Maximising Digital Opportunities in Adult Mental Health

Monday 28th January
#digitalmentalhealth
Session 1
Maximising Digital Opportunities in Adult Mental Health

#digitalmentalhealth

@HINSouthLondon healthinnovationnetwork.com
We connect academics, NHS commissioners and providers, local authorities, patients and patient groups, and industry.

We work to accelerate the spread and adoption of evidence-based innovations and best practice across South London and beyond.
Digital Mental Health: Long Term Horizons

Dr James Woollard
Senior Clinical Fellow in Mental Health Technology
January 2019
Mental health in the Long Term Plan (LTP) – an overview

Our headline ambition is to deliver ‘world-class’ mental health care, when and where children, adults and older people need it.

The NHS Long Term Plan published on 7 January 2019 commits to grow investment in mental health services faster than the overall NHS budget. This creates a new ringfenced local investment fund worth at least £2.3 billion a year by 2023/24. Further, the NHS made a new commitment that funding for children and young people’s mental health services will grow faster than both overall NHS funding and total mental health spending. This will support, among other things:

- Significantly more children and young people from 0 to 25 years old to access timely and appropriate mental health care. NHS-funded school and college-based Mental Health Support Teams will also be available in at least one fifth of the country by 2023.
- People with moderate to severe mental illness will access better quality care across primary and community teams, have greater choice and control over the care they receive, and be supported to lead fulfilling lives.
- We will expand perinatal mental health care for women who need specialist mental health care during and following pregnancy.
- The NHS will provide a single-point of access and timely, age-appropriate, universal mental health crisis care for everyone, accessible via NHS 111.
### Key mental health ambitions at a glance (by 2023/24)

<table>
<thead>
<tr>
<th>Ambition</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>345,000 more <strong>CYP</strong> will access help via NHS funded <strong>mental health services</strong> and school or college-based <strong>Mental Health Support Teams</strong></td>
<td>Provide better <strong>community mental health support</strong> to 370,000 people with <strong>SMI</strong> via new and integrated models of primary and community care</td>
</tr>
<tr>
<td>24,000 additional women will access specialist perinatal <strong>mental health services</strong>. The period of care will be extended from 12 months to 24 months post-birth</td>
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<td>Anyone experiencing <strong>mental health crisis</strong> will be able to call <strong>NHS 111</strong> and have <strong>24/7 access</strong> to the mental health support they need</td>
<td>380,000 more people will access <strong>NICE-approved IAPT</strong> services each year</td>
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<tr>
<td>Reduced <strong>length of stay</strong> in units with a long length of stay to the national average of 32 days</td>
<td></td>
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<td>Ensure that the parts of England most affected by rough sleeping will have better access to <strong>specialist homelessness NHS mental health support</strong></td>
<td>Expand geographical coverage of <strong>NHS services</strong> for people with serious gambling problems</td>
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<tr>
<td>Expand the existing <strong>suicide reduction programme</strong> to all <strong>STPs in the country</strong></td>
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# Key digital ambitions at a glance (by 2023/24)

<table>
<thead>
<tr>
<th>Digital technology</th>
<th>Digital Mental Health</th>
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<tbody>
<tr>
<td><strong>All secondary providers</strong>, including MH, will be <strong>fully digitised</strong>, including clinical and operational processes across all settings, locations and departments</td>
<td><strong>Digitally-enabled models of therapy for IAPT, perinatal and CYP</strong></td>
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<tr>
<td>People have <strong>access</strong> to their care plan and communications from their care professional via the NHS App</td>
<td><strong>Better information sharing</strong> to support mental health support in schools and the new models of primary and community support for SMI</td>
</tr>
<tr>
<td>Systems that <strong>support population health management</strong> in every ICS across England</td>
<td><strong>Use of decision-support tools and machine learning</strong> to augment our ability to deliver personalised care and predict future behaviour</td>
</tr>
<tr>
<td>Every person has access to a digital first primary care offer (or <strong>digital NHS “front door”</strong> e.g. appointments and prescriptions)</td>
<td>Creating the <strong>right environment and infrastructure</strong> for innovation to thrive: workforce, open source and open standards</td>
</tr>
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</table>
5 roles of technology

• Education of the public and dissemination of information
• Screening and Diagnosis
• Use in treatment and care
• Effective training and supervision
• Health system level intelligence

From The Lancet Commission on global mental health and sustainable development, The Lancet, 2018
www.england.nhs.uk
Core Digital Capabilities

- Interoperated Electronic Health Record
- Personal Health Record
- Electronic prescribing and medicines administration
- Digital tools (apps, therapies and enablers)
- Decision support tools, combined with AI and advance analytics
- Remote and mobile working
Quantified Patients, Quantified Clinicians
Sensor Platforms:
Wearable sensors
Mobile device sensors
Inside-ables

User Interfaces:
Screens
Smart Glasses
Smart Watches
Holographic VR

Physical Augmentation/Robotics
Companion Robots
Human Augmentation
Nano-technology
Drug delivery System

Bio-Medical Investigations/Analysis
Genome test
Brain Imaging
Blood tests

User Side Computation/Analytic s/AI - Localised Artificial intelligence capability on smart devices (e.g. computer vision)

Data Warehouses:
Electronic Health Records
Other data sources

Cloud base analytics/Al platforms
National data analytics capability
Personalise journey

Awareness of a problem prompted by an App, a friend, a link on chat forum

Initial connection with help, self-triage through digital tools

Online Self-referral to NHS IAPT service

Tailored, Digital Enabled Therapy

Self-Help through digital tools supporting recovery/wellbeing

References:
London Digital Wellbeing Platform
NHS.UK apps
NICE IAPT Pilot
Towards Blended, Assistive Realities

www.england.nhs.uk
Digital horizons in mental health
Technology is only as good as the sustainable behaviour change it supports...
Jameswoollard@nhs.net
@psycle_doc

www.england.nhs.uk
Dr Jack Barker,
Chest and General Physician –
King’s College Hospital

Chief Clinical Information
Officer
King’s College Hospital,
The Local Care Record and
Our Healthier South East
London Sustainability and
Transformation Partnership
To improve the use of Health and Care information within King’s and across South East London

Deployment and Development of an EPR across King’s
• eNoting
• ePrescribing
• eVital Signs

Development of Shared Care Records
• Use of Coordinate my Care for shared care planning
• Integration of Health and Social Care Data
• Creation of a shared data repository for pro-active care and analytics
• Establishment of cross-organisational Personal Health Records

So what has this got to do with integration of physical and mental health?
What might we want to do?

