NHS
Cheshire and Merseyside

Tackling Fuel Poverty in Cheshire and Merseyside

A population health management approach

Blueprint guide

Optum

Developed in partnership with Optum UK

Contents

Foreword

Can smarter use of data help us address the underlying factors shaping people's health and wellbeing? Can we generate actionable insights that help us make better use of our limited resources? And can we use this intelligence to bring together partners across the community to tackle health inequalities faster and at source?

These are crucial questions that lie at the heart of a series of fuel poverty projects we've established, all of which are using the power of population health management (PHM) to identify, target and support the most vulnerable patients within our communities.

Fuel poverty is a major public health issue for Cheshire and Merseyside. A third of Cheshire and Merseyside's residents live in the most deprived 20 per cent of neighbourhoods in England and about two in every five households across our region are currently defined as being in fuel poverty.

Being unable to heat your home properly is miserable for everyone concerned. But we know it is particularly dangerous for people with respiratory conditions, significantly increasing their risk of serious complications, unplanned hospitalisations, and premature death.

Furthermore, it is often the case that the most clinically vulnerable people affected by fuel poverty also have other co-morbidities or may be experiencing other issues such as mental illness, addiction or poor housing conditions that further exacerbate their health challenges.

In our 2023-28 Integrated Care Partnership strategy, we set out a commitment to zero in on fuel poverty as part of our wider mission to tackle health inequalities. Since then, the fuel poverty programme has worked closely with several local "trailblazer" sites, using linked health and social care data to help them identify the most critically vulnerable patients and deliver targeted support.

This blueprint document, developed in partnership with Optum UK, offers a step-by-step guide to how we did it: how we identified and engaged relevant organisations to establish the project sites, how we applied data filters to identify target cohorts based on risk, how the projects themselves were embedded and run on the ground, and what we are planning next to share learning and scale up this approach across other parts of our system.

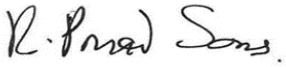
Although these are early days for the programme, what we're seeing from the patient and staff testimonials from our trailblazer sites is extremely positive. The feedback suggests that the application of this data and intelligence on the ground is actively transforming how community teams support their patients and service users.

And more than anything, it is the human stories that show the difference this can make to people's lives – how it is helping us to unlock new possibilities, fresh avenues of support, and better partnerships across the community to improve their wider health and wellbeing.

The challenge now is to build on this: by extending and refining the approach across other areas so more patients can benefit. We hope these learning resources, which capture the collective experiences and lessons of those involved in these early trailblazers, will help make that happen.

Professor Rowan Pritchard Jones

Executive Medical Director, Cheshire and Merseyside Integrated Care System



Section 1: Project overview

Introduction

With rising energy prices and other cost of living pressures, the number of households living in fuel poverty has increased across the UK in recent years – and there is strong evidence that this exacerbates a wide range of physical and mental conditions.

According to a recent Institute of Health Equity report, cold homes are linked to an increased risk of health conditions, especially respiratory and cardiovascular disease, as well as poor mental health and unintentional injury.

It is likely that many thousands of unplanned hospitalisations every year are directly associated with cold homes, and the National Institute for Health and Care Excellence (NICE) has said that simple preventative action could prevent as many as 28,000 deaths each year.

This blueprint describes the targeted work underway across Cheshire and Merseyside to reduce the risk of death and ill health by using population health management (PHM) techniques to identify, engage and support those at greatest risk.

1.54m people

across Cheshire and Merseyside have a medical condition that would seriously increase their risk of harm if their home is poorly heated.

490,000

of these are known to live in a fuel poverty 'hotspot', defined as being in the top 20% of most fuel poor areas in the country.

About the project

Supported by NHS England's Innovation for Healthcare Inequalities Programme (InHIP), Cheshire and Merseyside Integrated Care Board (ICB) brought together NHS, voluntary and community sector (VCS) and local authority partners to explore new ways of supporting people with respiratory illness who are living in fuel poverty.

Drawing on data which identifies the population cohorts at greatest risk of harm, several small "trailblazer" projects have been established across the integrated care system (ICS) footprint. These have involved multidisciplinary teams working together to reach out to high-risk groups with targeted interventions.

The trailblazers aim to:

- **Rapidly identify and engage high-risk patients**
- **Reduce the number of exacerbations experienced**
- **Improve adherence and effectiveness of inhaler therapies**
- **Enable quicker eligibility checks of patients suitable for a remote monitoring pathway**
- **Reduce fuel poverty debt by signposting sources of financial support.**

Longer term, it is hoped that these interventions will also help to ease pressure on local services by reducing GP appointments, accident and emergency attendances, unplanned hospital admissions and 111/999 calls for respiratory conditions aggravated by cold homes.

Who is involved?

Trailblazer projects are being established in the following places, involving a range of partners spanning NHS, local authority and third sector organisations:

- **St. Helens** started in February 2023
- **Knowsley** started in May 2023
- **Warrington** started in September 2023
- **The Wirral** is expected to start in winter 2023/24, focusing on pre-school aged children with a respiratory wheeze.

The data modelling and PHM methodology underpinning the work was developed by the following external partners:

- **Optum UK** provided consultancy and engagement support throughout the programme – this included facilitating a series of workshops attended by representatives across the ICS to determine target cohorts and the key interventions that would support them.
- **Graphnet** provides Cheshire and Merseyside's Combined Intelligence for Population Health Action (CIPHA) data platform and created fuel poverty dashboards within it to help shape the cohorts and identify high-risk patients.

