Cheshire and Merseyside
Health and Care Partnership

Data Into Action

DIA Update to ICB
January 2025

Reflections upon 2024 and plans for 2025

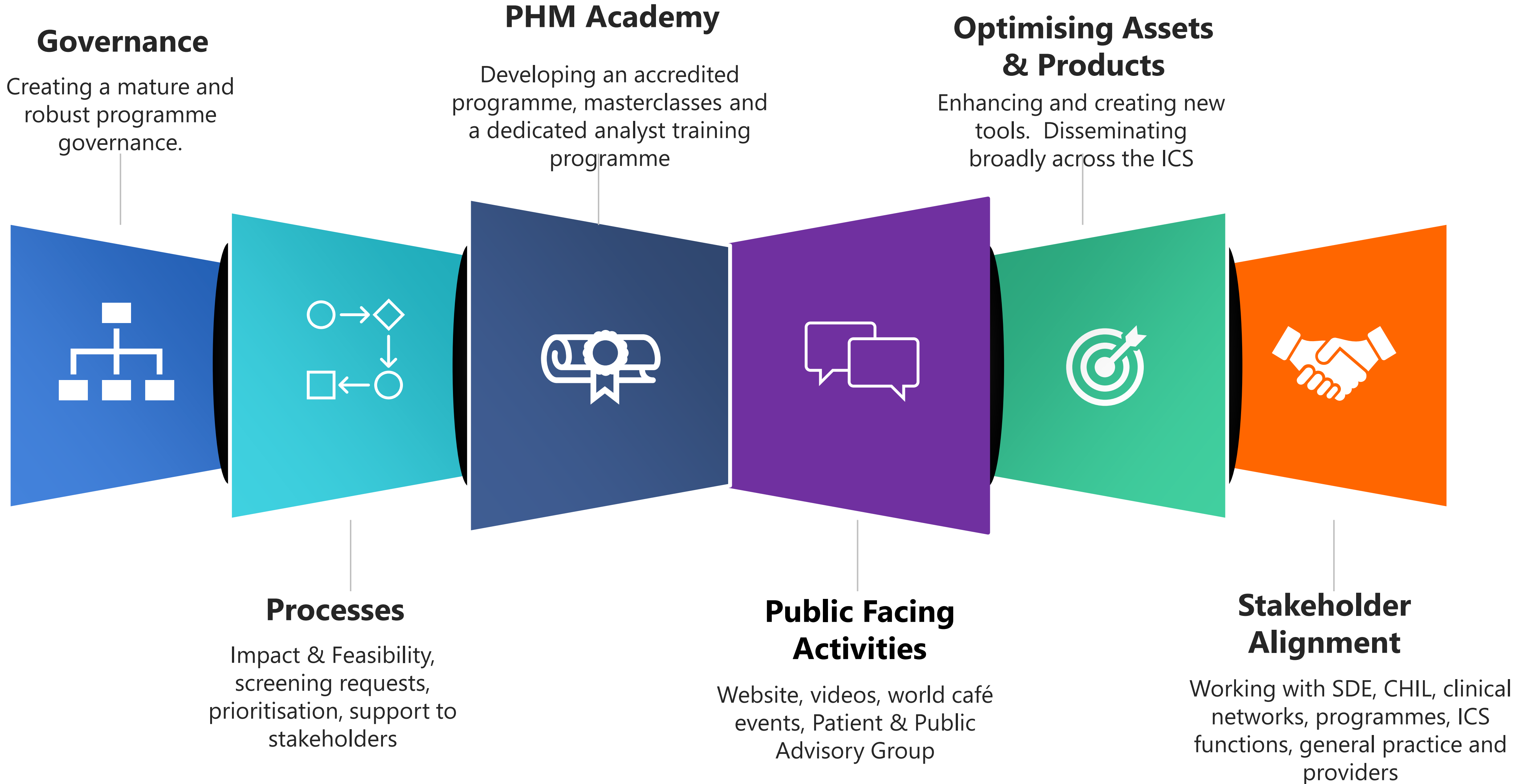
Structure of this update

1. 2024 Progress
   - Governance
   - Processes & Prioritisation
   - Population Health Management Academy
   - Public facing activities
   - Optimising Assets - case studies of interventions
   - Stakeholder alignment – example area Secure Data Environment (SDE)

