Health Innovation East Midlands
Local change, national impact

Health Innovation WEST MIDLANDS

Grow Digital Health Midlands

Neighbourhood Health Innovation Showcase

Thursday 22nd January 13:00 – 14:30

Office for Life Sciences

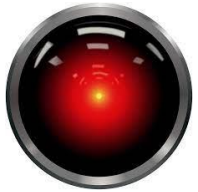
NHS

Welcome

Dawn Plummer – Digital Health Innovation Lead

Health Innovation East Midlands

Housekeeping



- This session is being recorded and will be shared publicly after the event.

- Please keep your microphone on mute if you are not speaking.

- Use the Q&A function in Teams to ask questions during the session or alternatively please contact:

healthinnovation-em@nottingham.ac.uk

Grow Digital Health Midlands

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Focus for today's event

- Neighbourhood Health theme
- Presentations from
  - Two Wave 1 sites within the Midlands region
  - 7 innovators from this year's Grow Digital Health Midlands programme
- Launch Neighbourhood Health innovation fund, with pots of up to £20k for promising projects arising from this session

Grow Digital Health Midlands

- Grow Digital Health Midlands is a collaboration between Health Innovation East Midlands and Health Innovation West Midlands
- Onboarding promising innovations with the potential to solve key problems within the NHS locally
- Designed to help UK technology companies develop and scale high potential digital health innovations within the NHS and care sector
- Brings together resource, expertise and networks across the NHS Midlands regions

Grow Digital Health Midlands

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Health Innovation WEST MIDLANDS

Agenda

Time	Topic	Speaker
13:00 – 13:05	Welcome and introductions	Dawn Plummer – Digital Health Innovation Lead, Health Innovation East Midlands
13:05 – 13:15	Implementing Neighbourhood Health in Nottingham City	Rich Brady - Director of Strategy and Partnerships, Nottingham City Place-Based Partnership
Innovator presentations - part 1		
13:15 – 13:22	Hope Programme	Gabriela Matouskova – CEO, Hope For The Community CIC
13:22 – 13:29	AirEmail	Ameet Bakhai – Co-founder, AirEmail Holdings
13:29 – 13:36	Surgfit	Michael Morgan-Curran – CEO, Asclepius Medtech
13:36 – 13:46	Population Health Management / Live Well in the Community	Frank Botfield – Assistant Director of Digital Strategy & Walsall Together Digital and Data Lead
Innovator presentations - part 2		
13:46 – 13:53	Appt Chronic Condition Management	Hector Smethurst - Founder & CEO, Appt Health
13:53 – 14:00	Heidi AI Medical Scribe	Gus Lyon – Primary Care Lead, Heidi Health
14:00 – 14:07	Expertcare	David Immleman – Founder & CEO, DXS International
14:07 – 14:14	Suvera	Ivan Beckley – CEO & Co-founder, Suvera
14:14 – 14:25	Neighbourhood Health Midlands funding opportunity	Dawn Plummer – Digital Health Innovation Lead, Health Innovation East Midlands

Link to agenda

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Implementing Neighbourhood Health in Nottingham City

Rich Brady - Director of Strategy and Partnerships

Nottingham City Place-Based Partnership

Nottingham City Place-Based Partnership

Implementing Neighbourhood Health in Nottingham City

Rich Brady,
Director of Strategy and Partnerships

Neighbourhoods, Neighbourhoods, Neighbourhoods

Policy Direction

- 10-Year Health Plan: Shift to a Neighbourhood Health Service
- Single Neighbourhood Providers (50k) supported by Multi-Neighbourhood Providers (100–250k)
- Neighbourhood Health Centres
- Health and Wellbeing Boards to lead neighbourhood planning
- Awaiting Neighbourhood guidance but there are 6 core steps to lay the foundations for effective Neighbourhood Health services

1. Agree neighbourhood footprints around natural communities ~50,000 people
2. Ensure good access to high quality general practice
3. Continue to improve the primary, secondary and mental health care interface
4. Agree plans for INTs focused on people with most complex needs at higher risk of hospital admission
5. Agree initial plan to reduce NEL admissions and bed days by increasing urgent, rehab and reablement capacity
6. Start to plan how to remodel outpatients' pathways


NHS
Nottinghamshire Healthcare
NHS Foundation Trust


CityCare
Building Healthier Communities


Nottingham
City Council


Nottingham
Community
and Voluntary
Service


Nottingham City
Place-Based
Partnership


Framework
For your future


healthwatch
Nottingham & Nottinghamshire


Nottingham
University
Hospitals
NHS
NHS Trust


Nottingham City
General Practice
Alliance


NHS
Nottingham and
Nottinghamshire
Integrated Care Board

National Neighbourhood Health Implementation Programme

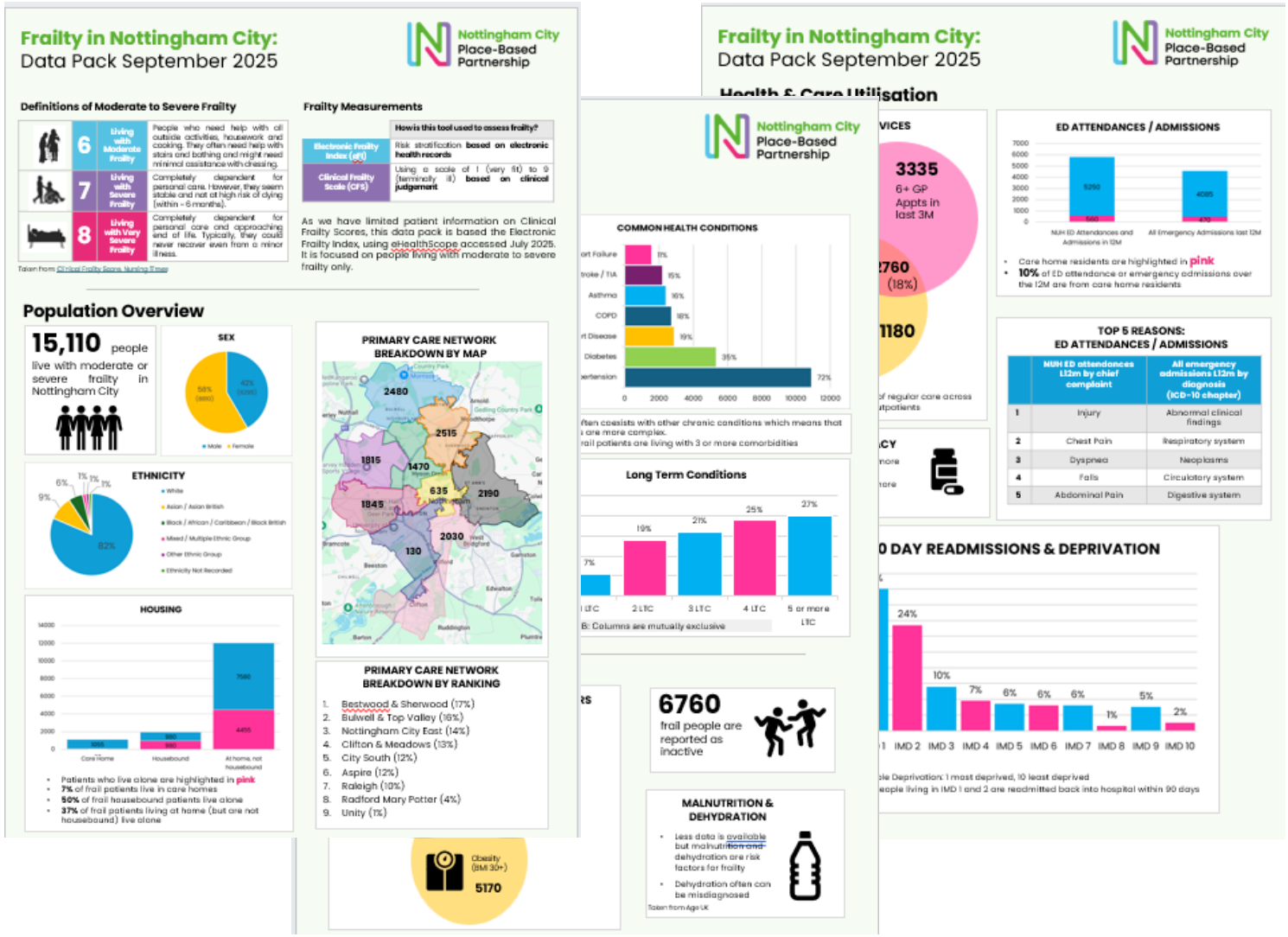
Nottingham City Place-Based Partnership

In September 2025, Nottingham City joined 42 other areas across the country to participate in the National Neighbourhood Health Implementation programme (NNHIP)

- No additional funding for the programme
- Local and National Coach
- Regular Communities of Practice
- National Webinars
- 3 x Regional Workshops

Initial focus: Adults with multiple long-term conditions / frailty and rising risk

Nottingham City – demographics / frailty



Population: ~330,000 (400,000 registered)

