Refreshments & Networking

Chair Opening Address

Dr Gurnak Singh Dosanjh

GP - LLR ICB

Case Study

NHS CARE
Volunteer Responders

Slido

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Case Study

Fiona Longhurst
Chief Knowledge Officer
Royal Voluntary Service

NHS CARE
Volunteer Responders

Enhancing patient care and workforce capacity

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Introduction to the programme

NHS CARE Volunteer Responders

NHS and Care Volunteer Responders (NHSCVR) is a large-scale, **NHS-approved** volunteering programme supporting the NHS and healthcare teams across England.

- Digitally delivered enabling fast, real-time volunteer deployment
- Adds capacity to healthcare teams & services to improve delivery
- Compliments existing volunteering programmes
- An inclusive programme with a diverse pool of volunteers
- Evolving programme developed using insights from local systems

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NHS CARE
Volunteer Responders

Over 43,000 volunteers

available to support

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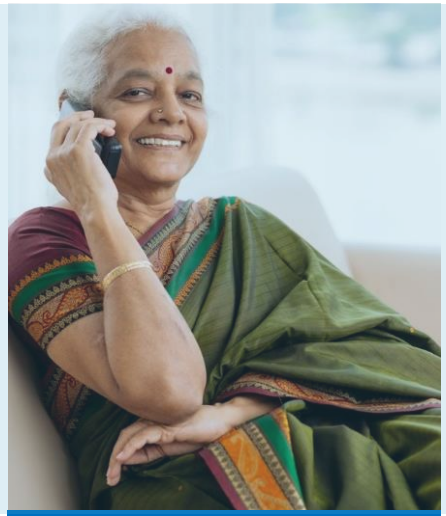
Volunteer support available

NHS CARE Volunteer Responders

NHSCVR volunteers offer targeted assistance tailored to the needs of your ICS, Trust, Ambulance Trust and Primary Care Services.

Driving Support

Community Response



Telephone Support

Site Support

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Driving support services

NHS CARE
Volunteer Responders

Pick Up and Deliver volunteers

- Drop off medication/TTOs and equipment to patients' homes following discharge.
- Collect and return equipment to the NHS to recycle and reduce waste/cost

✓ Quicker patient discharge

*Barnsley Hospital report **an 8% improvement in 'discharge by 17:00'** compared to baseline (Nov-Dec 2023)*

*Patients, on average, d**ischarged 3 hours earlier** in the day*

✓ Alleviate staff workload

✓ Resource optimisation

According to NHSE data 'If just two out of every five walking aids were returned, the average hospital could save up to £46k per year

https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/
https://www.england.nhs.uk/ahp/greener-ahp-hub/specific-areas-for-consideration/walking-aid-reuse/

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Testimonial – Barnsley Hospital

We have found the Pick Up and Deliver service to be incredibly helpful and necessary. We have already recommended it to other colleagues and department heads in the hospital.

The service is available seven days a week and is highly responsive, which is fantastic. There is no lengthy referral form required, which makes it easy to use.

Jaqueline Howarth, Operational Manager of Right Care Barnsley

Community focussed services

NHS CARE
Volunteer Responders

- **Telephone Support**

Calls to people in need of a friendly voice and a listening ear.

- **Community Response**

Assistance with essential shopping and prescription delivery.

- **Community Response – Connect**

Supporting individuals in enjoying social activities within the community.

✓ **Social and emotional support** for people who may otherwise feel isolated

✓ **Easing the burden on healthcare providers** by helping patients maintain a sense of connection and well-being

✓ **Reduced unnecessary GP visits** by addressing non-clinical needs

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Testimonial – Social Prescriber

“The people I refer are often suffering from loneliness, for a range of reasons. Generally, these people feel isolated and do not have regular conversations with others.

Through Check In and Chat calls they are able to stay socially connected.

One strength of the programme is how quick the support starts. Patients do not have to join long waiting lists and the calls start quickly so that they can get this important social support when they need it most.

Making referrals online is simple and I would recommend the programme to other healthcare professionals”

Natalie Rayner
Social Prescriber, Fenland

NHS Site Support Services

NHS CARE
Volunteer Responders

- **Stewarding Support**

Supporting vaccination clinics and/or pharmacists with seasonal vaccination programmes

- **Ambulance Support for NHS**

Supporting ambulance crews at A & E bays, offering refreshments and the opportunity for friendly conversation

- ✓ **Ability to scale up delivery of volunteers to meet local needs**
- ✓ **Already being used to support Covid-19 and Flu vaccinations**
- ✓ **Available to support wider NHSE vaccination and immunisation plans for 24/25**

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Testimonial – Pharmacist

I want to say a massive thank you to all the Stewarding Support Volunteers who have helped us deliver vaccines at the pharmacy so far. They have truly become like a part of the family. We have celebrated Diwali together, we have celebrated Christmas together, and we have built relationships and friendships for life.

Without volunteers it would not have been possible for us to deliver so many vaccines and keep our community safe

Shushma Patel, Co-Owner of PSM Pharmacy

Impact on clients

42%

People receiving Telephone Support **visit their GP less often** thanks to Volunteer Responders

36%

Attend A&E less often due to the assistance from Volunteer Responders

89%

of VR clients find this **service important**, with **63%** calling it **very important**.

72%

of VR clients are **highly satisfied** with the service, underscoring its **significant impact**.

62%

Report **higher satisfaction with the NHS** compared to just 49% in the general population (ONS, May 2024).

57%

are only receiving NHSCVR support

After having a stroke, I felt so vulnerable and disabled. Your service and the wonderful volunteers gave me back a bit of independence. 'Little steps forward' is what I have been told, I can do this with your NHSCVR volunteer support.

(Male, 45-54)

NHS CARE Volunteer Responders

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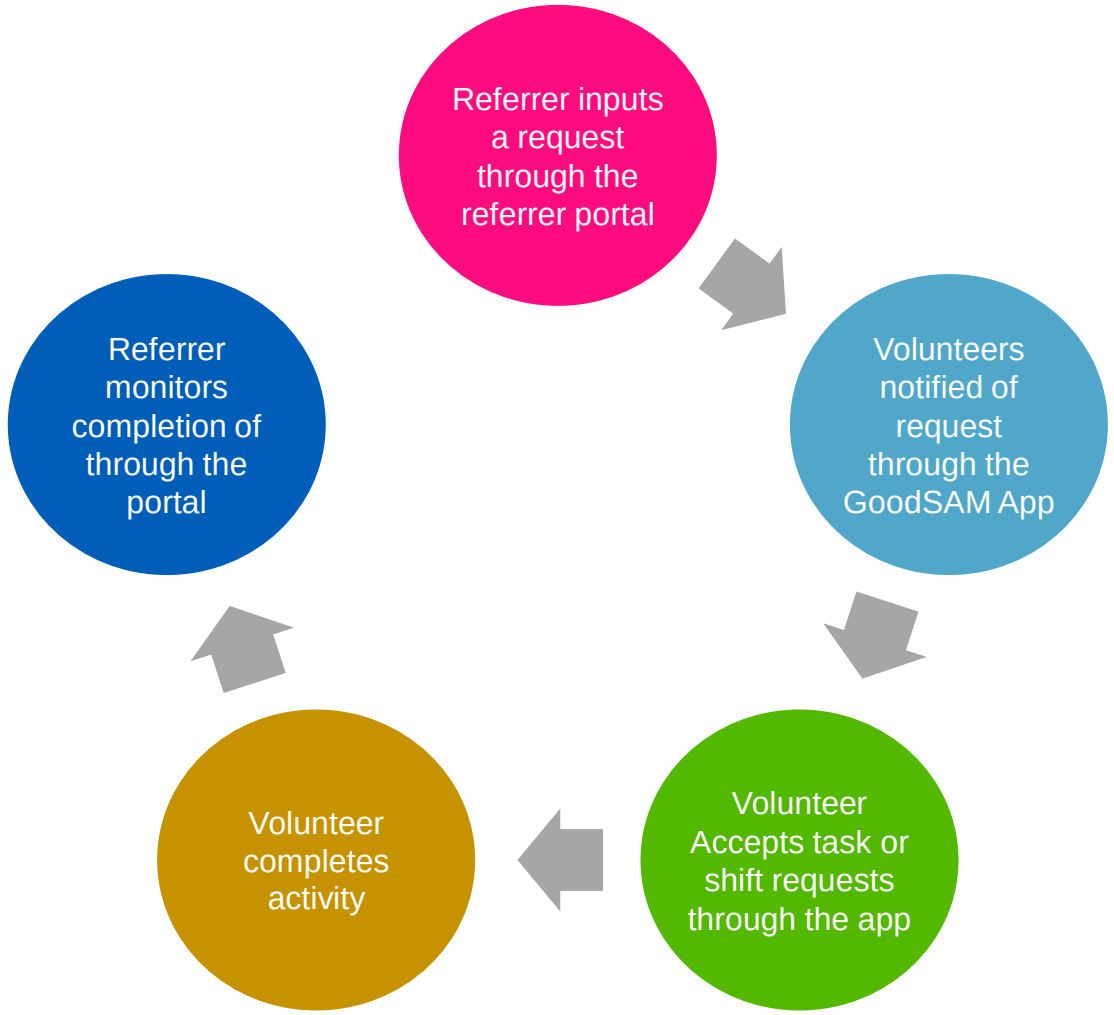
How to use the programme

NHS CARE
Volunteer Responders

Accessing NHSCVR services is straightforward and hassle-free, allowing you to quickly connect with the support you need.

Our streamlined processes mean you can request volunteers with minimal effort, saving valuable time and resources.

Referrers also have access to a library of assets and training tools for additional support.



76% *referrers agree that the* ***referral process is easy.***

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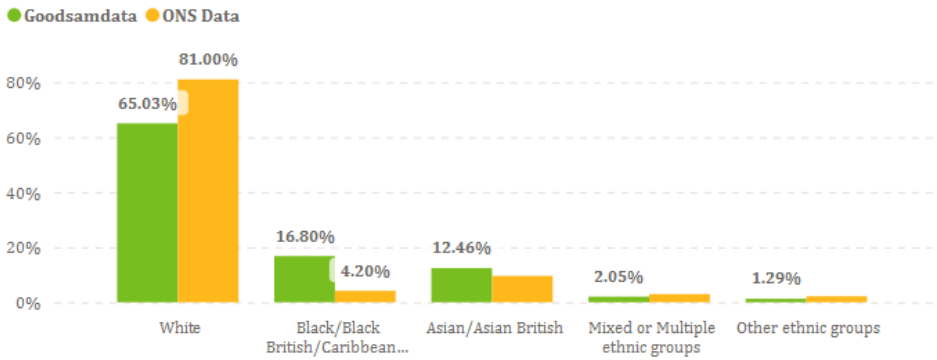
Volunteer support

- ✓ Volunteers recruited and supported centrally
- ✓ Appropriate background checks are carried out for **all volunteers** in-line with home office guidance
- ✓ Expenses paid for by the programme
- ✓ Problem Solving and Safeguarding Teams available 7 days a week

Volunteer profiles

NHS CARE
Volunteer Responders

% of Responders in ONS DATA Vs Goodsam for Different Ethnic Groups



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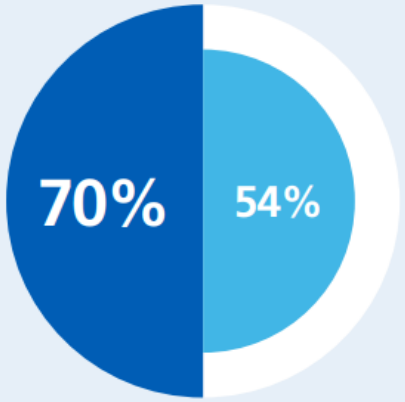
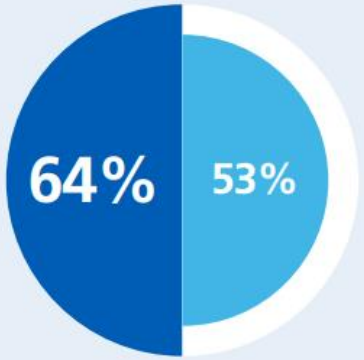
Impact on volunteers

