Learnings from the HSJ Summit 2018 Interactive Discussion Groups

Session Theme: Integrated and Personalised Care (for those with LTCs and frailty)

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Key Questions Posed

1. What are the key benefits that can be delivered through improved focus on personalised care?
2. What are the key tools of personalisation and integration that people have seen working and how can these be expanded?
3. How do we deliver real and long-term behavioural change in the populations we serve?
4. Who should be leading these developments? What role should STPs have?
5. What barriers exist and how do we unlock them?

Outcomes and Learnings

1. What are the key benefits that can be delivered through an improved focus/ process of personalised care?

- The key focus needs to be on delivering support to people in the way they truly want and need, not in the way that healthcare professionals think it should be provided (i.e. the traditional 'paternalistic' model)
    - This is a major shift – and one that many in the "health sector" are not yet ready to make
- This will:
    - Improve overall health outcomes
    - Make people more engaged, both in their own health management but also in the wellbeing of those around them and the wider community
    - Make people more active
    - Reduce unnecessary admissions to acute providers (thereby releasing capacity for others and/ or reducing stress on key services)

2. What are the key tools of personalisation and integration that people have seen working and how can these be expanded?

- Social prescribing works well, but could be expanded further via the creation of new roles, training and the creation of a local directory

    - For example, some areas have developed "Wellbeing Coordinators", who can take a holistic approach to the person and can advise on areas such as health, diet, exercise and social isolation
    - The use of "Health Coaches" could also be explored, which have proven to be successful in the United States
    - The idea of a "local directory" of services was well received – although these exist to some extent, they should be expanded to include all services and made clearly available to those both using services and those supporting people on how they wish to receive care
- A greater emphasis must be placed on shared decision-making, evolving from the traditional paternalistic approach to empowering the service user to direct their own care in conjunction with health, social care or community service professionals, and/ or a more informal support network, depending on what is right for them
    - There was some commentary on how more recently qualified GPs have been trained to adopt a more collaborative approach to decision-making, which needs to be adopted across the system
    - This requires a large shift in culture; listening to rather than telling people is not straightforward, and a large training/ retraining programme to avoid this change happening in decades not years
        - However, it is also important to recognise that some patients will still want to be directed by health professionals that they trust, which should also be taken into account if designing new training programmes
- Segmenting populations into key cohorts with tailored approaches has been helpful here. However, these can sometimes prevent truly personalised care and should be viewed as only the first step in delivering personalised and integrated care
    - For example, when developing personalised support plans, there is the need to move away from solely focusing on age as a determinant of health and consider other determinants such as affluence, activity-levels, digital-savviness etc.
- Personal health budgets are seen as a way of giving people with LTCs more choice and control over how money is spent to meet their needs; however, it was noted that roll-out of this approach has significant challenges, not least the multitude of challenges facing FDs, who may view personalised budgets as a risk and difficult to control within such a tight fiscal environment
    - The work being done by Tower Hamlets CCG was cited as a good example of this working well

(http://www.towerhamletsccg.nhs.uk/news/tower-hamlets-leads-the-way-on-personal-health-budgets/69794)

- Technology can play a key role to support the delivery of personalised healthcare – it can help consolidate information for service users/ patients and allow multiple providers (both in and outside the health sector) to interact with people in a more seamless fashion
    - Some noted that the previously held view of "digital was only for the young" was beginning to unwind – age should not be necessarily an impediment to the use of technology
    - However, it was also noted that some demographic groups in the UK, especially those in more deprived areas, will still have limited access to the internet and/ or mobile technology, so any models must work for those with and without access to technology
        - Failure here could potentially lead to further exclusion and marginalisation if not carefully taken into consideration

