Berkshire West
Integrated Care System

Berkshire West: PHM in Action

Dr Dan Alton
GP Partner, Wargrave Surgery, Berkshire
CCIO and PHM Clinical Lead, Berkshire West CCG
PHM Champion, NHS England

Background to Berkshire West ICP

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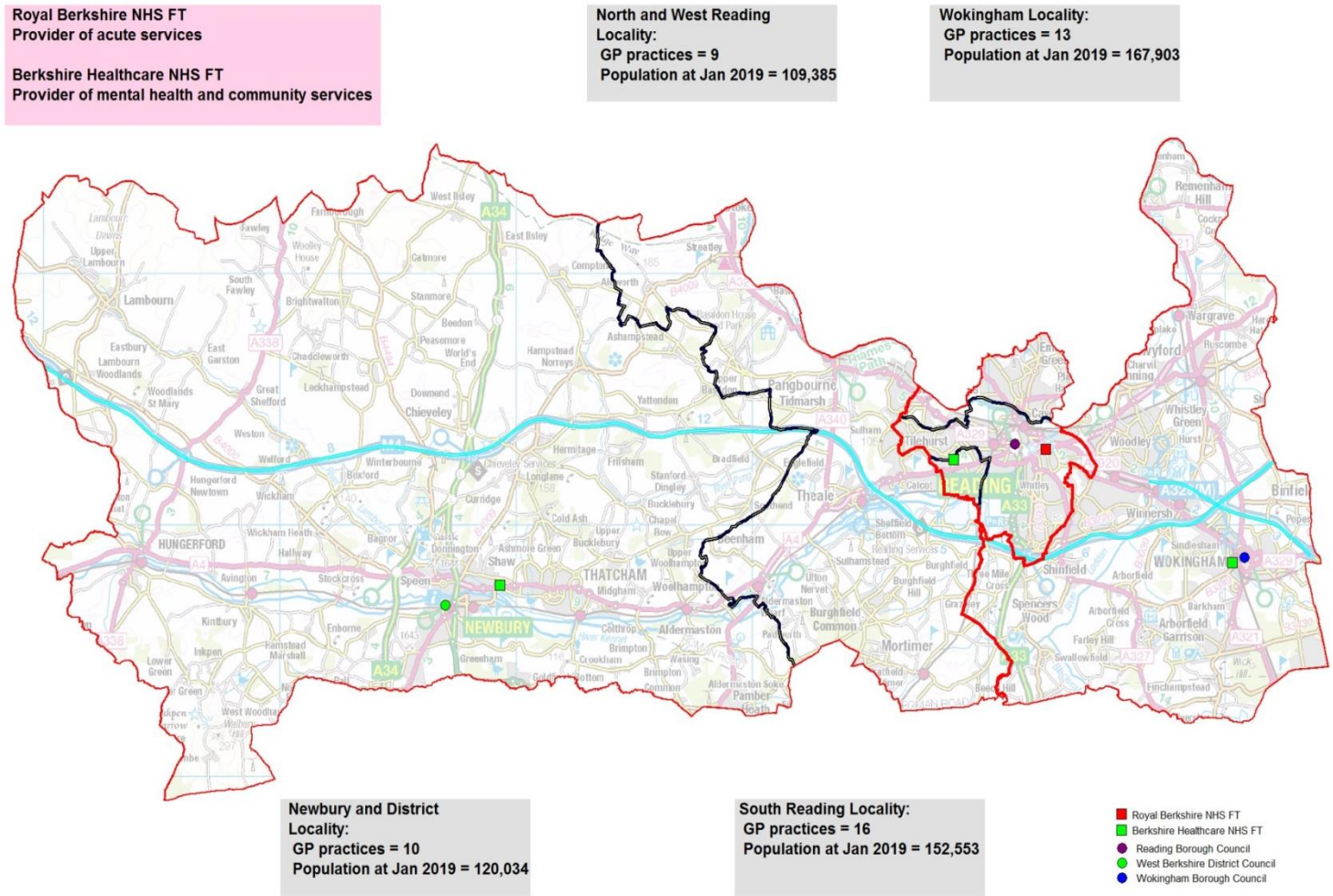