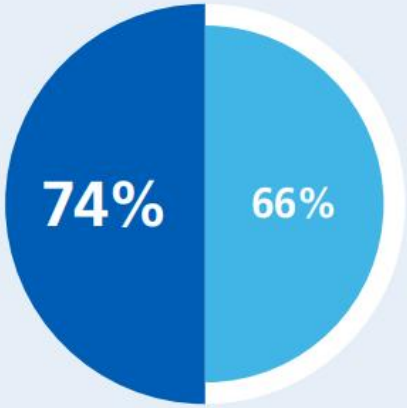
NHS CARE
Volunteer Responders



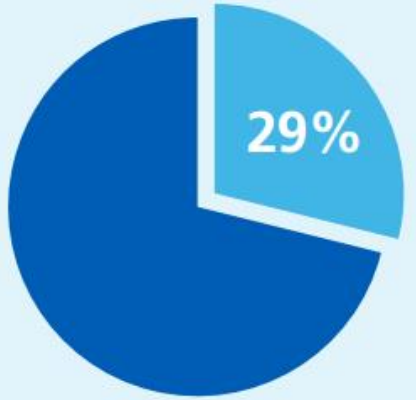
70% volunteers **feel a stronger sense of belonging to their neighborhood** (compared to 54% in the wider UK population)



64%volunteers **report higher community integration** (compared to 53% in the wider UK population)



74% volunteers **have greater trust in their community** (compared to 66% in the wider UK population)



29% Volunteers **credit NHSCVR with inspiring a career shift** or job pursuit in healthcare/NHS

Service provided by:

Key Takeaways

NHS CARE Volunteer Responders

- NHS-approved and free
- Easy to use with real-time support and training
- A growing, national pool of volunteers available immediately
- A trusted volunteer programme - all 42 ICS' are using in some capacity
- Potential workforce recruitment tool

Almost ***2 out of 3*** *front line staff said that NHSCVR had a* ***positive impact on their workload.***

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NHS CARE
Volunteer Responders

Thank you.

nhscarevolunteerresponders.org

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ROYAL VOLUNTARY SERVICE

GoodSAM Instant.Help

Geographical spread of volunteers

NHS CARE Volunteer Responders

Region	Total Volunteers (IDChecked since 20/02/23)
East of England	5794
London	4839
Midlands	11344
North East and Yorkshire	4337
North West	3221
South East	6722
South West	6647
Unmapped	539
Total	43443

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Case Study

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Case Study

Tom Scott

Chief Commercial Officer UK

Alcidion

Fireside Chat

Alison Tonge
Executive Director of Strategy and Innovation
Arden Gem

Arden&GEM
Integrated Resource Planning
HELPING SYSTEMS TO IMPROVE VALUE

NHS

Keynote Presentation –

Connected Planning from Strategy to Operations

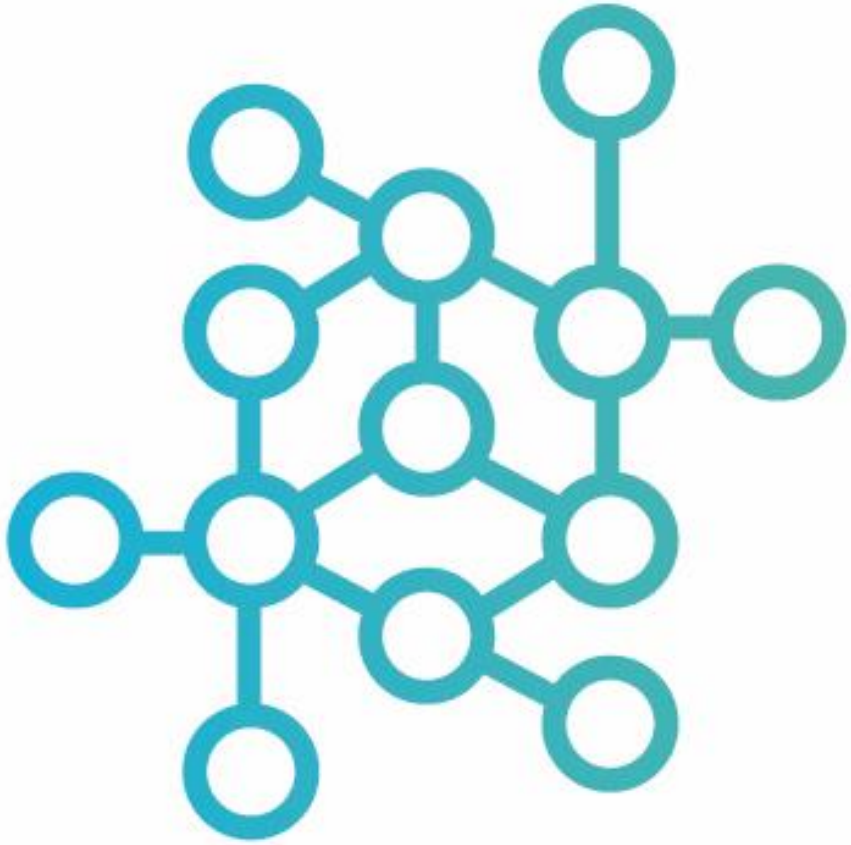
Alison Tonge
Executive Director of Strategy and Innovation

Arden&GEM

Introduction

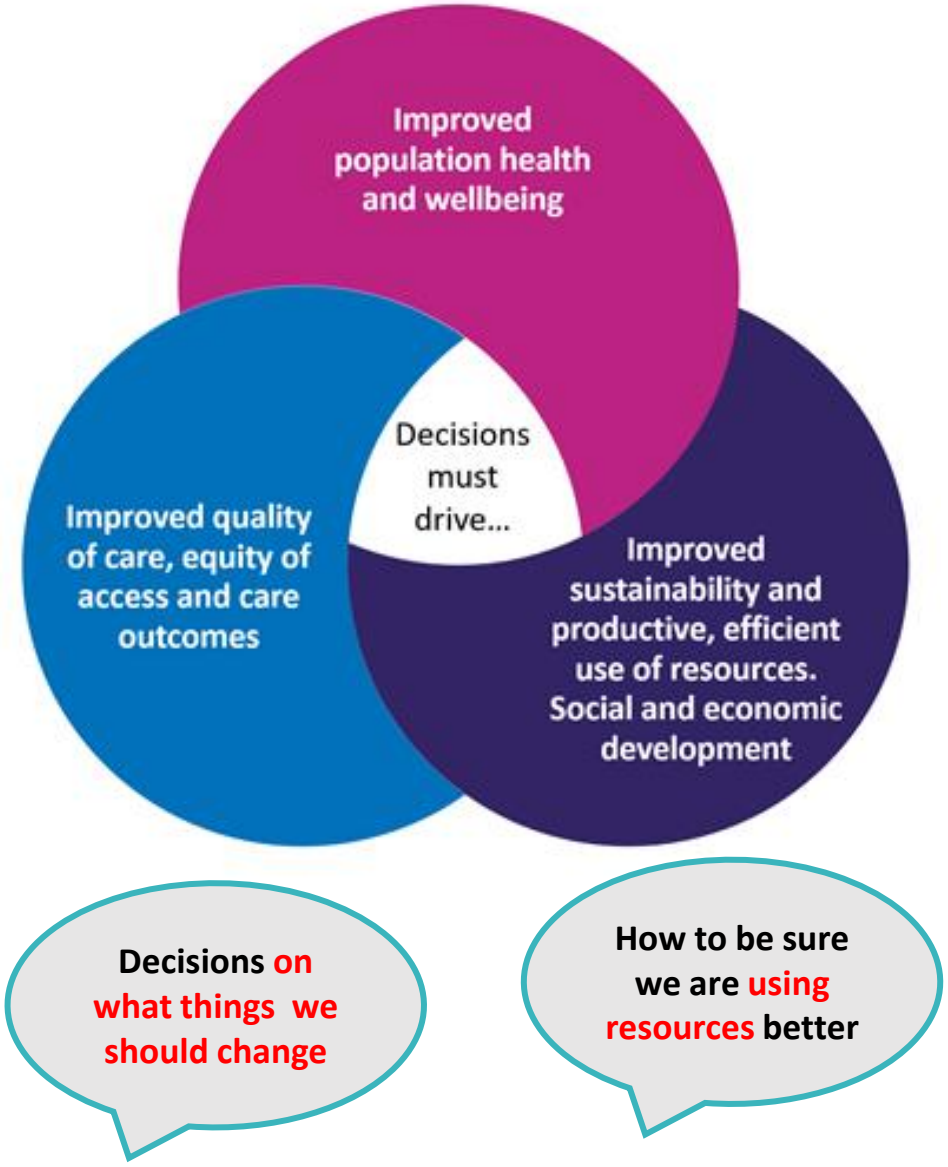
The NHS is a complex system – as we aspire to deliver better integrated care, we need to have a dynamic planning approach that enables transparency between the care we plan and deliver and the capacity, workforce, supplies, facilities needed.

We need to be able to understand interdependencies and drivers and most importantly how we measure our resources and performance across a team, division, organisation or population and system. In this presentation we will explore the challenges and opportunities in this goal of dynamic connected planning and some case studies and learning



Why good decision-making matters

- **Satisfaction at all time low** on access and waiting list right across the board
  - GP, Community, A&E, Elective
- **Causes include**
  - Funding very tight – including capital
  - Pandemic in UK – NHS 'closure'
  - Voice of staff and patients to drive innovation and improvement
  - Reorganisations
- **Priorities**
  - Empower staff and patients to improve our NHS
  - Adjust financial flows to recognise the importance of primary and community services
  - Deliver productivity through spread and adoption
  - Pivot the NHS to be a best practice partner for technology , AI and the Lifescience industry
  - Clarify the roles and responsibilities and management resources in oversight/regulation and ICB's



Decision making in the press

The lack of information about the performance and value for money of medtech products is leading to ineffective procurement and wasting scarce NHS funding, a senior government official has told *HSJ*.

The Department of Health and Social Care's MedTech director David Lawson told a roundtable organised by *HSJ* this month that "unwarranted variation" in the procurement process was "tying up funding that could otherwise be deployed to adopt and accelerate the use of the most effective medtech".

The NHS spends around £10bn each year on medical technology according to government estimates.

Evidence-based decision-making at the core of lean governance

15 March 2023

Dr Nadeem Moghal, Director & Chief Innovation Officer at Strasys International, tells us about how he is helping boards to reimagine their organisations, enabling leadership teams to place the right people in the right places to do the right jobs with the right resources, services and capabilities, resulting in a healthier

TECHNOLOGY AND INNOVATION

Decision-making should be a science

By Kate Cheema and Rony Arafin | 26 September 2023

1 Comment

Kate Cheema and Rony Arafin write about how professionalising healthcare analytics helps in unlocking the power of data for informed decision-making in the NHS which is a vital investment.

Government's Covid-19 decision making hindered by lack of strategy and planning

The IfG's latest report examines decisions made in three areas: economic support, Covid-19 testing, and the lockdown.

01 SEP 2020

DAILY INSIGHT

The mythbuster: Why the NHS is beset with bad decision making

By Steve Black | 8 July 2024

Connected decisions

Horizontally connected → Interlinking departments contributions → Across care pathways and settings for → Shared end benefits and results in common

Externally orientated for stakeholders

- Population
- Geography
- Health need

Quality [objectives, benefits, criteria, information measures and impact]

Impact outcome of decision is clear and made at right level to have impact

Productive time is invested in making decisions

Actionable we can act on the decision in a timely way

- Strategy board
- Tactical
- rational
- Operational

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The backbone of sound resource management decisions- strategy innovation and planning

HOW DO WE ACHIEVE THIS 04

Define operating model, performance/productivity, finance, workforce, activity/capacity.