2. Strategic Commissioning and Federated Data Platform

3. The ask of the Integrated Care Board

DIA Programme Development in 2024



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Governance

	DIA Board	DIA Ops Group	Data Access & Asset Group	Multi Prof Steering Group	Patient & Public Engagement	Data & Tech	FDP PHM
2024	Strategic oversight	Oversees all programme delivery elements	Approves direct care requests	Influences the application of tools	Overseeing all activity	Working with Secure Data Environment	
	Driven and shaped programme processes	Joint planning with partners	Approves research requests	Informs the Academy	Additional Communications workstream	Additonal Data Quality Forum established	
	Linked DIA to other governance	Widened membership		Topics for 2025 outlined, evaluation underway	World Café events and reports		
2025	Continued assurance	Scrutiny of all requests	Establish separate DAAG for research	Broaden input of academic institutions	Additional Patient & Public Advisory Group created & LCR Residents Assembly on Data & AI	Continue work to deliver SDE	Delivery schedule of groups & workshops
	Move to bi-monthly	Alternate formal/informal format	Agree precedents, streamline processes	Alignment with Research & Innovation Committee	PPIE move to bi-monthly	Support new data flows	Support from Innovation NW Coast

Programme Processes

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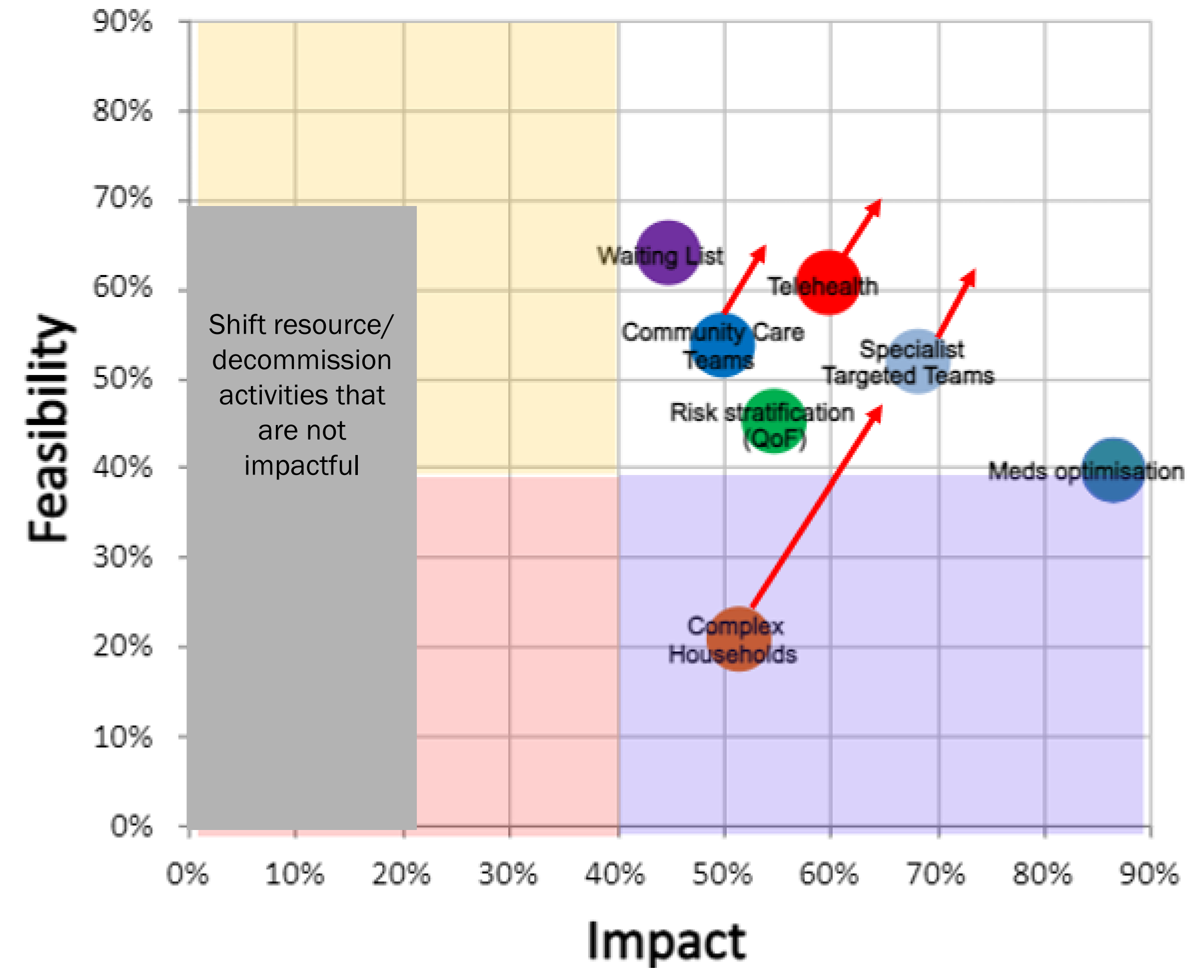
2024