- Identify patients with mental health issues
- Help them appropriately
- Allow Mental-Physical teams to interact appropriately
- Make sure that we are working to the highest standards
All KCH sites now have access to a “modern” Electronic Patient Record.
eNoting at the PRUH

**eNoting at PRUH Total: 107,495**

- Number of eNotes made:
  - X-axis: Sunday, November 11, 2018 to Sunday, January 06, 2019
  - Y-axis: 0 to 3,000

**eClerking at PRUH Total: 2,047**

- Number of Clerking tasks:
  - X-axis: Sunday, November 18, 2018 to Sunday, December 30, 2018
  - Y-axis: 0 to 60
A structured admission clerking
Leading to structured diagnosis capture
Bringing prevention to the public: “Fifty percent of the disease burden in England is due to four modifiable health behaviours – poor diet, tobacco, excessive alcohol, and physical inactivity.” (ch.1, p.5)

By the end of the clerking .......

Zztest, Major
ZCM General Surgery Ward
Male
45y (02-Feb-1973)

Health Issue Manager | Add - Zztest, Major

Health Issues | My ranked | Family History | Past Medical | Past Surgical

- Hypertension
  - Current smoker: Active (77176002)
  - Alcohol dependence: Active (86590000)
  - Acute delirium: Active (2776000)
  - Alzheimer's disease: Active (26920004)
  - Anxiety and depression: Active (231504008)

Diagnosis (SN)

Add New Health Issue
Select a Type: Favorite | Browse | Full Catalog Search

Select by Favorites:

25
Structured and coded diagnosis – why bother and how can we get better at it?

- Why bother?
  - Epidemiology
  - Care Pathways
  - Interoperability
  - Population Health
  - Care Planning

- How do we get better at capturing diagnoses?
  - Agreed work flows
  - Link to prescriptions
  - Link to results
  - Natural Language processing
 Organisation of Health and Care in London and the formation of Sustainability and Transformation Partnerships

- SE London
- (1.7 million)
- 220 General Practices
- (2) acute providers (providing largely hospital-based services)
- (0.2) ambulance services
- (3) community providers (providing services such as district nursing, health visiting)
- (1) integrated providers (for example organisations that provide both acute and community care)
- (2) mental health providers
- 6 Social Care Providers
New models of high quality, sustainable and integrated care
Unscheduled care | Planned care | Population Health Management

1. Robust digital operations in each organisation
2. Ubiquitous viewing of records across care organisations
3. Normalised data service for proactive care and population health management
4. Patient access and control
5. De-identified information for system planning & research
The “Ubiquitous view” within an organisation
The “ubiquitous view” – between organisations
Letter from KCH EPR

KING'S COLLEGE HOSPITAL

MULTIDISCIPLINARY THORACIC ONCOLOGY TEAM

Dr Robert Jones
Consultant Oncologist
Tel 020 7836 5022
Theroux 3

Dr George Board
Consultant Oncologist
Tel 020 7836 5022

Dr Ewan Wilson
Consultant Oncologist
Tel 020 7836 5022

Dr Helen Ellis
Consultant Radiologist
Tel 020 7836 5022

Dr Jane Manners
Consultant Radiologist
Tel 020 7836 5022

Dr Naomi Whitten
Consultant Oncologist
Tel 020 7836 5022

Dr Nick Myers
Consultant Surgeon
Tel 020 7836 5022

Dr Nina Smith
Consultant Surgeon
Tel 020 7836 5022

Dr Christine Reed
Consultant Chest Physician
Tel 020 7836 5022

Angelika Stolarska
Consultant Chest Physician
Tel 020 7836 5022

Key Workers

Mira Harewood
Clinical Nurse Specialist
mira.harewood@kcl.ac.uk
Tel 020 3298 4900

Emily Brown
Clinical Nurse Specialist
emily.brown@kcl.ac.uk
Tel 020 3298 4900

We welcome all correspondence with general practitioners

EL 4b
Clinic Date: 04 December 2017
Date Typed: 12 December 2017

Dr. George Board
Consultant Oncologist
Regulatory Medicine

Letter from GSTT EPR from LCR

Inpatient Adult Discharge Letter

Date: 01/02/2018

Diagnosis: Bronchial carcinoma

Mr. John Doe

Dear Dr. Board,

We are writing to inform you that Mr. John Doe has been discharged from the hospital. He was admitted with a diagnosis of bronchial carcinoma. During his stay, he underwent a successful surgical procedure. He is currently recovering at home and is expected to make a full recovery.

Inpatient Discharge Letter

Dr. Board,

Mr. John Doe has been discharged from the hospital. He has made a good recovery from his surgery and is currently being discharged.

Yours sincerely,

[Address]

Letter from GSTT EPR from LCR
Local Care Record – current coverage
Cumulative access to our Shared Care Record

- Accessed > 3 million times
- Accessed 160,000 times per month
- 26,000 unique users
Are we looking after patents with mental health issues properly?

- Normalised data service for proactive care and population health management
- Following the One London Model
- Requiring
  - Data from Primary Care
  - **Data from Secondary Care**
  - Data from other sources

During 2019, we will deploy population health management solutions to support ICSs to understand the areas of greatest health need and match NHS services to meet them. NHS Long term Plan
Summary

• We have made big strides in digitizing our inpatient and primary care services
• This has radically improved visibility of care records within organisations
• We need to increase the structure of those records
• We need to use Computerised decision support to improve quality of care and reduce variation
• We need to improve our analytics to support quality of care and reduce variation
• We have made significant improvements in ubiquitous viewing of data across whole care pathways
• We have a distance to travel to quality assure our services across whole care pathways
Thank you
Measuring happiness

Dr Derek Tracy
Consultant Psychiatrist & Clinical Director, Oxleas NHS Foundation Trust, London
Senior Lecturer, King’s College London

derek.tracy@nhs.net ; @derektracy1

Maximising Digital Opportunities in Adult Mental Health
January 28th 2019
Overview

- Measuring happiness
- Tracy’s paradox of electronic records
- What we can & should do
- Hearts and minds

since feeling is first who pays any attention
Measuring happiness

- Mental health presents unique challenges
- We lack biomarkers, and rely on self-reported and observed distresses

- This has raised two profound issues:
  - ‘What’ to measure (how/when valid, reliable is that?)
  - A lack of professionals’ use/trust/value in psychometric markers

- These are the issues that need challenging: the technological aspects are the easy bit...
Tracy’s paradox of electronic records

• Generally, they can tell us anything we’d like to know about patients except:
  • Do we get people well
  • Do they like the service they receive

• Irritatingly, patients seem very keen on knowing:
  • Do you get people well
  • Do people like the service you provide