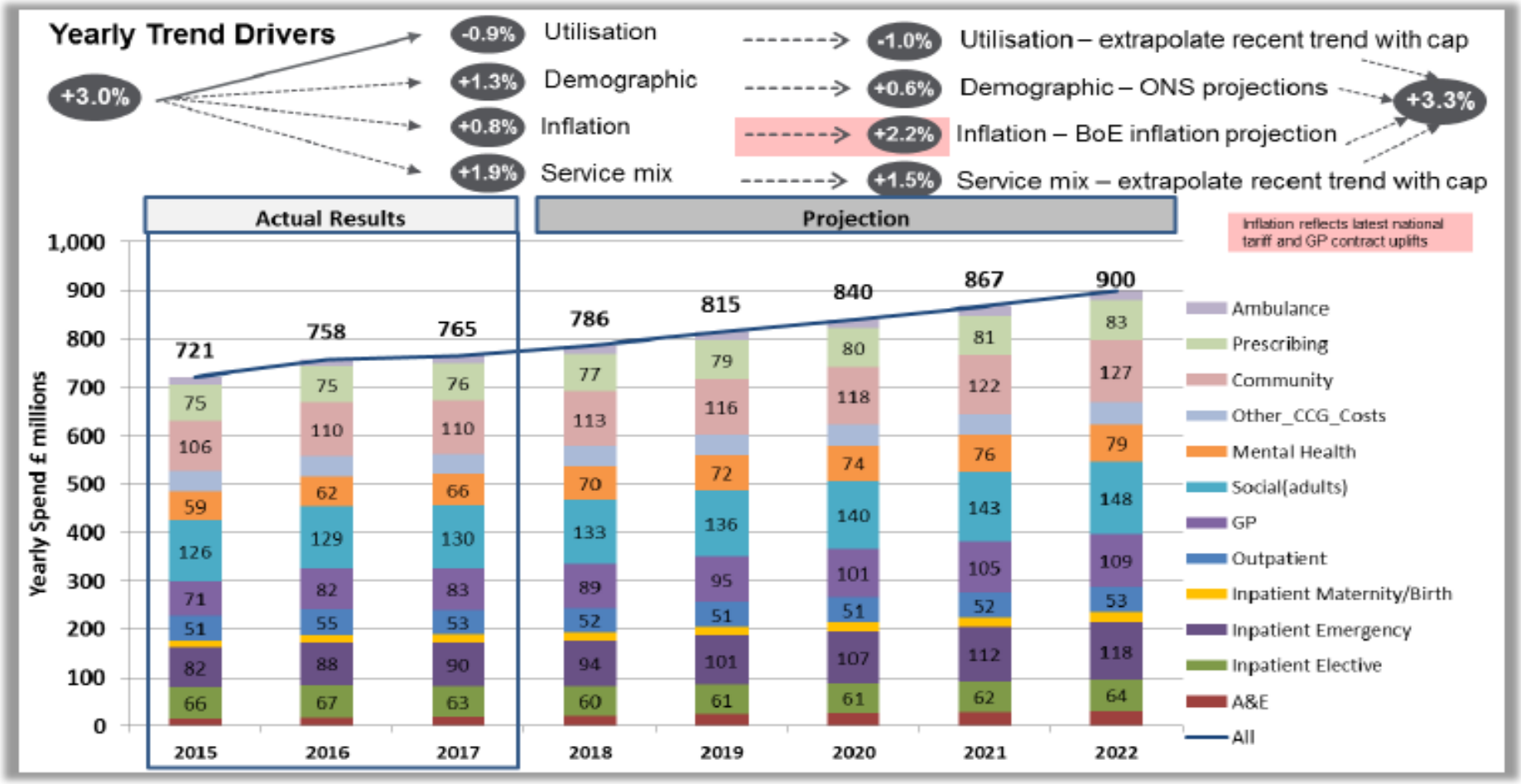


- BW is a locality within the BOB ICS
- 560K registered population
- 290k A&E attendance
- 695k Outpatient attendance
- 3.7million GP Consultations, (7.4 per person per annum)
- 14 PCNs
- 1 acute
- 1 MH and comm

The ‘do nothing’ scenario

~57% of projected spend is due to Over 65s.