WHERE DO WE PLAN TO BE FOR THE SELECTED PRIORITY 03

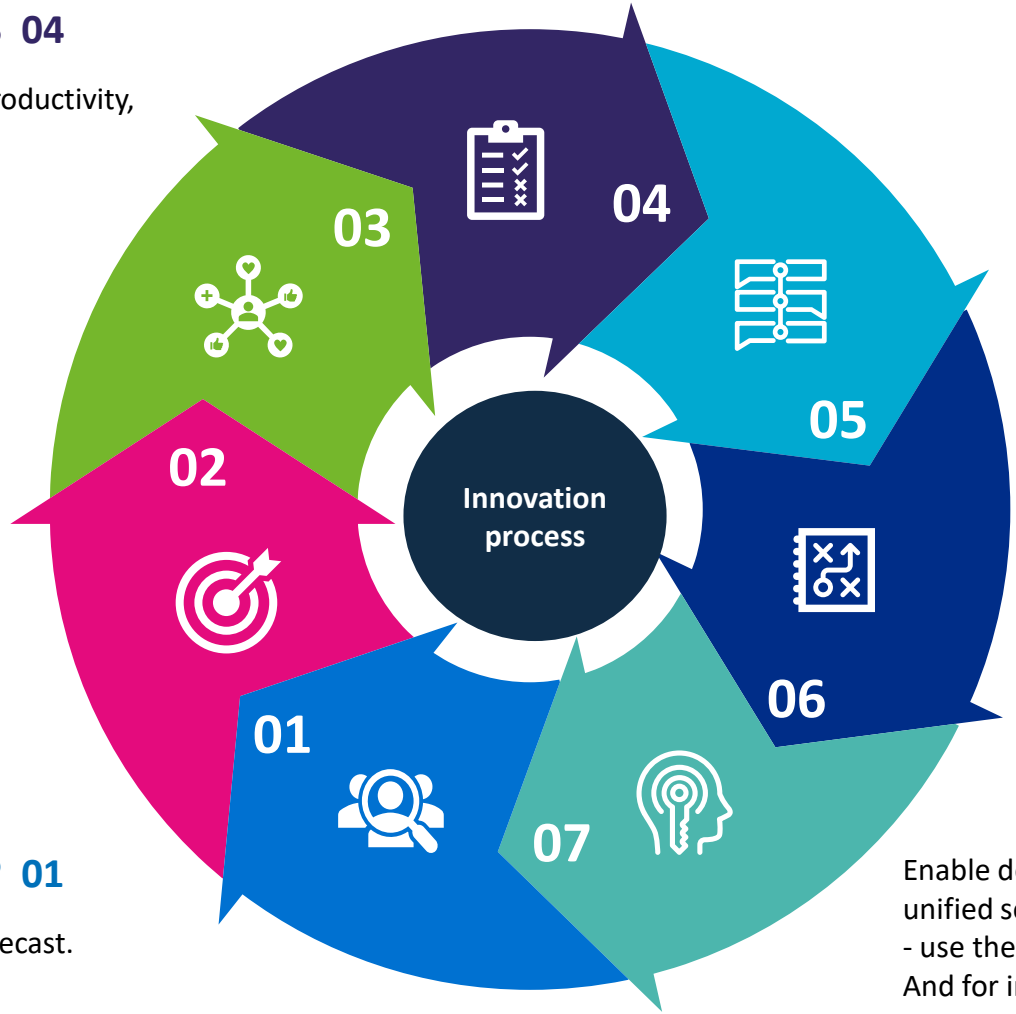
Define in terms of **BENEFITS** outcomes, quality, finance/efficiency, social, economic and environment.

PRIORITIES FOR IMPROVEMENT 02

Benefit orientated analysis -Informed by national, benchmarks and peers.

WHERE ARE WE NOW? 01

Current performance and forecast.



PLAN FOR ACHIEVEMENT 05

Model the impact of these initiatives on the desired results. For initiatives - roll up impact on the priority, the benefits and the resources.

SCENARIO MODELLING 06

Scenario model changes in internal and external factors, including drivers and enablers. Stress test your plan through scenarios (monthly, or with varying assumptions/ operating model)- test innovation .

ENABLE DECISION-MAKING 07

Enable decision-making using connected resource management, a unified set of data, measures and indicators. For in-year decisions - use the plan in making decisions on initiatives, and on your plan. And for in-year forecasts and medium-term impact roll forward - start to plan year 2 and 3 at same time as current year.

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Hackathon- inspire for new initiatives and ideation

- Using a hackathon to tackle complex NHS challenges in a day - NHS Arden & GEM CSU (ardengemcsu.nhs.uk)

- The social value innovator – strategy and tactics for success in a cash strapped world - NHS Arden & GEM CSU (ardengemcsu.nhs.uk)

"Our Innovation Hackathon provided a platform to spark ideas, increase collaboration, and exchange cross-organisational knowledge."

Ideation: Digital Transformation in Primary Care

Challenge Statement:
How can we support primary care to integrate and reduce variation in quality and value through adoption of digital solutions?

Improve access to routine appointments - avoid the "8am rush"

Standardise call / booking system across GP Surgeries

Look at how other countries are using AI in this space to improve access

Utilise digital triage systems

Improve self-monitoring uptake with self-assessment tools

Develop pathways for frequent users / attenders

Develop pathways less reliant on GPs – Pathway mapping aligned to clinical and social models

Utilise virtual clinics / Increase remote consultations

Improve linked data in primary care / care homes / 3rd sector providers

Standardisation across PCNs

Consistent Shared Care Records

Digital prevention products, monitoring devices at home

Improve digital inclusion, patient held records

Training for practice managers, PCN managers, backroom staff

Up-skilling clinical roles - matrons, paramedics, nurse practitioners

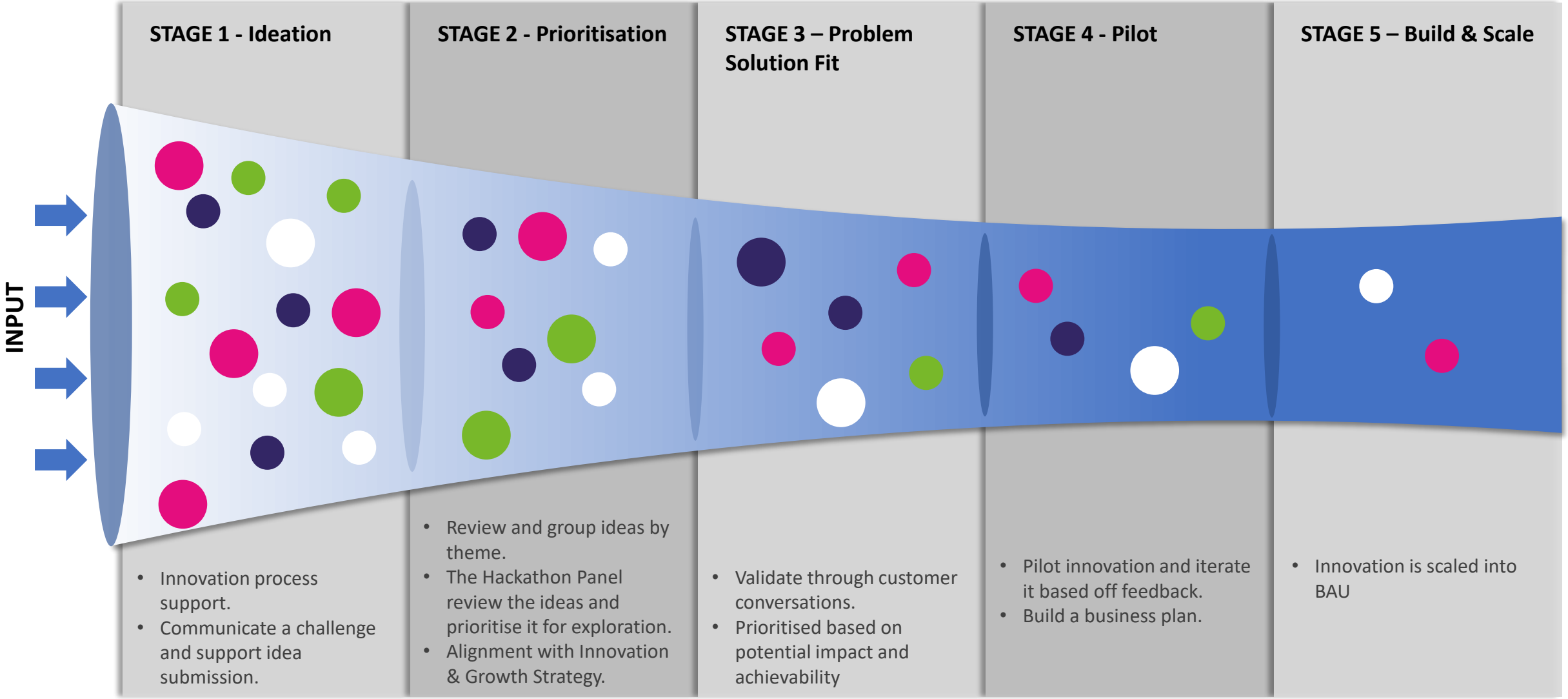
Use AI to aid decision making / diagnosis

Long stays in hospital – cannot discharge to community

Understand primary care capacity - capacity transformation

Innovation Funnel

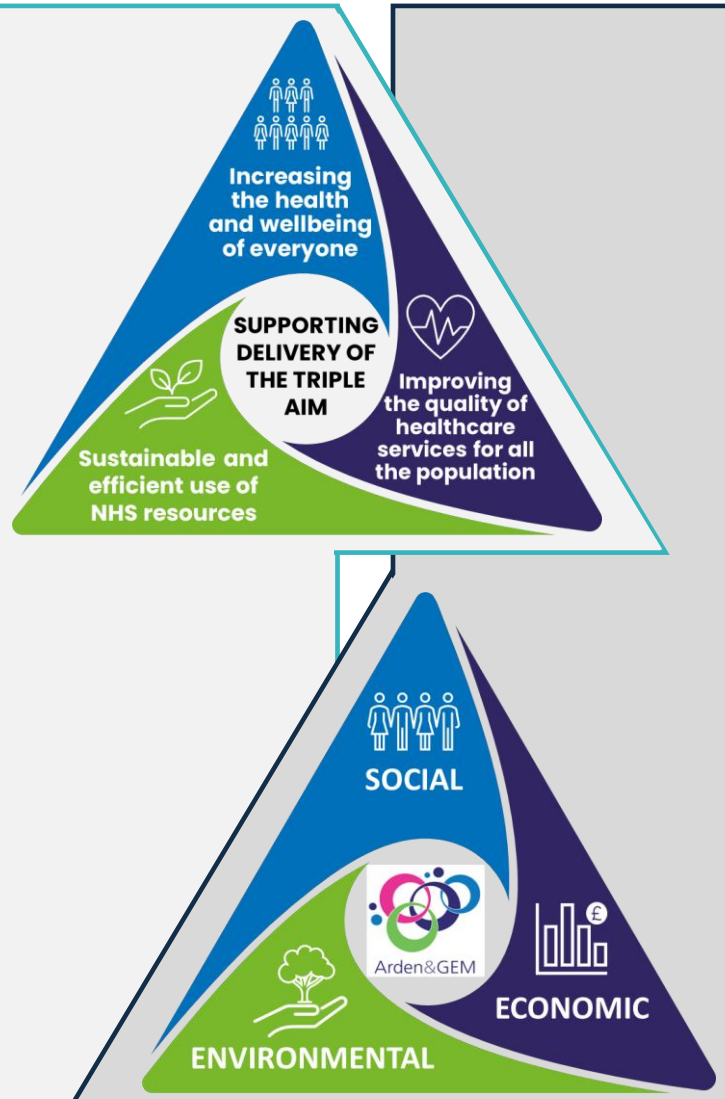
Arden&GEM
Health and social care systems support



Our impact measurement approach combines multiple dimensions of the triple aim agenda

SOCIAL VALUE MEASURES

- Promoting Local Skills and Jobs
- Supporting Responsible Growth
- Healthier, Safer, and Fairer Communities
- Decarbonising and Safeguarding Our World
- Social Innovation for Jobs, Growth, and the Environment
- Digital Inclusion
- Education and Awareness
- Support for Caregivers



CARE DELIVERY MEASURES

- Population Outcomes
- Clinical Outcomes, Cultural competence and Quality
- Patient Reported Outcomes, patient and family engagement
- Operational Productivity/Flow
- Staff Engagement and Wellbeing
- Efficient Use of Resources
- Research and Innovation
- Emergency Preparedness and Response

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Care delivery impact: Respiratory wheeze pathway

