Protect-NoW

Proactive Population Health and Care for Norfolk and Waveney

Protect NoW

Virtual Support Team Productivity Report 2023-2024

Protect NoW – Virtual Support Team Productivity Report 2023-2024

Protect-NoW
Proactive Population Health and Care for Norfolk and Waveney

In this last financial year, the Protect NoW Virtual Support Team (VST) successfully recruited to our 2 call agent vacancies. Resulting in us being at our full establishment of 5 operative calls agents since May 2023.

The team have continued to maintain 100% ICB mandatory training compliance and enrolled onto additional training opportunities to continue to expand our knowledge and expertise when offering services and engaging with patients. We have additionally all received training accreditation for motivational interviews.

We have supported and worked on a variety of projects across Norfolk & Waveney ICS. Resulting in us sending a total of 32,749 letters, 16,499 SMS's, attempted 55,860 contacts and us having spoken to 26,534 patients on the phone where we have offered support and where possible alternative services.

From the total of 32,749 patients we sent letters to, we had successful engagement with:

- 6,319 Patients from deprivation decile 1-2
- 5,490 Patients from deprivation decile 3-4
- 10,356 Patients from deprivation decile 5 and above
- 349 patients engaged with SMI
- 236 patients engaged with LD
- 473 patients engaged with Dementia

We have referred 8,928 patients across different NHS services (services offered being project specific based on the project specification and patient cohort)

Follow our work here:
https://improvinglivesnw.org.uk/our-work/healthier-communities/population-health-management/phm-projects/

Dementia – North Norfolk

Purpose: To contact patients of participating GP Practices coded as living with dementia.

Objective: To complete an initial triage call with the patient/and or identified carer/Power of Attorney to establish whether the patient living with dementia would like a telephone/face to face discussion with our District Council/ Norfolk County Council partners around non-clinical interventions to support their health and wellbeing and their careers.

Method: Protect Now Colleagues will work with a small project group to agree the list of triage questions and a script of the types of advice, information and practical interventions the patient or their carer will be able to receive should they wish to participate. Protect Now will make the initial call and then pass the information back to the relevant Practice Manager. The Practice Manager will share under existing Information sharing agreements/protocols with their Borough Council/Norfolk County Council.

Batch 1 letters sent on the 25th March 2023 – 4 Practise with a total of 400 patients, Calls to start in April 2024 and project to continue in this financial year.

Batch 2 – 4 Practise with a total of 404 patients, letters will be sent out in the week commencing the 8th March

IAPT – April 23 to 31st March 24

Protect-NoW
Proactive Population Health and Care for Norfolk and Waveney

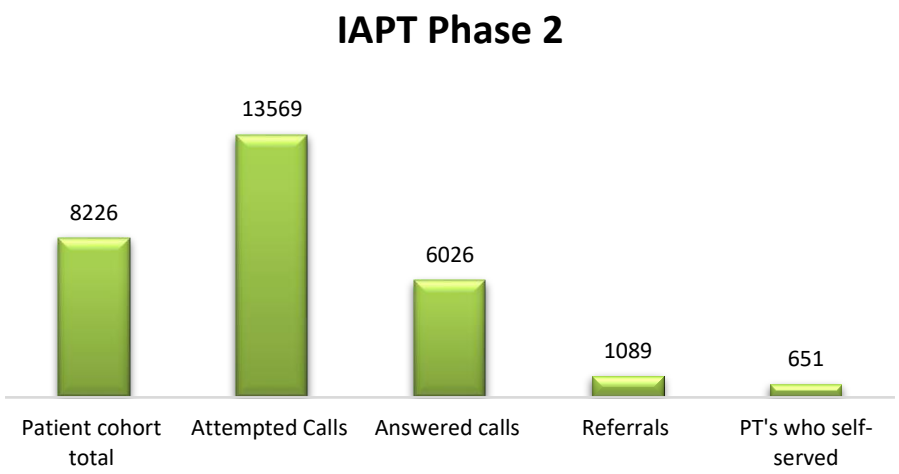
Patient cohort – All patients over 16 Prescribed first line anti-depressants in past 6 months. Over 80s excluded.

Purpose: To increase awareness of and access to the Norfolk & Waveney Wellbeing Service (IAPT) for people experiencing mild to moderate mental health problems such as anxiety disorders and depression. Appropriately use the capacity available within the Wellbeing service and meet the needs in our population.