The Programme

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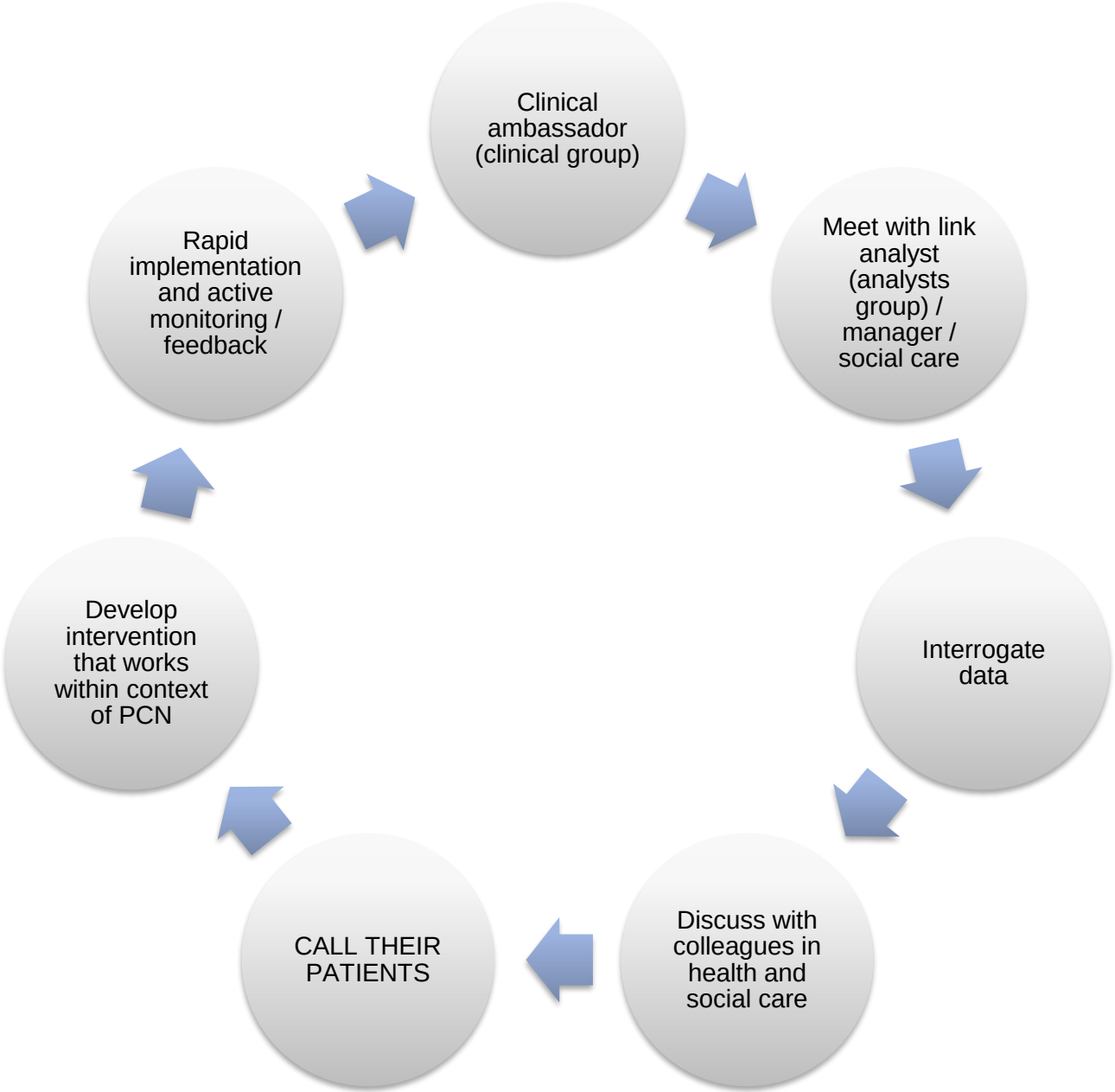
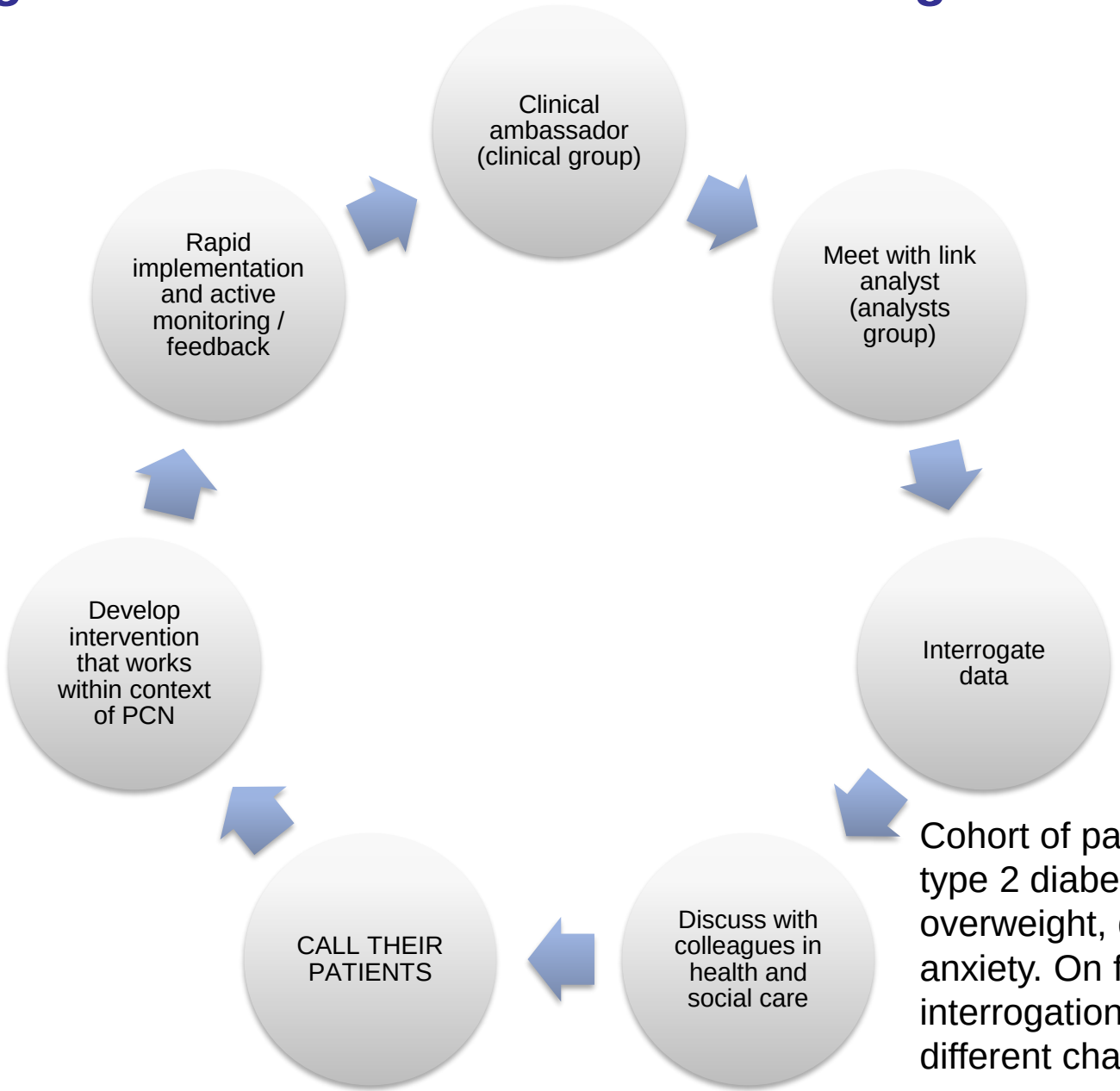
- ***Intensive 20 week NHSE programme***
- ***All levels of the system involved (health and social care / voluntary sector)***
- ***Allowed some 'breathing space'***
- ***PHE Analytical Skills Mapping Exercise***
- ***Analyst huddles***
- ***PHM Clinical Ambassadors***
- ***'Golden Triangle' Teams at all levels***
- ***Patient involvement***
- ***Sustained change***