About this guide

Developed by Optum UK on behalf of Cheshire and Merseyside ICB, this document aims to provide specific information about the PHM approach informing this work.

The guide is structured around the five stages of the PHM journey and is designed to help other ICSs who may be looking to undertake similar analysis and targeted action on fuel poverty within their area.

It is supported by a practical toolkit, developed in partnership with Health Innovation North West Coast, which provides further resources to help teams replicate the approach (see *Additional Resources, p22*).

Cohort definition	Bringing data and insight together to identify a target population we want to impact.
Defining outcomes	Using a logic model approach and user-centred design approach to define SMART outcomes for our intervention.
Defining interventions	Exploring the current challenge, case for change, potential root causes of the current situation, and begin to think 'what needs to happen now?' Brainstorming initial thinking around an existing intervention/ pathway to positively impact our target population.
Implementation planning	Refining our intervention approach and developing an implementation plan – getting into the detail of how we would measure the impact of the intervention, how it would be resourced, and how it could be delivered.
What's next and how to scale	Road-mapping the steps to sustainable implementation of the intervention beyond these workshops – and getting going.

Figure 1: *The five stages of the PHM journey.*

Section 2: Cohort definition

Overview

By linking data from the national fuel poverty data set to the individual patient records, the PHM approach has helped Cheshire and Merseyside ICS and its partners to:

Understand the proportion of citizens in a locality likely to be experiencing fuel poverty.

Identify cohorts of patients at highest risk of hospitalisation due to cold living conditions.

Facilitate a multi-agency response to engage and support these patients.

Measure the impact of these interventions over time.

The key datasets

Working in conjunction with Optum UK and Graphnet, the Cheshire and Merseyside project team has created a powerful method for understanding the proportion of citizens in a place likely to be most vulnerable to fuel poverty.

The approach brings together the following key elements:

- **Analysis of fuel poverty hotspots:** drawing on official government data, this identified the Lower Layer Super Output Areas (LSOAs) of around 1,500 people or 650 households with high levels of fuel poverty across the ICS.
- **Predicted and actual health care utilisation data:** using the Johns Hopkins ACG algorithms, the ICB population was also divided up into Resource Utilisation Bands (RUB) reflecting expected and actual usage of health care in acute and primary care settings.
- **Further stratification of fuel poor populations:** local CIPHA data also enables teams to assess the vulnerability of its fuel poor population using diagnosed condition, risk of admission, mortality risk and other factors such as living alone.

About CIPHA

CIPHA is a linked data platform which brings together health and social care data from across Cheshire and Merseyside. Originally established to support the region's COVID-19 response, CIPHA now helps NHS and partner organisations across the ICS to understand and map population health data to support service design and improvement. Find out more about CIPHA.

> **The beauty of the CIPHA data is that it allows us to stratify our fuel-poor population using risk of admission, mortality risk and other factors such as living alone. Applying these filters means we can break down a big societal challenge like fuel poverty into more manageable and actionable chunks – allowing precise and targeted support to be delivered where it's needed most.**
>
> Professor Rowan Pritchard Jones, Executive Medical Director, Cheshire and Merseyside ICS

Applying filters

The linked data is brought together on the Graphnet CIPHA platform, powering an interactive dashboard tool that allows populations to be segmented by patient list, demographics, fuel poverty rates, household energy rating, emergency admissions rates, risk of emergency admission and medication flags.

By applying filters, teams can then "drill down" into a selected population to create small, targeted cohorts of patients that are most vulnerable to ill health and hospitalisation due to their living conditions. Clinicians with a direct care relationship can also drill down to an individual patient and access a summary review of the patient record, which then provides at a glance the key information needed to support decision-making.