Ethnicity: 43% identify with ethnic groups other than White British

Deprivation: 57% of neighbourhoods among 20% most deprived nationally

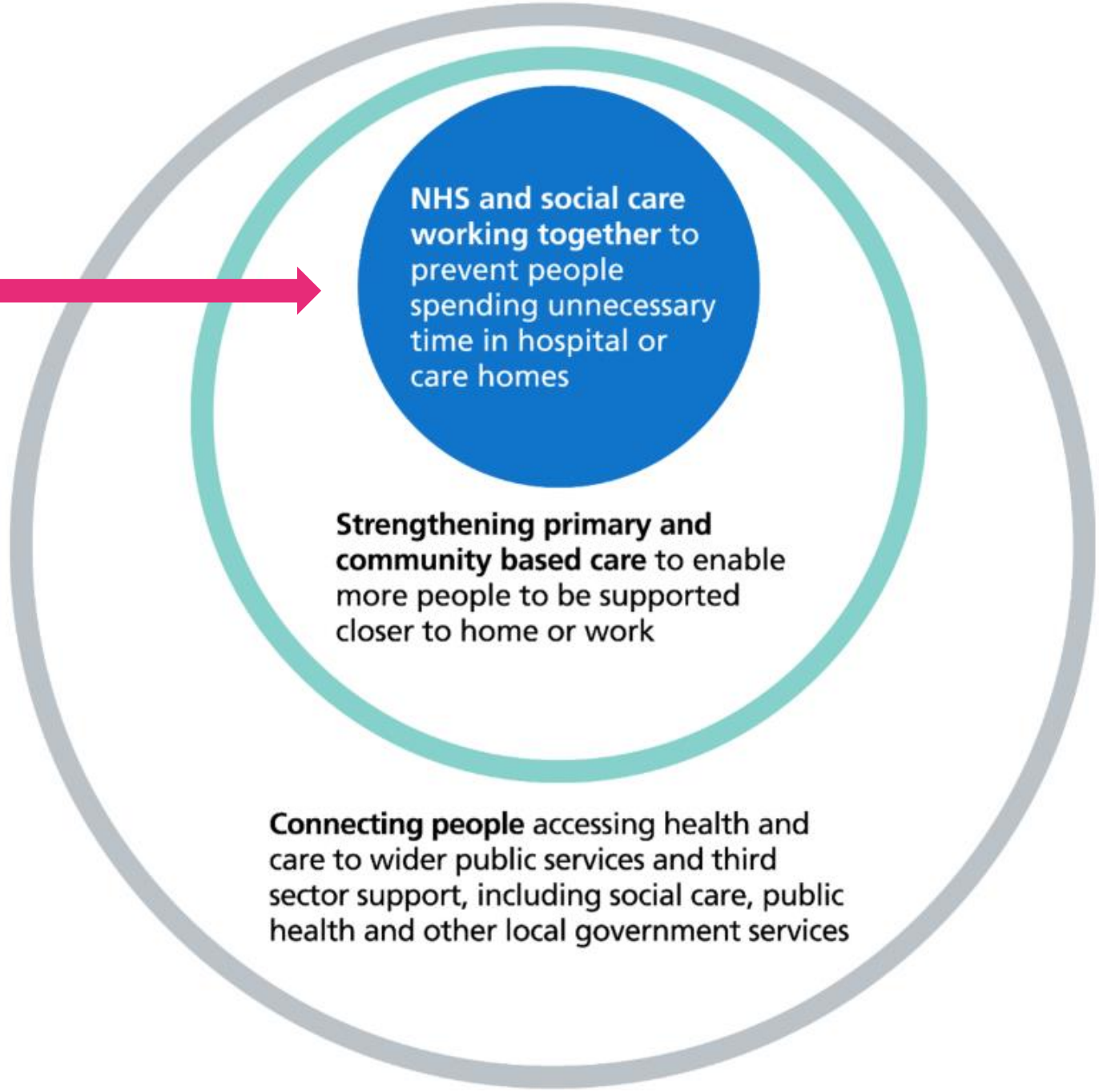
Age: 11% over 65

Frailty (EFI): 15,110 over 65 moderate/ severe

3+ LTC: 73% living with moderate to severe frailty have 3+ LTCs

Neighbourhoods: 9 (current working assumption based on PCNs)

Integrated Neighbourhood Teams

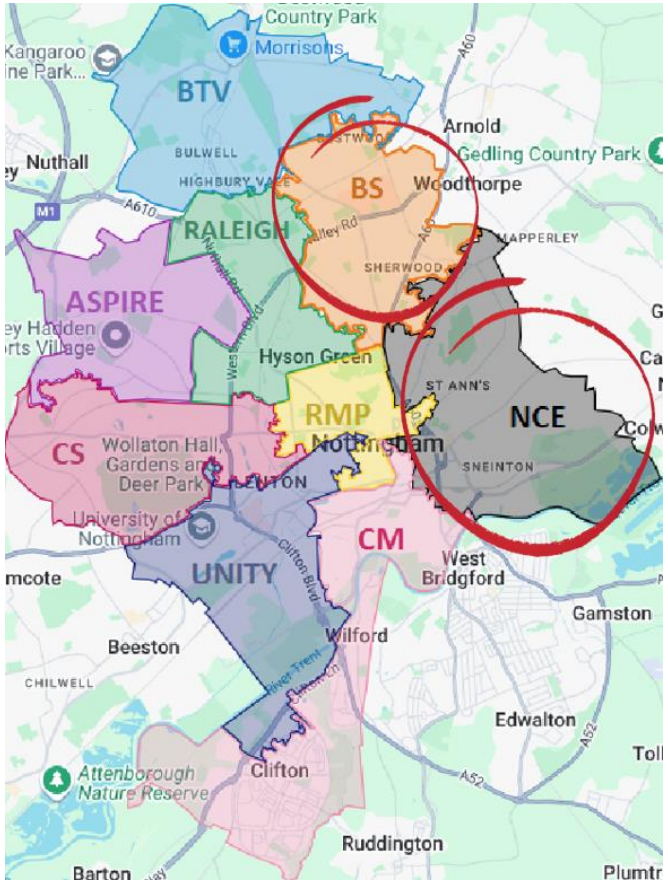


Integrated Neighbourhood Teams

Nottingham City Place-Based Partnership

WHERE: Pathfinders

- Bestwood and Sherwood
- Nottingham City East



WHO: Initial focus on complex care needs. Proactive identification:

- 55+ :LTCs, EOL, frailty
- + high user of activity

HOW: via weekly Neighbourhood MDT panels and co-working

- Community nursing
- Social Workers
- Social Prescribers
- GPs
- Community Geriatricians
- Nottinghamshire Hospice
- MH Nurses

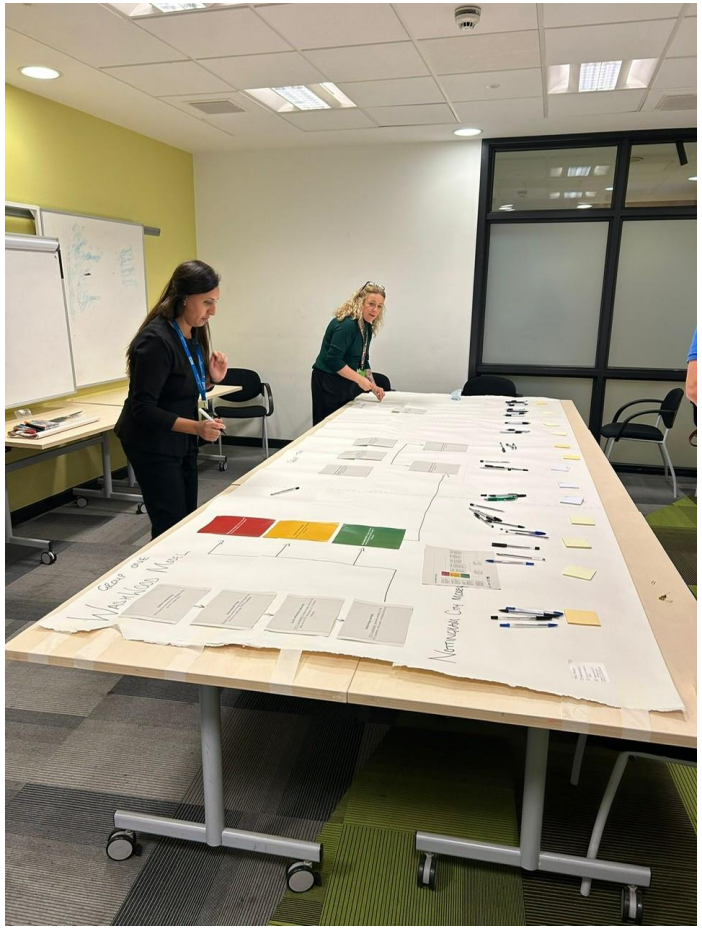
WHY:

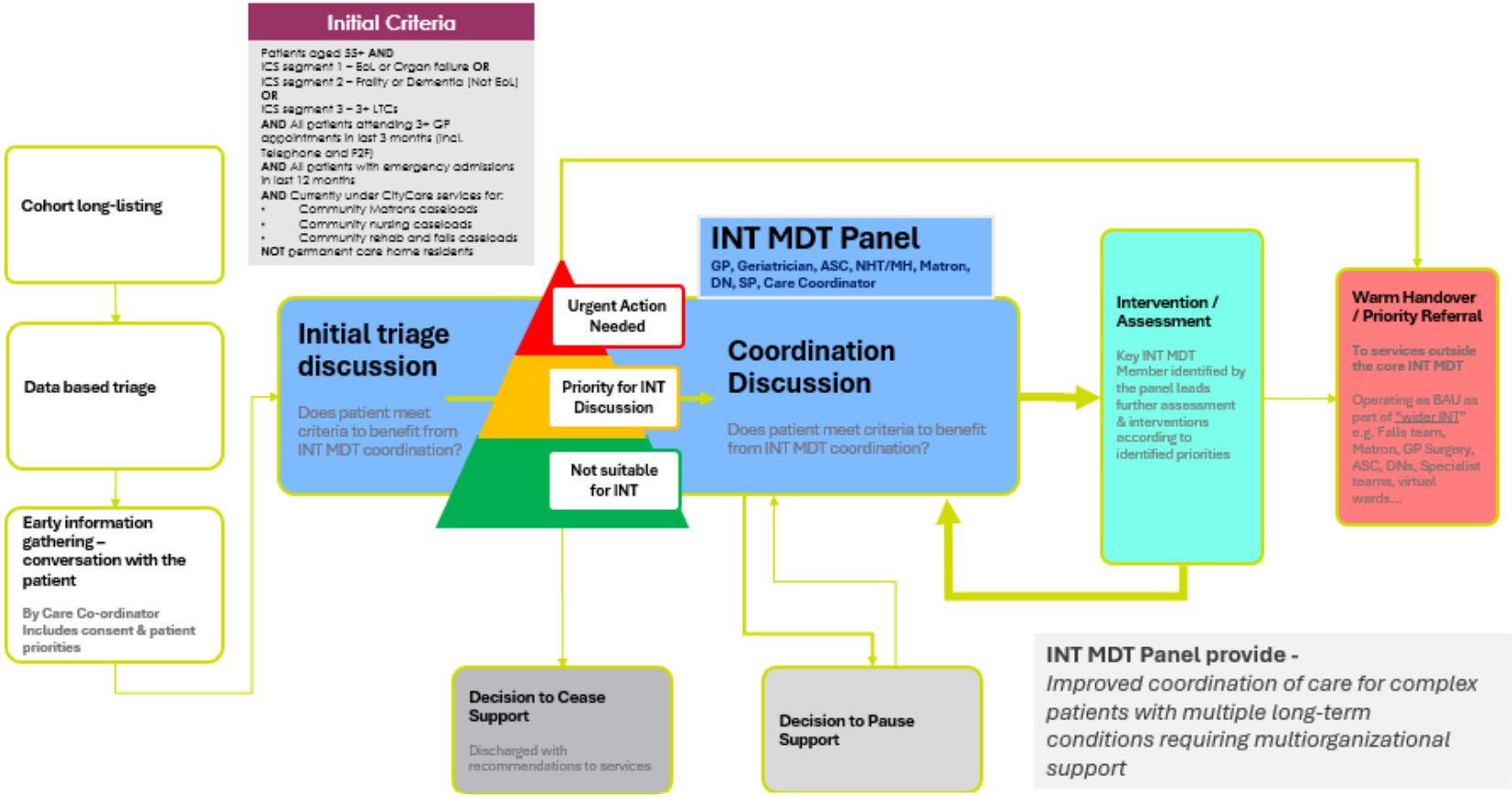
- Increased coordination *where people live*
- Personalised support that tackles inequalities and wider social determinants
- Recognise deterioration early
- Deliver prevention and behaviour-change support

Nottingham City East Primary Care Network

Working in partnership

Nottingham City Place-Based Partnership

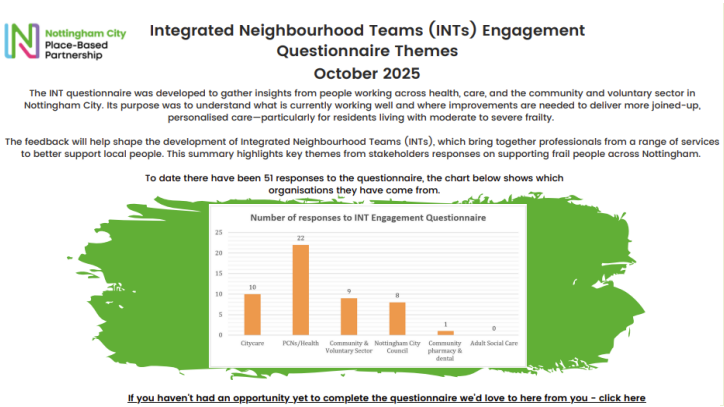




Communications and Engagement

INT Newsletters – System wide information and updates on INT development and roll out.

INT Engagement Questionnaire – Promoted to all staff to capture their thoughts and ideas for INT development to gain insights and themes.



Nottingham City Neighbourhood Health Group

LinkedIn [Join Here]

INT Podcasts – Exploring current thoughts and expectations of leaders in key partner organisations through conversations.

1 Agree neighbourhood footprints around natural communities ~50,000 people

2 Ensure good access to high quality general practice

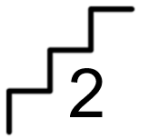
3 Continue to improve the primary, secondary and mental health care interface

4 **Agree plans for INTs focused on people with most complex needs at higher risk of hospital admission**

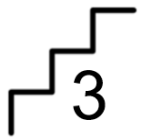
5 Agree initial plan to reduce NEL admissions and bed days by increasing urgent, rehab and reablement capacity

6 Start to plan how to remodel outpatients' pathways

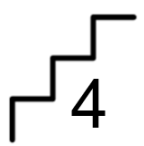
Agree neighbourhood footprints around natural communities ~50,000 people



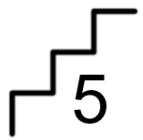
Ensure good access to high quality general practice



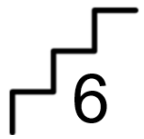
Continue to improve the primary, secondary and mental health care interface



Agree plans for INTs focused on people with most complex needs at higher risk of hospital admission



Agree initial plan to reduce NEL admissions and bed days by increasing urgent, rehab and reablement capacity



Start to plan how to remodel outpatients' pathways

Grow
Digital Health Midlands

Innovator Presentations

Part 1

Health Innovation East Midlands
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Health Innovation WEST MIDLANDS

Hope Programme

Gabriela Matouskova

CEO, Hope For The Community CIC

EMPOWER PEOPLE > IMPROVE OUTCOMES > REDUCE DEMAND

HOPE PROGRAMME IN NEIGHBOURHOOD HEALTH SERVICE:

Community-led self-management for patient activation

Gabriela Matouskova, CEO
Hope 4 The Community CIC

the hope programme®

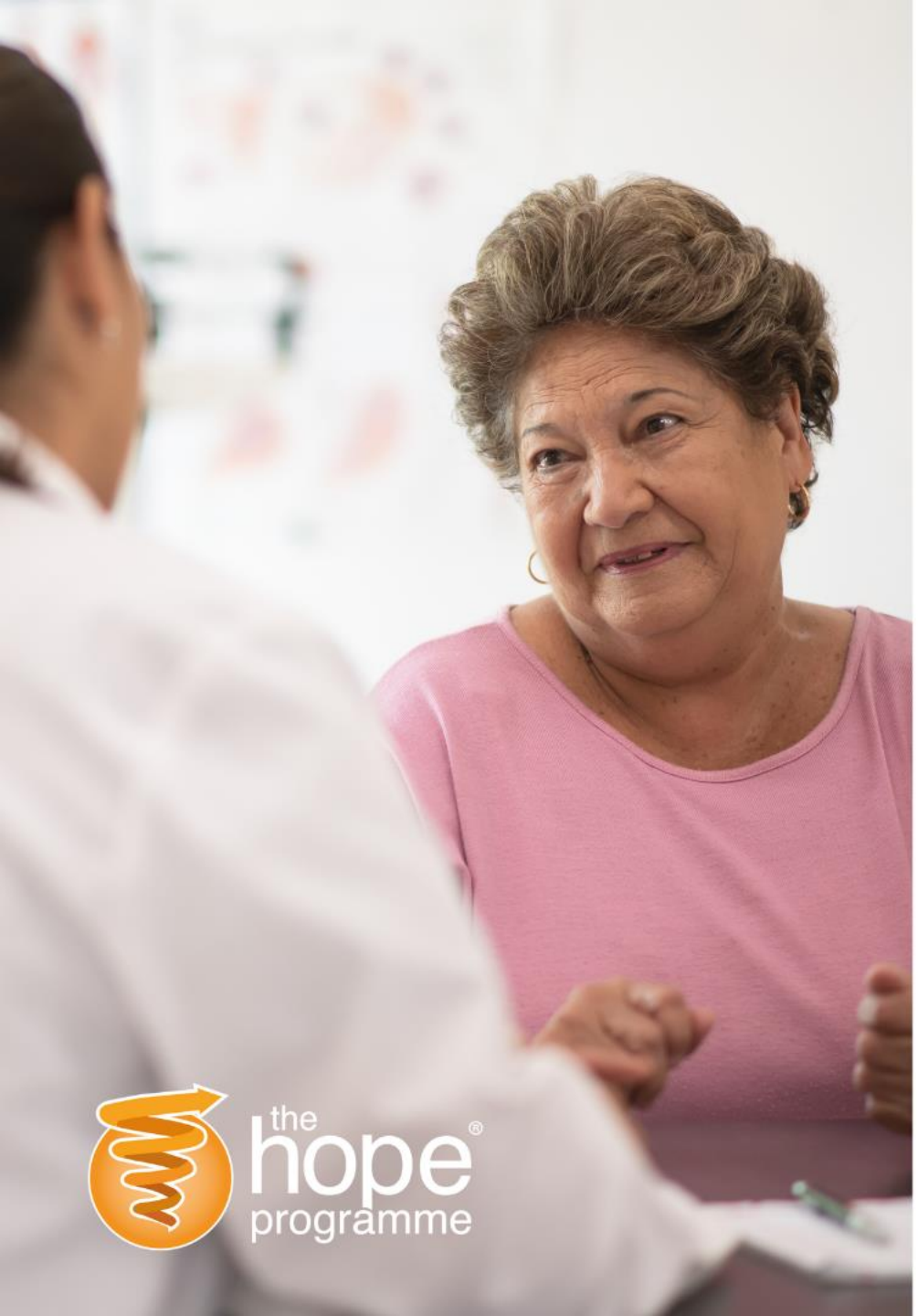
hope for the community

CERTIFIED SOCIAL ENTERPRISE • BUSINESS FOR GOOD •

UK SOCIAL ENTERPRISE AWARDS WINNER

NHS England Neighbourhood Health Guidelines

“Neighbourhood health aims to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and increasing their agency in managing their own care.”