3. How do we deliver real and long-term behavioural change in the populations we serve?

- The strong consensus was that people are already willing to engage in their own health and how to manage it – the key was to listen to them on what outcomes were truly important for them, and how they wished to achieve them
- The NHS (and others) therefore needs to be proactive about engaging people at the local level, developing initiatives to get citizens engaged
    - Engagement needs to begin before medical intervention, by reaching out to people in their homes and neighbourhoods
        - This supports the need to refocus on prevention, which could begin by engaging the younger demographics, for example by creating initiatives at schools and universities
    - Any initiative would benefit from the involvement of the voluntary sector and LAs and should consider other channels of engagement within the community (e.g. local churches)
        - The "Troubled Families Programme" is a good example of a targeted intervention programme run by Local Authorities
    - This engagement should be undertaken at the 30-50,000 population level ("neighbourhoods"), as anything wider would not factor in key local differences of populations
        - An illustrative example of this is how the definition of "frailty" varies across geographic denominations due to the unique composition of local populations
        - A successful case study of how this has been achieved is through the creation of a citizen panel in Surrey, where 3,000 citizens were recruited to mirror the demographics

of the region and using this as a virtual panel to test prioritisation and questions on what the community wants from a health and social care point of view

- Initiatives should focus on how to address the most vulnerable groups in society even though they might not represent a large proportion of population, as those are the groups that would benefit the most from personalised care
  - A successful pilot was noted where health professionals spend more time in their community, for example by attending homeless shelters (and other key community centres)
  - Close links with social housing providers was also noted as a successful route to connecting with populations that are not being successfully served by traditional models of care

4. *Who should be leading these developments? What role should STPs have?*

- Contributors commented that much of this activity needs to be fostered and delivered at a very local level
  - Personalised care relies on local passion and compassion; centrally dictated initiatives risk missing this passion and the momentum that has been developed in some areas
- The person who delivers personalised care advice/ support can be anyone, and indeed should be whoever is best placed to engage a person
  - Despite that, GPs were noted as often being the "natural start-point" for the development of personalised care
  - The success of nominated Wellbeing Co-ordinators was also discussed – though they must be immediately connected to all of the local providers of support across the NHS, LAs, voluntary and other sectors
- However, it was also agreed that relying solely on "bottom-up" actions and initiatives would not materially change the status quo – this was what has happened to date and progress has been too slow, despite the known benefits of engaging those with LTCs and frailty in their own health
- The general consensus was that STPs, and in particular ICS (or similar) models can provide the framework for this to be developed
  - Can support the redployment of budgets within a region to focus on prevention rather than treatment
  - Can bring in non-NHS organisations (e.g. LAs, the voluntary sector)
  - Could direct regional training programmes, or establish new roles to act as integrators (e.g. Wellbeing co-ordinators)

    - Can engage Primary Care providers at a more aggregated level to develop shared models and approaches
- Existing pilot schemes and case studies of successful ICSs could also be more widely documented and used to inform the development of future ICSs
    - The best way to drive progress was to recognise and share successful local models
- There is a need to recognise the importance of having a defined process and governance structure in place to guide the implementation of certain initiatives
    - Achieving any magnitude of change will require commitment within all levels of the NHS which should be taken into account when designing governance structures

5. What barriers exist and how do we unlock them?

- The approach to commissioning should evolve to allow for cross-sector collaboration and to ensure the correct incentives are in place
    - Commissioning could be more flexible in order to promote a better person-centric approach
        - This includes, for example, having the ability to move budgets from health to social care
        - At the local level, it is thought that adopting a more flexible approach to personal health budgets would also be beneficial
    - Financial models may need to be realigned to ensure they focus on the patient's needs and promote collaboration e.g.
        - The current tariff system promotes surgical procedures, which often does not represent the best outcome for the patient
        - Social prescribing needs to be financially recognised as an alternative to traditional models
            - Medical prescriptions are often seen as the "easier" and "cheaper" alternative
- There is a general lack of information and resources available to staff
    - An example of how this could be overcome would be by providing GPs and other key local advisors with a "directory" which includes all the services available inside and outside of the clinical context
        - This would need to be dynamic and adaptable to each patient