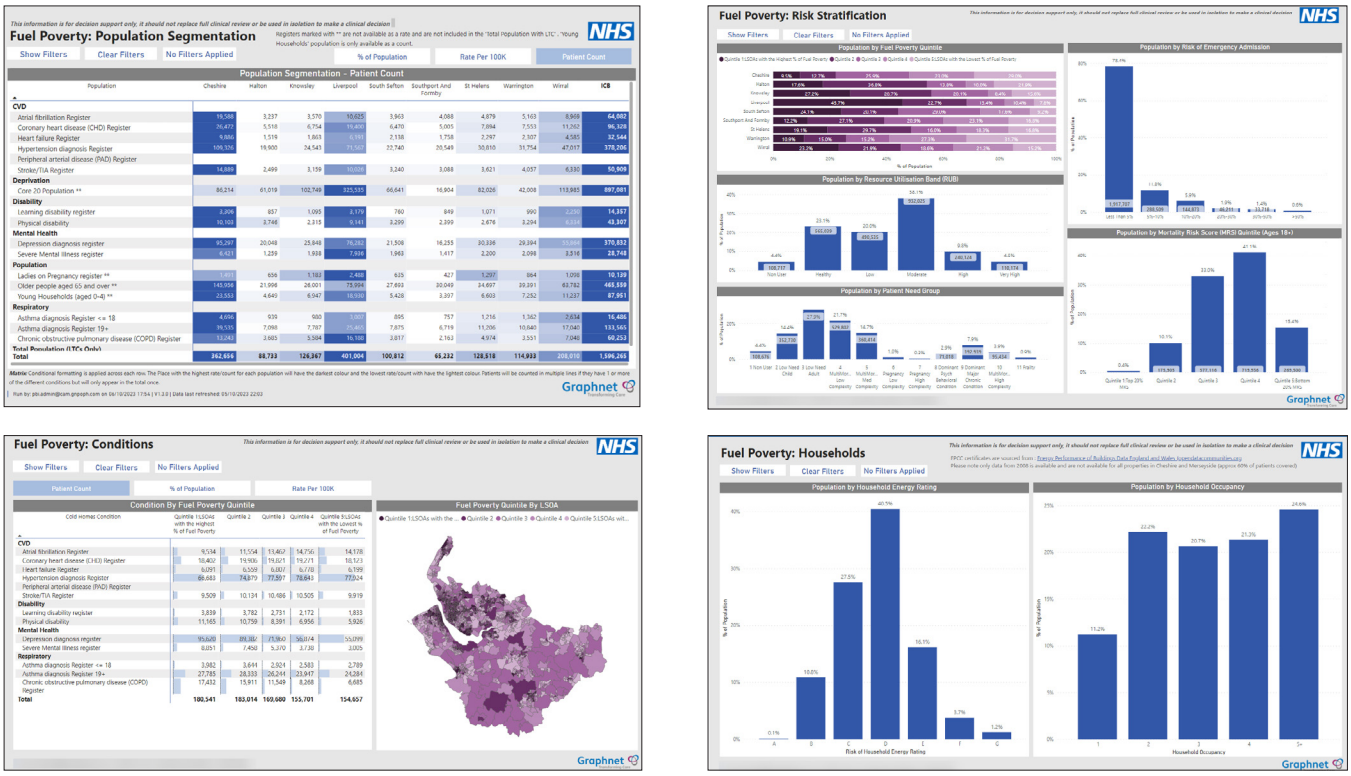


Figure 2: *The linked data dashboards allow teams to understand populations by clinical condition, household, demographic background, and other clinical risk factors.*

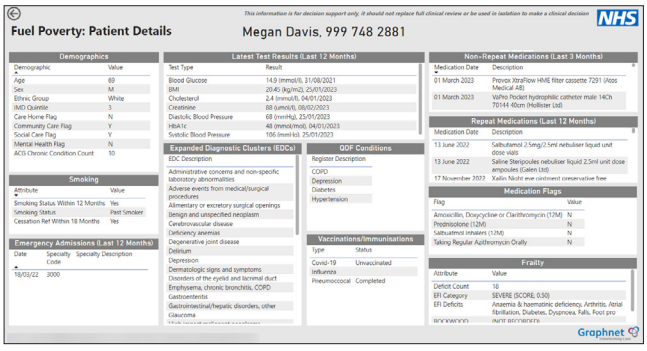


Figure 3: *Clinicians with direct care responsibilities can also use the dashboard to drill down to an individual patient, as per this demo view.*

> **The dashboard is very beneficial in drawing out things we have never thought of before. It is about working in a different way for these patients who are socio-economically deprived and living in poor housing.**
>
> Diane Green, Lead COPD Nurse and Service Manager, St Helens Community COPD Rapid Response Team

Defining the target cohorts

For the adult COPD groups, the following filters were applied:

- Had a COPD diagnosis in primary care
- Lived in a high fuel poverty neighbourhood (top 20% quintile)
- Does not live in a care home
- Has a 50% or higher risk of an emergency admission.

For the children's groups, the filters were:

- Children aged 0-4
- Prescribed a Salbutamol inhaler in the past 12 months
- Has a 5% or higher chance of emergency admission.

This led to the following target cohorts being defined across Cheshire and Merseyside:

Cohort 1

1,313 adults

- **37% live alone**
- **46% live in energy inefficient housing (EPC D to G)**
- **41% are registered with depression**
- **58% have hypertension**
- **47% are on coronary heart disease register**

Cohort 2

2,329 children

- **96% are in one of the Core20Plus5 groups**

Figure 4: *A breakdown of the two key cohorts identified through filtering of the linked data.*

Section 3: Defining outcomes

Developing an outcomes and measurement framework

Through facilitated workshops with local stakeholders, Optum UK helped the project teams to develop an outcomes and measurement framework to support their work, using the template provided below (*figure 5*). You can download the sample outcomes and measurement plan developed for the adult cohorts in the toolkit accompanying this guide — see *Additional Resources (p22)* for more information.

Rationale for intervention

This is the justification for the programme/intervention. For example, what is the nature and scale of the problem being addressed? What will happen if nothing is done?

Inputs	Outputs			Outcomes — Impact		
Inputs	**Participants**	**Activities**	**Outputs**	**Short-term**	**Medium-term**	**Long-term**
What we need/invest in?	Who we reach/involve	What we do	What we create	Results in terms of learning	Results in terms of changing action	Results in terms of change to the conditions
• Time • People • Money • Knowledge base • Expertise • Materials • Equipment • Space • Technology • Partners • Data • Engagement • Trust • Project management	• Practitioners • Patients • Educators • Decision-makers • Information officers • IG specialists • Analysts • Providers • Hospitals • Primary Care Networks • Community health trusts • Mental health trusts	• Develop • Deliver • Conduct • Support • Promote • Partner • Disseminate	• Capabilities • Infrastructure • Plans • Community • Networks	• Awareness • Knowledge • Attitudes • Skills • Interest • Opinions • Aspirations • Intentions • Motivations • Shared responsibility for a population • Increased patient activation	• Boost out of hospital care through delivery of PCNs • Enhancing prevention • Supporting people to age well • Enhanced access for urgent care • Further progress on care quality & outcomes • Right medicines, right time • Support transitions between secondary and primary care	• Population impacts • Improve staff experience • Improve population health • Reduce per capita costs • Improve patient experience • Reduce health inequalities

Figure 5: *Optum UK's logic model template for developing a measurement framework.*

Applying a whole person perspective

In addition, Optum UK created a pen portrait of a "typical" at-risk patient to help illustrate their personal circumstances, the challenges they experienced and the potential touchpoints where supportive interventions could make the difference.

