a provider collaborative supported by place based budget management and the move to innovative capitated payment models
- Quality management & improvement

**Place**

- Clinical and MDT care supported by risk stratification and population health analysis to identify gaps in care and unwarranted variation
- Benchmarking across network and within place to identify future service changes and development support

**PCN**

- Local population segmentation and stratification by socio-demographics, clinical or healthcare needs and service utilisation/costs
- Cross-PCN data on service utilisation, costs and outcomes data QOF data and comparison of metrics across PCN service specifications

**Person**

- Promotion of self care and personal wellbeing
- Read and write access to the shared care record to record self monitoring information (through devices) and to push self care personalised messaging and coaching
- Financial information to support personal health budgets

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**Example of plan spend and elements of the payment mechanism across multiple providers**
Where to start – population health management capability

<table>
<thead>
<tr>
<th>Infrastructure</th>
<th>Intelligence</th>
<th>Interventions</th>
<th>Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Organisational and human factors such as dedicated system leadership and decision making on population health and PHM</td>
<td>• Whole System Population Health Intelligence Function with multi-disciplinary analytical and finance teams equipped with advanced analytical tools and software</td>
<td>• Care model design and delivery through proactive and anticipatory care models with a focus on prevention and early intervention and reducing health inequalities</td>
<td>• Incentives alignment – value and population health based contracting and blended payment models</td>
</tr>
<tr>
<td>• Digitised health &amp; care providers and common integrated health and care record</td>
<td>• Timely analyses and actionable insight to understand health and wellbeing needs of the population, opportunities to improve care, manage risk and reduce health inequalities</td>
<td>• Community well-being - asset based approach, social prescribing and social value projects</td>
<td>• Workforce development and modelling - upskilling teams, realigning and creating new roles</td>
</tr>
<tr>
<td>• Linked health and care data architecture and a single version of the truth</td>
<td>• Agile and responsive ways of working across multi-disciplinary groups comprising clinical, improvement, analytical teams working hand in hand with providers</td>
<td>• Citizen co-production in designing and implementing new proactive integrated care models</td>
<td>• Enabling governance to empower more agile decision making within integrated teams</td>
</tr>
</tbody>
</table>
Equitable health improvement in east London
A digital journey

• High performing CCGs despite exceptional challenges

• A decade ahead of similar disadvantaged areas

ceg
Clinical Effectiveness Group
DIGITALLY INTEGRATED

- smart templates
- prompts/protocols
- searches
- smart forms
- dashboards
- responsive BI
PHISIC

Population Health Information System for Integrated Care
Learning Health System

is built on.....

- Trust
- Reciprocity
- Clinical focus
- BI and research

Digital infrastructure essential component

Wachter Review 2016
East London Practices – Exceptional success

C&H and TH 1st, 2nd in 25% QOF metrics;
Newham, Barking and Dagenham, Redbridge improvement++

C&H 2013
- 21st COPD FEV1
- 41st AF anticoagulated
- 148th Diabetes BP
- 181st Diabetes chol

C&H 2014
- 1st AF anticoagulated *
- 1st Diabetes foot exam
- 2nd CHD BP
- 2nd Stroke BP
* with exceptions

C&H 2015
- 1st BP target CHD, Stroke, PAD, CKD
- 1st AF anticoagulated (with exceptions)
- 1st COPD x spiro, MRC, FEV1
- 1st Asthma review
- 1st Diabetes exam
- 2nd Diabetes education
- 2nd Dementia review
- 3rd Hypn BP
- 3rd Diabetes BP

C&H 2016
- 1st AF Anticoagulated (with exceptions)
- 1st CHD BP
- 1st HYPTN BP
- 1st PVD BP
- 1st Stroke BP
- 1st Asthma 3Q
- 1st COPD MRC
- 1st COPD FEV1
- 1st Diab BP
- 1st Diab exam
- 1st Smoking advice
- 2nd Diab Chol
- 2nd Dementia
CHD BP <150/90mmHg QOF 2005-18