Care Delivery Measures	Baseline (Assessment of Current Status)	Target (Agreed Objectives)	Best Practice (Benchmarks)
Population Outcomes	Variation in equity of access and outcomes for population groups and geographies. Uptake of prevention and early intervention services.	Improve equity of access and outcomes across all population groups. Increase uptake of preventive services.	Benchmark top regions and adopt best preventive practices. Improve early asthma diagnosis and management. Increase preventive strategy uptake. Use health data to target high-risk groups. Promote social prescribing for issues like housing and pollution.
Clinical Outcomes, Cultural Competence, and Quality	Clinical outcomes and quality using national frameworks. Training in cultural competence.	Achieve high standards in clinical outcomes and care quality. Ensure all staff are trained in cultural competence.	Adopt GIRFT and BTS practices. Train all healthcare professionals in cultural competence. Use multi-professional teams for better diagnosis and treatment. Set up community diagnostic centres for timely diagnoses. Follow evidence-based asthma management
Patient Reported Outcomes, Engagement	Patient reported outcomes, involvement in care decisions, satisfaction.	High levels of patient and family satisfaction and engagement in care decisions.	Enhance self-management with education. Involve patients in care decisions. Use satisfaction surveys to improve services. Promote remote monitoring and follow-ups for easy care access.
Operational Productivity/Flow	Operational productivity measures including equity of access, waiting times, length of stay, adoption of digital solutions.	High operational productivity, reduced waiting times, efficient flow, widespread use of digital solutions.	Implement one-stop clinics. Standardise clinic templates. Use digital tools like electronic health records and telehealth. Monitor performance indicators to fix bottlenecks. Employ remote consultations and PIFU pathways to ease outpatient services.
Staff Engagement & Wellbeing	Staff well-being surveys on leadership, skill development, retention, teamworking.	High levels of staff engagement and well-being, effective leadership, and skill development.	Adopt top staff well-being practices. Provide regular training and development. Promote a positive work environment. Use surveys to address well-being. Encourage teamwork. Implement mental health support.
Efficient Use of Resources	Resource utilisation assessment, adoption of digital technology, integration of electronic health records and telehealth.	Optimal resource utilisation, full integration of digital technology.	Adopt best resource efficiency and digital integration practices. Use electronic health records and telehealth to enhance care and cut costs. Employ digital tools for remote asthma monitoring. Streamline and monitor resource use. Promote data and technology for better clinical decisions.
Research and Innovation	Contributions to medical research, implementation of innovative solutions.	Significant contributions to research and successful implementation of innovations.	Adopt top research and innovation practices. Join asthma trials and studies. Use digital tools and new treatments. Collaborate with academics. Encourage continuous improvement. Share successful innovations across healthcare.
Emergency Preparedness and Response	Capacity for responding to public health emergencies, maintaining care quality during crises.	High preparedness for emergencies, consistent quality of care.	Adopt top emergency preparedness practices. Update asthma plans regularly. Train staff with simulations. Ensure medication and equipment stockpiles. Establish clear communication protocols. Collaborate with public health agencies.

Social value impact: Respiratory pathway example

Social Value Measures	Baseline (Assessment of Current Status)	Target (Agreed Objectives)	Best Practice (Benchmarks)
Promoting Local Skills and Jobs	Current engagement with local workforce development initiatives is minimal.	Increase local employment opportunities and skills development programmes, especially for disadvantaged groups.	Partnerships with local job training programmes, apprenticeships, and community colleges.
Supporting Responsible Growth	Limited integration of social value considerations in procurement processes.	Implement procurement practices that prioritise social value and support local enterprises.	Procurement policies supporting local, eco-friendly suppliers and community health initiatives.
Healthier, Safer, and Fairer Communities	Moderate support for community health initiatives and vulnerable populations.	Enhance community health and safety initiatives, ensuring inclusivity and support for vulnerable groups.	Joint initiatives with community organisations, targeted asthma education, and partnerships with housing authorities.
Decarbonising and Safeguarding Our World	Efforts to reduce carbon emissions and environmental impact are not standardised.	Standardise and enhance efforts to reduce carbon emissions and environmental impact.	Use of greener inhalers, recycling programmes, energy-efficient practices, and telehealth initiatives.
Social Innovation for Jobs, Growth, and the Environment	Social innovation projects are sporadic and lack coordination.	Coordinate and expand social innovation projects to drive community growth and environmental sustainability.	Collaborate across sectors, encourage community participation, develop green spaces, and use mobile health units.
Digital Inclusion	Digital access and literacy programmes are insufficient.	Improve access to technology and digital literacy, particularly in healthcare services.	Bridge digital divide with free or low-cost internet, provide online resources, and offer digital literacy workshops.
Education and Awareness	Health education and awareness campaigns are sporadic and have limited reach.	Expand and intensify public health education and awareness campaigns.	Continuous campaigns, targeted asthma education, use of digital platforms, and collaboration with local media.
Support for Caregivers	Informal caregiver support is under-recognised and under-resourced.	Provide comprehensive support and resources for informal caregivers.	Training sessions, financial support, support networks, and access to professional health services for caregivers.

Integrated planning

We believe there are several key domains of planning, one of which is workforce. These areas impact one another so are connected but the connected element is rarely allowed for in planning.

"Initiatives" are business cases or change management programmes that are introduced by the organisation as part of the decision making process with the intention of impacting at least one of these areas.

Challenge question

How do you manage changes to a connected plan and keep control given the interconnected nature between planning areas?

What does a connected plan mean?

Clear governance is required to manage any changes introduced through a connected planning tool

Base Plan

Initial baseline plan is collated using separate models. These models are locked and reconciled, to demonstrate congruence between the 5 elements.

Revising the plan /budget- monthly unlock. Lock.

The base plan does not change. However, there is a monthly process of revising the year to date plan and budget as a result of 'DECISIONS'. Each of these decisions requires connection to all the other 4 elements of planning. A performance improvement initiative, a budget change, a business case, a workforce change…..

Scenario testing

Scenarios can be tested across all 5 elements, changing core drivers and assumptions on demand/activity, productivity, the impact of a key initiative, or a seasonal impact of disease. These scenarios can be used to build up a business case for a decision or to develop a plan for the following year, or a later period in the year. Scenarios may also be used to test forecasting and predicting impact.

The connecting points

The synchronisation of the base plan needs to be authorised by the relevant authority prior to dynamic operation of the plan

Base Plan Authorisation and control assurance	Finance	Workforce	Activity	Target performance indicators	Productivity	Initiatives
Finance	Plan and budget for income, pay, non pay, with cost centre analysis and balance sheet	All establishments are funded. If efficiencies assumed these are built in.	Resource funding [income/allocation is related to activity]	Resource funding[income/allocation] is related to the agreed target performance		Initiatives within the base are authorised to deliver financial impact of x
Workforce	Pay budget agrees to funded establishment	Establishment by type of professional group and grate	Activity and Workforce are matched by department/speciality etc in the plan	Target performance may include workforce	Base productivity – activity and workforce and improvement in productivity within the initiatives	Initiatives within the base are authorised to deliver workforce impact of x
Activity	Resource funding [income/allocation is related to activity]	Workforce has a related level of activity for the base plan	Activity as per the speciality, or service concerned. Including those that are support services	Performance indicators will include targets related to activity	Base productivity – activity and workforce and improvement in productivity within the initiatives	Initiatives within the base are authorised to deliver activity impact of x
Target performance indicators	Indicators for finance	Indicators for workforce	Indicators for activity	A range of indicators for quality, outcomes, cost, activity, workforce, productivity captured	Indicators for productivity	Initiatives within the base are authorised to deliver performance /productivity impact of x
Productivity	Resources are used in the productivity target and plan	Workforce used in the productivity target and plan	Activity delivered from the productivity and plan	Interdependency with any performance target in the plan that is dependent on improved productivity linked to an initiative	Productivity metrics for plan based on operational targets for the organisation/service line	Initiatives within the base are authorised to deliver performance /productivity impact of x
Initiatives	Impact on finance- costs and income	Impact on workforce	Impact on activity	Impact on productivity	Improvement built into the base arising from initiatives	Planned initiatives for each service /program

Initiatives and scenario testing

Initiative example:
An organisation initiative to reduce the number of agency doctors in A&E

1. This initiative will have an impact on
2. Finance reduction target
3. Activity impact
4. Productivity of remaining workforce
5. Workforce
6. The performance impact needs to be mitigated if there is a reduced level of staffing, how can other aligned initiatives help
    a) Digital support on the interface with A&E and 111 and Ambulance to direct patients
    b) Capacity and rota /scheduling
    c) Workforce mix and skills
    d) Optimisation of urgent care /primary care within the A&E services

As this scenario test is worked through by a planner the impact on the other component areas will be highlighted. These can then also be modified with commentary forming a clear decision log.

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Why do I need a planning & decision-making digital platform?

Lots of data, but are we using it to its full extent?

The truth is, while we have tons of data, turning it into meaningful insights can be a real challenge. Most of us find it tough to **break down data silos**, ensure that we have the **right skills to connect them**, and also use the **best tools** to analyse it.

Too often we analyse and connect data to answer **similar, or even repeated** questions, but we **start from scratch** every time we begin.

The planning platform takes away **manual efforts** and allows time to be spent on gaining a **better understanding** of what to do with your answer (as opposed to just finding it).

Need for digital enablers for better decision making

Most NHS organisations rely on excel as their primary tool for producing organisational plans and feedback from workshops is that as a planning tool this doesn't support their ambitions of what they want planning to be. Examples of constraints include:

Ability to roll up/roll down

[For example multiple organisations, operational -> strategic plans]

Hold large data volumes*

[cost centre/subjective code combinations, HRG planning, post planning, multiple months/years]

Clear governance and approval

[role based access, workflow approval process, reconciliations, planning commentary]

Holding >3 dimensions*

[ability to navigate easily across different iterations of plan through lenses of workforce, finance etc.]

Scenario testing and optimisation

[complex calculations linking domains and automated forecasts with overwrites]

Monitoring of plans and initiatives

[active tracking of whether previous plans/business cases are delivering on target]

*as an example ~80Bn combinations would be required to hold monthly planning information across a 5 year period modelling the impact of 50 different business cases across a 3 hospital site system that had 10 types of activity group taking place within 10 different specialties alongside 10 different staff groups with 4 staff categories and 20 possible pay points. This assumes multiple productivity measures (4) and different versions of a plan (6) along with various group summaries (e.g. quarterly, annual, total). The theoretical maximum for excel is ~17Bn in a worksheet.

Network Use Cases

ICS System Demand and Capacity Project

The challenge

The ICS System Demand and Capacity Project received endorsement from the ICB to conduct a project to evaluate whether the Anaplan platform is the right solution for ICS's longer term needs.

Current solutions didn't provide a system-wide position, were restricted by excel functionality, weren't owned by the ICB and weren't well used throughout the ICS.

The Project wanted to implement a tool that would enable:

1. A **joined-up view of system demand and capacity** on beds and services within acute, community, local authority and hospice settings.
2. Identification of parts of the system challenged by capacity to enable **focus and targeted action** to take place to improve the flow of patients/service users through the system.
3. **Predictive planning** over the short, medium and longer term to help determine what strategies are required to support winter demand management, and **where to invest** should winter monies become available via NHS England.

Our approach

The project team brought together system partners from across MSE with data leads, business analysts and solution architects from Arden & GEM and Anaplan.

- **Project success criteria** were agreed by the board for the following areas: technical solution, access, training, communications and IG.
- **Stakeholder engagement** took place in the form of user requirement workshops, surveys, show and tell events, and training sessions.
- **The data approach** was agreed with data leads including where data is sourced, assumptions, calculation methods, improving accuracy and automating feeds.
- **Testing** took place across 34 items relating to navigation, customisation, planning and forecasting with any identified improvement easily actionable.

Recommendations for how to take the project forward were made, along with the key actions to do this successfully e.g. appointing a business owner, creating a governance board and creating a business benefits model.

The benefits

The project demonstrated that progressing with the Anaplan build will deliver:

- A **system-wide view of demand and capacity** on beds and services for acute, community, local authority and hospice services to identify surplus or deficits in the immediate and longer term
- **Dynamic reports** that can be viewed across different dimensions and levels of detail e.g. down to pathway, ward, or day level to improve operational efficiency
- **Forecasting capabilities** where users can adjust factors such as admissions, length of stay and capacity to understand the impact on demand and capacity shortfall across settings and improve decision making
- Facilitating **a shared understanding** and improved collaboration between system partners
- An exemplar for gathering acute, community, local authorities and hospice data, along with a tool for forecasting future demand, that could be **replicated by other ICBs** and NHS England.

It's made it more real about what the outputs could look like and how we can get the best out of it .
The data will give us an opportunity to think about over-prescribing of care.
The way that the forecasting is built up from multiple inputs is impressive.

