A story of opportunity….

A data and evidence-driven approach to coordinated proactive and preventative care

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Finding another way…

A worsening situation…

- We take a **systemic, late focus to reacting to crises**
- We have made a **simple flow needlessly complex** though creating fragmented silos of work
- This results in **duplication, waste, and suboptimal use of our talent**
- This leads to **significantly increased pressure for our colleagues**
- The **decline in morale** and motivation results in more colleagues becoming disenfranchised
- The **impact on the population we serve** is widespread & dramatic – **increased waiting times, delays in treatment, and poorer outcomes**

…a different approach…

- **Technology-enabled care** is fundamental to our model
- We are moving to a truly population-based outcome model
- We are **responding to evidence and data** to target support for our population at an earlier stage
- By doing this, our workforce can make **a greater difference, earlier**
- Working together, our **relentless focus is on outcomes as a system for our population as a whole**
- It is a **long process & we are fully committed to it**.

It will deliver a step change for the population we serve and colleagues who support them

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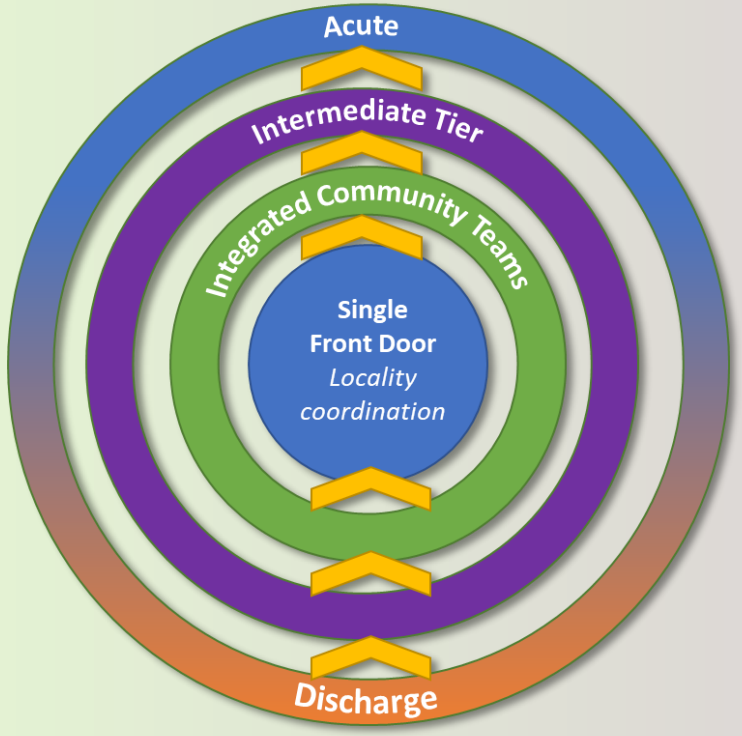
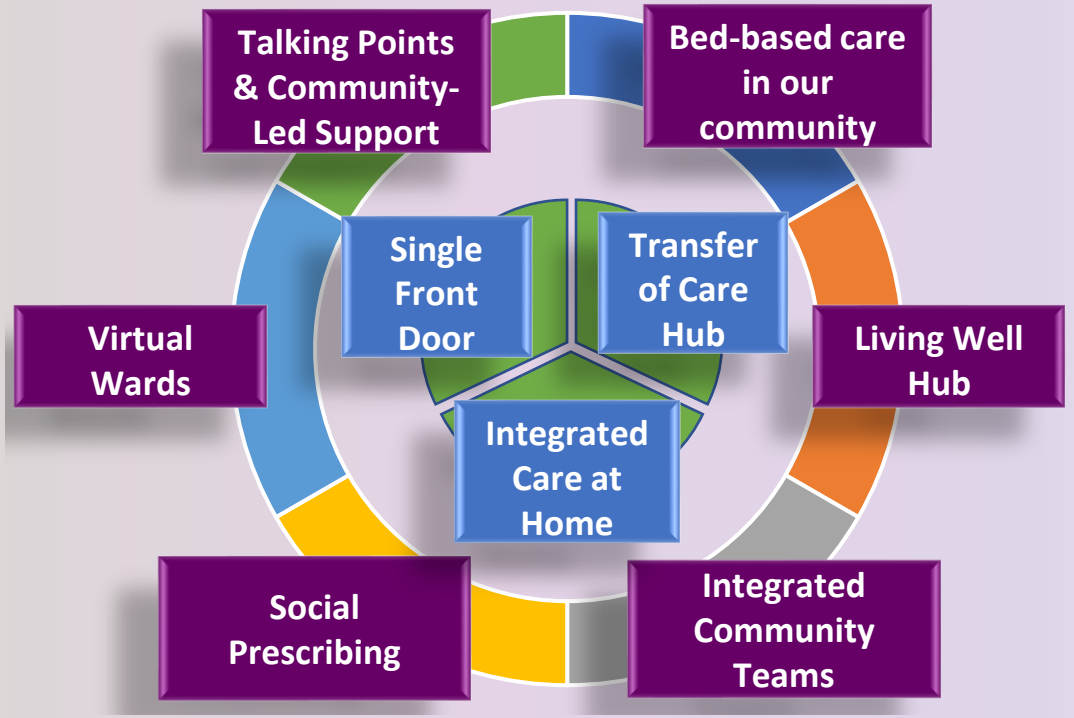
Warrington's One System – One Population – One Purpose – One Voice Model