% BP <150/90

% BP <150/90


75 80 85 90 95

Tower Hamlets

C&Hackney

Barking&Dag

Redbridge, Havering

Newham

England

Barking&Dag

Redbridge, Havering

Newham

Tower Hamlets

C&Hackney

% BP <150/90


75 80 85 90 95

% BP <150/90


75 80 85 90 95

% BP <150/90


75 80 85 90 95

% BP <150/90


75 80 85 90 95
Diabetes BP< 140/80mmHg
Index of Material Deprivation and QOF 2019
MOTIVATE – Dashboards near real time
APL-AF  Atrial Fibrillation Tool

Select Clinical System
- EMIS
- SystemOne
- Vision
- Microtest

Anonymised DATA

Press to locate CSV file(s)
Press START when data is cleared
RESET to clear
Date of last run: 16/11/2017

Filters

Prescribing
- All AF
- Warfarin/NOAC only
- Aspirin/Clopid only
- On Both
- On Neither

CHA2DS2-VASc (pts)
- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9

Complex risks
- NIH Stroke Scale
- Learning Disability
- Dementia
- On NSAID

Anticoagulation Contraindicated

Summary

Prescribing

Atrial Fibrillation Register
- 38

On Warfarin/NOAC only (6m)
- 25

On Aspirin/Clopid only (6m)
- 0

No treatment
- 1

Both Anticoag + Antiplatelets (6m)
- 2

CHADS2/2VASC ≥ 2 on anticoagulants
- 33

CHADS2/2VASC ≥ 2 on antiplatelets only
- 0

CHADS2/2VASC ≥ 2 with no treatment
- 1

CHADS2/2VASC ≥ 2 on both
- 1

Figure 1: Improvement of Therapy

- Anticoagulation
- Antihypertensives
- Statin

Therapy Optimised

<table>
<thead>
<tr>
<th>Patient</th>
<th>Reference no.</th>
<th>Usual GP</th>
<th>Age</th>
<th>Sex</th>
<th>CHADS2/2VASC (APL)</th>
<th>CHADS2/2VASC (GP)</th>
<th>HAS-BLED Score (APL)</th>
<th>On Aspirin/ Antiplatelets</th>
<th>On warfarin/ NOAC</th>
<th>On NSAID</th>
<th>On Refin</th>
<th>Maximus Review (Pharmacist or detailed GP review)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>944-01111</td>
<td>G15373</td>
<td>73</td>
<td>Female</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>24250</td>
<td>944-01112</td>
<td>G15373</td>
<td>82</td>
<td>Female</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
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<td>G15373</td>
<td>76</td>
<td>Male</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
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<tr>
<td>24250</td>
<td>944-01114</td>
<td>G15373</td>
<td>71</td>
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<td>5</td>
<td>2</td>
<td>2</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
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<tr>
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<td>944-01115</td>
<td>G15373</td>
<td>84</td>
<td>Female</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>24250</td>
<td>944-01116</td>
<td>G15373</td>
<td>78</td>
<td>Female</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>
Research

Promotion of rapid testing for HIV in primary care (RHIVA2): a cluster-randomised controlled trial

Werner Leiber*, Heather McMillan*, Jane Anderson, Nadine Medis, Andrea E Santos, Stephen Brenner, Handlu Brandi, Sally Kenny, Joanna Millard, Sihla Nigus, Sarah Langton, Jose Ayehou, Richard Flockhart, Graham Abel, Vidal Heel, Alison Brown, Catherine Rooney, Maria Sargison, Adrian Martin, Fern Tiers, F. Hugh Griffiths

• Now implemented in east London CCGs

New service models: Virtual renal clinics

• 50% reduction in nephrology OPD appts
Achieving successful improvement

It’s a system not a plug-in!
Capable

Evidence
Stakeholders
Consensus
Guidance and KPIs
Education

Actionable

IT support
Templates
Prompts
APL & Trigger tools
Patient recall
and review lists

Motivated

Financial targets
Dashboards
Peer performance

Learning
Actionable

• Web enabled – Integrated systems for IT
• IT decision support, search and analysis
• Locally engineered and responsive
• CCG, **GP provider**, and public health facing
• Academically supported

And also facilitated
OneLondon – Discovery    NHS

Integrated accessible data for
Direct care
Commissioning and Research
Timely, responsive and integrated: Covid

Rate/100,000 confirmed Covid to Jan 2021 LONDON

COVID Vaccination NEWHAM Feb 2021
White  S Asian  Black

EQUITY 90% Ethnic group self-reported
IMD score 100%
Learning disabled 99%
Care Homes – just added!