Objective: The identified cohort does not differ from the wider system. Increased access to the Wellbeing Service may result in benefits to the wider transformation include reducing the burden on primary care; improved employment outcomes; reduction in antidepressant prescribing; improved management of LTC; reduced need for secondary care services.

Method: Protect NoW will be sending out letters, follow up with SMS to incentivise self-referrals, followed up by calls to all of those who haven't responded to the offer and encourage patients to engage with the service.

Kick off March 2021 - Current reports only for 2023/2024 – To continue 2024/2025

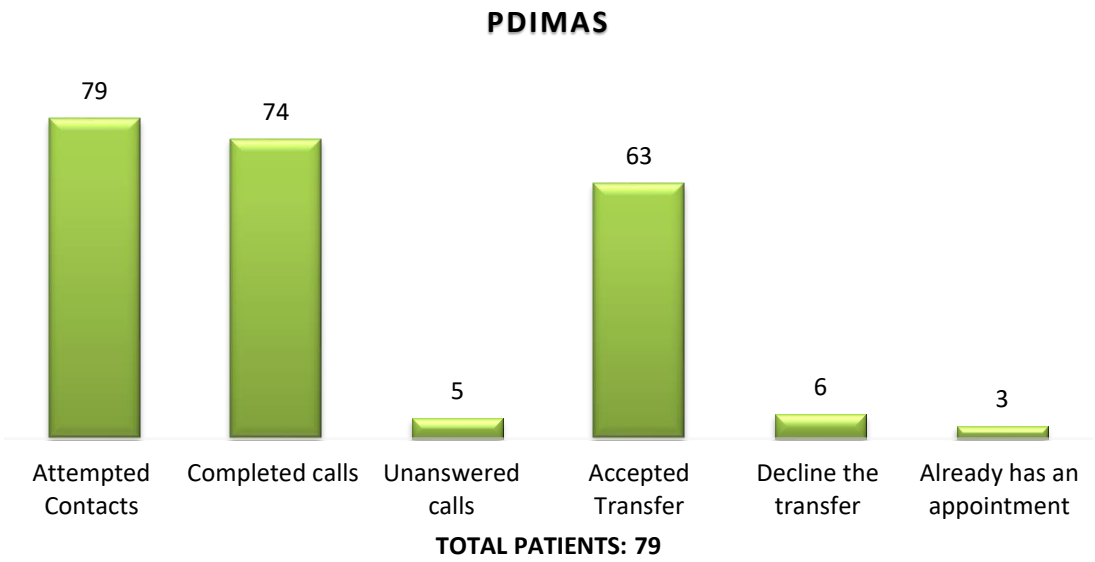


Protect-NoW
Proactive Population Health and Care for Norfolk and Waveney

PIDMAS - August 2023

Norfolk and Waveney ICB were asked to support James Paget Hospital, and Norfolk and Norwich Hospital to assist with the PIDMAS process by contacting all the patients who registered onto the PIDMAS website. Data coming in is based on patients registering their interest online and VST contact is to explain the PIDMAS processes and time frames.

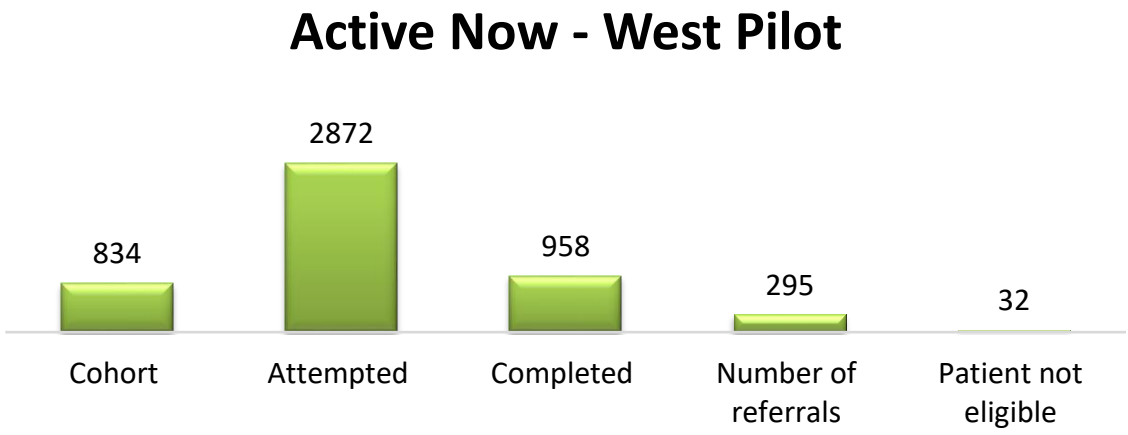
This is an ongoing project but there are no new numbers coming in. Possibility to contine in 2024/2025



Active Now – July 2023 – April 2024

Reaching out to patients who are at risk of diabetes and encourage them to keep active by referring them to Active Now service provider.