Integration of ASC with hospital wards is very interesting, appreciated the forecasting and ability to change capacity.
Good to be able to see the whole system.
Monthly Forecast/Planning view particularly helpful.

Arden&GEM

Arden&GEM
Integrated Resource Planning
HELPING SYSTEMS TO IMPROVE VALUE

NHS

Thank you!

Arden&GEM

www.ardengemcsu.nhs.uk
@ardengem
contact.ardengem@nhs.net

Case Study

HealthPathways Community

Slido

Please scan the QR Code on the screen. This will take you through to Slido, where you can interact with us.

SCAN ME

CONVENZIS

Case Study

Dr David Hambleton

Managing Director

Pathways Alliance Limited

HealthPathways Community

System Integration – behaviour & culture change in action

October 2024

Who am I?

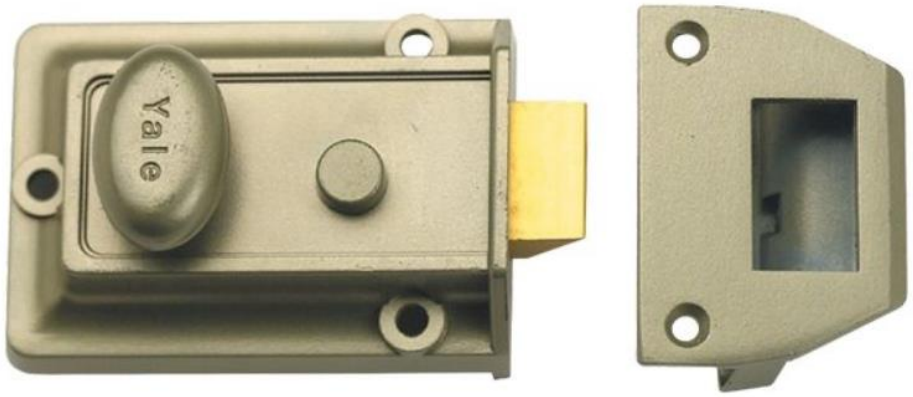

DH LEADERSHIP ALLIANCE
STREAMLINERS
Improving the health and wellbeing of people around the world
Dr David Hambleton
Chief Executive Officer, South Tyneside CCG

Practical examples

- GP incentivisation scheme
- Integrated community teams
- Alliance Leadership team
- Behaviour, language and shared purpose
- HealthPathways

What would you do at work tomorrow if the answer was already yes?

Doing things differently



Canterbury District Health Board

Te Poari Hauora ō Waitaha

The NHS in TLAs....

PCB

PCT

STP

ICB

SHA

ACS

WTF

ICP

CSU

CCG

STP

ICS

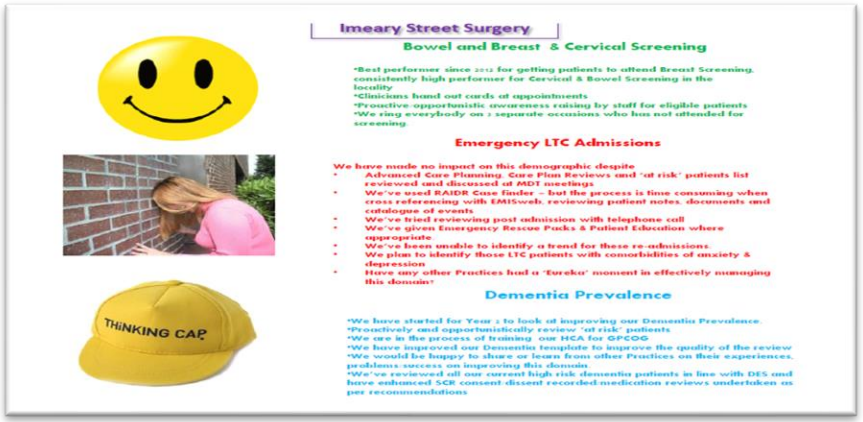
Practical examples…GP Incentive Scheme 2017

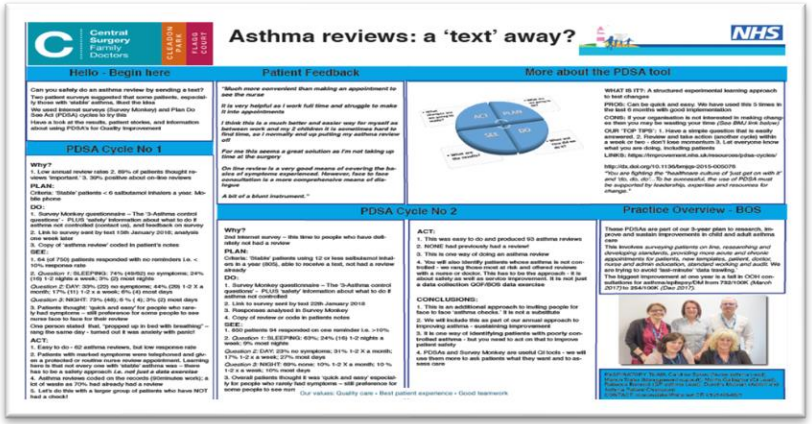
Better Outcomes Scheme (BOS 2 Option A) 2015/16 - v. 1.06