Proactive and reactive support to help our population to remain at, or return, home – **living well, independently** for longer

Place model



Preventative care – escalated response – discharge



Outcome

- Right support
- Right place
- Right time

Leadership & Culture | **Data & Evidence** | **Workforce & Training** | **Enabling Technologies**

Comms & Engagement | Information Technology | Commissioning & Provider Model | Professional Reference Groups

Foundation enablers for delivery & sustainability

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Single Front Door

Member of public with escalated need

Practitioner requiring support

Any contact channel

NWAS Cat 3 & 4

NHS North West Ambulance Service NHS Trust

Advanced communications staff **understand root cause**

Strengthen understanding using available information

Tunstall

Mosaic

systmone ONEPATIENTONERECORD

Resolve immediately **if achieves outcome**

Specialist support where required

Real-time assistive technology monitoring –

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Proactive outbound contact – **TEC and data driven based on risk**

Aristotle Business Intelligence

Qlik

Mosaic

CIPHA Combined Intelligence for Population Health Action

Deeper understanding of future wants & needs

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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

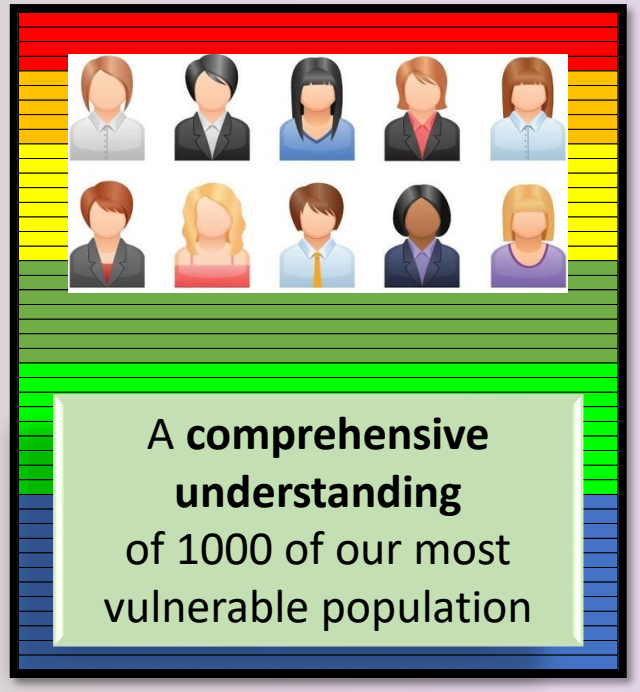
CIPHA Combined Intelligence for Population Health Action

Primary Care Data *by individual*

Aristotle Business Intelligence

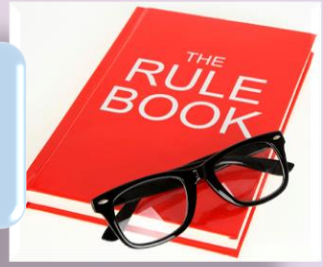
CIPHA Combined Intelligence for Population Health Action