- An Impact & Feasibility Assessment was created in May and used to define the programme priorities –
- DIA clinics for access to the data assets were established in the summer
- Joint strategy and planning session with Medicines Management, BI and DIA
- Work to embed DIA into the ICB commissioning, planning and strategic intentions processes
- Resource needs to follow – decommissioning; unwarranted variation

2025

- DIA has become formally recognised as an ICB programme – now sits within the Digital Directorate
- Embedded into the financial & contracting processes for this directorate
- Joint planning & prioritisation session with BI Population Health Team – new processes in development
- Joint planning session with Medicines Management, UoL and BI on Polypharmacy

Summary of the scorings for all 7 priority areas



HEALTH INNOVATION North West Coast COACHING ACADEMY

PHM Academy Driving Feasibility

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- 20 attendees on Cohort 1
- 2 more cohorts for 2024/5
- 150 analysts signed up for 9-month programme
- Cohort 2 commenced 8th November
- Cohort 3 – to start March 2025

- 84 people attended ECFT
- 63 people attended Waiting List Tool
- 55 People Attended Diabetes session
- 5 Drop-in Session for GPs Complex HH
- Complex HH Masterclass Match 2025
- Respiratory session in development

- DIA Website created
- Bite-size videos ECFT
- Case Studies
- Academy Animation
- Fuel Poverty Toolkit
- Primary Care & Service Processes

- Care Community Teams/ICTs
- Respiratory reviews in COPD hot-spot
- Prehab offer for diabetes & cancer
- 421 Users of ECFT
- 234 Users of Fuel Poverty Dashboard
- All tools have been accessed 6150 times in 2024 already

- Circa 2000 additional telehealth patients
- 1100 high risk surgical patient for rehab
- Circa 900 additional community patients
- Fuel poverty 650 patients supported
- 130 prehab offer for diabetics on w/l
- Circa.20 targeted COPD reviews ahead of winter
- 20,000 patient reach 2025

*ECFT – Enhanced Case Finding Tool

Communications & Public and Patient Engagement

2024

- World Café Events
- Patient forums
- The Use of Administrative Health Data for Research Report
- Population Health Management Academy video - CC381 Data Into Action 18 12 24 – YouTube
- Website development Data into Action

2025

- 'Use of data' Public awareness campaign – February- March
- Patient & Public Advisory Group
  - Training commenced
  - First meeting in February
  - Topics for engagement underway e.g. linking non-health data
- Liverpool City Region Residents' Assembly on Data and AI Innovation - Civic Data Cooperative
- Shared learning and joint working with children and young people data engagement leads

Integrated Care Teams Sefton Place (ICTs)