This was used as stimulus material to support conversations between professionals about how they might support people better.

Meet Catherine

Demographics

- White-British 74-year-old female
- Lives in top 10% most deprived areas in the country

Clinical conditions

- Smoker of 20+ years
- Has moderate COPD – attended emergency department twice in past six months for acute exacerbations
- Chronic cardiac and respiratory issues requiring multiple medications, but no home oxygen
- Awaiting left hip operation for 18 months

Home

- Lives alone
- Uses a wheelchair to mobilise due to deterioration whilst waiting for hip replacement
- Independent in activities of daily living (ADLs)
- Daughter is the main carer, but lives 50 miles away and in full time employment

Social concerns

- Lives in social, terraced housing with mould on walls and inefficient electric heating or water system
- Unable to pay most recent energy bill and put onto an energy meter
- Social isolation

Figure 6: *The example of Catherine, a fictional patient developed by Optum UK, is used to illustrate the wider psycho-social factors influencing her health and wellbeing.*

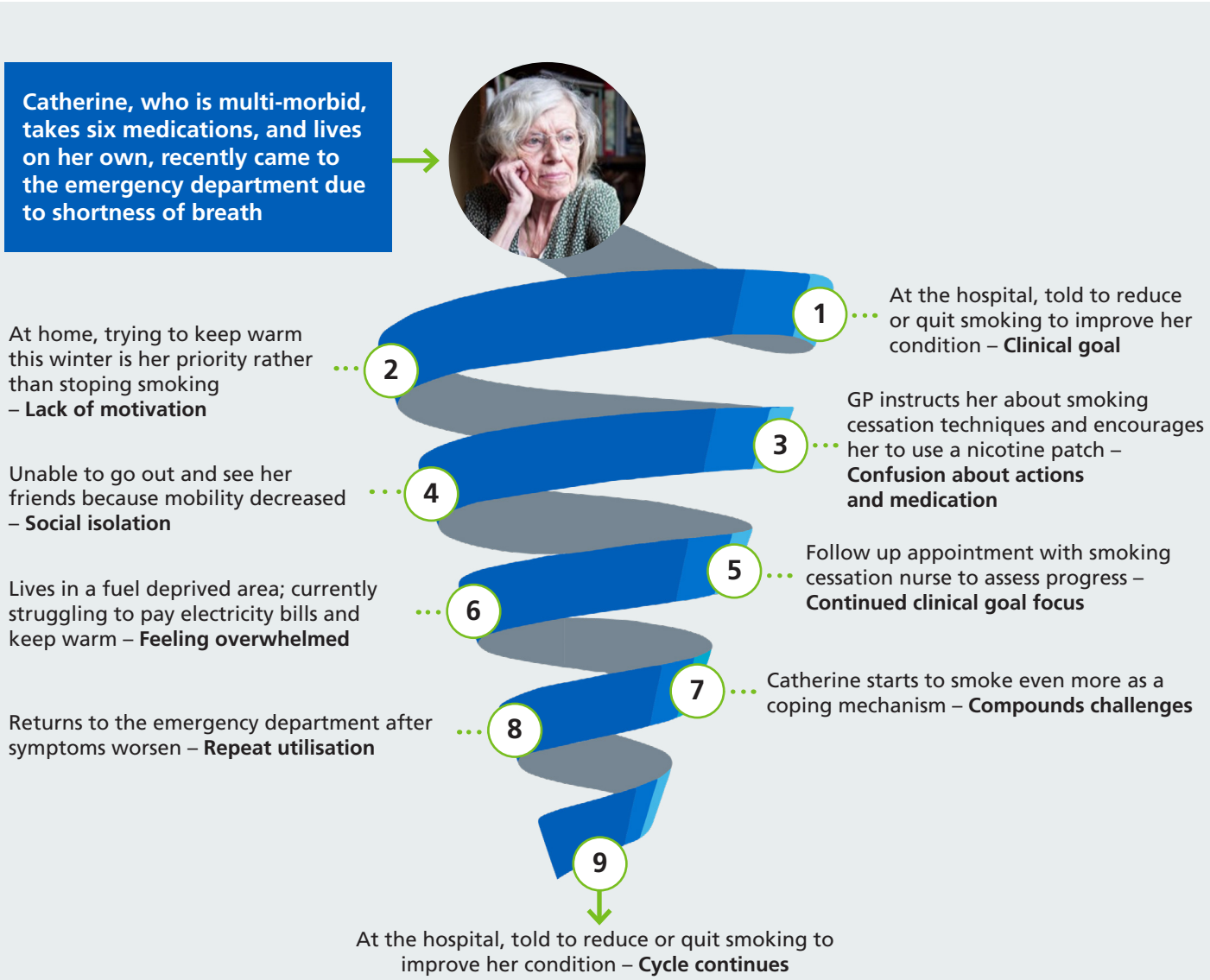


Figure 7: *The diagram above shows Catherine's current experience as she journeys through the health and care system – helping teams to consider how things might change at every touchpoint.*

> **Our workshops were designed to encourage professionals to think deeply about how fuel poverty affects people on a human level, and to consider what interventions might make a difference. The aim is to establish a 'one team' approach, built around a common goal and backed, of course, by precision data to help us pinpoint resources at those in greatest need.**
>
> Joao Tibúrcio Gomes, Clinical Facilitator, Optum UK

Section 4: Defining the interventions

Local engagement sessions

The ICB has initially engaged and identified lead professionals from across three of the nine places across Cheshire and Merseyside ICS to help it develop local trailblazer projects that would test out new ways of supporting high-risk patients in fuel poverty.