Identifiable shielding lists for LA and other
DATA NHS ICS DISCOVERY

Population Health
Information System for Integrated Care

PHISIC

Responsive, Accessible, timely data

Research
Direct care
BI Commissioning Public health
It’s a system… (federated)

• choose wisely
• clinically led
• facilitators
• data
• responsive
• patient apps

click wins and engaged
are the spinal cord integrated, accessible, timely and
responsive
integrated with GP records
Analytic teams + clinical support
Responsive, accessible, timely data

NHS DISCOVERY DATA

Population Health
Information System
for Integrated Care

PHISIC

Responsive, accessible, timely data

Research
Direct care

BI Commissioning
Public health
Dorset ICS

Introducing the DiiS

4th March 2021
18 Primary Care Networks

79 GP Practices

810,000 Registered Population
ICS - Intelligent Working Programme

Mission Statement:

We have an ambition to significantly transform the way information and data is used across the Integrated Care System to support the design and planning of health and care services. The Intelligent Working programme will deliver a data warehouse and management information system using data collected from the shared care record alongside that from GP practices, social care, community, mental health services and hospitals.

We will link these data sets and combine with demographic, housing and education information giving us county wide picture of our population health management.
COVID Vaccination Reporting

Covid Vaccination Status - Dose 1
Patients that have received Vaccination Dose 1

- **Vaccinated**: 294,181
- **80+ Years**: 54,609 (96.9%)
- **< 80 Years**: 238,058 (39.6%)
- **Vaccination Declined**: 3,935
- **Lives in a Care Home**: 5,148 (92.3%)

Filters
- Declined Vaccination
  - Exclude from Eligible Population
- Living Status
  - In a Care Home
  - Housebound

Eligible Groups

<table>
<thead>
<tr>
<th>Eligibility Group</th>
<th>Eligible</th>
<th>Vaccinated</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Home (Age 80+)</td>
<td>3,779</td>
<td>3,634</td>
<td>96.2%</td>
</tr>
<tr>
<td>Age 80+</td>
<td>52,562</td>
<td>50,795</td>
<td>97.0%</td>
</tr>
<tr>
<td>Care Home (Age &lt; 80)</td>
<td>1,800</td>
<td>1,514</td>
<td>84.1%</td>
</tr>
<tr>
<td>Age 75-79</td>
<td>38,193</td>
<td>36,816</td>
<td>96.4%</td>
</tr>
<tr>
<td>Age 70-74</td>
<td>51,108</td>
<td>48,661</td>
<td>95.1%</td>
</tr>
<tr>
<td>Clinically Extremely Vulnerable</td>
<td>21,507</td>
<td>18,207</td>
<td>84.1%</td>
</tr>
<tr>
<td>Age 65-69</td>
<td>43,369</td>
<td>37,613</td>
<td>86.7%</td>
</tr>
<tr>
<td>Clinical Risk (Aged 16-64)</td>
<td>98,647</td>
<td>86,730</td>
<td>39.2%</td>
</tr>
<tr>
<td>Age 60-64</td>
<td>33,893</td>
<td>12,212</td>
<td>36.0%</td>
</tr>
<tr>
<td>Age 55-59</td>
<td>39,823</td>
<td>8,810</td>
<td>22.1%</td>
</tr>
<tr>
<td>Age 50-54</td>
<td>40,353</td>
<td>7,616</td>
<td>18.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>659,552</td>
<td>294,181</td>
<td>44.6%</td>
</tr>
</tbody>
</table>

% by Ethnicity Group

- White British: 49.3%
- Unknown / Not Recorded / ...: 40.5%
- Community Minorities: 23.3%

% by Eligible Group

- Care Home (Age 80+): 16.2%
- Care Home (Age < 80): 17.0%
- Age 75-79: 13.0%
- Age 70-74: 11.8%
- Clinically Extremely Vulnerable: 6.9%
- Clinical Risk (Aged 16-64): 12.1%
- Age 60-64: 10.7%
- Age 55-59: 10.7%
- Age 50-54: 10.2%