• We want to know what is happening
  • For individuals
  • For teams
  • For services

wholly to be a fool
while Spring is in the world
What we can & should do

• **System issues;** needed to be:
  • Electronic
  • Built into digital records

• **Scale issues;** needed to be:
  • Valid, reliable, free
  • Pan-diagnostic: *a critical discussion point for us later*…. Common currency across mental health
  • Track three broad areas of care:
    • i) symptoms (how are you feeling) – CORE-10
    • ii) social (how is your life) – Camberwell Assessment of Need (short version)
    • iii) feedback (how was it for you?) - FFT

*my blood approves
and kisses are a better fate*
lady I swear by all flowers. Don’t cry
- the best gesture of my brain is less than
your eyelids’ flutter which says
we are for each other: then
What we want to do

• Understand *individuals* & changes in their well-being
  • Give people their own data
  • Let them log in at any time and feedback (smart phones, online)

• Understand *team morbidity longer-term*
  • Types of difficulties our patients tend to face
  • Consider our patient make-up, progression, and suitability to manage
  • Publish our data online; let people see what we do – a culture of transparency

• Understand *service issues*
  • Track people across teams, services, organisations: what works (/doesn’t), when, in whom?
  • Have services commissioned on outcomes – with educational caveats…
  • Life in a post-RCT world: embracing & exploring noisy real-world data
Hearts and minds

• You are not the people you need to talk to
• Nor are the people beside you
• You need to talk to the people who aren’t here

• Ask staff their opinions on EPR

• It needs to work for front line staff
• Leadership will be making it work for them, not you

• Future challenges: common currency vs mandated markers…

and death I think is no parenthesis

- e e cummings
“I have measured out my life with coffee spoons”
- T.S. Eliot, Love song of J. Alfred Prufrock

derek.tracy@nhs.net ; @derektracy1
Q&A

Dr James Woollard, NHS England
Dr Jack Barker, King's College Hospital & Our Healthier South East London STP
Dr Derek Tracy FRCPsych, Oxleas NHS Foundation Trust & King’s College London

@HINSouthLondon  healthinnovationnetwork.com
Using mHealth apps in Mental Health
ARE HEALTH APPS AND MOBILE HEALTHCARE THE FUTURE?

With over 326,000 health & fitness related apps currently on app stores & 5 MILLION downloads per day it is difficult to deny the rising popularity of the industry.

<table>
<thead>
<tr>
<th>Category</th>
<th>Downloads</th>
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<tbody>
<tr>
<td>Weight loss Apps</td>
<td>50 MILLION</td>
</tr>
<tr>
<td>Exercise Apps</td>
<td>26.5 MILLION</td>
</tr>
<tr>
<td>Women's Health Apps</td>
<td>10.5 MILLION</td>
</tr>
<tr>
<td>Sleep &amp; Meditation Apps</td>
<td>8 MILLION</td>
</tr>
<tr>
<td>Pregnancy Apps</td>
<td>7.5 MILLION</td>
</tr>
<tr>
<td>Tools &amp; Instruments Apps</td>
<td>26.5 MILLION</td>
</tr>
</tbody>
</table>

PROFESSIONAL ARE SEEING THE OPPORTUNITY WITH HEALTH APPS TOO

- 80% of professionals are using smartphones & medical apps
- 40% believe health technologies can reduce the number of visits to doctors' offices
- 93% believe these apps can improve patient health
Digital Health Apps by Category 2017

Sources: 42 Matters, Jul 2017; IOVIA AppScript Database, Jul 2017; IOVIA Institute, Jul 2017
Note: Chart displays share of categorizations. Growth normalized for sample. Numbers may not sum due to rounding; 2017 data includes 11,216 unique app categorizations. 2015 data includes 24,012 apps with 24,088 categorizations. View removes uncategorized apps from 2015 published numbers.
Disease specific app categories
What are the major blockers?

**Awareness**
Apps are not yet part of the day to day management of health and care related conditions

**Accessibility**
Finding and matching Apps to support your needs or those of your patients or service users is very difficult

**Trust**
The lack of a suitable quality indicator inhibits the embracing of Apps by end users and professionals in the health and care

**Governance**
The lack of clarity around the regulatory landscape and the appropriate governance foundations delivers organisational uncertainty.
Introducing ORCHA

L4 - Regulated
L3 - Condition Management
L2 - General Health
L1 - Advanced Wellbeing
L0 - Simple Wellbeing
Using Apps in Mental Health; a couple of Case Studies

01. South Yorkshire NHS Partnership Trust
This deployment is all about CAHM’s services and supporting the patients referred into the SWYFT CAHM’s service to help manage and improve.

02. Lancashire STP
Our earliest Microsite deployment, Lancashire is now going from strength to strength with over 2000 registered Professional users and thousands of visits and downloads.

03. Digital Healthy Schools
The DHS Programme looks to create activation communities around schools and is supported by a PHSE module to directly engage year 7 and 8 students.
Impact:

Take 1000 Patients suffering from depression...
Wait for Assessment

- 63.3%
  - Wait for Assessment
  - 5.4%
    - Not eligible for IAPT waiting list

Waiting to commence treatment

- 76%
  - 25.7%
    - Not commencing treatment
  - 19%
    - Treatment underway
  - 5%
    - Complete treatment

Treatment underway

- 80%
  - 5%
    - Not finishing treatment

Complete treatment

- 15%
  - 44.6%
    - Recovered
  - 55.4%
    - Not recovered
12 weeks later....
1,000 patients over 12 weeks...

- Weeks of waiting: 442 (23 days per person)
- Not seeing a therapist: 324
- Achieving recovery: 128
- Investment: £371,105

GP Apts = £24,000
IAPT = £347,105
Why not provide apps for those on waiting lists?

Why not provide apps for those not selected to see a therapist but still struggle with depression?

Why not provide apps for those not achieving recovery (reduce GP footfall?)
Doing something when we would otherwise likely be doing nothing?
The costs & potential savings...

- Hospital admission: £1,800
- A&E Attendance by ambulance: £325
- Attempted Suicide: 1 in 10 on waiting lists for mental health services
- Self Harm: 4 in 10 will attempt self-harm

Total: £15,273
Listen to a Clinical Psychologist using apps with her patients....
**KEY POINT**
1 app will not fit all!

- There are many different features available. These include 'education and information', health tracking, alerts and reminders, goal setting etc.

- Are you an iOS or Android user, fitbit or Garmin, Alexa or Google Home or integrated with EMIS v System One, Cerner v Meditech etc.

- What health or care issue are you looking for support around?

- These can include your Age, Gender and your physical and mental capabilities.

- Your personal Characteristics

- Features and Functions you require

- Technical Preferences
Thank You
Refreshments
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Session 2
Maximising Digital Opportunities in Adult Mental Health

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Presentation to HIN
Maximising digital opportunities in mental health
Jan 2019
Key challenges

• Are your patients well cared for in a safe environment?

• Is quality consistent?

• What and where are the issues?