A single, prioritised population list



A **comprehensive understanding** of 1000 of our most vulnerable population

How we prioritise based on need and personalised outcomes



Individual services *by individual*

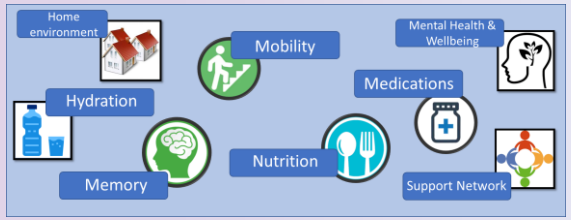
NHS Bridgewater Community Healthcare NHS Foundation Trust

Warrington 3rd Sector Health & Wellbeing Alliance

NHS Warrington and Halton Hospitals NHS Foundation Trust

NHS North West Boroughs Healthcare NHS Foundation Trust

Eight Fundamental Indicators *aligned to Marmot principles*



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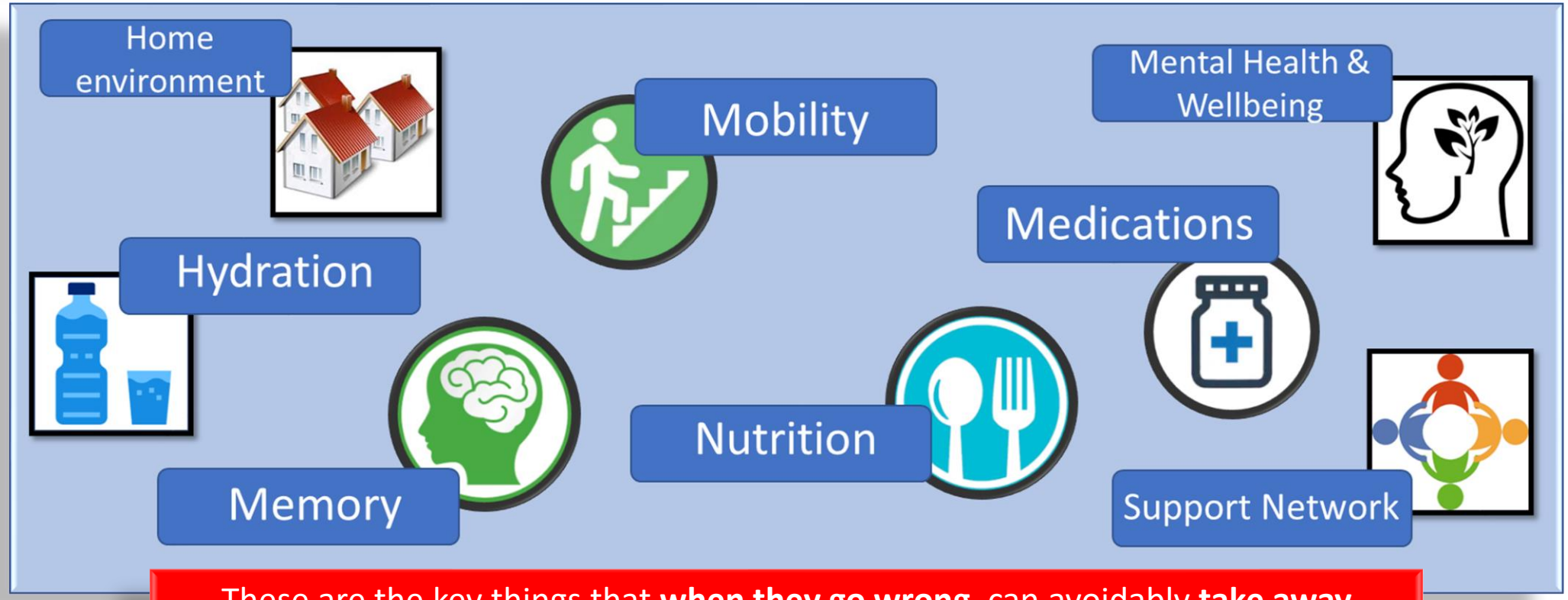
Our **Eight Fundamental Indicators** for our target cohort *(Clinical Frailty Score 4-7)…*

Look for any indications of **risk of losing independence**

All supporting our target cohort (CFS 4-7) to live well independently at home, living with

- **Very mild frailty**
- **Mild frailty**
- **Moderate frailty**
- **Severe frailty**



These are the key things that **when they go wrong**, can avoidably **take away someone's independence** and increase the risk of avoidable admission

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A story of opportunity…..

