# The future of technology in Health & Social Care

***Crating Partnerships and Changing Lives***

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# Finding another way…

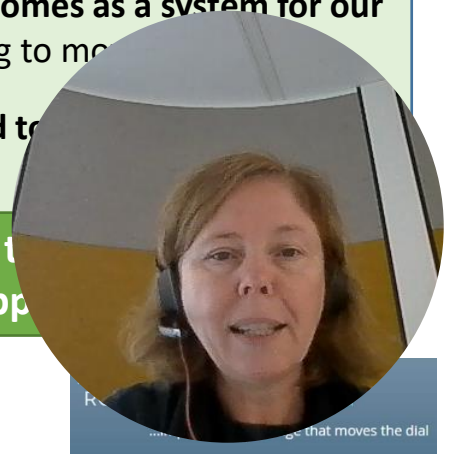
## A worsening situation…

- On the ground, our clinical, social and VCSE teams are reporting **constant, increasing and unrelenting levels of demand**
- As a place system, we take a **systemic, late focus to reacting to crises**
- We have made a **simple flow needlessly complex** though creating silos of work – and **one person appears in multiple silos**
- Working in these **organisational silos** results in duplication, waste, and suboptimal use of our talent
- We are driven nationally to measure success in **counting outputs not directly linked to patient outcomes**
- This leads to **pressure for our colleagues**, increased sickness and absence, reduced productivity, and increased risk to safety
- The **decline in morale** and motivation results in more colleagues disenfranchised from their chosen vocations
- The **impact on the population we serve** widespread and dramatic – **increased waiting times, delays in treatment, and poorer outcomes**
- **Traditional, fragmented silo models do not work** – there has to be another way

## …a different approach…

- We are moving to a **truly population-based outcome model**
- **Our focus is on doing the right thing at the right time for our population** and measuring **outcomes as a system not at individual service level**
- We have built **many of the constituent parts** which are integral to our **'one system – one population – one purpose'** model, with common design principles and success measures
- We are **responding to evidence and data** to target support for our population at an earlier stage
- By doing this, **a greater difference can be made, earlier** – our talented resources work responsively to patient need, often doing the basics well, early – **regardless of their job or badge** – with a laser focus on our **enriched personalised outcomes**
- Working together, our **relentless focus on outcomes as a system for our population as a whole** as one system is starting to mo
- It is a **long process and we are fully committed t**