Local clinicians and care professionals spanning NHS, local authorities and the voluntary sector took part in **facilitated workshops** led by Optum UK, which presented an opportunity for teams to understand and interrogate the local data and work together to develop targeted actions to support people at greatest risk.

As well as defining outcomes, these sessions explored how the patients would be engaged and communicated with, what specific interventions should be delivered by whom, and what sources of information would be needed to track progress and measure impact.

Community asset mapping

A further key element of the project design has been identifying and engaging the relevant, community-based organisations and wider sources of support for patients across each trailblazer area.

This was built into the planning process and involves active partnerships spanning primary and secondary care, local authorities, social housing organisations, charities and voluntary sector agencies, mental health services, drug or alcohol addiction services, energy providers and official government assistance schemes.

To support areas embarking on similar projects, the programme team has since created a **community asset map**, which lists various organisations, services and projects that are available across Cheshire and Merseyside to support people experiencing fuel poverty or help engage at-risk communities.

> **Being able to show people via the dashboard that you can quickly and easily identify a small cohort of high-risk patients to zero in on almost instantly made this feel more manageable and realistic for local teams. It's helped people see 'the art of the possible' and has really given the trailblazer projects a momentum of their own.**
>
> Lucy Malcolm, Programme Manager, Cheshire and Merseyside ICB

Cohort engagement

- Housebound patients – telephone?
- Technology literacy/access
- Can try text messaging, phone call, letter and possibly knock on the door?
- Consent of patient when engaging
- Co-ordination is key – the opposite of Covid test and trace? A care worker co-ordination would be good!
- Use early successes to promote services during further promotional activities
- Info in warm hubs
- Off-line versions of everything, for digitally excluded members of the cohort
- EMIS code that can be used to identify patients
- Good communication skills from the first contact with motivational interviewing techniques to engage
- Direct referral to Energy Project Plus via website – no need for data sharing protocol if patient agrees as service already exists for all Knowsley residents
- Attach a Survey Monkey questionnaire to explore issues around welfare support

Interventions

- Warm pack with hats and scarfs
- Inspect/fix broken boilers
- Provide emergency heaters and radiators
- Install LEDs
- Home visits
- Reduce damp, cold home
- Help with fuel bills
- Social prescribing
- Wider holistic support – could be early years, employment, education, social isolation
- Solar panels installation
- Help with wider debt and potentially legal issues. If we can get their trust with care intervention we may be able to persuade them to access more
- In-home interventions are best to gain the widest possible picture of how people's homes affect their health
- Help accessing carers
- Psychological support through Knowsley Community Respiratory Services
- Clinical review
- Mental health support
- Smoking cessation support
- Improved compliance with medication use
- Vaccinations
- Pulmonary rehab
- Inhaler optimisation
- Medication optimisation
- Improved compliance with medication use

Evaluation

- COPD Assessment Test (CAT) or one focussed on anxiety
- QOL
- Staff feedback survey
- Patient interviews
- Clinician interviews
- Reduce emergency department attendance
- Hospitalisation
- Education/employment
- Appropriate prescribed medication based upon evidence based medicine
- Smoking rate reduction
- Household energy rating
- Mental health and wellbeing improvement
- Increased compliance with medication use
- Wellbeing questionnaire
- Patient story
- Pulmonary rehabilitation completion
- Smoking cessation
- Levels of anxiety, depression reduced
- Lots of residents use far more energy than they need to at home. Following a home visit, Energy Project Plus could report on ££ saved through helping people reduce their thermostats/ set their heating controls correctly

Figure 8: *A sample output from design workshops to shape interventions for cohort 1 (adults with COPD).*

Section 5: Implementation planning

Co-ordinating delivery

Three adult COPD projects were initially established across Cheshire and Merseyside, using different delivery models in each case.

1

The St Helens trailblazer – the Warm Homes for Lungs project

In St Helens, Mersey and West Lancashire Teaching Hospitals NHS Trust community COPD service took the lead in co-ordinating and referring high-risk patients, drawing on a supportive network spanning primary care, the local authority housing and social services departments, mental health services and other third sector providers.

Although the project was largely supported by existing services, a small amount of non-recurrent funding was required for a Band 4 care co-ordinator to be recruited within the community COPD team. This crucial role is responsible for communicating with patients, coordinating their proactive wraparound care, and linking into other respiratory workstreams to improve outcomes for patients. The basic process followed for identifying, engaging, assessing and supporting patients is documented on the next page *(see figure 9)*.

2

The Knowsley trailblazer – led by West Knowsley Primary Care Network (PCN)

In Knowsley, the trailblazer project adopted a PCN-led approach, with a physician associate from West Knowsley PCN playing the co-ordinating role – again drawing together a similar range of local statutory and non-statutory partners to offer onward referrals and support to patients. As the physician associate is funded as part of the Additional Roles and Reimbursement scheme (ARRS), the project is entirely self-sustained for the moment.