MULTIPLE LONG-TERM CONDITIONS: THE REALITY IN EVERY NEIGHBOURHOOD

1 in 4

PEOPLE LIVE WITH ONE OR MORE LONG-TERM CONDITIONS

- **People with LTCs and unpaid carers want to but often lack the skills and confidence to self-manage**
- **People with low activation are more likely to use emergency care and seek help only in crisis, leading to avoidable system costs**

HOPE: HELP OVERCOME PROBLEMS EFFECTIVELY

the hope® programme

Coventry University

- **EVIDENCE BASED** self-management courses built on 25+ years research
- rooted in positive psychology, mindfulness, and cognitive behavioural therapy
- **CO-DESIGNED** with users, clinicians and academics
- **PROVEN** across multiple long-term conditions and carers
- **COMMUNITY-LED** by social enterprise founded and run by people with lived experience in partnership with public and impact sector organisations

33,000 PEOPLE BENEFITTED TO DATE

EMPOWER PEOPLE: PERSON-LED + HOLISTIC + FLEXIBLE COURSES

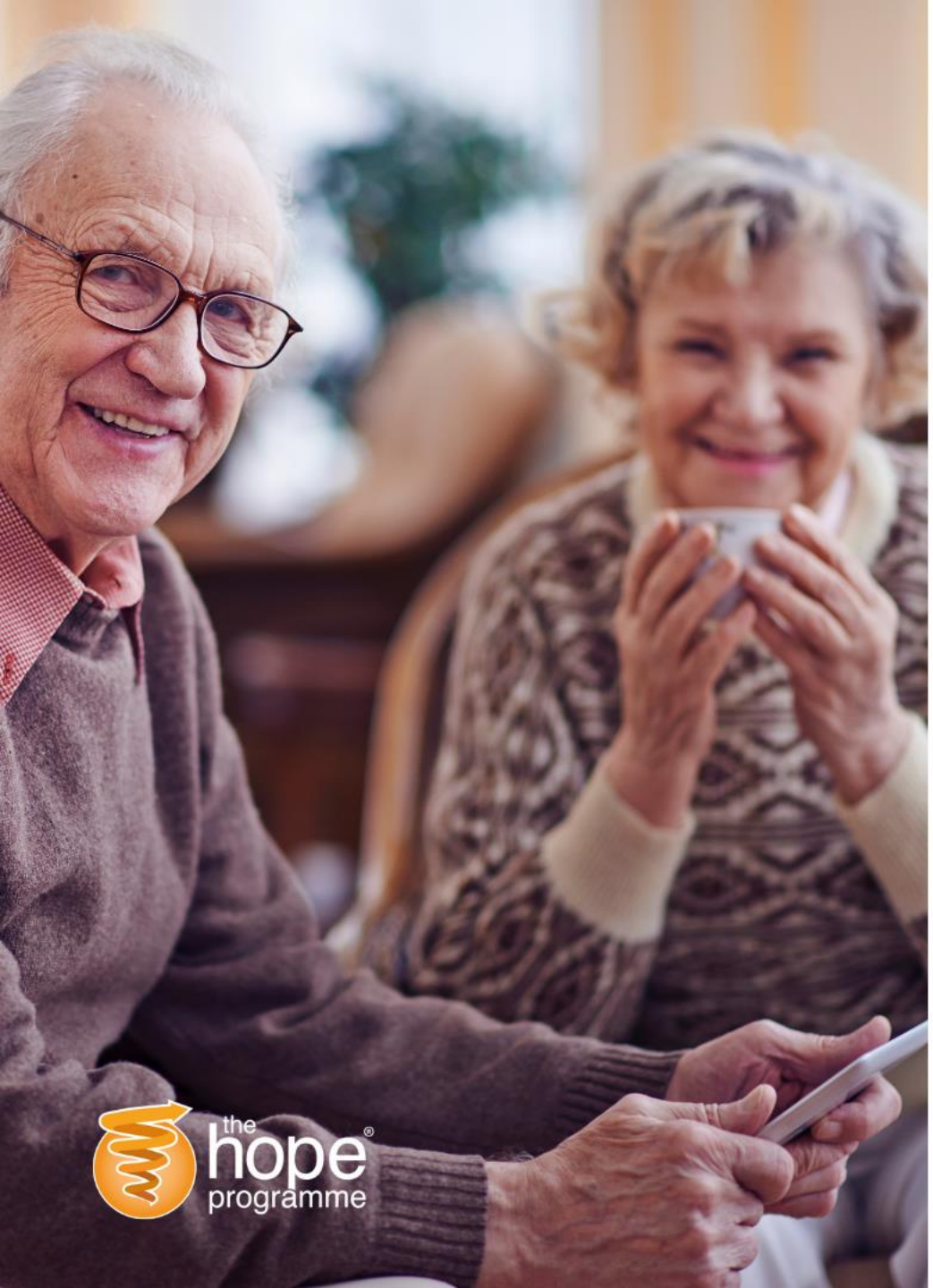
the hope programme

adult (18+)
any long-term condition(s)
unpaid carer
low level mental health needs
lonely and isolated
low motivation and/or confidence

DIGITAL
at home
anonymous
asynchronous
groups or self-guided
online community

IN-PERSON
in community
groups
local facilitators
trusted partners

Goal setting · Fatigue management · Stress management · Healthy eating · Physical activity · Communication · Dealing with setbacks · Personal strengths · Mindfulness · Challenging unhelpful beliefs · Gratitude · Self compassion



IMPROVE OUTCOMES

Coventry University

RESEARCH

↑ mental wellbeing
↑ patient activation
↑ quality of life
↓ depression and anxiety

IMPACT

↑ increased capacity across NHS, VCSE, and local authority
↓ reduced health inequalities
↑ social value

www.h4c.org.uk/research-and-impact

Part of the NHS Digital Neighbourhoods Programme

digital first

- region wide
- at scale
- group-facilitated or self-guided
- online community

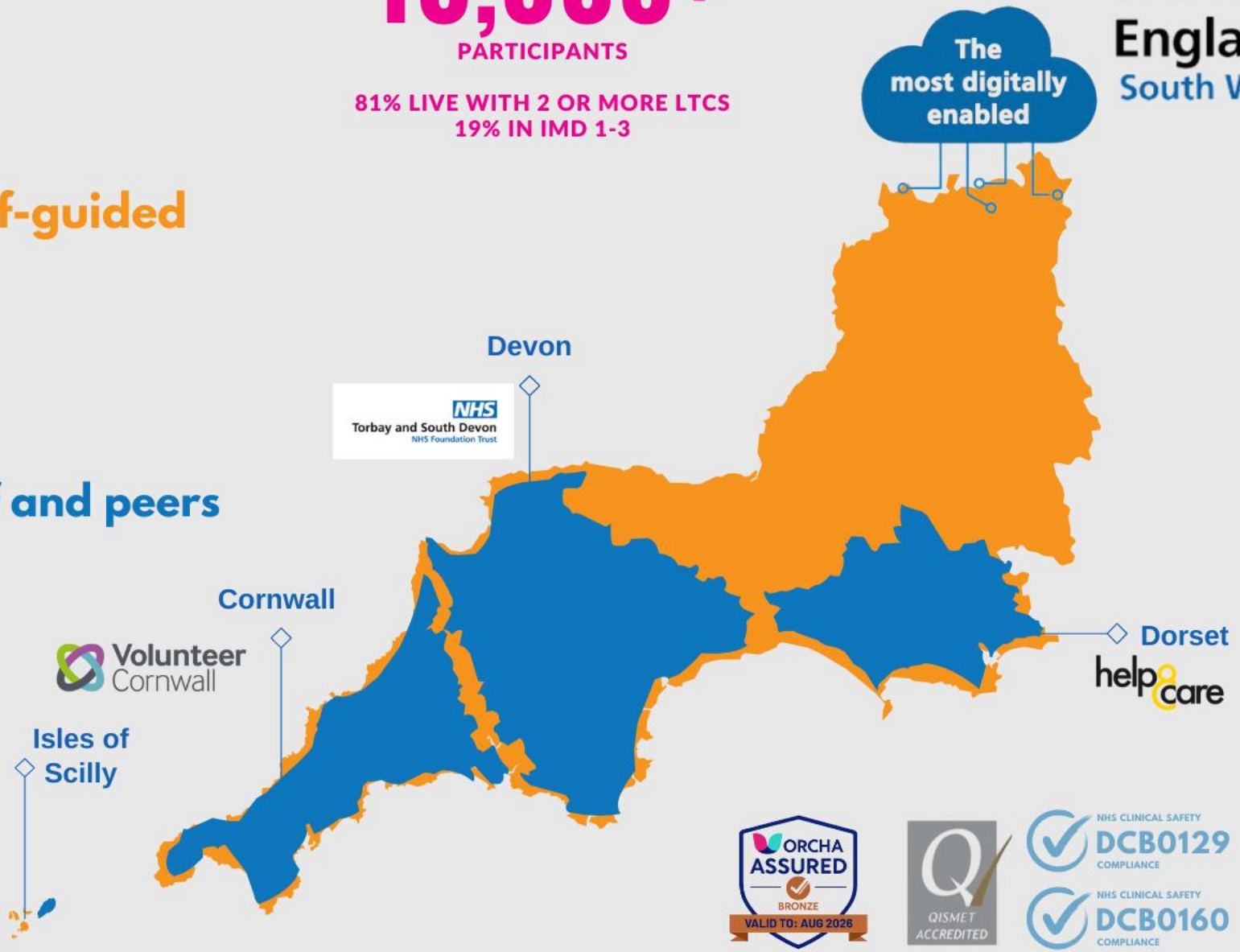
in-person

- local groups
- trained VCSFE/NHS staff and peers to sustain delivery

10,000+
PARTICIPANTS

81% LIVE WITH 2 OR MORE LTCS
19% IN IMD 1-3

NHS England South West



the hope® programme

ORCHA ASSURED BRONZE VALID TO: AUG 2026

QISMET ACCREDITED

NHS CLINICAL SAFETY DCB0129 COMPLIANCE

NHS CLINICAL SAFETY DCB0160 COMPLIANCE

REDUCE DEMAND

PATIENT ACTIVATION

NHS England South West

Activation - the knowledge, skills and confidence in self-managing health leads to:

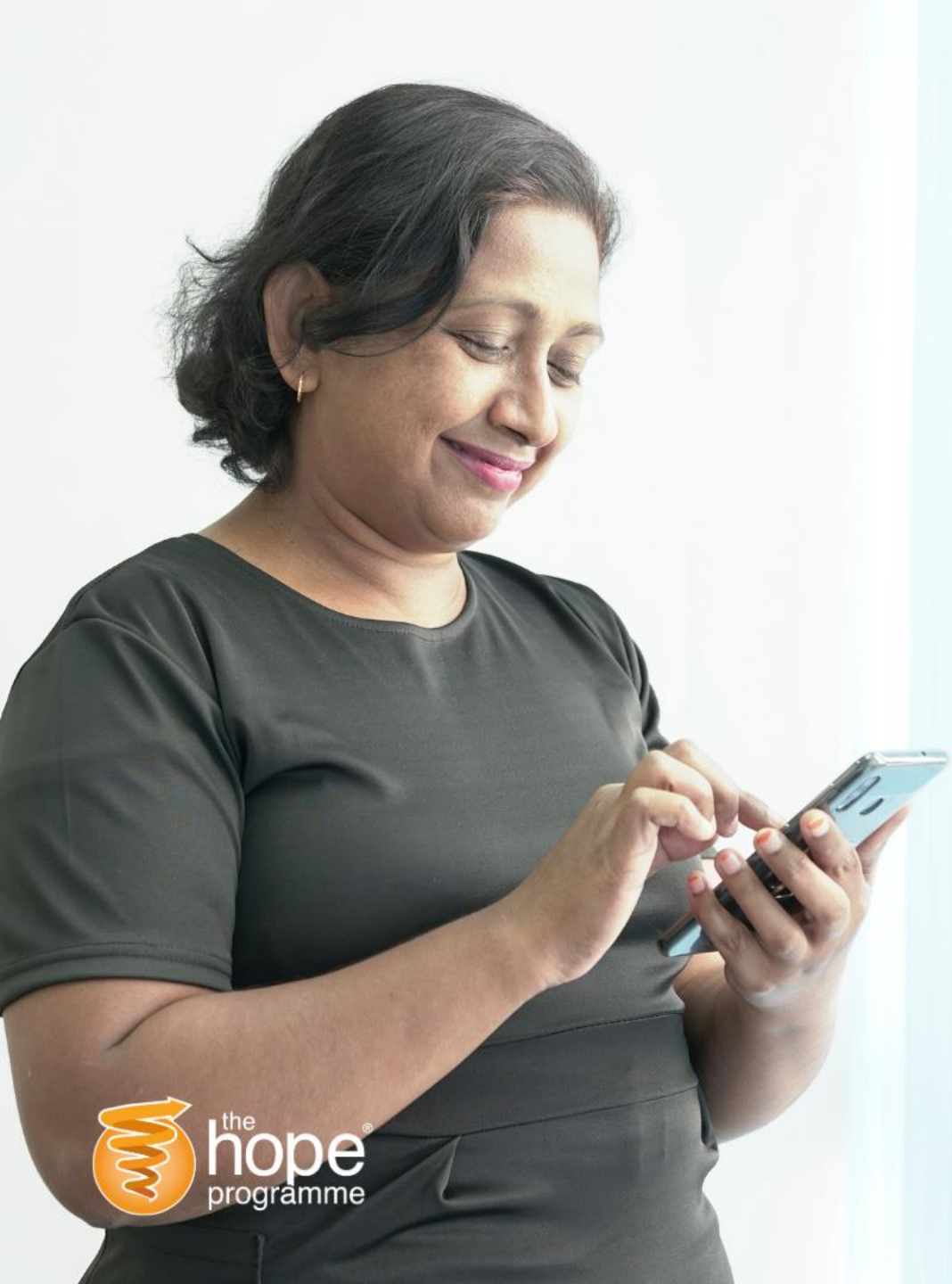
- better health outcomes
- lower cost of care
- better patient experience

PATIENT ACTIVATION MEASURE® (PAM®) N=373

PAM levels	Pre HOPE	Post HOPE	Difference
Levels 1-2	65%	37%	-28%
Levels 3-4	35%	63%	28%

EXPECTED IMPACT ON COST SAVINGS

From **373 HOPE participants** 65% started in the lowest activation levels—reaching those with greatest need. Post HOPE, this had fallen to 37%, with many moving into higher activation, leading to an average saving of **£2,250** per person, generating expected annual savings over **£839,311** and great value in terms of ROI.



“For me, the Hope Programme gave me tools to deal with life.

It taught me to break problems down, be proactive, and manage my health better.”

HOPE PROGRAMME: SUPPORTING 6 CORE COMPONENTS OF NEIGHBOURHOOD HEALTH

- **Modern general practice** - structured, evidence-based self-management course signposted via social prescribing and personalised care roles
- **Neighbourhood MDTs** - shared activation-building pathway for multiple conditions; PAM data for integrated care planning
- **Integrated intermediate care** - supports confidence-building and symptom management; enables safe discharge and home-first recovery
- **Secondary care contribution** - practical self-management resource for post-treatment handback (surgery, cancer, long COVID)
- **Community & mental health services** - peer support, digital tools and skills-building alongside existing provision for daily self-management
- **Population health & inequalities** - targets low-activation, multiple-condition populations in high-deprivation areas; tracks PAM improvements

EMPOWER PEOPLE > IMPROVE OUTCOMES > REDUCE DEMAND

TALK TO US ABOUT HOPE

Gabriela Matouskova, CEO
gabriela@h4c.org.uk - 024773 601 53

or visit our website **www.h4c.org.uk**

NHS Collaborative Procurement Hub
Partnership with Purpose

Awarded Supplier
Social Impact

SCAN ME

Hope For The Community CIC is an award winning social enterprise empowering people to manage their wellbeing and to flourish in their working and personal lives.

hope for the community

CERTIFIED SOCIAL ENTERPRISE • BUSINESS FOR GOOD •

UK SOCIAL ENTERPRISE AWARDS WINNER

AirEmail

Ameet Bakhai

Co-founder, AirEmail Holdings

NHS Problem - Published

- Not able to Cope with Email Volume

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9676904/

3047 NHS Staff Surveyed

47%

1 in 2 Use home time on work emails

57%

>1 in 2 Can't Switch off on leave

EMAIL IS **DISTRACTION FROM FROM THE WORKLOAD**. IT'S IT'S ALWAYS AT THE BACK OF OF YOUR MIND.

NHS Consultant, Focus Groups 2021

I **DREAD COMING BACK** AFTER ANNUAL LEAVE

NHS Manager, Focus Groups, 2021

WE **NEED A TRUSTED SYSTEM** THAT CAN BE TRAINED WELL

NHS Nurse, Focus Groups, 2021

AirEmail

AirEmail estimates from NHS DigiWell study and NHSE FOI: 2024 7. 5 Billion Emails