• How do you empower front-line staff to own quality in their area?
Typical manual audit process takes valuable clinical time away from patients
The Problem

The Solution
• Live reporting
• Snapshot of quality
• Trend easily visible
• Simple, intuitive inspecting
• Add photos and free text comments
• Reduces inspection time by half
• Results immediately available for all users
• Live reporting
• Drill down transparency
• Area/ward to Divisional/Site/Organisation views
• Easily spot issues and common themes
The benefits

- Saves money
  - Full context
  - Transparent
  - Consistent
  - No paperwork
  - Comparable

- Improves quality
  - Quick & easy
  - Customisable
  - Act instantly
  - Manual inspection
  - Perfect Ward

- History & evidence
- 75
Value-for-money

From £1 per area per day
For 1-2 inspection types. Pricing scales with the range of inspections carried out

This includes unlimited:

Inspectors Viewers Devices Inspections Reports Customisation Updates Photos Comments
Growing and recognised

Customers

Royal Free London NHS

Welsh University Teaching Hospital NHS Foundation Trust

Barts Health NHS

West Suffolk NHS Foundation Trust

King’s College Hospital NHS Foundation Trust

London Ambulance Service NHS

NELFT NHS

Sherwood Forest Hospitals NHS Foundation Trust

Wakefield Clinical Commissioning Group

North Middlesex University Hospital NHS

Barnsley Hospital NHS Foundation Trust

London North West Healthcare NHS

Weston Area Health NHS

The Queen Elizabeth Hospital

King’s Lynn NHS Foundation Trust

Salisbury NHS

Medway NHS

The Dudley Group NHS Foundation Trust

The Royal Buckinghamshire Hospital

Humber NHS

Buckinghamshire Healthcare NHS

Ashford and St. Peter's Hospitals NHS Foundation Trust

The Princess Alexandra Hospital NHS

Cambridge University Hospitals NHS

Croydon Health Services NHS

Recognition

Digital Health London ACCELERATOR

HSJ 2016 Awards Finalist

HealthInvestor Awards 2017 Finalist

Pfizer Healthcare Hub

techworld

ehi

HSJ VALUE IN HEALTH

FINALIST
Barts experience: implement at scale, at speed

Caterina Raniolo @CaterinaRan Jun 13
Midwife Rebecca Walker doing the Perfect Ward audit on the Birth Centre which gives her assurance that the ward is safe, well led, responsive, caring and effective.

Hazel R Murwisi @Hazel_Rue Jul 9
Want to know how to do an inspection on the Perfect Ward app? We are in Seminar room 2, Willow lodge @WhippsCrossHosp #WelImprove #ITProud using technology to improve outcomes.

Caroline Alexander @CAlexanderNHS Feb 12
Had a live demo of @Perfect_Ward by andymm1968 and uploaded it to my iPad today – this is going to revolutionise our approach to audit and improvement & key Helping us get 2 good & outstanding consistently across @NHSBartsHealth.

Alwen Williams @A_WilliamsNHS Nov 12
Many thanks @CGZimuto @Emma23574234 & Zurka for a real time demonstration of @Perfect_Ward @WhippsCrossHosp @NHSBartsHealth. Huge potential to improve the quality of care to our patients! Very impressive.

Andrew McGovern RN MSc BSc @andymm1968 May 25
And that’s 1000 @Perfect_Ward inspections @NHSBartsHealth.
“The Perfect Ward app has given me that amazing opportunity to look at what we are doing any moment of the day across any part of our geography.”

Stephanie Ward
Chief Nurse
North East London NHS Foundation Trust
Thank you
Improving access to Advice and Guidance in Mental Health – Oxleas NHS FT

28th January 2019

Rachel Matheson & Scott Welpton
Oxleas NHS Foundation Trust:

Oxleas provides a wide range of health and social care services in south east London, specialising in community health, mental health and learning disability services.

Oxleas is the main provider of specialist mental health care in Bexley, Bromley and Greenwich.

Consultant Connect:

Consultant Connect is the NHS’s most widely used Advice and Guidance System covering over 60 CCGs and Health Boards in the UK in both physical and mental health.

Consultant Connect has been in use in South East London since 2016 and now covers 4 separate trusts and 6 CCGs.
A third of all GP consultations involve Mental Health. Both the CCG and Trust recognised their GPs needed more support for mental health patients

- Better support GPs with the care of their patients within primary care
- Improve responsiveness for Greenwich GP patients requiring specialist mental health advice, assessment and treatment
- Better streamline demand for referrals (i.e. better understand the urgency of referral and reduce unnecessary referrals)
- Ultimately advice and guidance given at an early/primary mental health stage aspires to prevent people to go on to use secondary mental health services
- Improve relationships between GPs and mental health services
Why does Telephone A&G have a large impact in Mental Health?

- Reassurance about urgent referrals is time-dependent which favours telephone advice over written advice
- Consultant advice on complex management is often too complicated for email
- Email may work for simple pharmacological or pathway advice, but complexity or nuance favours the speedy exchange of questions of a conversation
- In summary, there is no simple substitute for a clinician-to-clinician conversation.

Clinicant-to-clinician conversation is an evidence-based, fast and effective form of managing referrals (Kings Fund paper: Referral Management: Lessons for Success)

It ensures patients get the right care and reduces unnecessary referrals, assessment appointments and hospital visits.

Whilst Offering Advice and Guidance was a national indicator in the 2017-2019 CQUIN for Acute Trusts, this was not the case for Mental Health services.
How it works

1. GP accesses system by calling a unique Dial-In Number or through the app
   Accesses advice on all specialties on offer

2. NHS # input
   For medico-legal tracking

3. Calls linked to groups of clinicians in "hunt group"
   Improves answer rates

4. Calls digitally recorded and available to clinicians
   Fully encrypted medico-legal record

5. GPs & clinicians provide call outcomes
   At end of call by selecting from keypad options, option on App or by SMS

6. The service is managed and all activity & outcome data is provided to the CCGs, Trusts and Practices

As calls are routed to clinician’s mobile phones, the clinicians do not need to be desk based. Clinicians fit the calls around their existing work by only taking calls if they are in a position to do so. Therefore, no changes to job plans are required.
The Results so Far

Since launch in August 2018 67 calls have been answered through Consultant connect. On average this is 3 calls per week.