% by Deprivation (1 = Most Deprived)

- IMD Deciles: 16.3%
DiiS Safeguarding

Safeguarding Insights
This report focuses on only those with a currently active safeguarding flag

Latest Date:
23 February 2021

Population Count % Total Population
47,810 6%

16% Most deprived
10% Community Mih...
5% Clinically Exte...
11% Least deprived
2% Housebound
2% Is a carer

Deprivation Deciles (where 1 is most deprived)

Safeguarding Description
- At risk of domestic violence
- Police domestic incident report
- Victim of domestic violence
- Vulnerable adult
- Subject of multi-agency risk ass...
- Child is cause for concern
- Child in need
- Subject to child protection plan

Top 5 comorbidities
- 14.6% Asthma
- 14.6% Depression
- 14.6% Diabetes
- 14.6% Hypertension

Proportions by PCN/ GP Practice/ LA Ward

Key characteristics
- Family neighbourhood
- Renting from social landlord
- Families with children
- Lower wage service roles
- Pockets of social housing
- Relatively stable finances
- Small bills can be a struggle

Contents
- Safeguarding Insights
- Adult Safeguarding Insights
- Children & Young People Safeg...
- User Guide
Stephen.slough@dorsetccg.nhs.uk
Digital Portfolio Director
Our Dorset ICS

Heather.case@nhs.net
Head of DiiS
Our Dorset ICS
Using Data to Direct our Workforce during Covid

The data from DiiS helped us identify specific patient cohorts segmented by Covid 19 risk factors, mental health and social vulnerability.

We can target different workforces to these groups depending on clinical and social need thus developing a workforce intervention matrix that sits over the segmentation matrix, ensuring a bespoke offer to specific patient cohort need.

This ensures a more structured approach that can be embedded into the ‘front door of primary care’, utilising all members of the SP team inc link worker, health coaches, volunteers and voluntary organisations in a proactive and holistic way.
The columns across the top represent the national clinical criteria for COVID-19 risks, grouped into:

- Conditions indicating a need for self-isolation, sub-segmented into people with one or multiple risks in this category
- Conditions which indicate the need for shielding

Segments down the side represent people with no mental health or social vulnerability concerns; MH or social vulnerability concern; or both.

Emerging need from integrated care system partners to manage new or existing non-Covid risk to avoid medium to long term consequence to population & future system demand.

The intelligence will allow a wider lens approach to the holistic needs of the population allowing the integrated care system to mitigate against future predicted demand on services such as mental health, long term condition management and socio economic impact on health and wellbeing.
### Intervention Matrix