Elderly Frail

- To date 194 elderly at-risk patients in Sefton have been contacted by the ICTs to offer proactive support
- ICTs in Sefton commenced enhanced case finding in November 2023 following a period of consultation with partners and training in the use of the system
- The initial approach limited searches to 2 GP practices in phase 1 and 14 GP practices in Phase 2 in order test the system and processes in place and seek feedback from partners
- Phase 3 searches included 9 GP practices who had not previously been engaged with as part of the enhanced case finding process
- Searches were staged to ensure that patients were added to the ICT Caseload in a staggered manner to avoid breaches of the ICTs assessment standard of 2-weeks from referral
- Most common services for onward referral were Sefton CVS, OT, Physio, Meds Mgt, Mental Health & Social Workers. In phases 1 – 3 only 5 service users required case discussion with their GP practice.

High Intensity Users

- Next phase has commenced with a new criteria – High Intensity Users, adults with 20+ A&E attendances in the previous 12-months in South Sefton (24 patients identified) and 14+ AED attendances in Southport and Formby (31 patients identified)

Sefton Place High Intensity Users					
Patients	A&E Attendances	GP Encounters	Inpatient - Emergency Admissions	111 Queries Count	999 Calls Count
55	1457	8575	263	1089	1551

Cheshire East Care Communities

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- **GP Practice Engagement:**
  - All Cheshire East GP Practices have signed the data signing agreement enabling their data to flow from EMIS
  - All Cheshire East GP Practices have =>1 user with Patient ID view. Many have several users, including GPs, Practice Nurses and Practice Managers.

- **Cheshire East Care Communities:**
  - All 8 Care Communities have used CIPHA searches to establish their focus cohorts for the Better Care Fund Investment Projects. Clinical leads and Coaches have worked through the criteria they feel would best suit their individual work plans
  - Feedback from the Communities illustrates the value they feel having this data has added; intervention with these patients is specific, appropriate and targeted
  - Several patient stories have emerged of how searches have found patients that previously were under the radar, but who now are receiving the support they need
  - The population segmentation approach has enabled us to illustrate, via Patient Need Groups, how each cohort is reflected within the Healthcare system, via activity and cost. This intelligence is crucial as we plan Community projects for 2025/6
  - Latest data across the Communities indicates that c2,150 patients have been identified via searches and c450 have received specialist intervention.
  - The work is ongoing through 2025 with many more clinics and appointments planned.

Long Term Conditions

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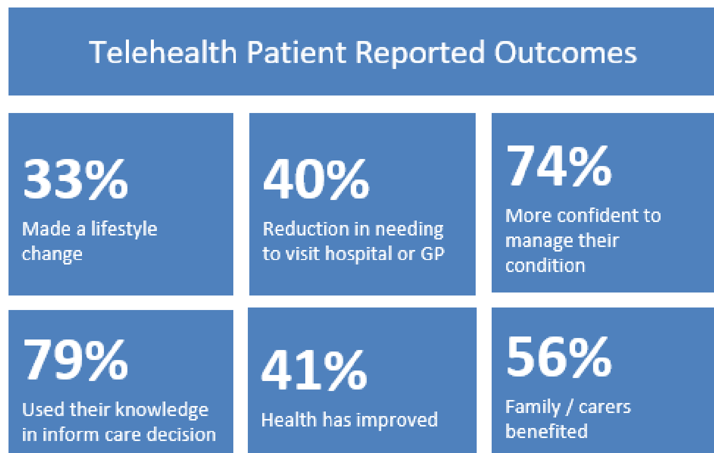
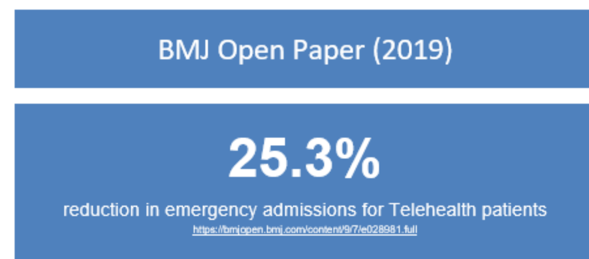
Telehealth