The development of the intervention



The development of the intervention in Wokingham North PCN and South Reading PCN

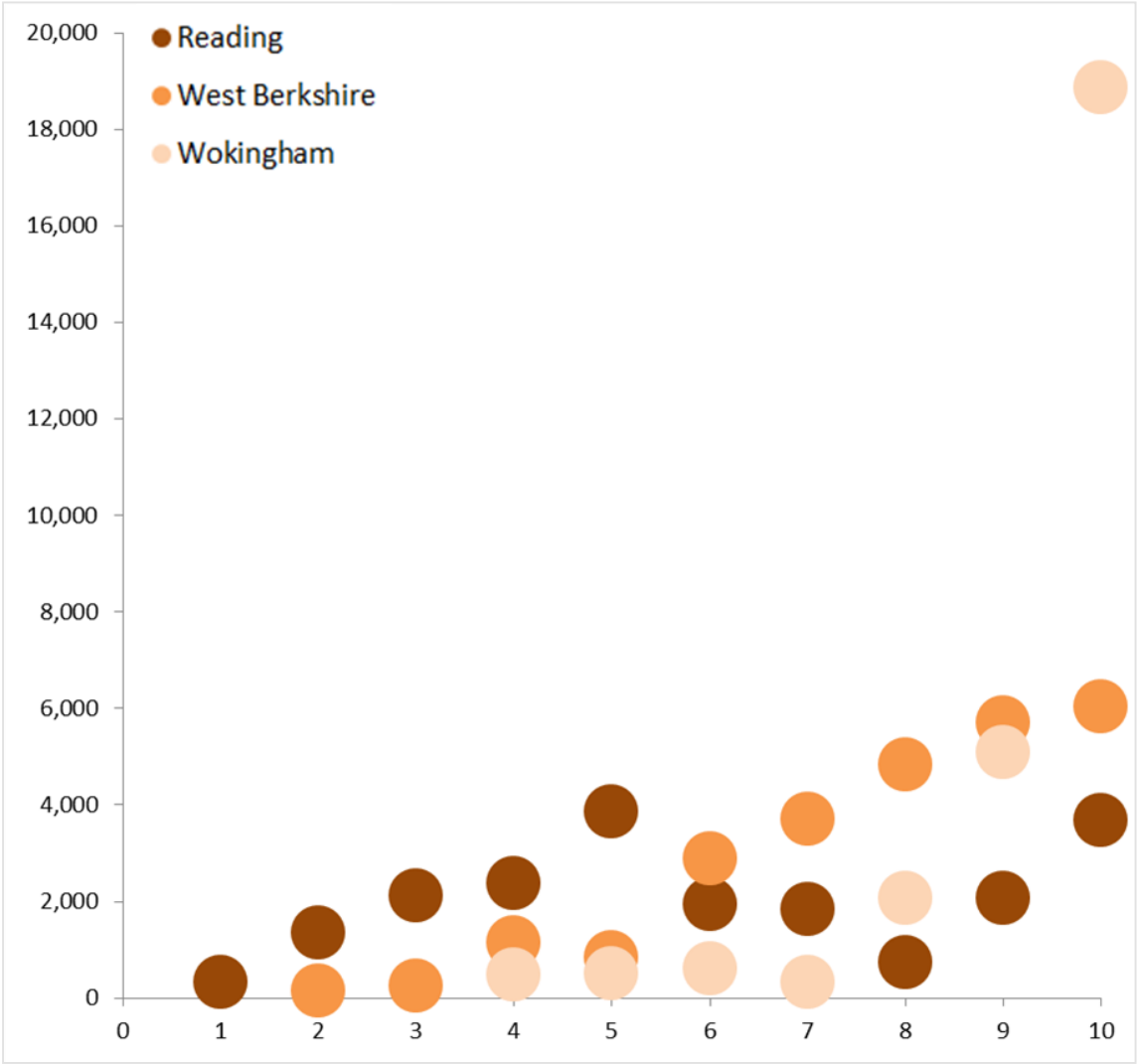


What staff are available?

’Get under the skin of the problem”, work with patients

Cohort of patients with type 2 diabetes, overweight, depression or anxiety. On further interrogation, very different characteristics

Patient 1 – Wokingham North PCN



Outcomes from an example ward-round

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MT is 56 years old and works as a management consultant. He has an extremely busy life, often travelling for work. He