The provider informed us there are some capacity issues at their end, and by the 8th of March they still have patients from January, February and March to contact. Planning to be completed in April 2024



Completed Projects

Protect-NoW
Proactive Population Health and Care for Norfolk and Waveney

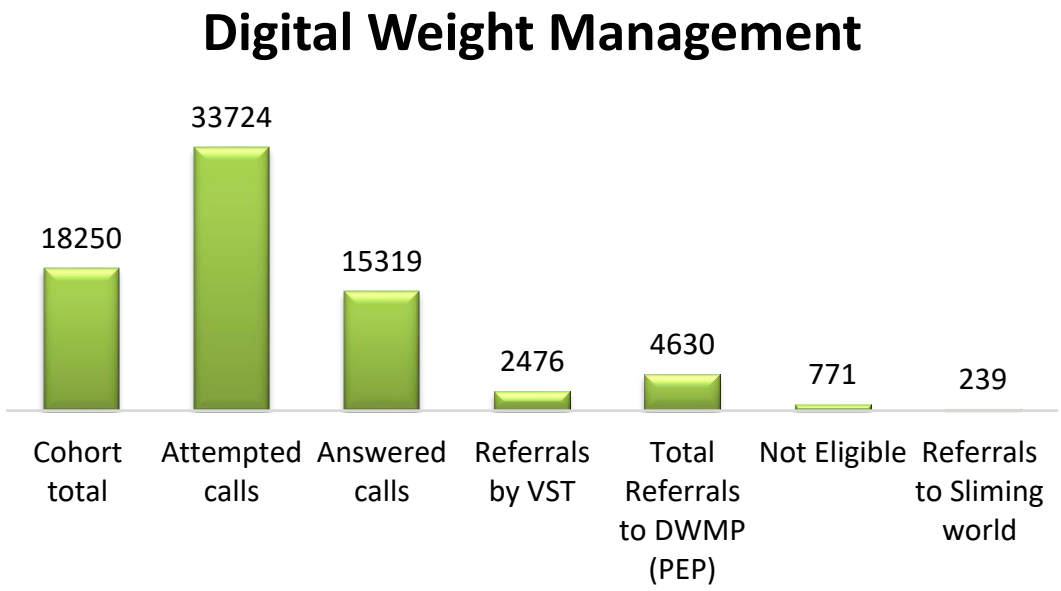
DWMP 7th July 2023 to 25th March 2024

Patient cohort – All patients over 18 with BMI over 30 (for minorities over 27.5) with Hypertension and Diabetes. Over 80s excluded.

Purpose: Increase uptake of the Digital Weight Management Programme (DWMP) in Norfolk and Waveney over 12 months to support adults living with obesity who also have a diagnosis of diabetes, hypertension or both to manage their weight and improve their health.

Objective: Make 31,200 patient contact attempts to promote the benefits of DWMP to eligible individuals and identify those willing to be referred immediately, passing on details to practices to enact (completion of referrals will be reliant on practice activity).

Method: : Protect NoW will be sending out letters, follow up with SMS to incentivise self-referrals, followed up by calls to all of those who haven't responded to the offer and encourage patients to engage with the service.
Details of patients consenting to referral to be passed back to practices to action via agreed email address. If any practice reaches its referral allocation limit PM will agree with practice if they will continue processing further referrals without payment.