Working Age Adults Advice Line:
• 19% Routine Referral Made,
• 31% Urgent Referral Made
• 50% Referral Avoided

Older Adult Advice Line:
• 30% Routine Referral Made
• 50% Urgent Referral Made
• 20% Referral Avoided
Next Steps

• Extend to offer Consultant Connect to our Urgent Care Centre which is GP led

• In February 2019 Greenwich will have a single point of access for primary care plus mental health with Consultant Connect becoming an integral part of the new model

• Evaluation in August 2019 to include qualitative measures
scott.welpton@consultantconnect.org.uk

rachel.matheson2@nhs.net
Proactive Health Coaching in Mental Health
Background and previous experience
Background information

• Health Navigator is an organisation focused on innovative behavioural interventions and offers a Proactive Health Coaching (PHC) service

• This material has been developed with the aim of increasing the understanding of PHC, and to give some background to the intervention

• This material should be regarded as **preliminary and confidential**, and is only complete together with the relevant verbal presentation. This material should therefore not be distributed.

• For more information about this material and PHC please contact Karin Hogsander (Interim Managing Director) at [karin.hogsander@health-navigator.co.uk](mailto:karin.hogsander@health-navigator.co.uk)
Agenda

• Example of pre-study to understand population before implementation

• Example topics for discussion when setting study up

• Preliminary results from Stockholm study
Nearly 86 000 Stockholm residents had at least one inpatient event or visit to outpatient psychiatric clinic in 2011

Residents 18+ yrs, Stockholm, 2011

Residents with psychiatric diagnosis at inpatient / outpatient psychiatric clinic

95%
(1,554,281)

Other residents over 18 yrs age
Predominantly young or middle-aged patients seek psychiatric care
Residents over age 18 receiving a psychiatric diagnosis as psychiatric inpatient or outpatient, 2011

Gender profile

100% = 85,730

Male 45% (38,207)
Female 55% (47,523)

Age profile

Note: Forensic psychiatry excluded. Source: VAL (central database in Stockholm county council covering all healthcare contacts, costs, etc.)
Alcohol-related diagnoses were the most common among psychiatric inpatients who seek care

Share of patients* who during 2011 was diagnosed as an psychiatric inpatient at least once

- Alcohol related disorders: 6%
- Major depressive disorder, single episode: 2%
- Other anxiety symptoms: 2%
- Reaction to severe stress: 1%
- Other psychoactive substance related disorders: 1%
- Encounter for medical observation for suspected diseases and conditions ruled out: 1%
- Poisoning by, adverse effect of and underdosing of drugs: 1%
- Bipolar disease: 1%
- Encounter for full-term uncomplicated delivery: 1%
- Schizophrenia: 1%

6% of patients have had at least one psychiatric inpatient event during 2011
Diagnoses of anxiety and depression were the most common in psychiatric outpatient clinics

Share of patients* who during 2011 at least once diagnosed in psychiatric outpatient clinic

- Other anxiety symptoms: 19%
- Major depressive disorder, single episode: 14%
- Alcohol related disorders: 14%
- Major depressive disorder, recurrent: 10%
- Reaction to severe stress, and adjustment disorders: 9%
- Attention-deficit hyperactivity disorders: 8%
- Bipolar disease: 7%
- Encounter for medical observation for suspected diseases and conditions ruled out: 7%
- Encounter for general examination without complaint, suspected or reported diagnosis: 5%
- Specific personality disorders: 4%

* 85,730 patients with at least one psychiatric inpatient event or visit to psychiatric outpatient clinic with psychiatric diagnosis in 2011

Almost a fifth of patients have visited psychiatric outptients and been diagnosed with “Other anxiety symptoms”
Care costs for this patient group was SEK4.4bn, equally split between psychiatric inpatient and outpatient costs

Total care (somatic and psychiatric) including prescriptions, 2011. 100% = SEK4.4bn
1% of psychiatry patients are responsible for ~15% of total care costs, 10% are responsible for half of costs

Total care (somatic and psychiatric) including prescriptions, 2011

Source: VAL (central database in Stockholm county council covering all healthcare contacts, costs, etc.)
Patients have both psychiatric and somatic inpatient events
2011

Source: VAL (central database in Stockholm county council covering all healthcare providers, costs, etc.)
Small group of very high care costs patients among patients with psychiatric diagnosis and somatic co-morbidity

Residents with both psychiatric diagnosis and =>2 care events with somatic diagnosis 2011 (6 848 residents)

Note: Forensic psychiatry excluded. Source: VAL (central database in Stockholm county council covering all healthcare contacts, costs, etc.)
These patients are often both somatic and psychiatric inpatients

Residents with both psychiatric diagnosis and >=2 care events with somatic diagnosis 2011 (6,848 residents)

<table>
<thead>
<tr>
<th>Cost segment</th>
<th>Age (median)</th>
<th>Inpatient days (average)</th>
<th>Visits (median)</th>
<th>Cost (median, kSEK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>45 yrs</td>
<td>15 8 61 72</td>
<td>88</td>
<td>1,519</td>
</tr>
<tr>
<td>1-2%</td>
<td>57 yrs</td>
<td>16 18 20 34 88</td>
<td>77</td>
<td>943</td>
</tr>
<tr>
<td>2-3%</td>
<td>49 yrs</td>
<td>410 24 29 67</td>
<td>63</td>
<td>780</td>
</tr>
<tr>
<td>3-4%</td>
<td>59 yrs</td>
<td>11 17 21 30 79</td>
<td>86</td>
<td>673</td>
</tr>
<tr>
<td>4-5%</td>
<td>59 yrs</td>
<td>8 11 16 31 64</td>
<td>69</td>
<td>593</td>
</tr>
<tr>
<td>5-6%</td>
<td>62 yrs</td>
<td>12 17 23 27 80</td>
<td>84</td>
<td>551</td>
</tr>
<tr>
<td>6-7%</td>
<td>62 yrs</td>
<td>11 20 12 28 70</td>
<td>96</td>
<td>509</td>
</tr>
<tr>
<td>7-8%</td>
<td>54 yrs</td>
<td>12 19 16 23 71</td>
<td>71</td>
<td>473</td>
</tr>
<tr>
<td>Samtliga</td>
<td>62 yrs</td>
<td>17</td>
<td>35</td>
<td>146</td>
</tr>
</tbody>
</table>

Source: VAL (central database in Stockholm county council covering all healthcare contacts, costs, etc.)
Agenda

- Example of pre-study to understand population before implementation

- Example topics for discussion when setting study up

- Preliminary results from Stockholm study
How could we in an attractive way design a pilot to evaluate Proactive Health Coaching with psychiatry patients?

**Target group**
- Which target group of patients may reap the most benefit from a PHC-like solution?
  - Which diagnoses?
  - When in the pathway?

**Enrolment**
- When and how are patients most appropriately identified and included in the programme?
  - At discharge?
  - At the point of an emergency care visit?

**Goals**
- How do we formulate our goals?
  - Reduced symptoms (overall).Liberal?
  - Fewer inpatient stays/shorter inpatient stays/quicker discharge?
  - Improved access?