was diagnosed with type-2 diabetes six years ago, is overweight, and has previously suffered with anxiety and depression. He struggles to attend his nurse-led diabetes monitoring appointments and his HbA1c is in the mid 70s. He is aware that he needs to make lifestyle changes, but explained that his main priorities in life are paying his mortgage, and keeping up with his work. He doesn't really have time to 'deal with his diabetes' right now.

Intervention

Multi-disciplinary evening clinics

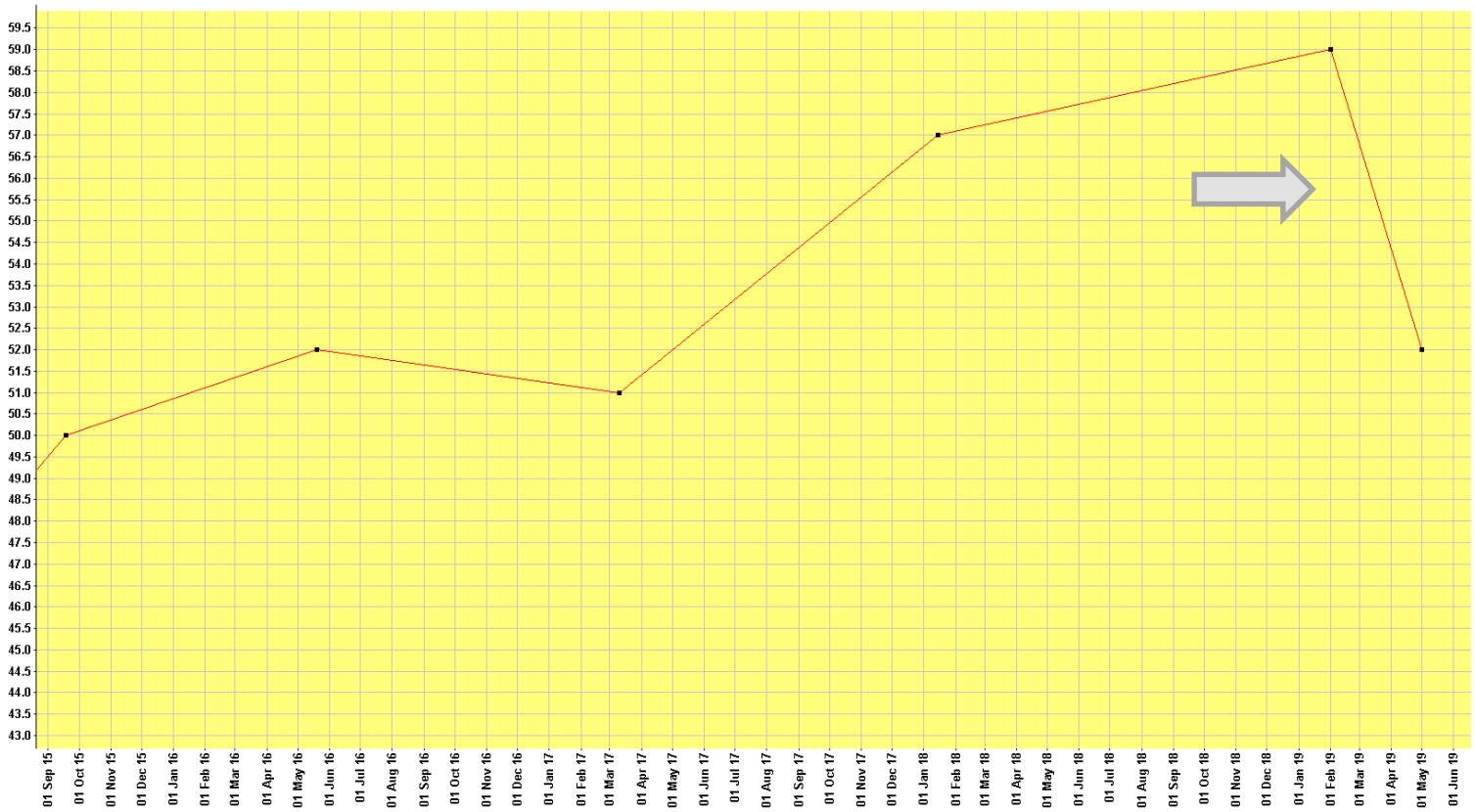
- Diabetes lead GP
- Diabetes specialist nurse
- ‘Lifestyle GP’
- Psychology input