Meet Maureen (86 years old)

Clinical Frailty Scale - Mild Frailty

Increasing

Readmission risk

39%

Primary / LT Conditions

- Physical support – Personal Care
- Asthma
- Atrial Fibrillation
- Coronary heart disease
- Congestive heart failure
- Cancer
- **COPD**
- Dementia
- Diabetes
- **Hypertension**
- Kidney Disease
- Learning Disability
- **Mental Health**
- **Osteoporosis**
- Rheumatoid Arthritis
- Stroke / TIA

Services

Reactive

ED x 3
(2x falls not resulting in significant injury)

Non-elective admission
No substantive procedure
(>21 day LoS)

Proactive

- Neurology
- Community Respiratory
- Memory Services
- Domiciliary Care

Integrated Community Team Opportunity

- **Community Frailty Assessment & Support**
  Medication – Mental Health – Falls Risk - +++
- **Technology-enabled care**
- **Strength, Balance & Exercise**
- **Falls prevention**
- **Local support networks**

Technology enabled, data-driven picture of developing need to proactively contact via Single Front Door

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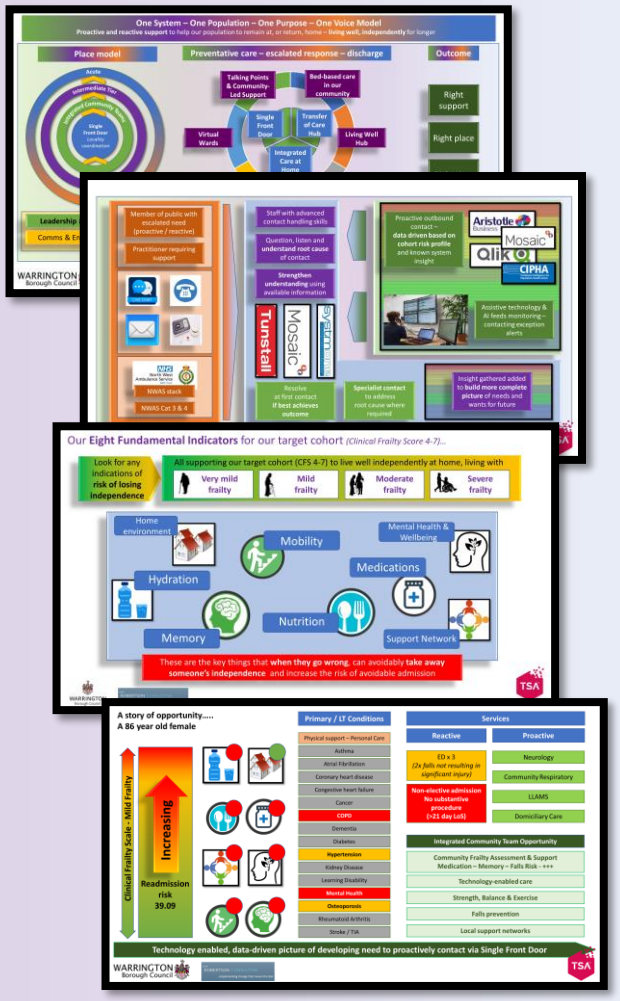
Ambitions for a data driven, technology enabled journey of truly integrated, **personalised care**

- Create **outcome measures** which focus on **living well independently at home or the place they call home**
- Move towards **cohort and population-focused ways of working**, avoiding creating artificial silos to subdivide populations
- **Using a joined-up data set from health, social care, housing, technology-enabled care partners, VCSE and broader sectors**
- Use data and technology to **support people at an earlier stage, to reduce avoidable and wasted money, crisis-driven interventions with poorer outcomes**
- Make it easier for colleagues to **transition seamlessly between health, social care, housing and broader sectors**



Co-design led by those with lived experience, to lead gloriously ordinary lives

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Thank you

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