Completed Projects

Protect-NoW
Proactive Population Health and Care for Norfolk and Waveney

Digital Weight Management National Report

OFFICIAL SENSITIVE

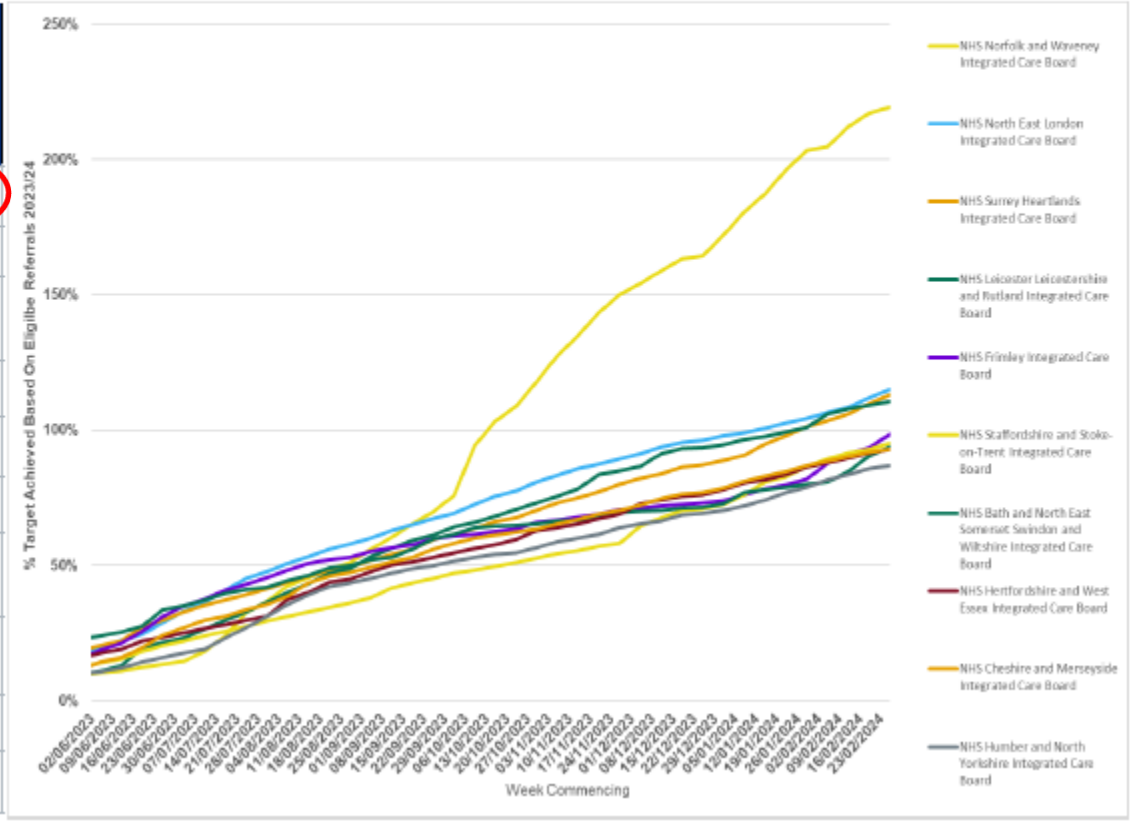
Top 10 ICBs: Eligible GP referrals

NHS

Eligible Referrals: Top 10 referring ICBs February 2024

Region	ICB	Total no. of eligible GP referrals in 2023-24	% Target achieved (using eligible referrals)
East of England	NHS Norfolk and Waveney ICB	5219	219%
London	NHS North East London ICB	5553	115%
South East	NHS Surrey Heartlands ICB	2362	113%
Midlands	NHS Leicester Leicestershire and Rutland ICB	2651	110%
South East	NHS Frimley ICB	1494	98%
Midlands	NHS Staffordshire and Stoke-on-Trent ICB	2602	95%
South West	NHS Bath and North East Somerset Swindon and Wiltshire ICB	1758	94%
East of England	NHS Hertfordshire and West Essex ICB	2728	93%
North West	NHS Cheshire and Merseyside ICB	5492	93%
North East and Yorkshire	NHS Humber and North Yorkshire ICB	3217	87%