**Efforts**
- Given goals, which type of effort will give most benefit for the lowest cost?
  - Which channel? (online, telephone, home visits)
  - Which competences/capabilities? (nurses, multi-skilled teams)
Which groups of psychiatric patients may be most suitable for Proactive Health Coaching?

<table>
<thead>
<tr>
<th>Patients with psychiatric and somatic co-morbidity</th>
<th>Overview</th>
<th>Benefits</th>
<th>Potential question marks</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHC with Health Coach offered to patients with psychiatric and somatic co-morbidity, e.g. frequent visitors, (patients who were previously excluded)</td>
<td>• High care costs</td>
<td>• Present Health Coaches have excellent ability to help</td>
<td>• Would only reach the psychiatric patients who have a somatic co-morbidity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mixed selection from emergency psychiatry (or at discharge)</th>
<th>Overview</th>
<th>Benefits</th>
<th>Potential question marks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Coaches working with psychiatric emergency provider</td>
<td>• Could offer improved access; no risk of doubling up with existing support programmes</td>
<td>• Enrolment easier as relatively few locations</td>
<td>• Lack of current evidence for this study design</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Schizophrenia and/or bipolar patients</th>
<th>Overview</th>
<th>Benefits</th>
<th>Potential question marks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Coaching (possibly more intense than existing programme) offered after discharge</td>
<td>• High care costs</td>
<td>• Clear evidence base</td>
<td>• May require more resources and be more challenging than existing PHC programme</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Depressed patients in Primary Care</th>
<th>Overview</th>
<th>Benefits</th>
<th>Potential question marks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Coach offered to patients with light/medium severity depression in Primary Care</td>
<td>• Existing evidence for clinical benefit and cost effectiveness, recommended by SBU [Swedish Government Agency]</td>
<td>• Possibly challenging to enrol patients given dispersion across organisations and locations</td>
<td></td>
</tr>
</tbody>
</table>
Status update

Status of study

- 76 patients enrolled; 51 intervention 25 controls, 2 Health Coaches
- We are reaching ca 9% of estimated target group of 854 patients
- Number of patients so far too small to analyse and interpret results, we can so far see a lower care consumption for the intervention group (ca 15%)

Activities to increase enrolment flow to study

- Activity at psychiatric emergency unit in order to increase enrolment and reinforce the process:
  - In the clinical unit:
    - 12 staff meetings
    - Daily/weekly iteration with Health Coaches
    - Intranet and mailings
  - Process adjustments
    - Enrolment via wards
    - Identification of patients with assistance of medical secretaries

Top priority to accelerate enrolment or study hypothesis may
Agenda

• Example of pre-study to understand population before implementation

• Example topics for discussion when setting study up

• Preliminary results from Stockholm study
76 patients have been included in the study (9% of potential target group of 854 frequent visitors during Jan-Oct 2014)
Reasons given by patients for not participating

Distribution of reasons:
43 out of 66 patients state they do not wish to take part

- Main addiction/current addiction
- Confusion
- Not resident in area
- Current aggressive behaviour
- Terminally ill
- Blind
- Do not wish to take part
- Unknown reason

Source: Reasons for non-participation as reported by clinic staff
The study comprises 76 patients, of which 51 receive the intervention and 25 were randomised into control group.

Overview of the study population:
- 51 patients (average 159 days in study) receiving intervention
- 25 patients (average 147 days in study) in control group

Age distribution:
- 29% 30 yrs
- 23% 31-40 yrs
- 21% 41-50 yrs
- 20% 51-60 yrs
- 9% 60+ yrs

Gender distribution:
- Intervention: 30% Male, 70% Female
- Control: 50% Male, 50% Female
Patient volumes are low, but we see slightly lower care consumption among those supported by a Health Coach.

Total care cost per patient and year (kSEK):
- Control: 328
- Intervention: 282
- Reduction: 46 kSEK (-14%)

Psychiatry – inpatient days per patient and year:
- Control: 107
- Intervention: 95
- Reduction: 12 days (-11%)

Somatic care – inpatient days per patient and year:
- Control: 6
- Intervention: 3
- Reduction: 3 days (-45%)

In total a stronger effect than in the somatic target groups but not statistically significant.

Source: HN analysis
Digital Solutions in Practice:

Kardia Mobile

Alex Lang, Project Manager
Stroke Prevention Programme

@HINSouthLondon  healthinnovationnetwork.com
**Key statistics**

There are more than **100,000 strokes** in the UK each year. That is around one stroke every five minutes.

There are over **1.2 million stroke survivors** in the UK.

Every **two seconds**, someone in the world will have a **stroke**.

Stroke is the **fourth biggest killer** in the UK. Fourth in England and Wales, and the third biggest killer in Scotland and Northern Ireland.

More than **400 children** have a **stroke** every year in the UK.

A **third** of stroke survivors experience depression after having a **stroke**.

More than **8 out of 10 people** in the **England, Wales and Northern Ireland** who are eligible for the emergency clot-busting treatment, thrombolysis, receive it.

In **Scotland** only **1 in 10** of **all patients** will receive this treatment.

Almost **two thirds** of stroke survivors leave hospital with a disability.

People of working age are **two to three times** more likely to be **unemployed** eight years after their stroke.

The cost of stroke to society is around **£26 billion** a year.
Atrial Fibrillation
Hello
my name is
Undiagnosed
Opportunities across the AF pathway

AF toolkit Detect, Protect and Perfect
Working together across London to prevent AF related strokes

Within the three AF domains Detect, Protect and Perfect we have highlighted nine opportunities for improvement. The AF Improvement Cycle on the following page provides a framework in which each opportunity for improvement should be considered.
Kardia Mobile ECG device and app by AliveCor

AliveCor Heart Monitor and AliveECG app for detecting atrial fibrillation

Medtech innovation briefing
Published: 5 August 2015
nice.org.uk/guidance/mib35

Summary

The AliveCor Heart Monitor and AliveECG app are, respectively, a pocket-sized ECG recorder and a mobile device application for analysis and communication of the results. Two fingers from each hand are placed on the AliveCor Heart Monitor to record an ECG, which is transmitted wirelessly to the AliveECG app. The aim of the device is to identify paroxysmal atrial fibrillation (AF). Two
Recording ECG

Reporting ECG

Emailing ECG

Printing ECG

To start recording, place your fingers on the pads.

No abnormalities were found in your EKG.

Add Share to Files

Copy Print
So, which healthcare and non-healthcare settings would you target?
How will this support people with mental illness?