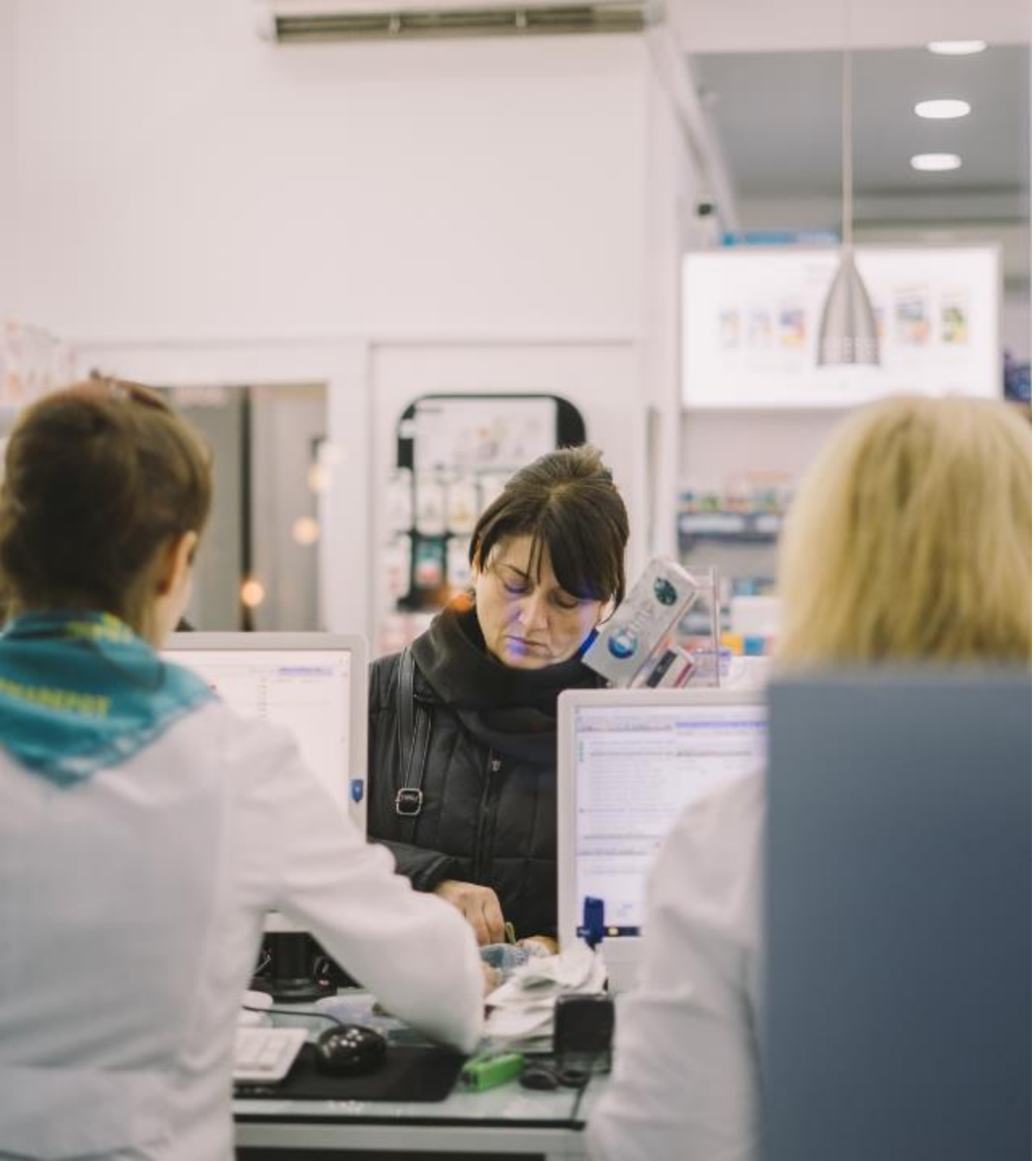
19 Million

patient related emails will be unread annually

>1 Million patients care delayed

>3,600 patients per day affected

AirEmail



ÈHĪĜÌ ÈHI Ì HĬ ĬHÎ Í

AirEmail

Ç ÑÕŐÒÒŌŊ Ç ÑÑMÕPOFMØÑ Ï PIVIŅŅRÒPO ĜÖMÒÕÏ PØÑCÆCE

ÈÒØØĜÖMÒÕa POÑ ĈŒP Í Ç Ï MŐŐØŐQÑŇMŌŇ ÑQÒŇÑŌŃŃŇHŌNŎŔ PŎŒÕ

AIREMAIL SOLUTION

The only email tool designed for healthcare email

The only email application approved for NHSmail integration

The only digital communications tool validated in a clinical trial*

Scalable, adaptable, affordable and user friendly

NHS DigiWell Study 2024

AirEmail

AirEmail – Smart Categories, Patient ID identifier, Hyperlinks, Key Tasks and Keywords Highlighter

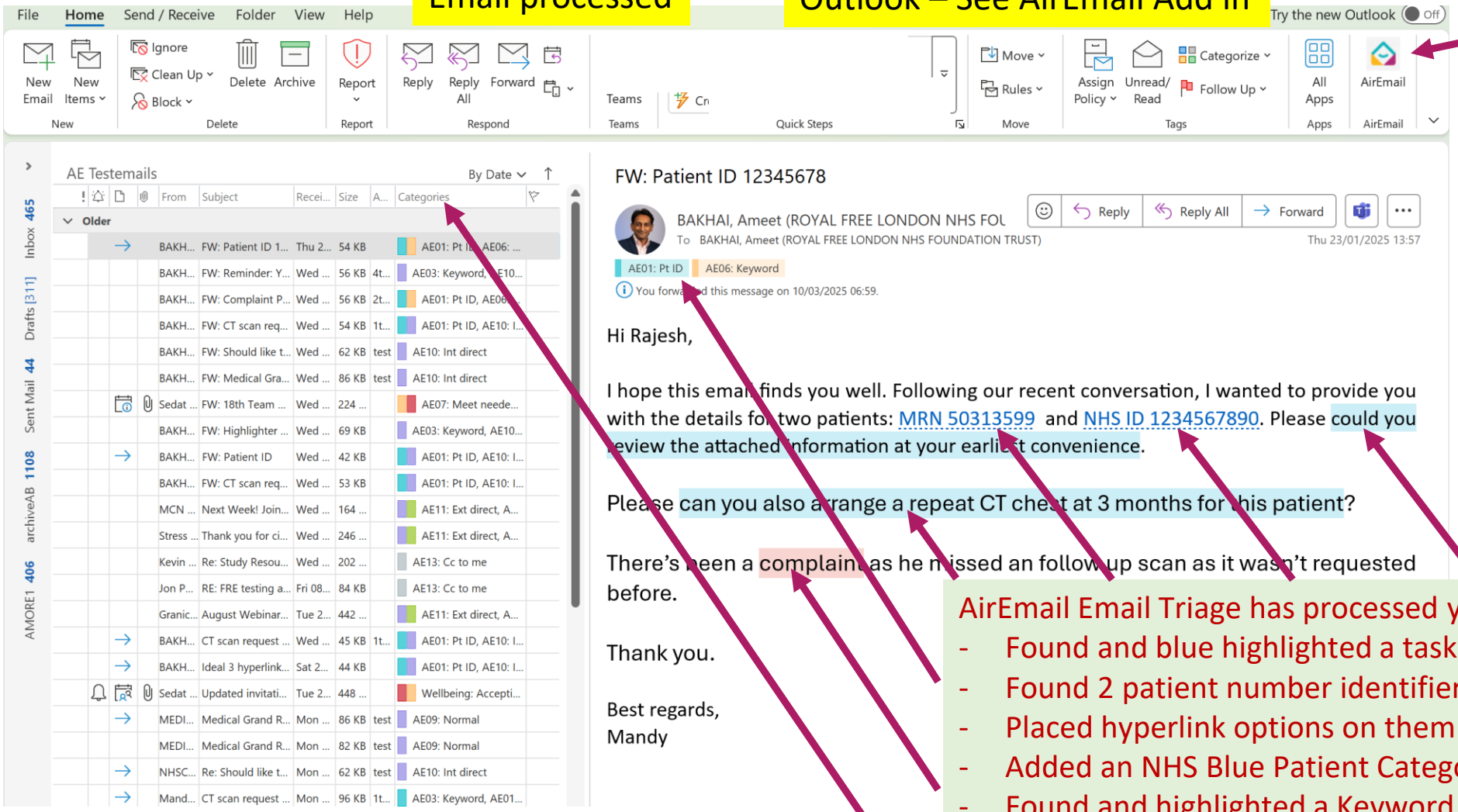
Email processed

Outlook – See AirEmail Add in

AirEmail

Improves Clinical Safety

Improves Productivity



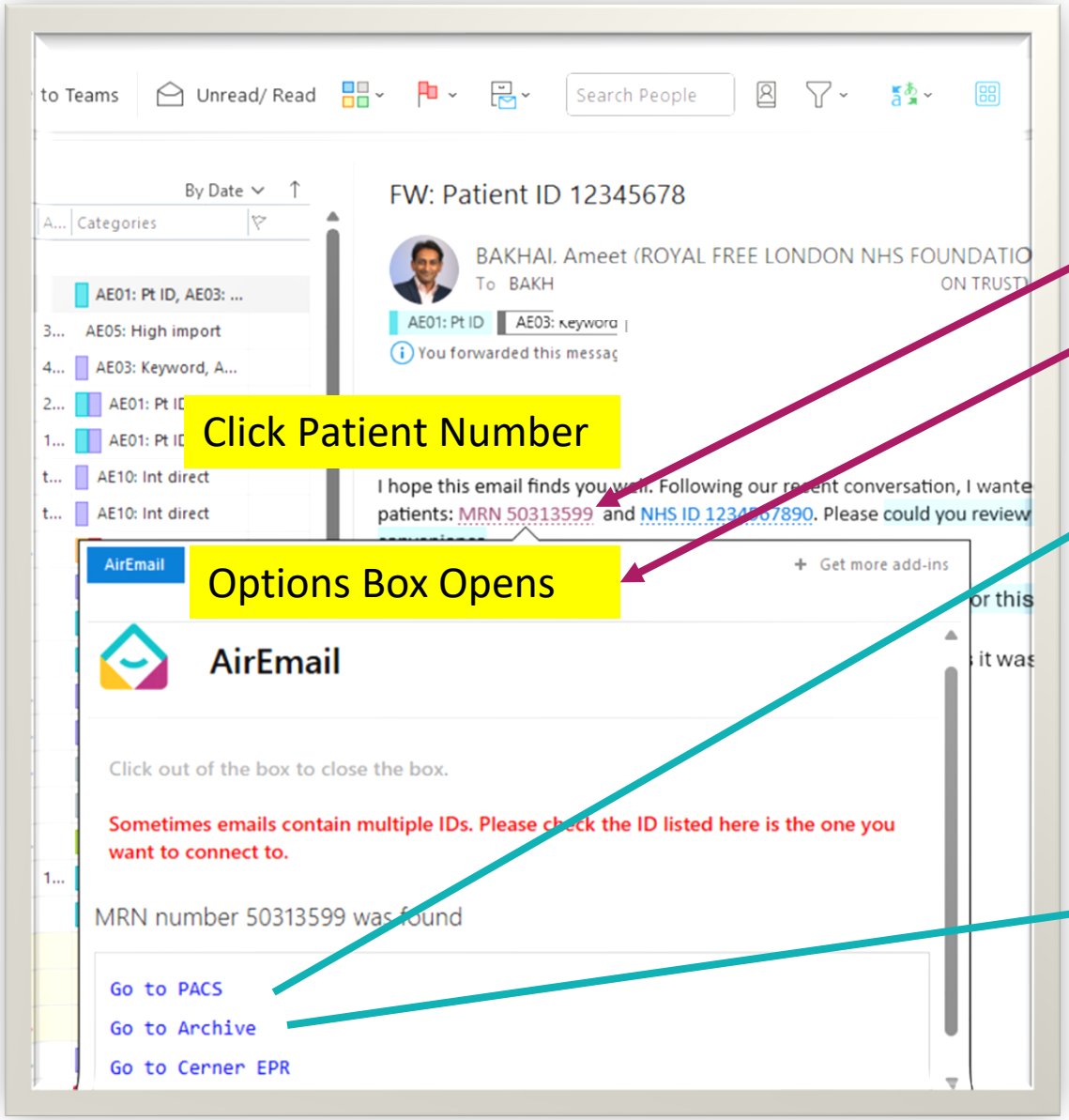
AirEmail Email Triage has processed your email and