Eligible Referrals: Graph to show top 10 referring ICBs in 2023-24



Completed Projects

Protect-NoW
Proactive Population Health and Care for Norfolk and Waveney

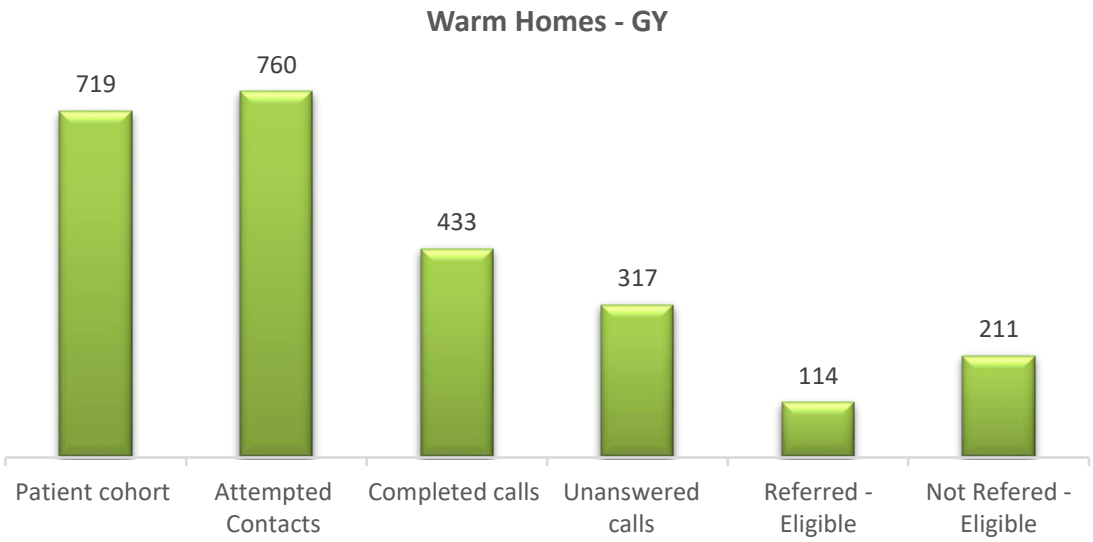
Warm Homes Dec 23 – to March 24

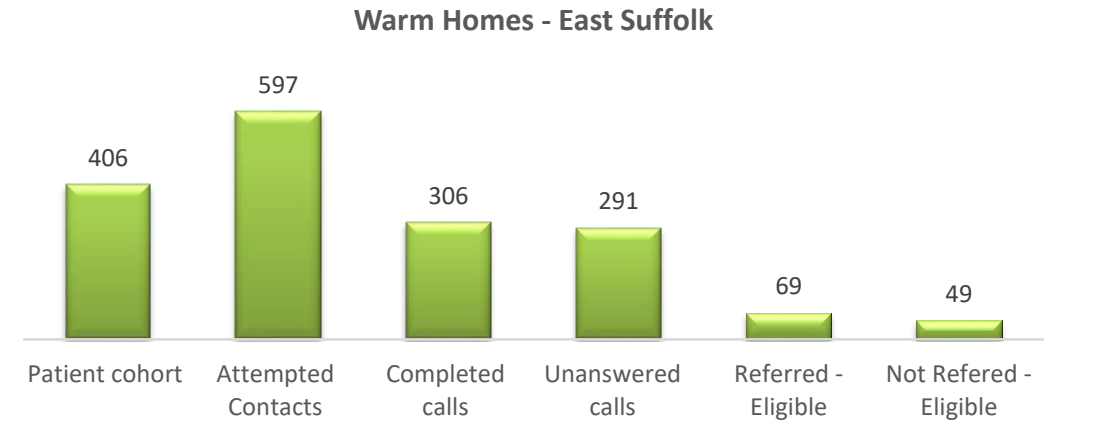
Patient cohort – Patients living in the GY&W area, living with COPD or other respiratory conditions, focussed on deprivation area 1 and 2.

Purpose: The project will demonstrate the value of place partners working collaboratively to link data sets, enabling specific vulnerable households at increased clinical risk during colder weather to receive non-clinical support to protect and improve their health.

Objective: To positively impact on exacerbations of chronic respiratory ill health caused by living in cold homes and fuel poverty.

Method: Partnership working in GYW to enable a target PHM approach to identify clinically and socially vulnerable residents eligible for financial support including the Household Support Fund (HSF), and wider non-clinical interventions.





Completed Projects

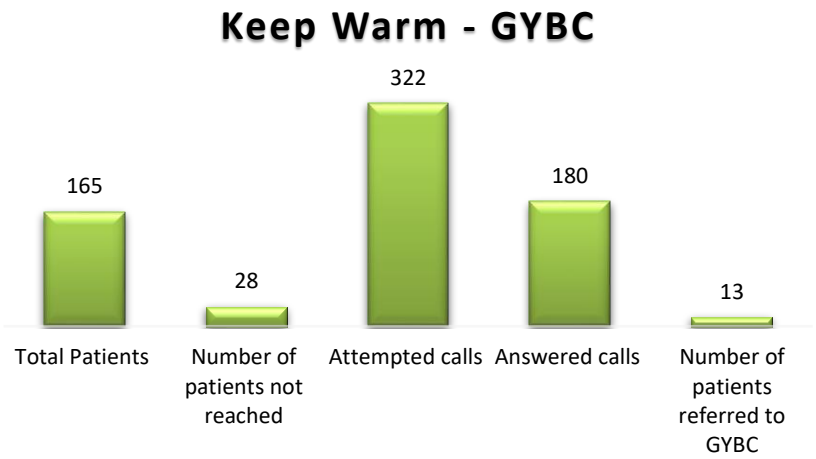
Protect-NoW
Proactive Population Health and Care for Norfolk and Waveney