**…which will deliver a step change for t**
**serve and colleagues who supp**

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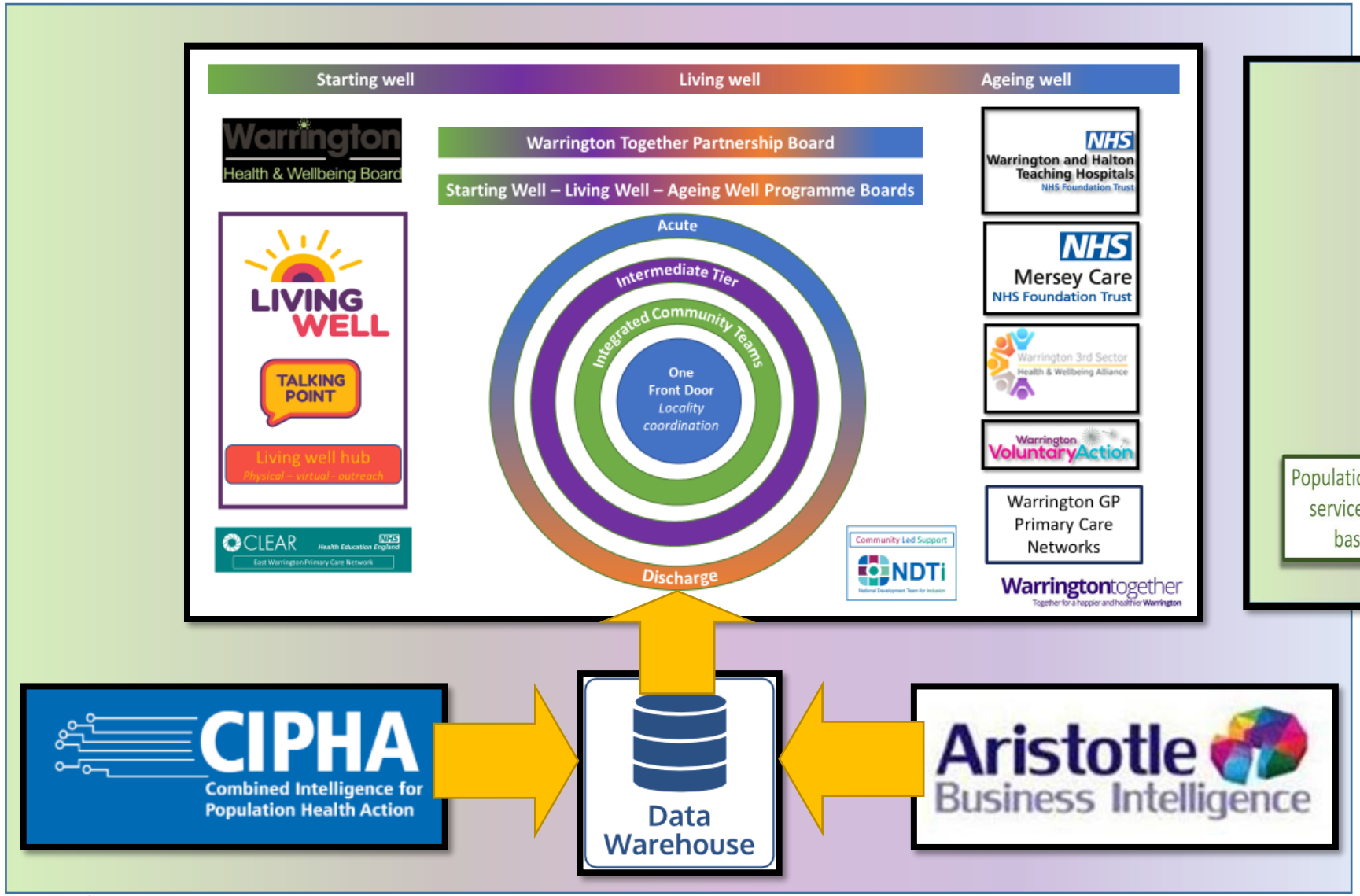
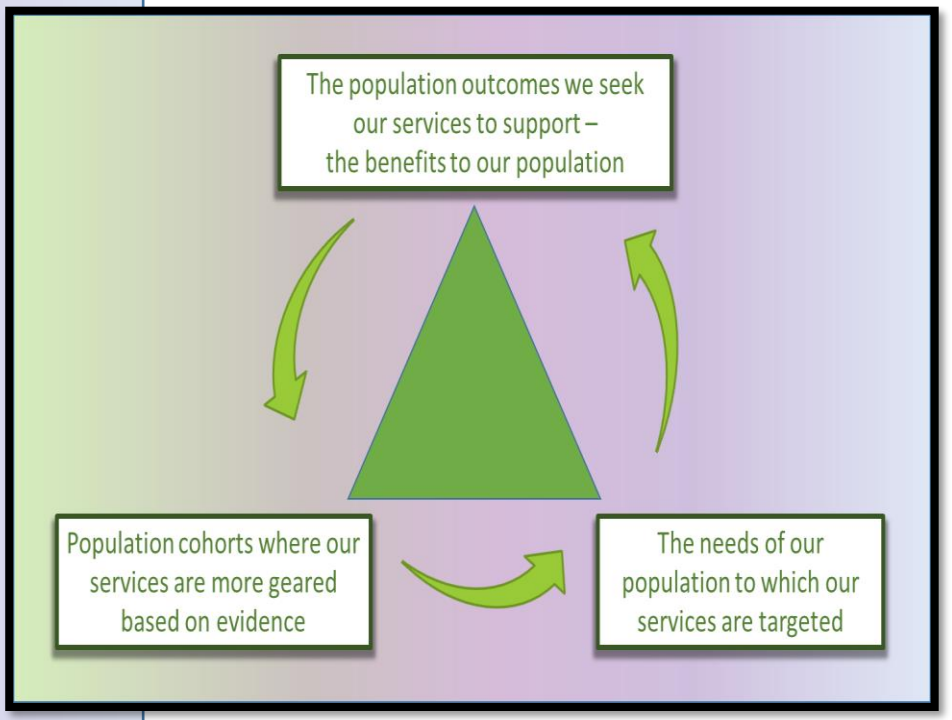
# A partnership approach to Population Health Management

*Using blended health, social care and housing data to improve outcomes*

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# Creating a single prioritised list of our population…

*Bringing multiple data and evidence sets together with NHS number at the unique identifier*