3

The Warrington trailblazer – led by its Respiratory Rapid Response team

In Warrington, a project has started in time for winter 2023/24. The local Respiratory Rapid Response team is responsible for accessing the dashboard and arranging clinical reviews of patients working with the GP practices that patients are registered with. A respiratory matron contacts patients by telephone in the first instance and then arranges a home visit with a member of the team.

During the clinical review, the staff member will discuss onwards referral for other health and wellbeing services and obtain consent for doing so where appropriate. A follow-up call is made by the team to the patient a week after the review and feedback is sent to the GP practice. The Respiratory Rapid Response team is also leading the Respiratory Virtual Ward for Warrington. The project has been integrated with other work of the team and no additional resources have been required for its delivery.

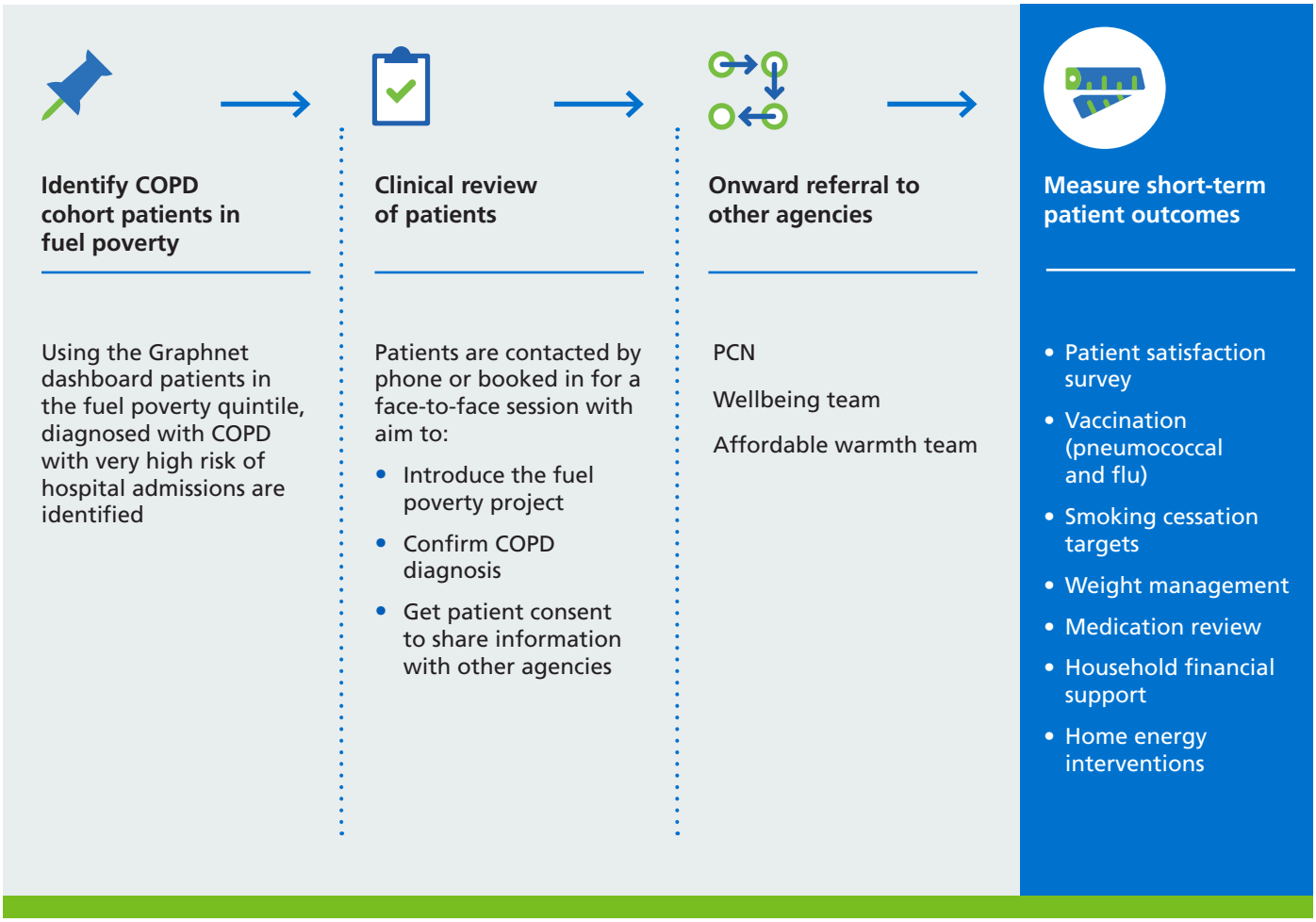


Figure 9: *The St Helens model involves the local community COPD team working with partners across the community to identify and support high-risk patients living in fuel poverty.*

We are working with the pulmonary rehab team, smoking cessation, weight management, social prescribing, the affordable warmth team, the household improvement team – social services were [also] involved, and our specialist nurses, counselling services, think wellbeing and some other charities.

I think the good thing is that we've been able to offer them an hour's appointment, so it's not been like a 10-minute phone call. It's kind of a 'come in and sit down with us for an hour and let's have a holistic conversation about everything.'

Frontline practitioners involved in trailblazer project, interviewed as part of an early evaluation study carried out by Graphnet.