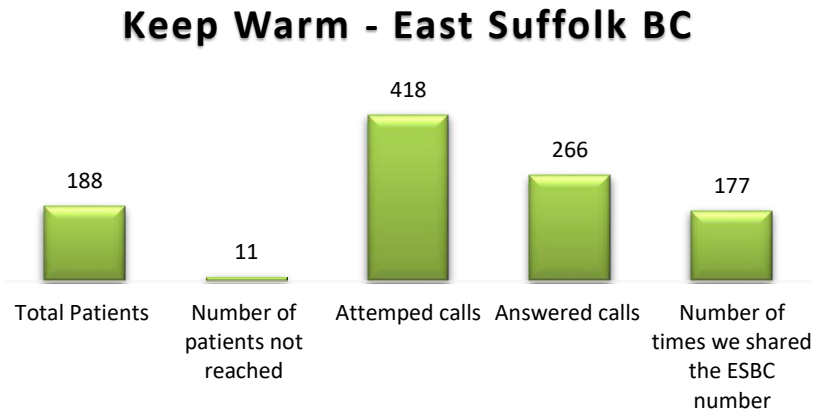
Patient cohort – Patients living in the GY&W area, living with COPD or other respiratory conditions.

Purpose: The project will demonstrate the value of place partners working collaboratively to link data sets, enabling specific vulnerable households at increased clinical risk during colder weather to receive non-clinical support to protect and improve their health.

Objective: To positively impact on exacerbations of chronic respiratory ill health caused by living in cold homes and fuel poverty.

Method: Partnership working in GYW to enable a target PHM approach to identify clinically and socially vulnerable residents eligible for financial support including the Household Support Fund (HSF), and wider non-clinical interventions.
Completed in April 2023

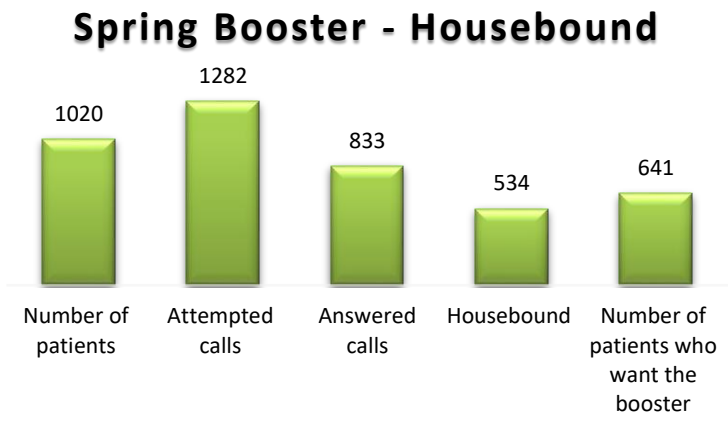




Completed Projects

Protect-NoW
Proactive Population Health and Care for Norfolk and Waveney

Covid Vaccinations – Support Practices to Identify and confirm Housebound patients who want the Spring Booster Covid jab in order to get home visits organised.
9 Practices requested our support, a total of 1019 patients. We identified that 43% were no longer housebound and overall we had 77% uptake on the vaccine offer.
Completed in April 2023