- People living with a serious mental illness experience once of the widest health inequality gaps in England
- 3.7 x higher mortality with a life expectancy 15-20 years less than the general population
- The disparity is complex and multifactorial
- 2 in 3 deaths are from physical illnesses that can be prevented
Adults with severe mental illness (SMI) are more likely to have physical health conditions

When compared to the general population of the same age group, people with severe mental illness (SMI)* aged 15-74 are more likely to have:

- Obesity: 1.8x
- Asthma: 1.2x
- Diabetes: 1.9x
- Chronic Obstructive Pulmonary Disease: 2.1x
- Coronary Heart Disease: 1.2x
- Stroke: 1.6x
- Heart Failure: 1.5x

*Sample of people with SMI registered with a general practice
Adults with severe mental illness (SMI) die younger, from a range of conditions, than adults in the general population.

A measure of the extent to which adults with SMI die younger than adults in the general population, by condition:

- Liver disease: 5x in 2014/15, 4.7x in 2013/14, 4.2x in 2010/11, 4.5x in 2009/10.
- Respiratory disease: 1.9x in 2009/10, 1.5x in 2010/11, 3.3x in 2011/12, 3.1x in 2012/13, 3.7x in 2013/14, 4.7x in 2014/15.
- Cardiovascular disease: 5x in 2014/15, 4.7x in 2013/14, 4.2x in 2010/11, 3.3x in 2011/12, 3.1x in 2012/13, 3.7x in 2013/14.

*People with SMI are defined as people in contact with secondary mental health services.*
Kardia Mobile in mental health settings

• Discussions with the three mental health trusts in south London

• A digital innovation that may benefit service users and help narrow healthcare inequality

• Clinicians understood rationale behind opportunistic testing for AF to reduce risk of CVD but some barriers to work through

• Trialled Kardia with small number of service users & at staff health & wellbeing events leading to SOP & wider roll out
Two for the price of one…

- Service users receiving some mental health medications require ECG monitoring

- 12 lead ECG may be declined or not practical e.g. housebound or acutely unwell

- Although not what it was originally designed for, clinicians using Kardia Mobile ECG to calculate QTc interval to safely prescribe medication

- Can be followed up with 12 lead ECG once practically possible
Some feedback…

“Thanks for your help with this client. It was a real help to his treatment plan. He was not agreeing to have an ECG prior to this because of his mental state and paranoia. By having this test with the Kardia as part of his treatment plan it has meant that the consultant is able to prescribe medication for his psychotic disorder”.

“He attended the hospital this week and consented to have blood tests- which is a great step forward and I feel is in part due to the use of the Kardia machine”.
<table>
<thead>
<tr>
<th>Jan - Nov 2018 (inc)</th>
<th>AF detection</th>
<th>Pulse checks</th>
<th>Detection rate</th>
<th>Detection prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community geriatricians</td>
<td>37</td>
<td>261</td>
<td>14.2%</td>
<td>1 in 7</td>
</tr>
<tr>
<td>GP practices</td>
<td>182</td>
<td>3132</td>
<td>5.8%</td>
<td>1 in 17</td>
</tr>
<tr>
<td>Hospital</td>
<td>49</td>
<td>923</td>
<td>5.3%</td>
<td>1 in 19</td>
</tr>
<tr>
<td>Fire safe and well</td>
<td>1</td>
<td>19</td>
<td>5.3%</td>
<td>1 in 19</td>
</tr>
<tr>
<td>Community therapy teams</td>
<td>9</td>
<td>200</td>
<td>4.5%</td>
<td>1 in 22</td>
</tr>
<tr>
<td>Podiatry</td>
<td>28</td>
<td>675</td>
<td>4.1%</td>
<td>1 in 24</td>
</tr>
<tr>
<td>Mental health</td>
<td>28</td>
<td>913</td>
<td>3.1%</td>
<td>1 in 33</td>
</tr>
<tr>
<td>Community nursing teams</td>
<td>5</td>
<td>251</td>
<td>2.0%</td>
<td>1 in 50</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>35</td>
<td>1814</td>
<td>1.9%</td>
<td>1 in 52</td>
</tr>
<tr>
<td>Public health</td>
<td>29</td>
<td>1832</td>
<td>1.6%</td>
<td>1 in 63</td>
</tr>
<tr>
<td>Prison</td>
<td>1</td>
<td>774</td>
<td>0.1%</td>
<td>1 in 774</td>
</tr>
</tbody>
</table>
Project impact to date
(1\textsuperscript{st} Jan – 30\textsuperscript{th} Nov 2018)

Possible AF  Possible strokes prevented  Potential lives saved  Potential costs avoided (health)
404  16  4  £215k

Preventing 4 strokes saves one life.
Mean healthcare costs in first year following stroke is £13,452 (Xu et al. 2018)
Need to treat 25 people with AF the prevent one stroke.
Some reflections…

• Making a compelling case for adoption – e.g. data and infographics
• Relationships are key – face to face training and support
• Capture learning along the way and use it to improve the process e.g. pathway design, sharing resources and feedback
• Build networks that allow adopters to share their experience e.g. community of practice, connecting people / technology
• Innovation at pace and scale – AHSN Network
• Involving service users at all stages of innovation and spread
• Building long term partnerships with multiple stakeholders - CVD
• Sharing success – e.g. abstracts and conferences
Summary

• Kardia has proven to add value to service user and clinician, BUT...

• Big opportunity for digital across the CVD detect, protect, perfect pathway to tackle inequalities

• NHS Long Term Plan highlights prevention, CVD, mental health, self management and digital at its centre

• System-wide cultural shift towards a greater emphasis on prevention and embracing digital solutions
Morning round up & afternoon taster
Dr Geraldine Strathdee CBE
#digitalmentalhealth
Lunch & Networking
#digitalmentalhealth

@HINSouthLondon  healthinnovationnetwork.com
Session 3
Maximising Digital Opportunities in Adult Mental Health

#digitalmentalhealth

@HINSouthLondon healthinnovationnetwork.com
Good Thinking – London’s Digital Mental Well-being Service

HIN Conference
28 January 2019

Dr Richard Graham – Clinical Lead, Good Thinking
Londoners’ Mental Health

Every year 1 in 4 people will experience a diagnosable mental health problem

18% of adults who have mental illness meet criteria for common mental disorders but are not diagnosed

Anxious?
London has the highest proportion of the people with anxiety in all the UK

£26 billion
Each year the wider economic & societal impacts of mental ill health costs London billions

£550 million
London boroughs spend millions per year on social care for supporting people with common mental health issues

“Basic and too-often ignored problems in our city”
Discovery and go-live phases

Worked with Londoners to co-design the service. It determined that Londoners wanted the service to be:

- Inclusive
- Friendly
- Non-judgemental
- Empowering
- Collaborative

- Multiple ways of offering support outside conventional mental health service
- Avoided the associated stigma
- Available 24/7
- Online – (web and app-based)
- Peer-to-peer
- Face to face
- Good Thinking went live in November 2017,
- Overseen by a steering group with representation including Directors of Public Health, Public Health England (PHE), and Clinical Commissioning Groups (CCGs)
How does Good Thinking work?