Process and practices

The trailblazer sites have developed standard operating procedures (SOPs) to support the new patient pathways. These included protocols for inviting patients in for review, standard scripts and questionnaires to support clinical reviews, and feedback forms and patient monitoring proformas to ensure patient outcomes are tracked consistently. You can download the latest available SOPs in the toolkit accompanying this guide (see *Additional Resources, p21*).

Data governance

Cheshire and Merseyside has a mature and well-developed governance framework for the use of CIPHA data and the request for using CIPHA data to develop the fuel poverty analytics was considered and approved by the CIPHA Data Asset and Governance Group.

- A version for non-direct care professionals to use, such as ICB staff, place-based teams, and public health professionals. This allowed high-level analysis which did not drill down to small numbers or patient identifiable data.
- A version for GPs which allowed access for GPs to stratify their responsible registered population and drill to patients.
- A version for specific respiratory place-based teams which allowed access for the teams to stratify patients with COPD in a specific GP-registered population.

Both direct care dashboards were secured with row-level security (RLS) and access to the dashboards was provided through an established access request policy where access to any dashboard had to be approved by a trusted authority user.

Safety

The Graphnet clinical safety team reviewed the dashboard and created a clinical safety case before release. Each direct care dashboard carries a note about the dashboard being used as a decision support tool and not to be used in isolation – thereby signposting to the user that other data sources need to be used. This also counters situations where data flows from providers can cause delays in updates to dashboards and information does not run at 'real time'.

Monitoring and oversight

The Cheshire and Merseyside fuel poverty programme supports a commitment made in the 2023-2028 Health and Care Partnership strategy, which has been jointly developed by NHS, local authority and voluntary and community sector representatives across the area.

All trailblazer teams produce monthly highlight reports which go to a **Fuel Poverty Steering Group** established by the ICB. The programme team also report regularly into the ICS's **Digital Transformation and Clinical Improvement Oversight Board, the Cheshire and Merseyside Respiratory Network** and the NHS England **InHip programme team**.

Section 6: The patients' perspective

At the time of writing, nearly 150 high-risk adult COPD patients across the trailblazer sites have been supported through this work.

While a full evaluation is due to be completed in 2024, the following case studies, based on real-life testimonies from the projects (fictional names are applied), show how this targeted approach is making a difference.

Joe's story

Joe has COPD and pulmonary fibrosis and requires high-flow oxygen 24 hours per day. He also has mobility problems and had been experiencing problems getting out of the house without a ramp for his scooter. With rising energy bills, he described having to choose between heating his home or using his oxygen.

Identified as part of St Helens trailblazer, Joe was referred to the local council's affordable warmth team for household assessment. He has been given an occupational therapy assessment for a stair lift and ramp assessment and was also helped to register on the Priority Services Register with his energy provider.

Joe has since had his boiler replaced and a full risk assessment of his home carried out, including the storage of the oxygen, ventilation and fire breakers, and the care of the new oxygen concentrator he has been prescribed. A new bespoke ramp has also been installed to improve his mobility and independence. He has received financial support via the Household Support Fund to assist with heating costs.

In addition, the community COPD team conducted a full medication review. This resulted in further improvements to his treatment, which should both reduce his energy costs and improve his quality of life. The team have also had conversations with Joe and his family about how to manage his deteriorating conditions – including discussions about advanced care planning and end of life care – while Joe's wife was referred to a local carers' society for support.

"It's been a choice between heating my home or using my oxygen."

Mary's story

Mary was living in poor quality housing which included signs of a rat infestation. She has a medical history of COPD, poor mental health, and substance misuse and alcohol problems. She is a smoker, unvaccinated for COVID-19 and Pneumococcal, and has had four unplanned hospital admissions in the last year. She has also been non-compliant with outpatient hospital appointments.

As well as initiating a range of medical interventions, the St Helens trailblazer project team connected Mary with wider sources of support, including referrals to a social prescribing link worker, weight management and smoking cessation services, pulmonary rehabilitation classes and mental health support.

She has also been given masks and filters for nebulised therapy, a type 2 respiratory failure oxygen alert pack and COPD management and inhaler optimisation advice. Her home is currently being assessed by the local household improvement team and she has been encouraged to connect with the Change, Grow, Live service to help with her drug misuse.

"Our advocacy can offer a gateway to much wider avenues of support for at-risk patients."

Paul's story

As well as experiencing financial challenges with his energy bills, Paul was living in poor quality social housing blighted with mould. He has a diagnosis of COPD, a history of poor mental health and struggles with mobility (he recently had a fall in his bathroom). He also smokes.

Supported by the St Helens community COPD team, Paul has now been referred to smoking cessation services, pulmonary rehabilitation, mental health support and social prescribing. He has also been given a physiotherapy appointment via his GP to improve his mobility issues.

St Helens Council is working to improve his living conditions. He is being assessed by the household improvement team and has had a home improvement officer assigned. The mould issue in his home has now been treated and he has received financial assistance via the Household Support Fund.

"Working together means we can support people with complex needs more effectively."

Early evaluation of the St Helens trailblazer project found that:

122 patients

have been successfully contacted to date

100%
were referred to the local affordable warmth team

100%
were referred to the local wellbeing team

14%
were referred to the pulmonary rehabilitation team

81%
received payments from Household Support Funds

£49,500
has been paid to households as a result

As of 17 October 2023

> **These trailblazer projects show what can be achieved if you combine smart data with strong and active collaboration between the NHS and local partners. As well as expanding this approach to other parts of the ICS, there's no reason why we can't apply the same principles to other health challenges in future. It's been invaluable to us.**
>
> Sarah Sibley, Respiratory Lead for Cheshire and Merseyside ICS

Section 7: Next steps and lessons learnt

Expanding the programme

Additional fuel poverty trailblazer projects are expected to start in the Wirral and St Helens for a pre-school respiratory wheeze cohort by the end of 2023. Further engagement is underway with place directors to identify other trailblazer sites to go live in 2024.