The use of Telehealth to support patients with long-term health conditions has been operational within Cheshire and Merseyside since 2011/12. So far, c.23,000+ patients have been supported by Mersey Care's Telehealth Team across Liverpool, St Helens, Sefton, Wirral, and West Cheshire. To date following patient outcomes has been identified…





https://bmjopen.bmj.com/content/9/7/e028981.full

A subsequent evaluation is being conducted by Mersey Care and CHIL

Using the Enhanced Case Finding Tool the Telehealth team in Liverpool have increased their caseload from **250** in early in 2024 to almost **2000** by the end of 2024.

"The team loved doing these reviews. They felt that they were meeting very unwell patients"
Community Respiratory Team Leader

Respiratory Risk Stratified Targeted Review - Patient Criteria (Proof Of Concept)

- Identify high-risk patients (18+, smokers, >75% risk of admission)
- Intervention - comprehensive COPD review
- The patient uptake rate of 87% far exceeded expectations
- All patients received respiratory education
- Roll out across the ICS
- Work with network to roll out at scale. Joint masterclass in early Spring
- Work alongisde Fuel Poverty

Fuel Poverty

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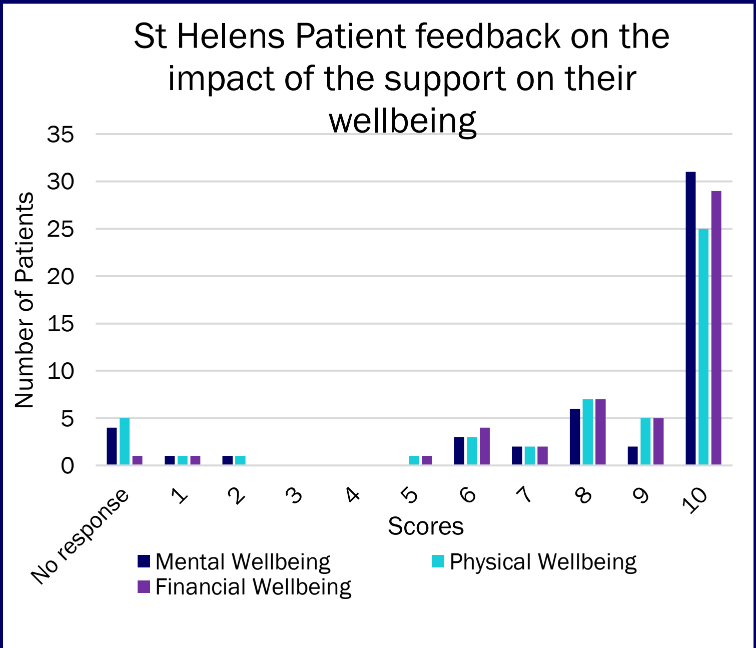
The Fuel Poverty Projects have proactively identified patients living in fuel poverty with a respiratory condition using the CIPHA dashboard. Patients have been contacted and offered a range of clinical, social wellbeing and financial support. There are four existing projects in St Helens, Knowsley and Warrington targeting patients with COPD or children with a respiratory wheeze. Further projects are in development in Liverpool, Sefton and Wirral.

Deliverables

Since 2023 across four projects, over 650 people have been identified and contacted with the following outputs:

- £362,000 in total allocated to patients from Local Authority Household Support Fund
- Over 500 people have had their medicines optimised
- Over 100 people referred to pulmonary rehabilitation
- Over 270 households added to the utility providers' Priority Register
- 100% of children seen now have a management plan
- Over 350 people referred to social prescribers, smoking cessation, weight management or health trainers



Outcomes

Initial findings of a detailed evaluation of data from two COPD projects over a 12-month period and using a control group indicate the work has led to a reduction in the number of presentations at A&E and admissions to secondary care (unpublished).

Feedback from 50 patients supported through the St Helens COPD project overwhelmingly expressed a positive impact on mental, physical and financial wellbeing.

There are early signals that the St Helens pre-school wheeze project has had a positive impact on admissions and A&E attendances.