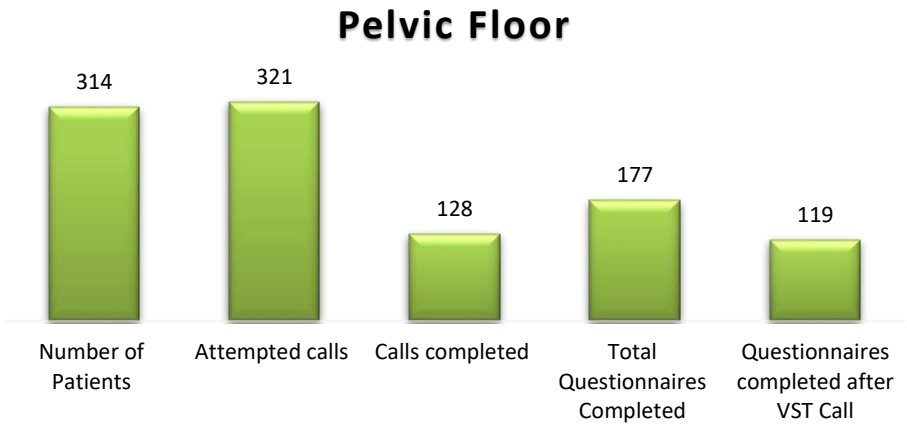


Active Now Norwich – Reaching out to patients who are at risk of diabetes and encourage them to keep active by referring them to Active Now service provider. Norwich pilot 3 practices, 144 patients. The update on the offer was of 39%. We are currently working to extend this project to the West of Norfolk.
Completed in April 2023

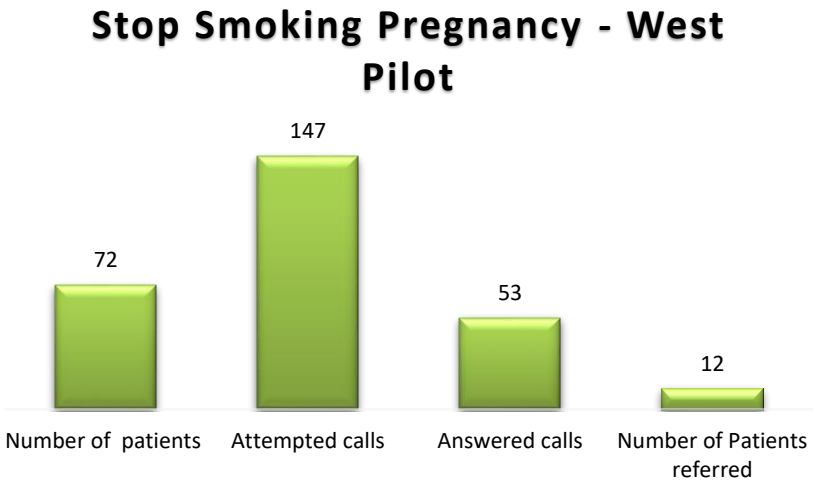
Completed Projects

Protect-NoW
Proactive Population Health and Care for Norfolk and Waveney

Pelvic Health – Reaching out to patients currently on the NCHC waiting list and encourage them to fill in the online questionnaire so that patients can be supported by the appropriate provider. We found yhat 67% of patients responded to the questionnaire after the VST intervention. Completed in May 2023



Stop Smoking in Pregnancy – West Pilot only – reach out to currently pregnant women and offer support to stop smoking by explaining the positive impact this will have for both mother and baby health. 72 patients registered under QEH (West residents only) based on answered calls we have a 23% uptake on referrals to Smoke Free Norfolk. We have been advised by Smoke Free Norfolk that they were able to contact 4 patients, only 1 of whom has set a stop smoking date. Completed April 2023



Completed Projects

Protect-NoW
Proactive Population Health and Care for Norfolk and Waveney

NNUH Oculoplastic: Currently NNUH has a 65+week wait list for patients waiting for be seen and treated under the oculoplastic speciality. ICB has procured this service with 2 external providers capacity to perform the treatment within 6 weeks. To tackle inequalities, VST will support NNUH by calling these patients and offer them this service to everyone in that waiting list.

Batch 1 (July 2023)	Total
Number of PT's	638
Attempted Contacts	859
Completed calls	547
Accepted referral to provider	397
Rejected referral to Provider	126
Not Eligible	30
Maybe	17

Batch 2 (September2023)	Total
Number of PT's	523
Attempted Contacts	1064
Completed calls	460
Accepted referral to provider (PID)	317
Rejected referral to Provider	96
Not Eligible	18
Maybe	9

NNUH Spinal : Currently NNUH has a 78+week waiting list for patients waiting under the spinal/back pain. The ICB has commissioned N2S (Norfolk and Norwich Surgical Limited) to run a back pain clinic to assist with clearing the backlog of long wait patients. VST will support NNUH by calling these patients and offer them this service to everyone in that waiting list.