Group consultations

Health Action Plan

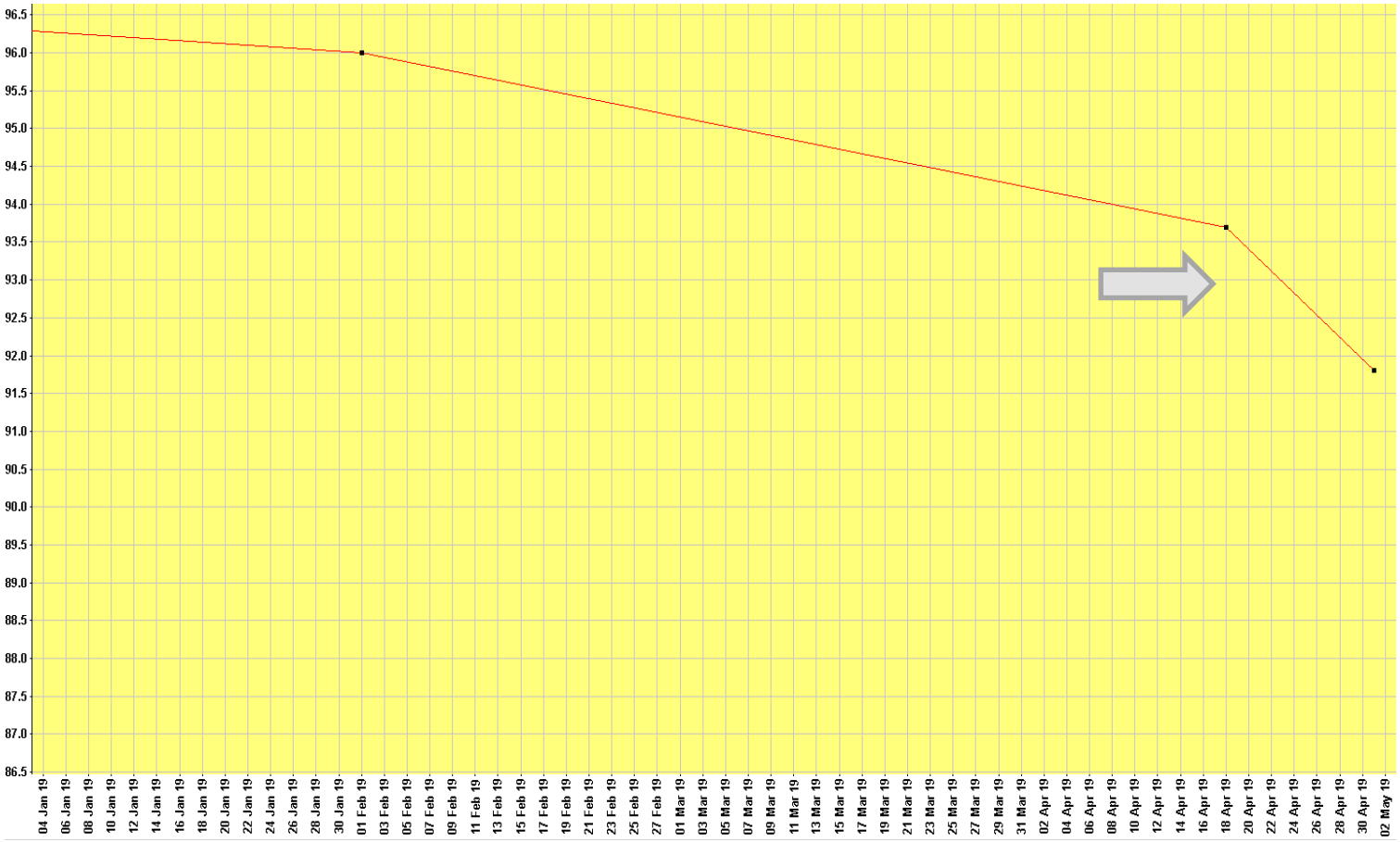
Outcomes

- HbA1c takes 3 months to change.



Outcomes

- Weight



Patient 2 – South Reading PCN

CR is 69 year old retired Nepalese women, married to a retired soldier. She was diagnosed with type 2 diabetes around ten years ago. She speaks limited English, with her husband translating for her in appointments, and has not attended any formal diabetes education. She is overweight and suffers with depression. Her main priorities are her family and community, although she enjoys walking and cooking.

Intervention

- Close engagement with community / community centres
- Adjusted Patient Education Course in Nepali delivered by Nepalese nurse
- Group consultations with patient cohort
- Backup from diabetes consultant (virtual clinic)

Next steps

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- Learn from successes and quickly disseminate good practice
- Improved data analytics
- Extend network of clinicians from across the system to promote approach / act as ambassadors
- Learn from other areas of the country
- Patient ambassadors

What has worked well over the past 20 weeks

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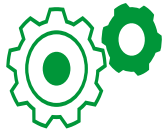
Infrastructure

- Begun to understand the opportunities from adopting a PHM approach for a Place and System
- Developing the PCN and Analytic community PHM capabilities, enhanced with the PHE PHI skills mapping
- Creating a learning and social movement culture to embrace PHM
- Understanding the design and delivery partners to move PHM forwards
- Beginning to link with Town and Parish Council to shift focus to prevented care

Intelligence

- Creation on Analyst huddles, bring together the analyst community with clinicians
- Mapping the skills capabilities Berkshire West ICS to identify strengths and gaps
- Creating of PCN data packs to support New Clinical Directors
- Learning on how the ICS can strengthen the Connected Care Infrastructure to become the single version of the Truth



Interventions

- MDT working across the PCNs
- Identification for Clinical Ambassadors to spread PHM approach and Interventions
- Adopting a logic model to testing interventions
- Linking the Analyst huddles to PCNs

Lessons Learnt

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- Our population expects us to work as a single system using our collective resource, and information to deliver care that is organized and tailored around people, not services or organisations.
- The data and expertise we have in our system allows us to move from a reactive system to a proactive system, preventing crisis and actively managing it in a holistic way, rather than picking up the pieces afterwards
- Developing our Population Health Management capability is a key enabler to this.
- Through this programme we have identified ***8 critical areas*** we must get right if we are to maximize the benefits to patients and realise the benefits from our prior investment

1. Core PHM leadership and resource	**2. Connected Care Infrastructure**
3. PCN Development at scale	**4. Governance**
5. System Level Analytics	**6. Delivery Methodology**
7. Aligning Incentives	**8. Engagement & Communications**

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Questions?