As more patients benefit from these pathways, the ICB programme team will work with local projects to develop a full evaluation to help them to understand the impact these interventions are having on patient outcomes and demand on primary care and hospital services. This will support a case for change, which will be used to scale up the approach across other parts of the ICS.

In conjunction with Health Innovation North West Coast, the Cheshire and Merseyside ICB has also developed a practical toolkit to help other NHS organisations who may considering a similar PHM-inspired approach to identifying the most clinically vulnerable people living in fuel poverty – see *Additional Resources (p22)* for more information.

> **Sharing good practice is vital for developing an effective, system-wide approach to addressing complex issues like fuel poverty. We are pleased to be working with Cheshire and Merseyside to capture the lessons from these projects and support their ongoing efforts to expand this approach.**
>
> Rhiannon Clarke, Respiratory Programme Manager, Health Innovation North West Coast

Lessons learnt

If you are thinking about embarking on a similar project, either within Cheshire and Merseyside or elsewhere in the country, here is a summary of the five key lessons that these projects have drawn from their experiences.

1

Ensure all stakeholders can access relevant data and are supported to make sense of it.

Start by working with ICB analytical teams and commercial partners to understand what linked data is available across your ICS and how you can best share it with partners. In Cheshire and Merseyside, the programme team worked with Graphnet to build an interactive dashboard that helped local teams define and identify the people most in need. Whatever solution or tool you arrive at, make sure it is supported with appropriate training and guidance on how to use – in this case, Graphnet provided training videos to support users.

2

Focus on small numbers to start – but be ready to scale up.

Make sure you define a realistic number of people to support across each locality. Starting small helps to get work underway and means that you can use the learning to grow the projects over time. Keeping cohort sizes to a manageable level helps local teams to adapt and improve their support offer more easily using a test-and-learn approach. It also makes evaluation easier as you can track patient journeys more easily. However, do make sure you are also thinking about how to scale up the programme by building an evidence base and case for change.

3

Allocate adequate time for engagement.

Remember that it will take time to gather all the relevant stakeholders needed and then to build interest, relationships, common goals and refine a delivery plan – planning for the support needed in winter should start in the summertime. Be careful too not to "reinvent the wheel": it is often best to build on existing services and projects that offer health, wellbeing and financial support for people. By working with your existing community assets, you can create a holistic offer which makes best use of the resources available.

4

Provide appropriate pre-appointment information.

Bear in mind that some people may be suspicious of the proactive offer of support being made, particularly where the offer is from an organisation outside of the NHS, or if they feel that this support should be given to others more in need. Our projects are now pulling information leaflets together to be shared with people before they have their appointment for the clinical review to explain the background to the project, what will happen at the appointment and what the onwards referrals might include. It is hoped this will help to manage expectations and provide assurance the services offered and the stakeholders involved are genuine and connected. It will also provide details regarding eligibility and entitlement of some offers to encourage people to take them up.

5

Focus on building patients' trust through consistent, open communication.

We have learnt that maintaining a single point of contact for the project has helped to build the relationship and trust between the care-co-ordinator and patient. This means that patients have been more willing to open up and share information about the other issues or problems they are experiencing that may be affecting their physical and mental health, including housing and financial issues. Do consider what else may be deterring patients – for example, one of our projects found when they made telephone calls to patients their numbers were appearing as withheld or from out of the area, which was putting people off answering the calls. The service found a way to ensure local telephone numbers were used for phone calls, which improved the contact rates with patients.

Section 8: Additional resources

The Fuel Poverty toolkit

Working with trailblazer sites, Cheshire and Merseyside ICB has developed the following "toolkit" of practical resources to help other teams across the ICS and beyond who would like to use this methodology to target high-risk patients in fuel poverty. It includes:

Process maps

Developed for each of the local trailblazer teams, these show a step-by-step process on how to engage individual patients, provide interventions, monitor progress, and gather feedback.

Asset map

This provides a detailed list of local organisations and agencies available to support people experiencing fuel poverty or which can help engage at-risk communities.

Standard operating procedures

These describe the protocols and procedures used across the patient pathways established in trailblazer sites.

Sample outcomes and measurement plan

This provides details of the sample metrics and methods of data collection for the adult COPD cohort.

Case studies and testimonials

This brings together a selection of anonymised case studies and patient and staff testimonials from project areas. It will be supported by detailed evaluation showing the measurable impacts in due course.

All resources can be downloaded from the Health Innovation North West Coast website.

How Cheshire and Merseyside ICB can help

The Cheshire and Merseyside ICB is available to help health and care partners across its system footprint to develop similar approaches to tackling fuel poverty.

It can help by:

- Sharing its experiences and the lessons learned so far
- Connecting you with existing projects already delivering this work
- Supporting you in planning and designing a project for your area
- Helping you to develop an evaluation plan to support your project.

You can also join the Cheshire and Merseyside Fuel Poverty Steering Group to share information and learn from others.

Key contacts

As well as supporting local teams, the Cheshire and Merseyside Fuel Poverty programme team and our partner Optum UK are happy to field enquiries from other areas outside the ICS who may be embarking on similar projects.

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