Embedding a holistic care

"I've understood for a long time about why the determinants of health were important, and that health care is only a very small part of that. But that feels like a very big issue to tackle. The fuel poverty project has really brought to light what you can do in a medical consultation to think about wider determinants of health. So now, I do ask patients during my standard consultations, you know, what's your home like? Is it cold?".

Sarah Sibley, Respiratory Lead for Cheshire & Merseyside ICB.

"The dashboard is very beneficial. Things we have never thought of before. It is working in a different way, for these patients who are socio-economically deprived and living in poor housing. We now know the quintile of deprivation patients are living in and flagging that"

Dianne Green, Lead COPD Nurse, St Helens Community COPD Rapid Response

Aligned Proactive Models of Community Care – Three DIA Priority Areas (Telehealth, Specialist Targeted and Community care teams)

Strategic approach to alignment and effective management of patient cohorts. Darzi acute to community. DIA working with Place teams & Clinical Networks

Work has commenced on these areas, but ambition is to adopt consistently across ICS in 2025

Community Care Teams

Targeted Proactive Frailty Care & MDTs, Social Care Support

Targeted Proactive Diabetes Care

Targeted Respiratory & Fuel Poverty Offer

Telehealth

Targeted support to patients on Waiting Lists

Targeted Proactive Heart Failure Care

Targeted Proactive Renal & Hepatology Care

Proactive Models VCFSE & other partners

Needs and risk led patient care – more holistic responsive. Catalyst for integration. Promotes population evaluation rather than service specific

Exploration and development of these areas for 2025

Stakeholder Alignment Example - Secure Data Environment supporting research

- CM contribute to the development of the NW SDE – and have received circa **£800K** in each of the years 2023/24 and 2024/25 to develop technical capability, IG and public patient engagement.
- University of Liverpool reference CIPHA and SDE in bids where the NHS is the 'action space' – these bids total circa **£15M** and the work directly addresses CM ICB priority areas eg meds management, public health, population health, childhood studies etc. For 2025/26 bids in development including NWC ARC will exceed **£15M**

- The SDE platform will be operational during the latter part of 2025 and the technical platform will be running in shadow from February 2025. CM ICB are the leaders across the NW ICBs in supporting the platform with 'test' projects and have currently 11 'pipeline' research projects that are being assessed in pilot in CM ICB through a CM SDE data access group.

2025 Enhanced Focus

Strategic commissioning including exploiting the capabilities of a PHM product on the Federated Data Platform

Strategic Commissioning

Complex Households – DIA Segmentation

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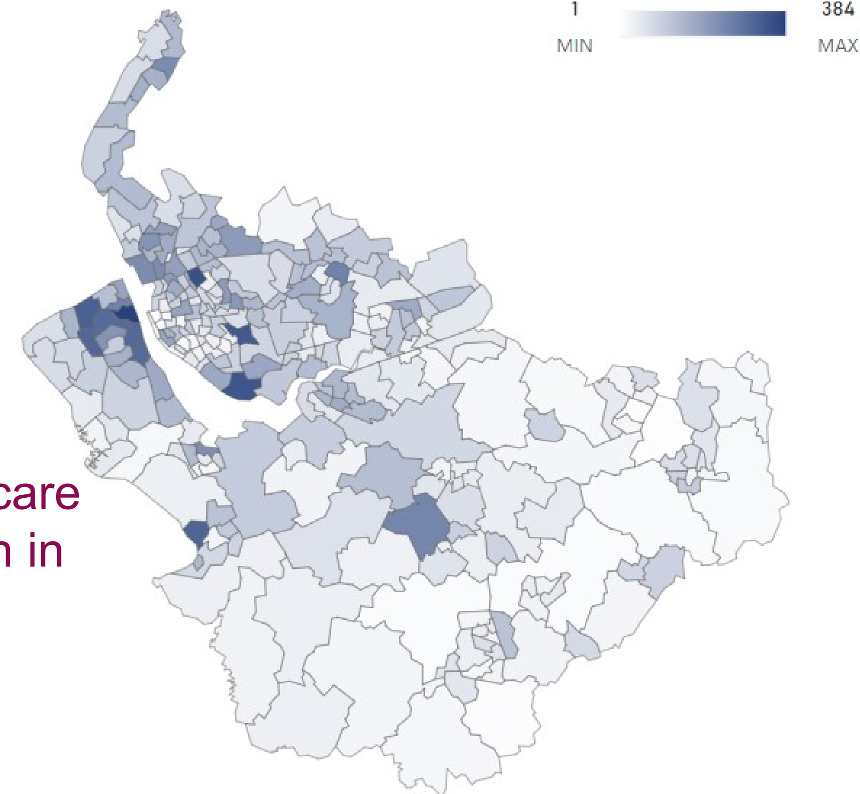