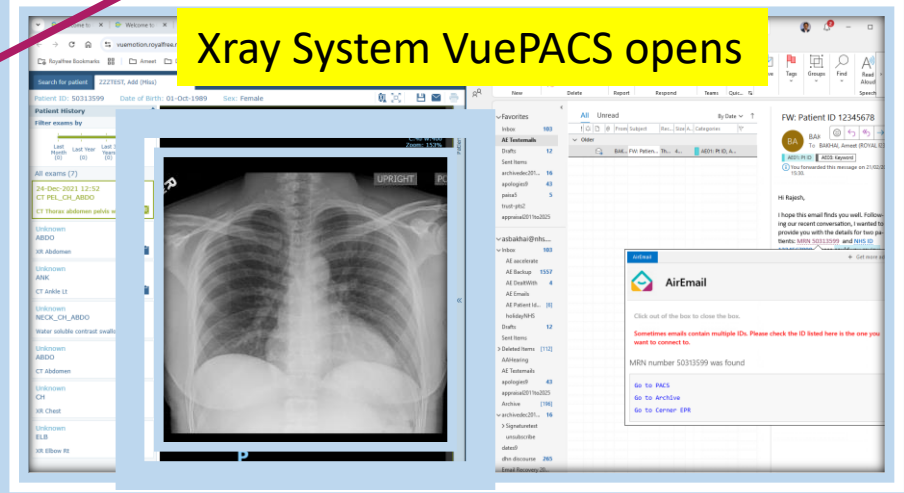
- Found and blue highlighted a task in the text for you
- Found 2 patient number identifiers
- Placed hyperlink options on them both
- Added an NHS Blue Patient Category to the email
- Found and highlighted a Keyword " complaint"
- Added a Keyword Category on the email
- Colour coded the category Amber as High Priority

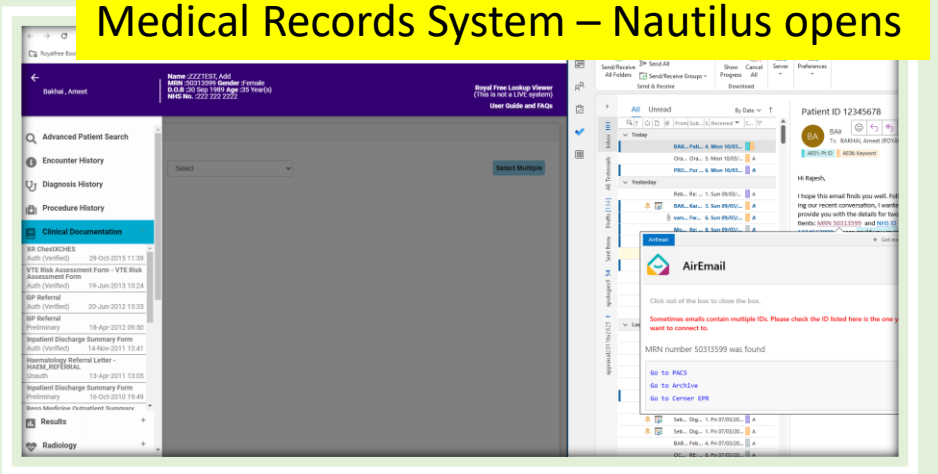
AirEmail

AirEmail is the 1st System to connect Outlook to Clinical Systems

AirEmail has
- Placed a hyperlink option on the patient Medical Record Number in the Email
- Allows an options box to open up
- AirEmail then allows you to open Xrays or Medical Records directly from the Email
- Saves times and Prevents Human Errors