	2014/15 - 2015/16 Indicator Changes	Indicator	Indicator Description	Method of Performance Management	Explanatory Note	
	No change	EoL 1	1% palliative care register	To be collected using MIQUEST query	Baseline data extraction will give a snapshot at 1st July, Miquest query at 6 months for position statement, Miquest query at 12 months for end position. Practice achieves indicator if end year position is >1% on palliative care register	Register size 1% 100% of payment Register size >0.9% 75% of payment Register size >0.8% 50% of payment
	Ammended	EoL 2	Advanced care planning (ACP) & DNACPR and ACP documentation in place, MCA1&2 and ADRT if appropriate	To be collected using MIQUEST query	8CME - End of Life Advanced Care Planning The care plan can be either -- e.g. End of Life Advanced Care Plan or an Emergency Health Care Plan (EHCP). The A should be shared with partners Notes - CCG are looking for th register who also have a DNACP Read codes to be used for DNA End of Life Advanced Care Plan death should be shared with pa	at least 73% of register that have care plans: 100% of payment (upper quartile for BOS1) at least 48% of register that have care plans: 75% of payment (mean for BOS1)
d of Life	No change	EoL 3	Preferred place of death - increase number of patients who die at place of choice.	To be collected using MIQUEST query	CCG are looking for an increase choice and a description of the happening. You should provide preferred place of death -- plea place of death from the End of L Care Plan. Number died at preferred place given time period. Read codes to be used for Pref	
	Ammended - Event reviews to use 'Caulfield end of life	EoL 4	Event review where patient not died at PPD	Self reported	Self report the process the prac and the number undertaken dur records/meeting notes etc. as e an action plan may improve the place.	
	New	EoI 4.1	Audit and peer review	Peer review session	Practices to complete event rev Practices will be required to en	
	New	EoI 5	Special patient notes (SPNs)	To be collected using MIQUEST query	SPNs should be completed for: • All EoL patients; • 1% of patients on the palliativ • All patients in nursing and res Special Patient notes to be rea	
	Ammended to add in newly diagnosed by PRIMARY or secondary care	CVD/CKD 1	Post diagnosis appointment	To be collected using MIQUEST query Self reported	The post diagnosis review will b CHD; 662N - chronic heart dis annual review, 9h0 - Exemption heart disease monitoring done, chronic heart disease verbal in monitoring 1st letter (2nd) (3rd), 9Oh5 - chronic heart disease t AF; 9hF0 - patient unsuitable/e resolved, 9Os0 (1) (2) - AF moni 9Os4 - telephone invitation HF; 8HBE - heart failure follow informed dissent, 662 - cardiac failure annual monitoring, 662T practice nurse heart failure clir heart failure resolved, 9Or0 - h invitation, 9Or2 - verbal invitat (2nd) (3rd)	
	New	CVD/CKD 1.1	Post diagnosis appointment and practice register	To be collected using MIQUEST query Self reported	Offer review appointments to ne care and to those on the practi Post diagnosis review will be id CKD Codes for stage 3-5 - 1Z12, CKD monitoring, 66i - CKD 1st l telephone invitation, 9Ot4 - ver	
	New	CVD/CKD 1.2	CKD register	To be collected using MIQUEST query Self reported	CKD register up to date within t prevalence meets the average ensure patient management of C CKD Codes for stage 3-5 - 1Z12,	
	New	CVD/CKD 1.3	Development of process and template to	Event participation and feedback - follow up to be collected using	Pulse check code - 242	
Respiratory	Ammended	COPD/RSP 3	Newly diagnosed WITH COPD OR ASTHMA - post diagnosis review	To be collected using MIQUEST query	Once a patient is newly diagnosed WITH COPD OR AS secondary care, GP/Practice to offer a 'post diagnosis weeks to establish shared care plan.cline, 6 months ar Read codes to be used for new patients: MIQUEST rep 66YB - chronic obstructive pulmonary disease monitor review, 9h51 - exempted/unsuitable, 9h52 - informed d monitoring 1st letter (2nd) (3rd), 9Oi3 - verbal invitatio invitation, 66YL - COPD follow up 66YJ - asthma annual review, 9OJ4, 9OJ5, 9OJ6 - asth (3rd) 9OJ8 - telephone invitation 9OJ7 verbal invitat	
	New	COPD/RSP 4	DNA Review patients	Self reported	Review patients who have DNA'd in 14/15 QOF year an going forward. Establish new and innovative ways to e reach patients and communicate with them for example mail or skype. Consider how Data can be gathered an support the patient to maintain their independence, fo	
	New	COPD/RSP 5	Smoking in Pregnancy	To be collected using MIQUEST query	When information is passed from a midwife to a practic practice is to put an alert on the practice system. Sm services should then be discussed further with the pat contacts. The patient should be referred into smoking Read codes to be used - 62, 621 - patient pregnant, 8 advice.	
	No change	COPD/RSP 7	Implement personal management plan - COPD	To be collected using MIQUEST query	CCG is looking for COPD patients to have either an em shared care management plan in place. Practices shou shared care management plan developed jointly betwe Read codes to be used for Implement personal manage on 66YI - COPD self-management care plan	
	NEW	COPD/RSP 7.1	Implement personal management plan - Asthma	To be collected using MIQUEST query	Implement personal management plan for asthma (adult with written material. A suggested plan will be co-ordi code - 663U, asthma personal management plan	
	New	COPD/RSP 7.2	Inhaler review	Self reported	Identify patients who are ordering more than one salbu (averaged over a 3 month period) and ensure they are appropriate. Ensure they are using a personal manage	
	Ammended to include lifestyle advice and other appropriate	COPD 8	Increase MRC>3 at pul rehab or C4L	To be collected using MIQUEST query	COPD and MRC scoring codes to be the same as QoF Increase the proportion of patients of MRC breathless pulmonary rehab OR C4L activity as appropriate Read codes to be used for Increase MRC>3 at pul reha 173k, 173I (MRC > 3), 8H7u - Refer to pulmonary rehab 9M0 - unsuitable for pulmonary rehab	
	New	COPD 9	Links with schools	Self reported	Ensure practice makes contact with and has relevant Ensure practice knows how to signpost to school nursi	
	New	COPD 10	Education/ peer review	Event participation and feedback	Review a sample of admissions (50% of Q4 14/15) and u respiratory (adults and adolescent) admissions seen to be increasing. Attend peer review meeting on this topic. CCG will provide scope of the audit in due course.	
CVD/CKD	New	CVD/CKD 1.3	Development of process and template to record pulse	Event participation and feedback - follow up to be collected using MIQUEST query	Pulse check code - 242	Practices should demonstrate evidence of template 100% of payment
	NEW	CVD/CKD1.4	Mental Health Reviews, ensure that SMI indicators to be measured /recorded	Self reported	BP, FBG/hbalc, fasting lipids, Albumin:Creatinine Ratio, BMI, Alcohol/drugs/smoking status. (smoking, alcohol, albumi & BP are in the QOF indicator for standard reviews)	at least 91% of patients who have had Mental Health Review and SMI code recorded : 100% of payment at least 81% of patients who have had Mental Health Review and SMI code recorded : 75% of payment at least 71% of patients who have had Mental Health Review and SMI code recorded : 50% of payment
	New	CVD/CKD 3	Considering appropriate advice	Self reported / Training	Ensure all new members of staff are trained in • identifying anxiety and depression and able to make appropriate referrals to talking therapies (incl IAPT). • VBA training for smoking cessation	Evidence that all new staff have received appropriate training will achieve 100% of payment. .
	New	CVD/CKD 4	Education	Event participation and feedback	All relevant members of staff to participate in CKD, Diabetes and Renal Disease training at Education Session (Aug/Sept) - IMPAKT Tool.	Evidence that all appropriate staff have received training will achieve 100% of payment. .
	New	CVD/CKD 5	Uging IMPAKT	Self reported / Training	Practices to commence using the IMPAKT tool to help identify and manage patients	Evidence of regular use of the IMPAKT tool quarterly will achieve 100% of payment. .
	New	CVD/CKD 6	Education	Training/event participation and feedback	All Staff to be trained in how to use the C4L 'referral process' make relevant referrals to C4L programme or have a discussion with the patient about self care/maintaining a healthy lifestyle. - Drop in sessions at the TITOs will be run, as well as the opportunity for discussions at practice visits	Evidence that all appropriate staff have received training will achieve 100% of payment. .
	New	CVD/CKD 7	Referral to C4L/ Lifestyle advice	To be collected using MIQUEST query	Make relevant referrals to C4L programme or have a discussion with the patient about self-care and maintaining a healthy lifestyle. Read codes collected - lifestyle counselling, 67H - referral to healthy lifestyle programme, 8H1u	All patients should have record of counselling or referral recorded in the medical record will achieve 100% of payment.
	Ammended	CVD/CKD 8	Max tolerated ACE Inhibitors	To be collected using MIQUEST query	Ensure all patients with HF on maximum tolerated treatment for condition and ensure they are monitored as appropriate. Practices to use the QoF code for patients who are on maximum tolerated ACE inhibitors. Practices to ensure this code is put on all patients who are on maximum therapy. This is usually applicable for patients with HF. Read codes to be used for Max ACE inhibitors: 8B6Q - Patient on maximum	at least 32% of patients who have maximum ACE recorded: 100% of payment. (upper quartile for BOS1) at least 21% of patients who have maximum ACE recorded: 75% of payment. (mean for BOS1) at least 10% of patients who have maximum ACE recorded: 50% of payment. (lower quartile for BOS1) less than 10% of patients who have maximum ACE recorded: 0% of payment (below lower
	New	CVD/CKD 9	Anticoagulation	To be collected using MIQUEST query	Ensure all patients with Atrial Fibrillation have appropriate anticoagulation	All patients should have recorded of anticoagulation recorded. Warfarin, NOAC, Clopidogrel/Aspirin or not suitable for anticoagulation. Will achive 100% of payment
	New	CVD/CKD 10	Chronic Disease Reviews	Self Reported	Chronic Disease Reviews should be delivered to have an emphasis on supporting self-management and provide patient with written material (booklet or information leaflet). This should include providing self-help information to those with CKD 3 and	All patients who attend for review should have self managment advice recorded:achieves 100% of payment.
	New	CVD/CKD 11	Managing care	To be collected using MIQUEST query Self reported	Ensure patients with a LTCs have a copy of their personal management plan and that clinicians use a SDM conversation approach. Read codes collected - CKD register (3 or above) + has self management plan, 8CMY - shared decision making 8CI	at least 91% of patients who have a personal management plan recorded : 100% of payment at least 81% of patients who have a personal management plan recorded : 75% of payment at least 71% of patients who have a personal management plan recorded : 50% of payment less than 70% of patients who have a personal management plan recorded : 0% of payment
Cancer	Ammended	CA 1	Screening Awareness	Self reported	Use leaflets from LD team (CCG will provide) on cancer screening programmes within the annual LD review	Practice should describe the process they use to ensure that patients with learning disability are given appropriate information regarding all cancer screening programmes : 100% of
	Ammended	CA 2	Screening post DNA	Self reported	When the practice is informed via the Screening Programmes that a patient has DNA'd, practice to contact the patient to understand reasons for not attending	Practice should describe the process they use to ensure that patients who do not attend screening are contacted and advised to on the benefits of screening: 100% of payment
	No change	CA 3	Use CDM appointments to raise/endorse cancer screening	Self reported	Describe the process, materials used and approach taken.	Practice should describe the process, materials used and approach taken and validate with a small audit of at least 10 patients: 100% of payment
	Ammended - to comply with NICE guidelines in regard to referral	CA 4	Use of cancer risk tool	Self reported	Use a validated cancer risk tool when available (anticipated 2016), and comply with nice guidance regarding referral.	Practice should describe how it has implemented NICE guidance NG12 including use of a risk assessment tool once developed: 100% of payment
	No change	CA 6	Pts. aware of 2ww referrals	Self reported	To ensure that every patient being referred on a 2ww pathway knows that they are being referred to exclude cancer	Practices should demonstrate that every patient being referred on a 2ww pathway knows that they are being referred to exclude cancer: 100% of payment
	No change	CA 9	Audit of cancers diagnosed via non-2ww	Self reported - Reflective audit	To review all patient notes diagnosed with cancer not referred on a 2ww pathway to determine whether there were missed opportunities for earlier referral and implement appropriate changes	Practices should present the audit findings including lessons learnt and evidence these were shared within the practice: 100% of payment
	New	CA 10	Cancer strategy	Self-report	Work collaboratively with CCG and partners to develop a strategy on improved cancer outcomes and a strategy to encourage patients to present early with symptoms - Participate in 2 CCG wide cancer audits as directed by the clinical	Practices should provide information to the CCG within a reasonable timescale: 100% of payment
	New	CA 11	Cancer performance indicators	Self-report	Work collaboratively with CCG and partners to look at cancer performance indicators and audit results on a CCG and practice level. Use the data and the results of the audit to develop action plan on prevention and early presentation. CCG to set out in self report template what is required.	Participation in meetings or events to review cancer outcomes within the practice 50% of payment Development of a practice strategy to improve cancer outcomes 50% of payment
	Ammended	COPD/RSP 1	Identify patients at risk of COPD (3 indicators) and screen with spirometry	Practices to use RAIDR information in Primary care dashboard in the COPD tab	Identify the cohort of patients over 35 who smoke (or have other risk factor) and have recorded episodes of: exertional breathlessness; chronic cough; regular sputum production; frequent winter "bronchitis"; wheeze or chest infection in the last 12 months who were not screened in the last 3 years and screen for COPD with spirometry.	at least 91% of patients in this group who have a Spirometry recorded : 100% of payment at least 81% of patients in this group who have a Spirometry recorded : 75% of payment at least 71% of patients in this group who have a Spirometry recorded : 50% of payment less than 70% of patients in this group who have a Spirometry recorded : 0% of payment
	Ammended	COPD/RSP 2	Review patients on inhalers not on register	Self reported	To review patients receiving prescriptions for inhalers who are not on the COPD/asthma register who were not reviewed in the last 3 years.	at least 91% of patients in this group who have a review recorded : 100% of payment at least 81% of patients in this group who have a review recorded : 75% of payment at least 71% of patients in this group who have a review recorded : 50% of payment less than 70% of patients in this group who have a review recorded : 0% of payment
					Once a patient is newly diagnosed WITH COPD OR ASTHMA IN PRIMARY OR secondary care, GP/Practice to offer a 'post diagnosis' appointment within 4 - 6	at least 75% of patients who have COPD or Asthma who have offer of a review appointment recorded: 100% of payment (upper quartile for BOS1)

GP Incentive Scheme 2018

- Have the money
- Look at your data
- Do some improvement work
- Produce a poster to share your learning





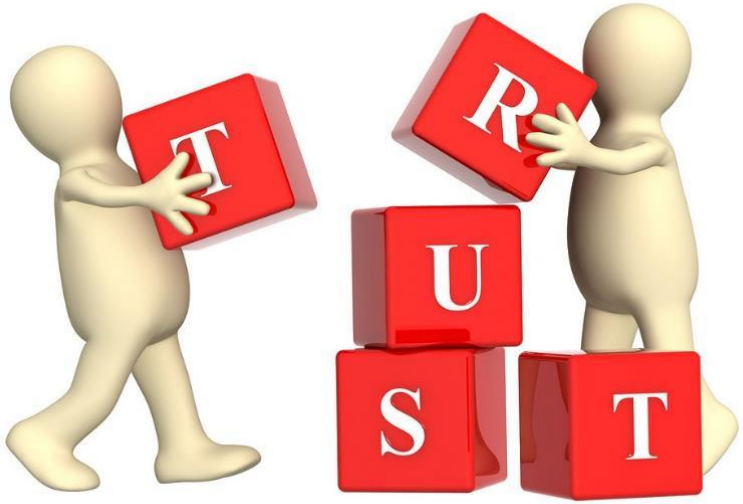
DH LEADERSHIP ALLIANCE

NHS South Tyneside Clinical Commissioning Group

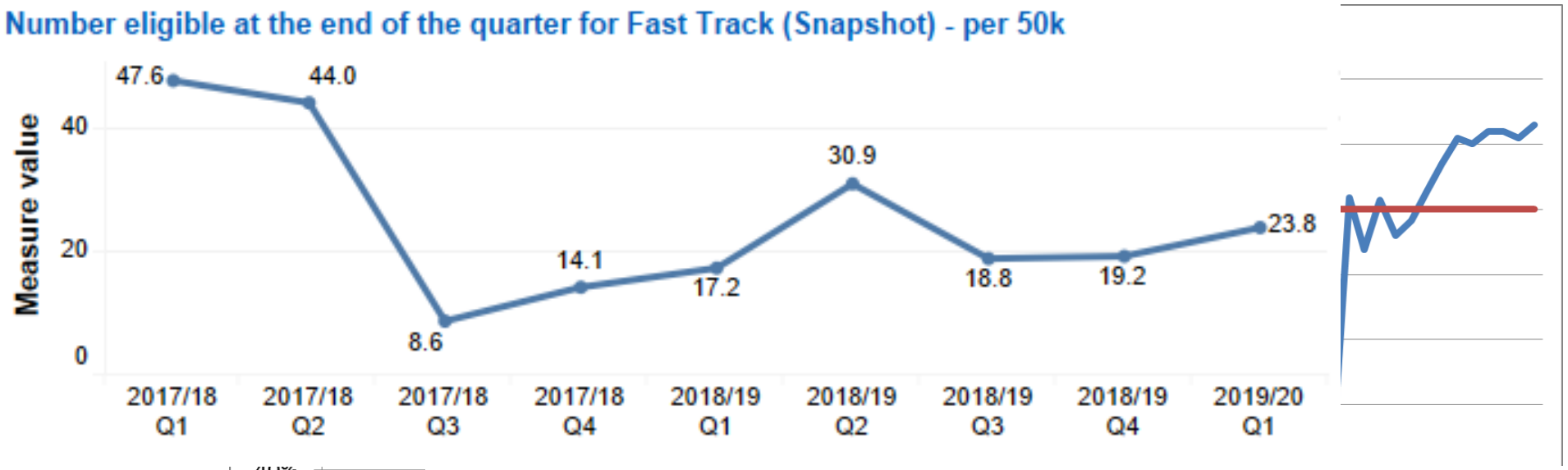
Continuing Heath Care – where we started

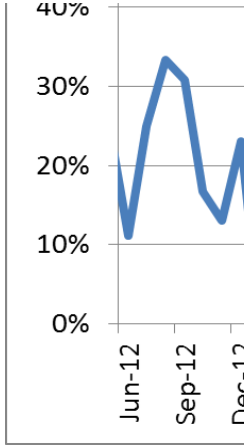
‘Save our Financial Future’