[System-wide health needs segmentation: innovating integrated care for complex needs households | European Journal of Public Health | Oxford Academic]

8 % of families account for 34 % of health and social care costs for families with children. This was £ 315 million in total.

NIHR | National Institute for Health Research

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System Opportunity

Improve experience, outcomes and cost

It is estimated that around 1 in 3 of the households with complex needs in Liverpool have used Citizens Advice On Prescription at least once between 2018 and 2022.

- Client reported outcomes: reduction in anxiety and depression by 20%
- Reduction in antidepressant prescribing by 73 Average Daily Quantities per person per quarter.
- 7 fewer A&E attendances per 100 clients per quarter.
- No adverse effect on GP consultations
- Small decrease in emergency admissions

Living conditions to be added to NHS records

Social housing residents' living conditions will be added to their medical records

BBC News Living Conditions

Prima - Search News

1. Influencing Office Public Sector Innovation (OPSI) work across Liverpool City Region
2. Explore opportunities for Social Prescribers to use the Complex Households Tool
3. Commence using Housing Association data in partnership with appropriate local services
4. Family based models of care – households with multimorbidity & multiple needs – joint rather than aged specific, siloed interventions

NIHR | National Institute for Health Research

The Health Foundation

citizens advice Liverpool

Prifysgol Bangor University

Strategic Commissioning

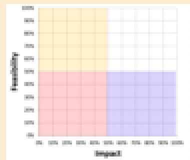
6 Key Enabling Actions for Complex Households 2025

Pop Health Academy

Upskill, empower and adopt.
Broaden the offer to include VCFSE and other partners

Knowledge Store

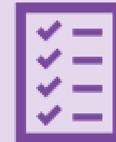
Library of specifications, use-cases, impact & evidence, engagement work, help guides etc



Impact & Feasibility

Assess and prioritise interventions in a robust and consistent manner

Business As Usual



Make inroads in existing BAU processes to embed Complex HH – e.g. commissioning intentions, PDRs, contracts, Place Boards