<table>
<thead>
<tr>
<th>Covid Care Models matrix</th>
<th>No specific Covid risks</th>
<th>Single high risk (local)</th>
<th>Multiple High Risk (local)</th>
<th>Very High Risk/Shielding (National)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All / no specific vulnerabilities</td>
<td>Whole population messaging on social distancing, health and wellbeing support and exercise</td>
<td>Practice nurse check in by phone</td>
<td>Practice nurse check in by phone</td>
<td>Personalised messaging on social distancing and health management for specific groups e.g. cancer, maternity, heart failure, diabetes etc.</td>
</tr>
<tr>
<td>Cross cohort considerations for further tailoring of care offer</td>
<td>Maintain social distancing</td>
<td>Holistic care planning (care plan virtual review/LTC patient APP)</td>
<td>Holistic care planning (care plan virtual review/LTC patient APP)</td>
<td>Home visits where remote access is not possible to address long term health challenges, Lewisham U3A etc.</td>
</tr>
<tr>
<td></td>
<td>Social Prescribing to help and Kindness website for pan-Dorset support directory.</td>
<td>Sign posting to take health options national/local for particular conditions e.g. Help Disabilities national self management web platform.</td>
<td>Sign posting to take health options national/local for particular conditions e.g. Help Disabilities national self management web platform.</td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td>National websites, apps and helplines (guided by National MH Covid workbook)</td>
<td>Practice nurse check in Caring</td>
<td>Practice nurse check in Caring</td>
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<td></td>
<td>Leaflet drop</td>
<td>Digital literacy, access</td>
<td>Digital literacy, access</td>
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<td></td>
<td>Town council helpline</td>
<td>Key worker?</td>
<td>Key worker?</td>
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<td>Crowded or poor quality housing</td>
<td>Crowded or poor quality housing</td>
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<td>Access to outdoor space</td>
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<td>Cross provider approach to health and social care support offer</td>
<td>Cross provider approach to health and social care support offer</td>
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<td></td>
<td></td>
<td>Social prescriber targeted resource to where most needed</td>
<td>Social prescriber targeted resource to where most needed</td>
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<td>Social vulnerability</td>
<td>Leaflet drop</td>
<td>Social Prescribing to help and Kindness website for pan-Dorset support directory</td>
<td>Social Prescribing to help and Kindness website for pan-Dorset support directory</td>
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<td>Town council helpline</td>
<td>Practice nurse check in</td>
<td>Practice nurse check in</td>
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<td>Social Prescribing to whole community of Help and Care or local SP</td>
<td>Holistic care planning</td>
<td>Holistic care planning</td>
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<td>Health and wellbeing worker assigned</td>
<td>Health and wellbeing worker assigned</td>
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<td>Social Prescribing to help and Kindness website for pan-Dorset support directory</td>
<td>Social Prescribing to help and Kindness website for pan-Dorset support directory</td>
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<td>Social vulnerability + mental health</td>
<td>Social prescriber assigned to conduct wellness calls</td>
<td>Practice nurse check in</td>
<td>Practice nurse check in</td>
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<td></td>
<td>Social prescriber assigned to conduct wellness calls</td>
<td>Holistic care planning in partnership with patient (and carer where relevant)</td>
<td>Holistic care planning in partnership with patient (and carer where relevant)</td>
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<td>Social Prescribing to Help and Kindness website for pan-Dorset support directory.</td>
<td>Practice Nurse for Initial contact, then Health and Wellbeing worker with MHCT</td>
<td>Practice Nurse for Initial contact, then Health and Wellbeing worker with MHCT</td>
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<td>Social Prescribing to help and Kindness website for pan-Dorset support directory</td>
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<td>Social Prescribing to help and Kindness website for pan-Dorset support directory</td>
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<td>Increased risk of serious illness with COVID-19: Diagnosed/suspected</td>
<td>Social Prescribing to help and Kindness website for pan-Dorset support directory</td>
<td>HCA proactive approach</td>
<td>HCA proactive approach</td>
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<td>Monitoring via patient APP and pulse oximetry</td>
<td>Monitoring via patient APP and pulse oximetry</td>
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<td>Social Prescribing to help and Kindness website for pan-Dorset support directory</td>
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<td>led proactive care management and monitoring</td>
<td>led proactive care management and monitoring</td>
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<td>Monitoring via patient APP and pulse oximetry using virtual ward approach</td>
<td>Monitoring via patient APP and pulse oximetry using virtual ward approach</td>
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<td>Social prescribing offer such as LHA smoking cessation support, weight management support for obesity</td>
<td>Social prescribing offer such as LHA smoking cessation support, weight management support for obesity</td>
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<td>Social technology working alongside more traditional delivery</td>
<td>Social technology working alongside more traditional delivery</td>
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**Cross provider approach to health and social care support offer:**
- Proactive support offer phone call
d- Town council helpline
d- Telephone befriending
d- Social Prescribing to self management service offer, targeting to community volunteer support.

**Digital technology working alongside more traditional delivery:**
- Proactive support offer phone call
d- Town council helpline
d- Telephone befriending
d- Social Prescribing to self management service offer, targeting to community volunteer support.

**Key worker:**
- Digital literacy, access
- Caring responsibilities, who? How?
- Crowded or poor quality housing
- Access to outdoor space

**English not first language**

**Making use of community based assets**
- Social Prescribing to self management service offer, targeting to community volunteer support.
Digital solutions have been around for years but now is a real opportunity to work smarter using PHM data.
TACKLING HEALTH INEQUALITY
OUR AIM PHM IS OUR ENABLER
A recording of the webinar, slides and resources will be shared on the **Integrated Care Learning Network**.

To join the network email

[![integratedcare-manager@future.nhs.uk](integratedcare-manager@future.nhs.uk)](integratedcare-manager@future.nhs.uk)

5 March 2021