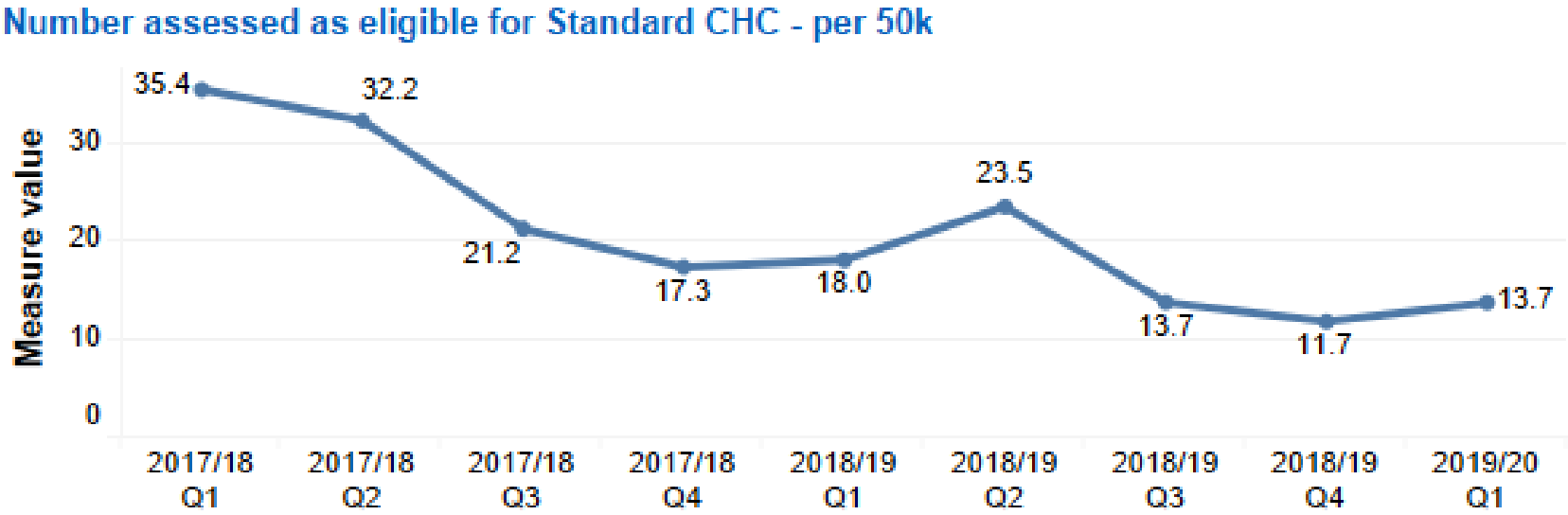
Continuing Heath Care – something had to give!



Early indications of success - CHC







DH LEADERSHIP ALLIANCE

Alliance Leadership Team

DH LEADERSHIP ALLIANCE

NHS South Tyneside Clinical Commissioning Group

Alliance Leadership Team

Shared purpose & language

Alliancing

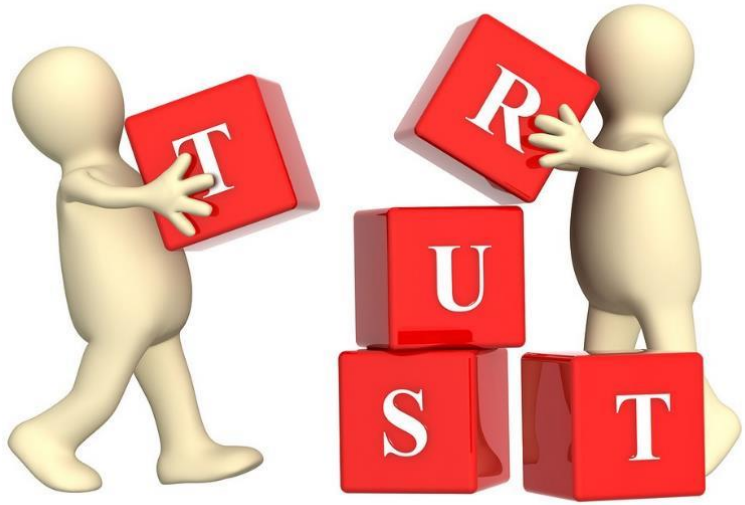
Best for patient, best for system

Teaming

Wearing the England shirt'

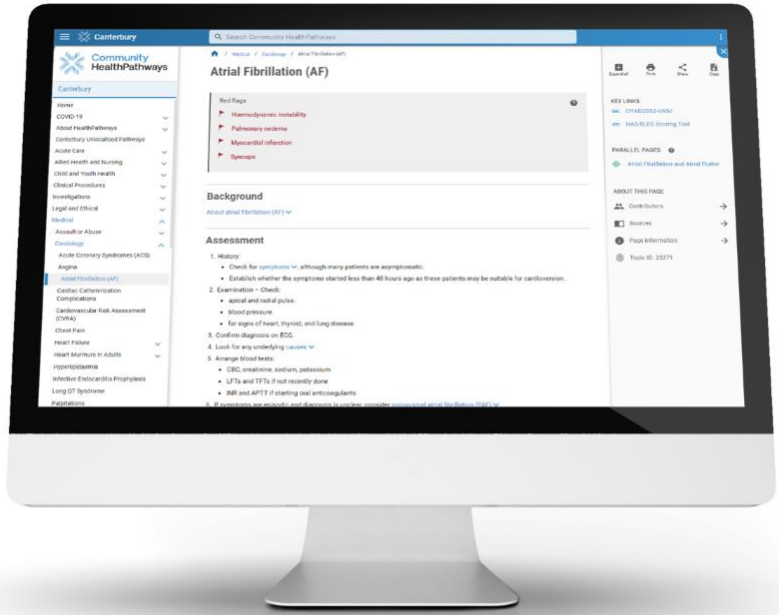
Better together

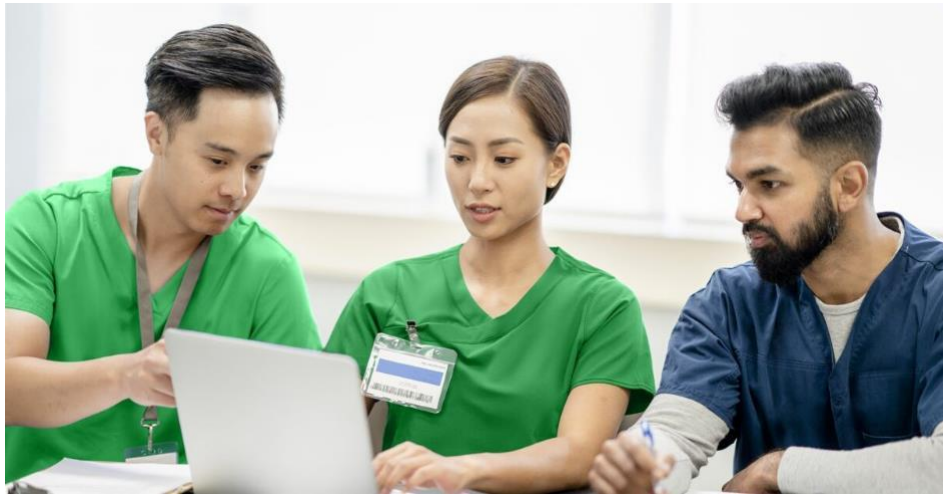
Fundamentals of our approach



DH LEADERSHIP ALLIANCE

HealthPathways





The HealthPathways Community at a glance 2023

Australia and New Zealand regions

United Kingdom regions

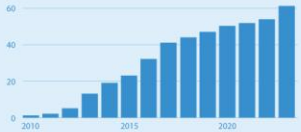
Total number of implementations

61

Total patient numbers in regions

34.5M

Cumulative number of regions over time



Clinical pathways localised	Pages currently being localised	Page reviews completed	Page reviews in progress	Services in HealthPathways Directory
19,416	4,151	18,881	4,125	45,808