Connected Care Record

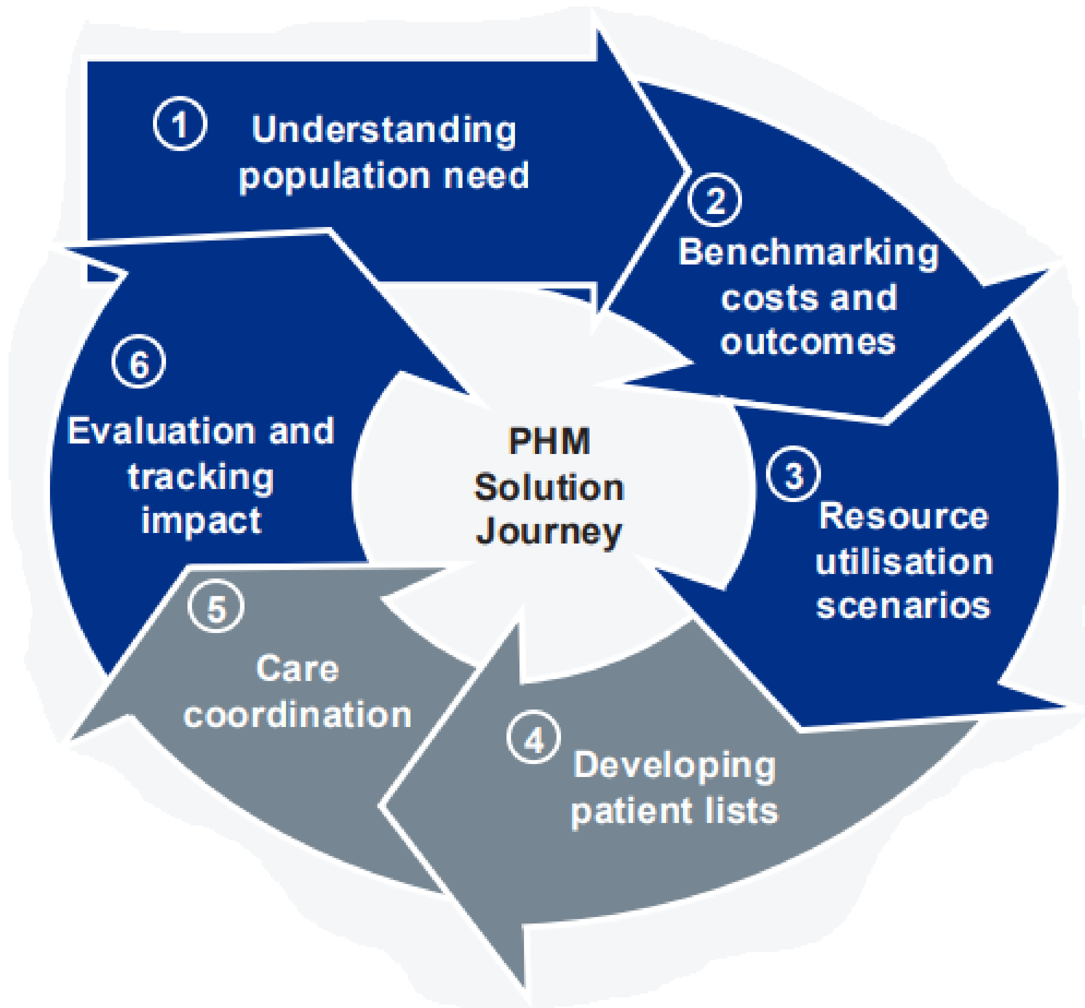
Key enabler to effect better system management of Complex HH. Reducing duplication & fragmentation

Financial & Contractual Innovation

Innovation in practice to promote outcomes based models, resource realignment, efficiency gains and effective collaboration

Enabling methodology NHS IMPACT: An approach to continuous improvement

Federated Data Platform



Added Value for 2025:

- Brings additonal resources and capabilities to the ICS
- Addresses some of our skills and capacity gaps
- Provides strategic support to linking patient level costing datasets
- Supports a robust health economics and population health management approach
- Important to achieve insight for effective strategic commissioning
- Enables us to assess and redesign the allocative model – creating system opportunities
- Link to the CMAST work on FDP – all trusts signed up to this now. Patient Tracking List Tool

Summary of the year ahead

1. Consolidation of progress to date, enhance capabilities and focus energies - continue commitment to DIA priority areas but extend reach, scale and impact
2. Refine and reset the governance as we move into this next phase
3. Optimise the data assets and research capabilities in alignment with priorities
4. Maximise the reach of the PHM Academy to ensure we are moving to a learning system
5. To intensify the value of FDP PHM investment by embedding in the Complex Households Strategic commissioning piece
6. Strengthen the knowledge, skills and business continuity within the team
7. Integrate with the other components within the Digital infrastructure – e.g. Connected Care Record
8. Work with places to oversee integrated proactive models

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What is the ask of the Integrated Care Board?

Mandate an accountability framework to support an approach to strategic commissioning that ensures that we scale and embed DIA priorities and products

- Create an appropriate governance at place to ensure that DIA proactive models of care are designed and mobilised as part of a wider Community approach
- Embed the six key enabling actions for Complex Households