Batch 1 (August 2023)	Total
Number of PT's	654
Attempted Contacts	944
Completed calls	661
Accepted referral to provider	533
Declined referral	62
Already had appointment	25
Maybe	6

Completed projects

Protect-NoW
Proactive Population Health and Care for Norfolk and Waveney

Proactive Falls Support Project: NCC has initiated a project regarding contact with current or past social care clients that have increased risk of falls. The aim is to offer these clients some proactive interventions to reduce the fall rate and to keep them independent within their own homes for longer. Protect NoW are contacting patients to offer the interventions and follow up with them to understand their impact in reducing falls risk. Project has been completed on the 20th October with all 3 phases contacts been attempted more than 3 times per day on different dates and times.

Total pts 700	Total
Attempted calls	977
Answered calls	548
People who accepted Referral	152
Number of referrals made	236
People who Opt out	163
Number of Ppl with fear of falling	114
Not elliggle	83
Hospitalised PT's	24
Wrong details	69

Referrals per provider	Total
Fire services	23
Active Now	17
NFS	39
Assistive Tech	37
Voluntary Norfolk	56
Health - NHCH	53
Health - ECCH	11

Falls Project - Calls schedule				
Batch Falls	Letters	1st Calls	Check-In Calls	Follow-up Calls
1	25th April'23	2nd May'23	27th Jun'23	17th Oct'23
2	12th May'23	30th May'23	25th Jul'23	17th Oct'23
3	22nd May'23	6th Jun'23	15th Aug'23	17th Oct'23
4	30th May'23	13th Jun'23	22nd Aug'23	17th Oct'23
Unanswered calls	N/A	27th Jun'23	5th Sept'23	17th Oct'23
5	19th Jun'23	4th Jul'23	12th Sept'23	17th Oct'23
6	26th Jun'23	11th Jul'23	18th Sept'23	17th Oct'23
7	7 th Jul'23	17th Jul'23	25th Sept'23	17th Oct'23

NCC has agreed to send us a report after each batch and calls status, however so far, we only received report for the 1st calls made for batch 1.
Meetings with NCC evolution team and VST took place on the 27th of September where they collected feedback from all call agents regarding the project, the challenges and the potential.
NCC evaluation team agreed to share evaluation documents as soon as they finish their inquiries which will include speaking to some patients.

Completed projects

Protect-NoW
Proactive Population Health and Care for Norfolk and Waveney

Proactive Falls Support Project Check-In calls – These calls were Offered to patients who had been referred to services on the 1st phase, the intention behind this was to understand if the providers had actioned in time frame agreed and ascertain if the intervention was positive and if patient continues (or not) with fear of falling.

Referrals not actioned by provider (Data extracted from 1st phase)	Total
Fire services	2
Active Now	5
NFS	8
Assistive Tech	9
Voluntary Norfolk	22
Health - NHCH	16
Health - ECCH	6

Total pts Follow up calls (1 to 7) 150	Total
Attempted calls	210
Answered calls	113
Number of referrals Actioned by providers	168
Patients not reached	37
Number of ppl who had fall since 1st call	10
Number of ppl who fear falling (who wanted 2nd calls)	22
Patients who can't remember talking to us	8
Patients who wanted a 3rd call	18

Falls Support Project: part 3

Proactive Falls Support Project Final calls –Offered to patients on second phase, to understand if the interventions where successful, especially those who have not been actioned by the time we made the 2nd call and escalate to NCC any PTs who required further support.

PHM waiting on NCC to analyse trends, outcomes and follow up on escalations where applicable.

Completed in October 2023

Total pts Follow up calls (1 to 7) 16 (NCC will contact 2)	Total
Attempted calls	23
Patients Reached	14
Patients NOT reached	2
Registered referrals	18
Received interventions	10
Number of ppl who fear falling (who wanted 3rd call)	5
Patients who can't remember talking to us	1
Patients happy with method used to reach out to them and offer support	14
Escalations to NCC	8

Pipeline 2024-2025

Protect-NoW
Proactive Population Health and Care for Norfolk and Waveney

Project Title	Project Description
IAPT Phase 3 – Living with Long Term Conditions	This will be offering the same offer as phase 1, but we have LTC trained clinicians that can offer a slightly enhanced assessment that can hopefully support managing the MH and LTC needs, we also have a LTC online workshop that will be encouraged **On Hold.**
IAPT Phase 3 – Living with Menopause	This will be encouragement to attend the dedicated menopause webinar, as well as an assessment if needed to support low mood and or anxiety that may relate to wider menopausal symptoms. **On Hold.**
Health Checks	We have identified around 70k patients who have failed to attend heir health check, possible alignment with Public Health for this project.