**Population Health Data**
***by individual***

Aristotle Business Intelligence

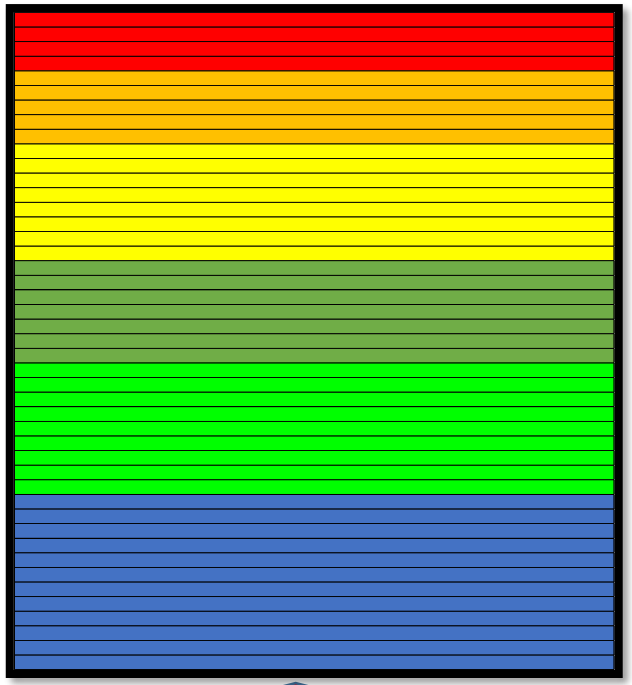
NHS Midlands and Lancashire Commissioning Support Unit

**Primary Care Data**
***by individual***

Aristotle Business Intelligence

NHS Midlands and Lancashire Commissioning Support Unit

**A single, prioritised population list**



**Individual services**
***by individual***

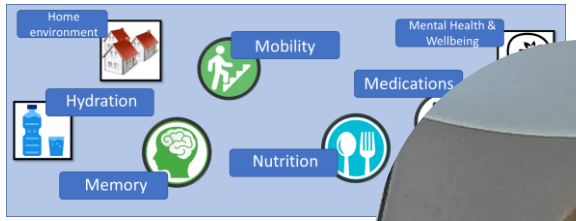
NHS Bridgewater Community Healthcare NHS Foundation Trust

Warrington 3rd Sector Health & Wellbeing Alliance

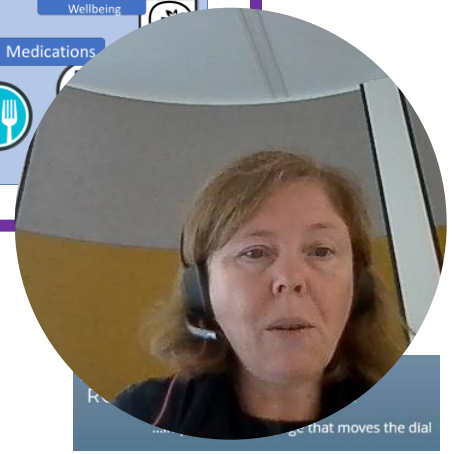
NHS Warrington and Halton Hospitals NHS Foundation Trust

NHS North West Boroughs Healthcare NHS Foundation Trust

**Fundamental Indicators**
***aligned to Marmot principles***




How we prioritise based on need and personalised outcomes

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# A proactive, data and evidence driven

*Targeting a **cohort of individuals** based on risk profile and acting as one to identify and meet their needs and enrich their outcomes, sustainably*

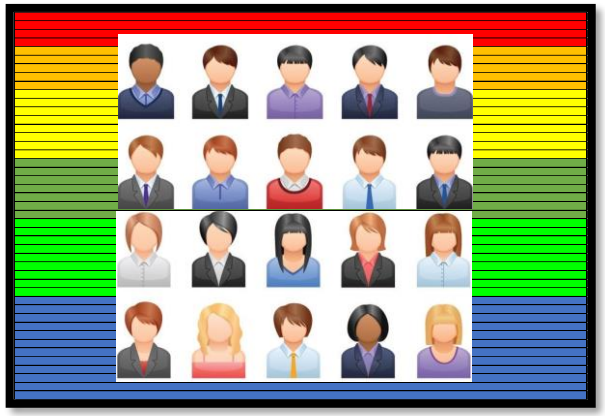
## Stage 1 – **Our first tranche of people** at materially increased risk

**Risk strat**

**Data set**

**Initial tranche of people at materially increased risk**

**Prioritised list**



1. Identify service duplication and gaps for the initial group and **act to resolve**
2. Identify deficits in the Fundamental Indicators and **act to optimise**
3. From the group of people, identify **trends in services and data** by local area
4. **Outcomes-driven** – is it moving the dial for this population?
5. Use this insight to feed into and **form the basis of mainstream design**