Uses social media marketing (Twitter, Facebook, Google) to find Londoners searching for terms associated with common mental health conditions and directs them to Good Thinking.

Four common mental health conditions: anxiety, sleep deprivation, stress, low mood
How does Good Thinking work?

Personalised support indicated following a simple three question wellbeing quiz. A more extensive self-assessment also available. Suggests five on and offline products to support and boost good mental health.
Good Thinking Usage to date

Nov '17 - Nov '18

180,000 visitors

125,000 unique IP addresses

55,000 repeat users

NEW USERS 90,000
April '18 - Nov '18

30.5% repeat users
69.5% new users

Steady user growth

Nov '18 180,000

Goal: 63,000

Apr '18 50,000

Stakeholder communications campaign:

NEW USERS 20,000
1 - 31 Oct '18
Good Thinking usage to date

180,000 visitors
Nov '17 - Nov '18

400,000 personalised searches

72% free

107 unique resources for common mental disorders

28% paid

No. resources to treat:

<table>
<thead>
<tr>
<th>Disorder</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>62</td>
</tr>
<tr>
<td>Low mood</td>
<td>69</td>
</tr>
<tr>
<td>Sleepless</td>
<td>56</td>
</tr>
<tr>
<td>Stress</td>
<td>53</td>
</tr>
</tbody>
</table>

anxiety
depression
stress
sleeplessness
Visits by device, time, and day

Visits by time of day:
- 12 AM: 0
- 3 AM: 5K
- 6 AM: 10K
- 9 AM: 15K
- 12 PM: 20K
- 3 PM: 25K
- 6 PM: 30K
- 9 PM: 35K

Visits by day of week:
- Sunday: 0
- Monday: 2K
- Tuesday: 5K
- Wednesday: 10K
- Thursday: 15K
- Friday: 20K
- Saturday: 25K
Top 10 resources accessed

1. Sleepio*
   Online programme that teaches proven techniques to fall asleep faster, stay asleep longer and wake up feeling refreshed.

2. Be Mindful*
   Online mindfulness course to develop lifelong skills to help manage difficult emotions and better cope with life's stresses.

3. NHS Sleep and tiredness advice
   Comprehensive health information and advice using videos, articles and other resources.

4. Anxiety UK
   Support service for people living with anxiety. It provides information and support via an extensive range of services, including 1:1 therapy.

5. The Campaign Against Living Miserably
   Free helpline and web chat support service for men feeling down or depressed for any reason.

6. Rethink
   Charity providing expert, accredited advice and information to anyone experiencing a mental health problem.

7. Mental Health Foundation
   Website with useful tools and resources for all things related to mental health and wellbeing.

8. The Mix
   Online support service providing free, confidential support and counselling for young people under 25.

9. Living Life to the Full
   Free online courses based on the principles of cognitive behaviour therapy to learn skills for coping with stress.

10. SAM
    Mobile phone app designed to help manage anxiety by building a personalised anxiety management toolkit.
Aim for 75% of local authority and NHS organisations in London to adopt Good Thinking as a source of self-care for employee well-being.

- Raise awareness to professionals in signposting to Good Thinking as a first-line self-help resource.

- Expand the service and campaign to 16 – 18 year olds.

- Commence initial peer-to-peer input through existing online community forums; making use of this group functionality to establish groups for people that cannot be found easily.

- Pilot and roll-out online self-referral to all London’s Improving Access to Psychological Therapies (IAPT) services.
Proposed work plan for 2019/20

- Scope out the use of Good Thinking to ages 13 – 16 (by 2020).
- Make Good Thinking available to all schools
- Further expand peer-to-peer networks.
- Explore direct referral into London’s digital IAPT services.
- Good Thinking introduced to London’s top 100 employers as part of their employee well-being support.
- 50% of London’s universities using Good Thinking to support student wellbeing.
- Further testing and introduction of apps and resources.
- Exploration of mixed app and online peer support.
- Further development of a range of materials and resources to support the use and adoption of Good Thinking.
Uptake projections

33% of population with common mental health conditions by 2020
NHS Innovation Accelerator Exemplar
Meet the Companies:
90 Second Pitches

@HINSouthLondon
healthinnovationnetwork.com
“Brain in Hand saves us money, but it also so good for those people who use it”

Liz Fairhurst, Exec Member Adult Services HCC

@brain_in_hand

David Fry
07770950380
davidfry@braininhand.co.uk
www.braininhand.co.uk
LOWER MY DRINKING
Get Healthier, Feel Better

@Breaking_Free

breakingfreegroup.com
A platform that makes Mental Health Act assessment set-up and claim form submission quicker and simpler.

s12solutions.com
info@s12solutions.com

@S12Solutions
Smoke Free
Stop smoking now

@SmokeFreeMobile
Avril Copeland
Founder/CEO

@TickerFit
The Burden of Long Term Conditions

1% At clinic/hospital

@TickerFit
The Burden of Long Term Conditions

1% At clinic/hospital

99% At home
For Young People Living with Cystic Fibrosis

- Tailored programmes of education & exercise
- Parent/guardian dashboard
- Trend data V’s snapshot view
For Mental Health

- Currently seeking clinicians, academics and patients to partner with to develop a solution to support patients living with mental health difficulties

@TickerFit
Thank you!

Avril Copeland
avril.copeland@innerstrength.health
Meet the Companies:
Table Discussions

@HINSouthLondon
healthinnovationnetwork.com
<table>
<thead>
<tr>
<th>Table:</th>
<th>Company:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Brain in Hand</td>
</tr>
<tr>
<td>2</td>
<td>Breaking Free Group</td>
</tr>
<tr>
<td>3</td>
<td>ORCHA</td>
</tr>
<tr>
<td>4</td>
<td>Dr Julian</td>
</tr>
<tr>
<td>5</td>
<td>IOCOM</td>
</tr>
<tr>
<td>6</td>
<td>Locum’s Nest</td>
</tr>
<tr>
<td>7</td>
<td>My Possible Self</td>
</tr>
<tr>
<td>8</td>
<td>S12 Solutions</td>
</tr>
<tr>
<td>9</td>
<td>Smoke Free</td>
</tr>
<tr>
<td>10</td>
<td>TickerFit</td>
</tr>
</tbody>
</table>
Opportunities & Challenges: Panel Discussion

Eve Critchley, MIND
Liz Ashall-Payne, ORCHA
Dr Asif Bachlani, South West London & St George's Mental Health NHS Trust
Muj Husian, HIN Mental Health team
Dr Jonty Heaversedge, Priamry Care & Digital Transformation (London), NHS England

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Thank you!

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