Total people contributing feedback or to pathway development

GPs	Specialists	Nurses	Allied Health
9,855	7,756	8,373	5,703

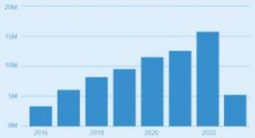
Total feedback posts

1,713,117

Page views in last 12 months

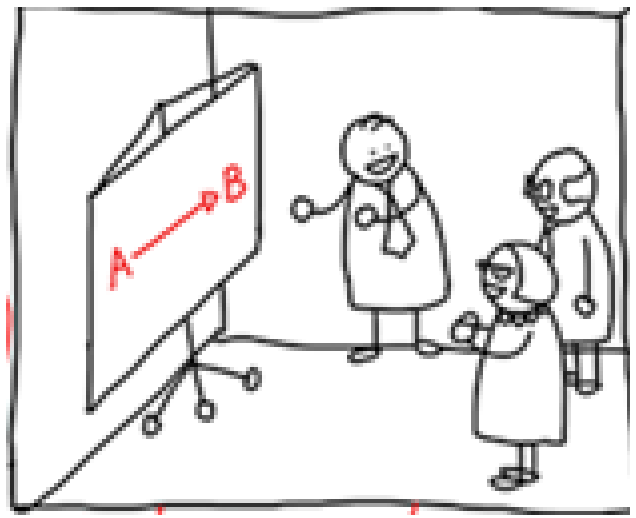
15,486,320

Total website page views



DH LEADERSHIP ALLIANCE

- **Health pathways**: South Tyneside implemented a tool developed in Canterbury to map patient pathways. As in Canterbury, the biggest impact from this tool was reported to come from the process of developing it, which involved conversations between GPs and hospital clinicians that helped to create new relationships and break down barriers.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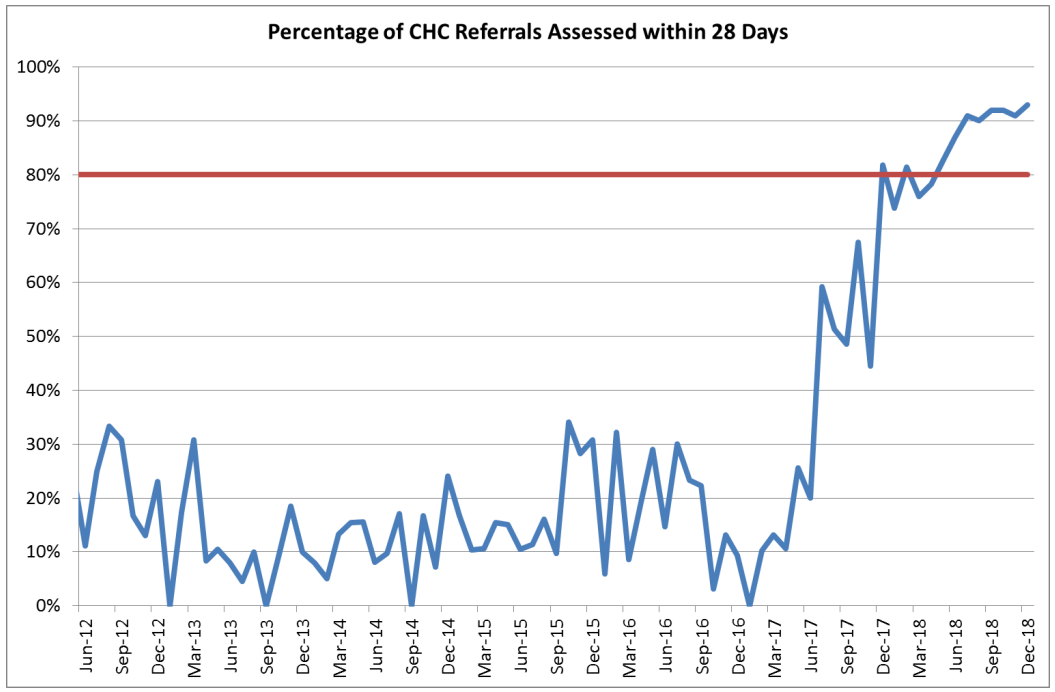
Percentage of CHC Referrals Assessed within 28 Days
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jun-12
Sep-12
Dec-12
Mar-13
Jun-13
Sep-13
Dec-13
Mar-14
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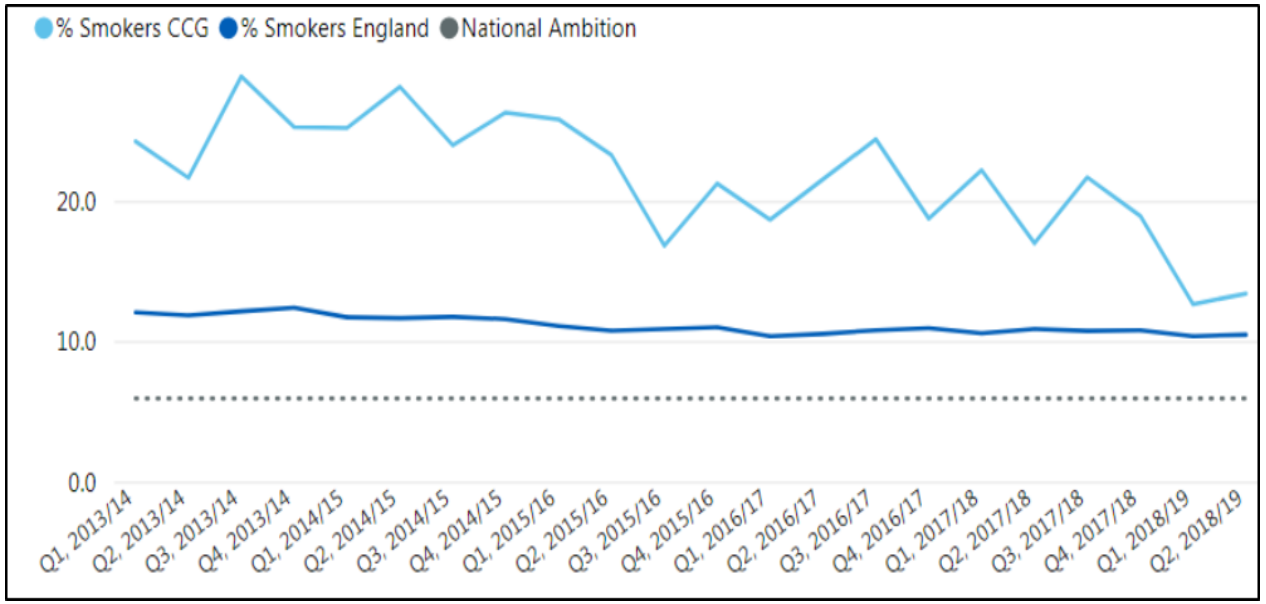
% Smokers CCG
% Smokers England
National Ambition
20.0
10.0
0.0
Q1, 2013/14
Q2, 2013/14
Q3, 2013/14
Q4, 2013/14
Q1, 2014/15
Q2, 2014/15
Q3, 2014/15
Q4, 2014/15
Q1, 2015/16
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Q4, 2016/17
Q1, 2017/18
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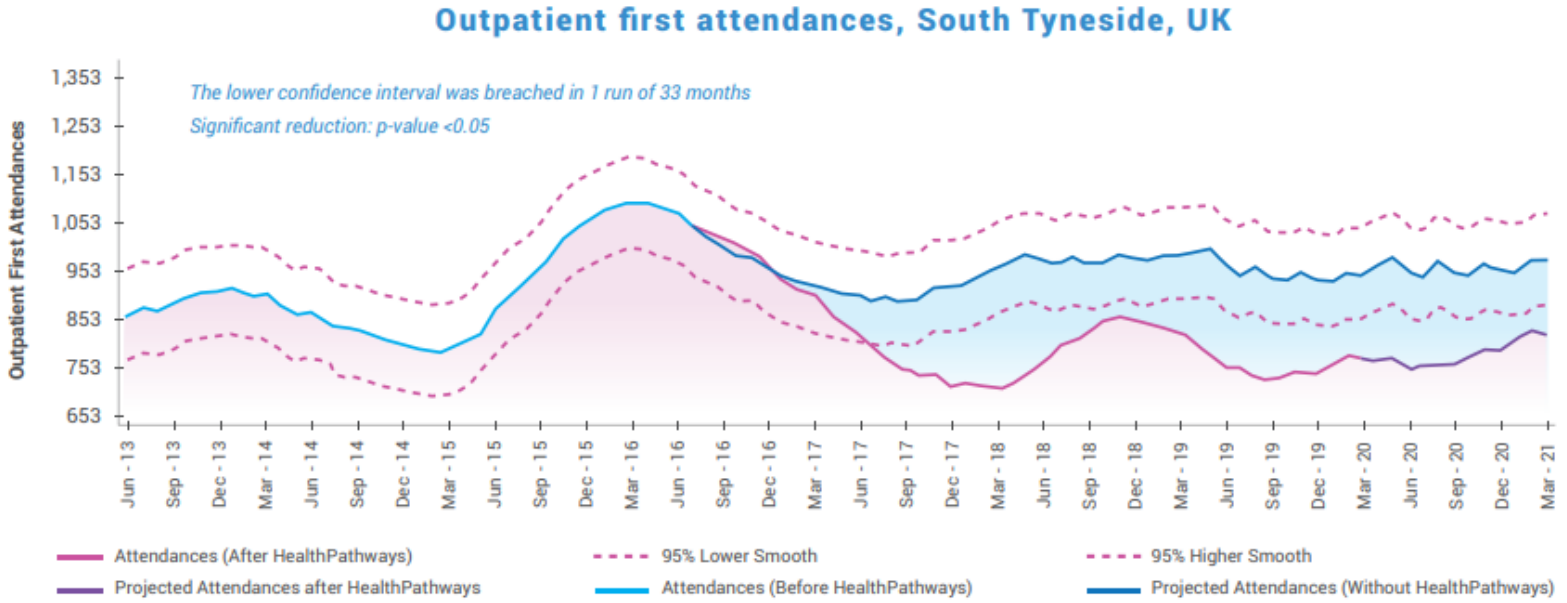
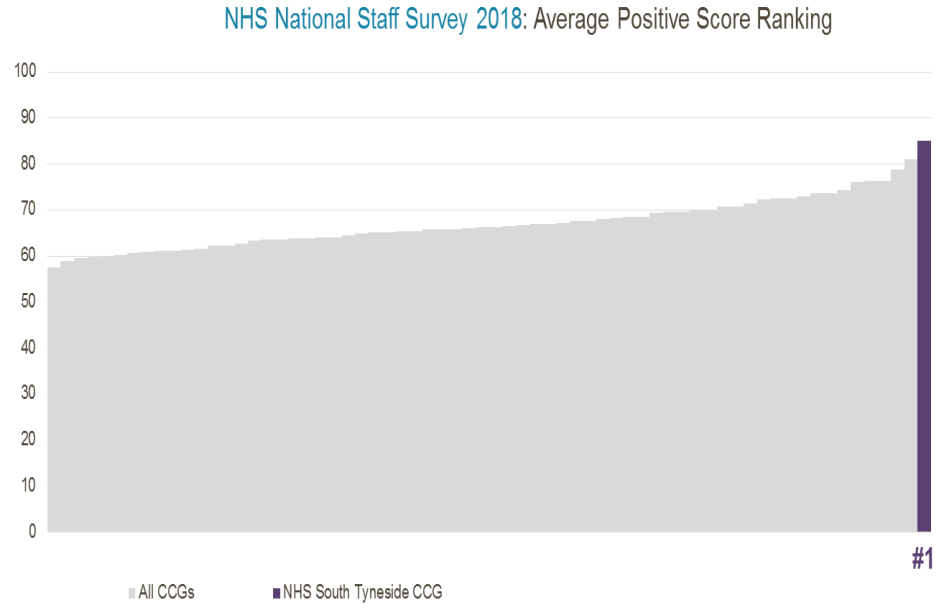
Q3, 2017/18
Q4, 2017/18
Q1, 2018/19
Q2, 2018/19


Outpatient first attendances, South Tyneside, UK
The lower confidence interval was breached in 1 run of 33 months
Significant reduction: p-value <0.05
Outpatient First Attendances
1,353
1,253
1,153
1,053
953
853
753
653
Jun - 13
Sep - 13
Dec - 13
Mar - 14
Jun - 14
Sep - 14
Dec - 14
Mar - 15
Jun - 15
Sep - 15
Dec - 15
Mar - 16
Jun - 16
Sep - 16
Dec - 16
Mar - 17
Jun - 17
Sep - 17
Dec - 17
Mar - 18
Jun - 18
Sep - 18
Dec - 18
Mar - 19
Jun - 19
Sep - 19
Dec - 19
Mar - 20
Jun - 20
Sep - 20
Dec - 20
Mar - 21
Attendances (After HealthPathways)
95% Lower Smooth
95% Higher Smooth
Projected Attendances after HealthPathways
Attendances (Before HealthPathways)
Projected Attendances (Without HealthPathways)

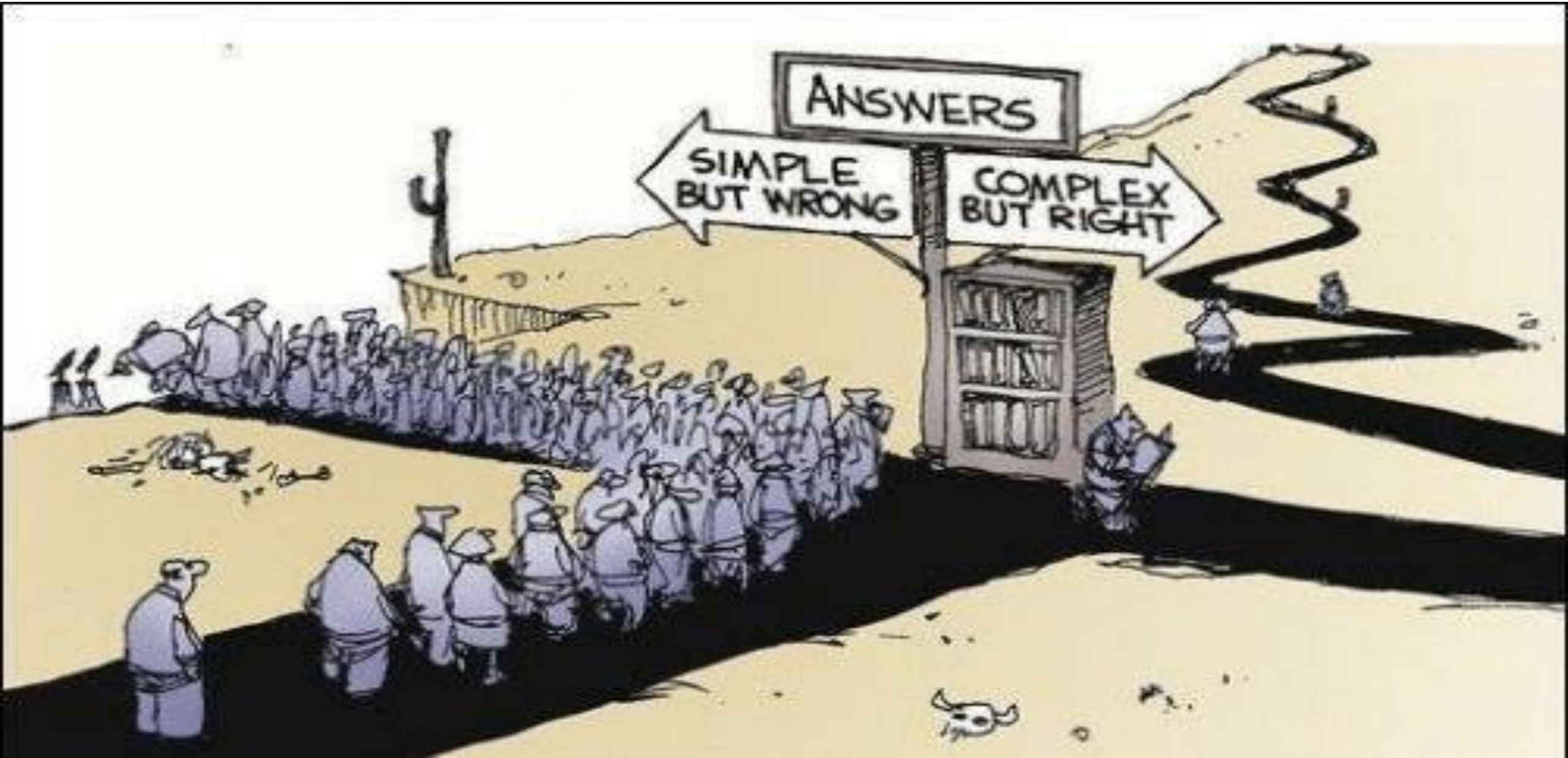

NHS National Staff Survey 2018: Average Positive Score Ranking
100
90
80
70
60
50
40
30
20
10
0
#1
All CCGs
NHS South Tyneside CCG

Hints, tips & learning

- Leadership is creating an environment
- Building trust is critical – and difficult
- Focus on language and behaviours
- Don’t worry about organisational structures or governance
- Learning and Leadership are team sports
- Stick at it!

DH LEADERSHIP ALLIANCE

If you think competition is hard, you should try collaboration



HealthPathways Community

How about we trust people? -
Someone has to trust first

October 2024

Lunch & Networking