## Stage 2 – Population-wide

1. Insight into the proactive care and support for our population – based **delivering optimal outcomes for the people of Warrington**
2. **System protocols – a 'rulebook' -** to determine which proactive teams should see which individuals in what order, based on agreed data-driven approach
3. **Active virtual caseload management** – like air traffic control, managing flow in and out, ch… continuou…
4. **Learning a…** is it …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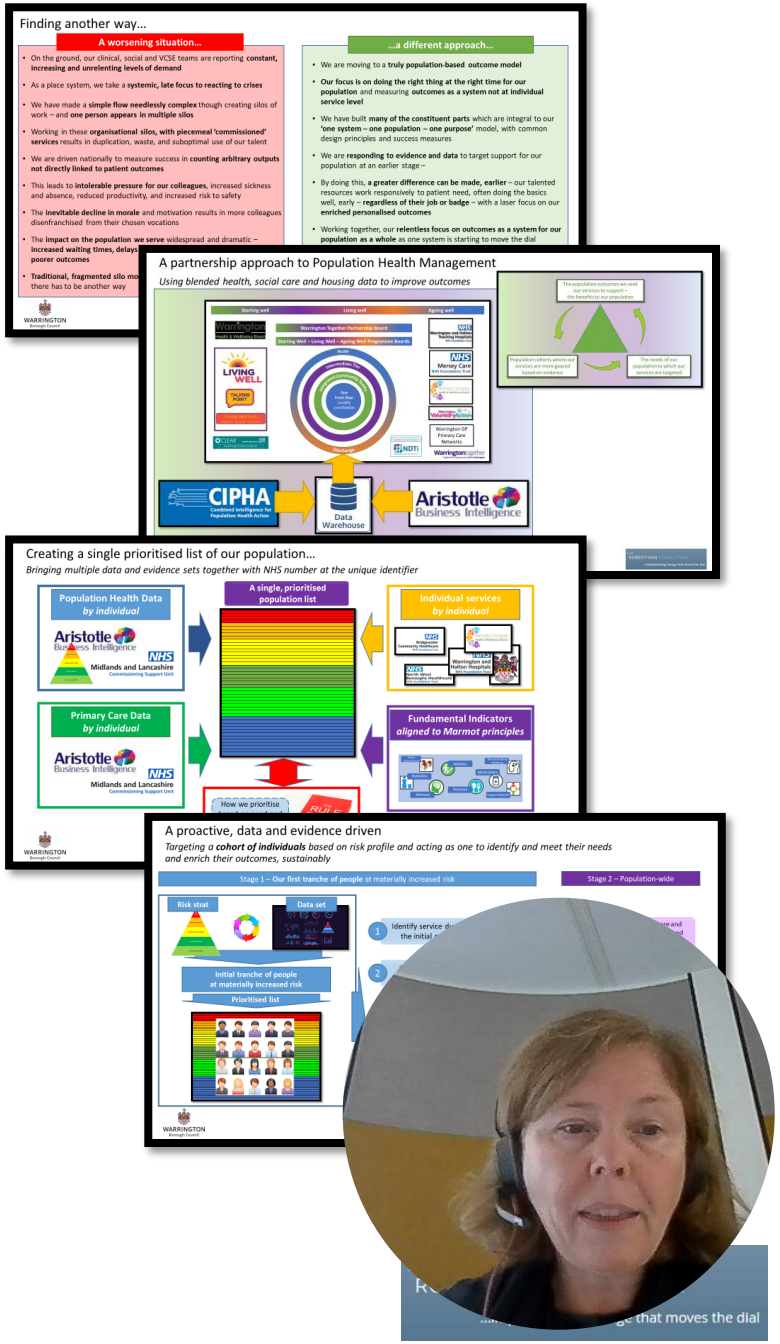
# Challenges health, social care and TSA can overcome together

- Create **outcome measures** which focus on the system doing the right thing for the person to live well independently at home or the place they call home – by extension, **avoiding 'KPI's which focus on silo service output measures**, often at the expense of delivering true outcomes
- Move towards **cohort and population-focused** ways of working, avoiding creating artificial silos to subdivide populations
- Move away from trying to prove how much 'value' each part of the jigsaw delivers; instead, focus on **to what degree the dial moves for the population** we serve, and **ensure all work sails in the same direction**
- Advocate a truly person – and population – centred approach, **enabled by a joined-up data set**
- **Using a joined-up data set, between health, social care, housing, VCSE and broader sectors** sharing data for a population across a place
- **Use the data and technology** to fund supporting people at an earlier stage, to reduce crisis-driven interventions with poorer outcomes
- Make it easier for colleagues to **transition seamlessly between health, social care, housing and broader sectors**, without artificial contractual barriers & salary variances getting in the way
- Ensure our leaders are focused on, and as a team held to account for, population-based, **sustainable population health outcome delivery**

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