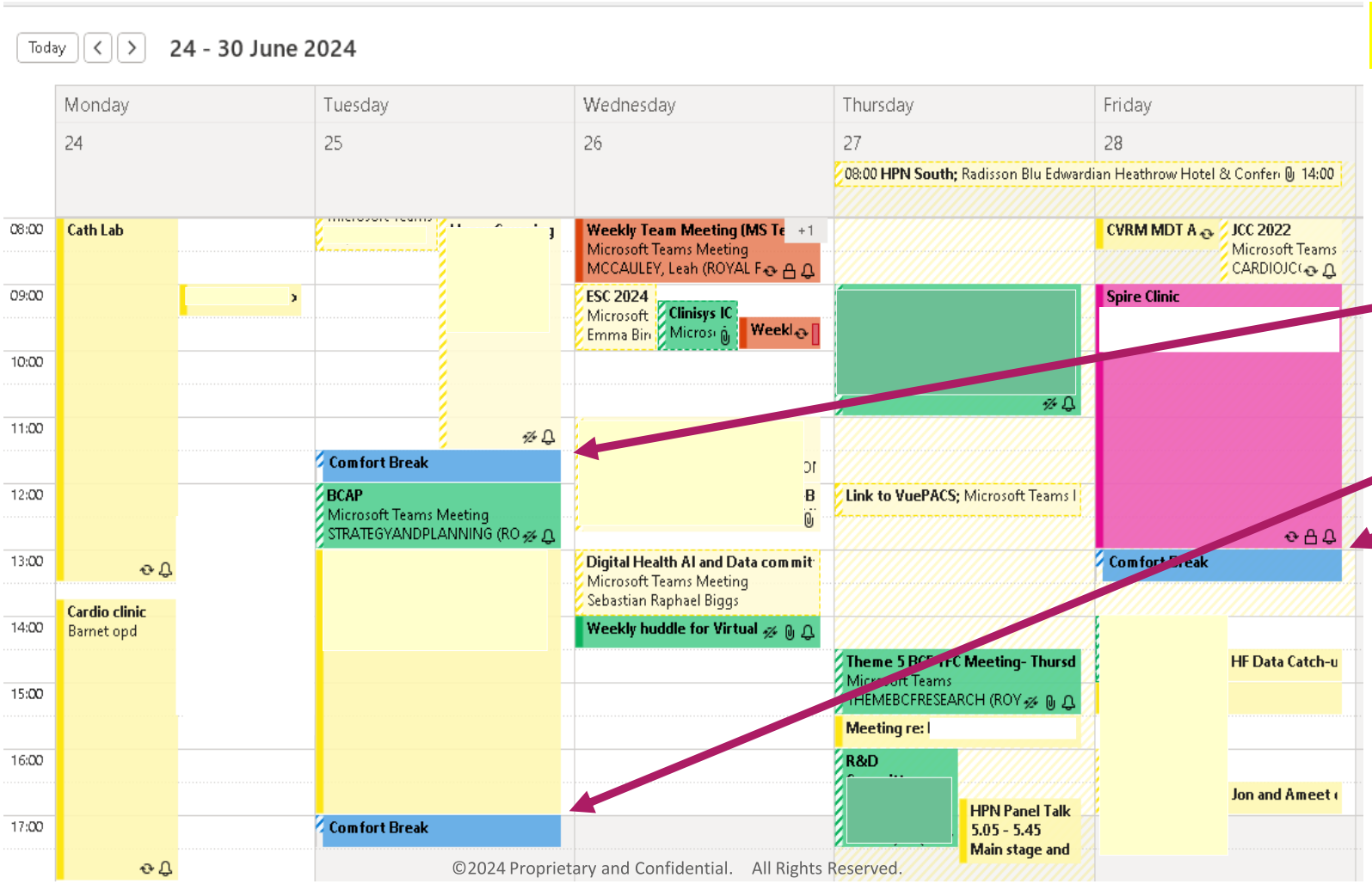
Improves Productivity

Improves Clinical Safety

Hyperlink functions require trust permissions

AirEmail

AirEmail – Automatic Comfort Break Feature



Outlook Calendar

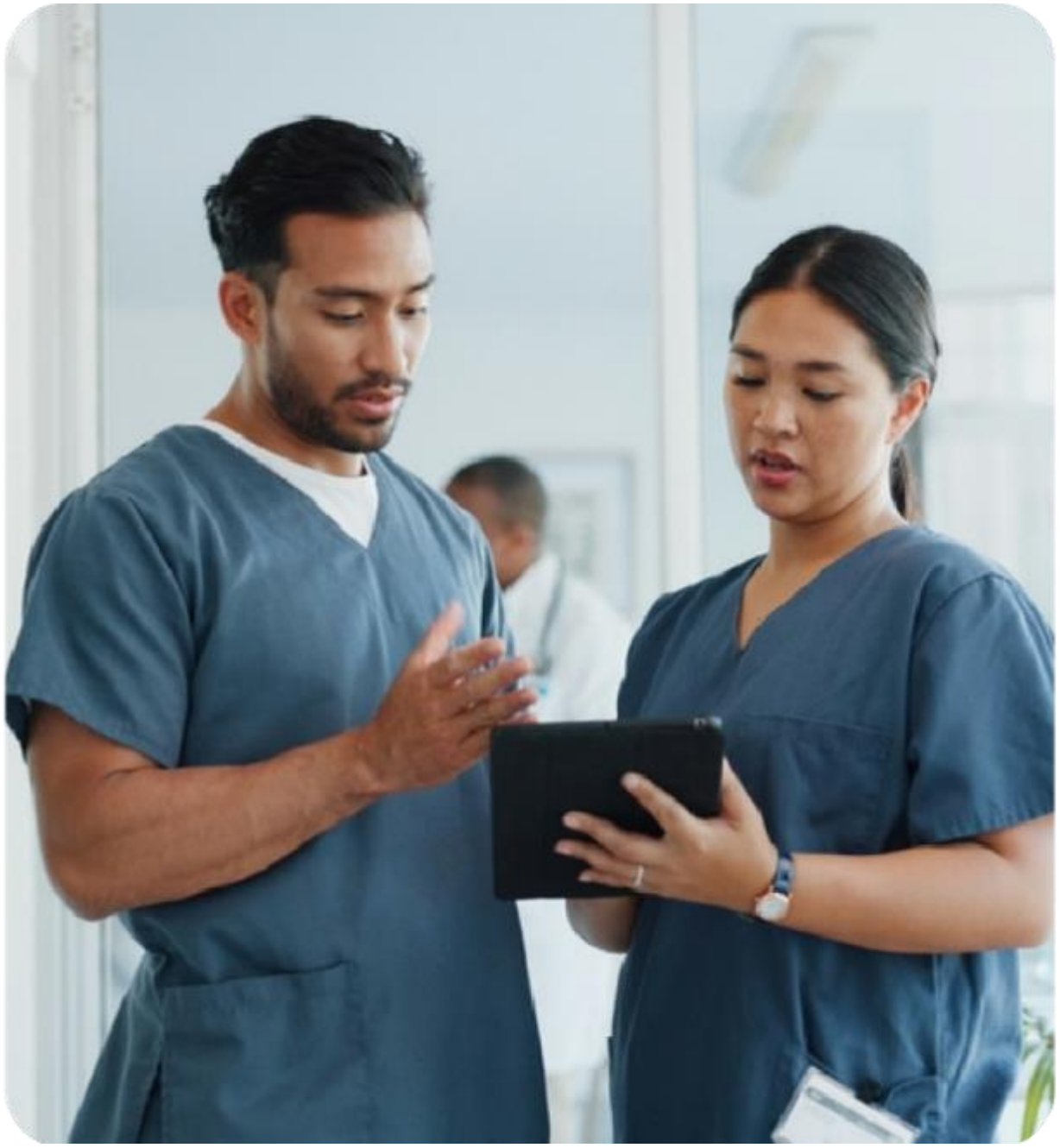
AirEmail Comfort Break feature

Has automatically added comfort breaks in after 3 hours of continuous meetings

Comfort Breaks

Improves Staff Wellbeing

AirEmail



NHS DIGIWELL STUDY RESULTS

The 1st Healthcare Communications Software Trial in the NHS!

AirEmail

Í GĬ GÒNÒJ ÑÕÕĬPÞÑŘ ÑÑCÈÒNJŌ ÑQVÕPMPÒŌNJ ÈÒØĜÖMÒÕ ĈCEPÍ GĬ ÍHGĪ ÈŐŐØŎQÑŇ FŎÖ Ö ÞŌÒŃVPÒŎŌCEFÕÒŌÒŃMÕPØÒMÕ

Informed consent to take part in the study – NHS Staff

Participants load AirEmail into **"Silent Mode"**

Email statistics data collection - without AirEmail

Participants use AirEmail features **“Active Mode”**

Email statistics data collection - with AirEmail

Study consent	60-day prior to to loading AirEmail	2-week Before-Study Control Period	ČÁERÑÑÔ Î ŌNŎMØŇÒŌŌNJ ĬÑØÒŌÑ	8-week Active Period	After-Study Control Period
	Retrospective email statistics data collection - without AirEmail		ĬMØPÒŃÒŌŐMŌPCE ŃŎÖ ŐŌÑPÑ ÈÒØĜÖMÒÕ**training (~30 minutes minutes)**		Email statistics data collection - without AirEmail **“Offboard Mode”**

Participants completed 5 surveys (Baseline, Onboarding, Active Period Weeks 2 and 8, and study end). NHSE approval obtained to collect NHSmail statistics data using Microsoft Graph permissions.

AirEmail

NHS DigiWell Study Results of AirEmail Tool

Data 66 Users, 369,899 Emails www.nhsdigiwell.com

	Emails		Target >2% Improvement	P <0.06 is significant
CLINICAL SAFETY				***Rank-Sum***
Mean Time to Reply Clinical	*N = 5408*	67 vs 55 hrs	12 hrs (17% Faster)	P<0.0001
Mean Time to Reply Clinical High Priority	*N = 3028*	68 vs 51 hrs	18 hrs (26% Faster)	P=0.0307
Mean Time to Action Clinical	*N = 9733*	75 vs 54hrs	21 hrs (28% Faster)	P<0.0001
Mean Time to Action Clinical High Priority	*N = 4860*	94 vs 45 hrs	49 hrs (52% Faster)	P<0.0001
PRODUCTIVITY				
Mean Time to Reply	*N = 75,264*	93 vs 84 hrs	9 hrs (10% Faster)	P=0.2168
Mean Time to Action	*N = 183,426*	70 vs 59 hrs	11 hrs (16% Faster)	P=0.0001
Mean Time to Action High Priority	*N = 109,558*	56 vs 49 hrs	7 hrs (12% Faster)	P=0.0531
Mean Time to Action High (Ideal)	*N = 46,755*	39 vs 30 hrs	8 hrs (22% Faster)	P=0.5203
Less Unread Emails*	*N = 239,170*	1.72% vs 1.09%	0.63% (36% Less Unread)	P<0.0001
STAFF WELLBEING (Quality of Life)				
HADS Anxiety Score (0-21)	*N = 36 Users^*	7.77 vs 6.77	1.00 (13% Less Anxiety)	P=0.01

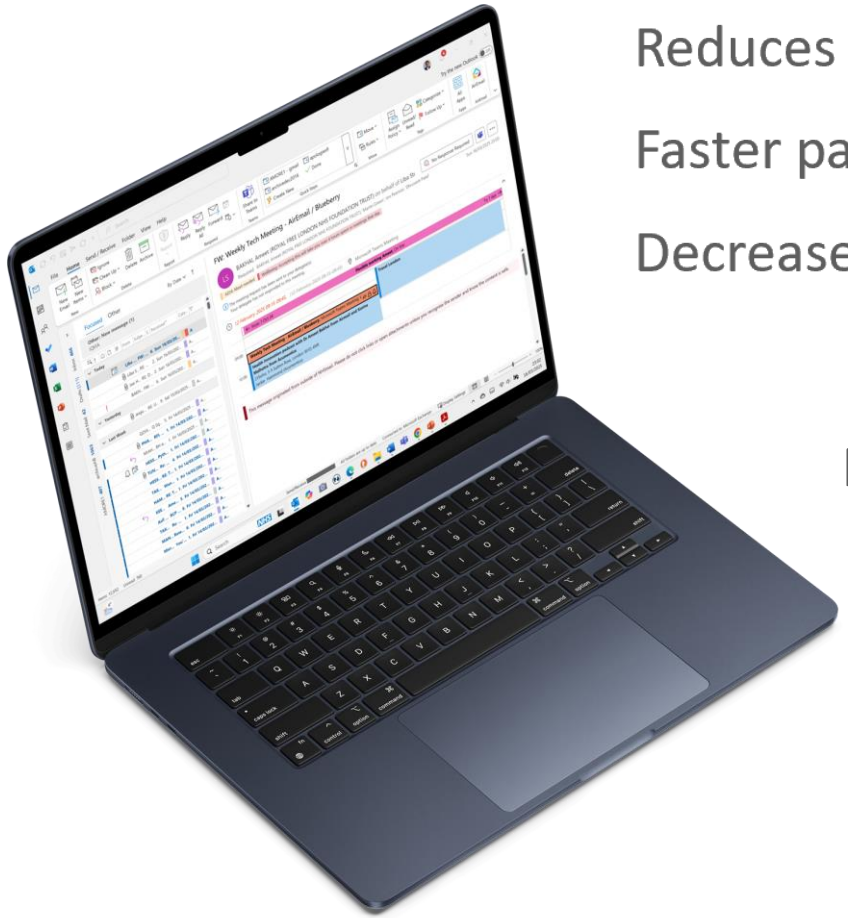
Efficiency Target >2% Improvement Considered Significant – John Quinn NHS CIO

Ideal Users (high adoption) = Users with Large Read Ratio (>80%) or low unread volume (<1000) and Median action times < 10 hrs

** 4 Outliers excluded for Email Overwhelm (37.45% Unread emails Inbox), ^ 1 outlier excluded for non-email anxiety event*

AirEmail

AirEmail key Benefits evidenced prospectively in the in the



Reduces missed emails by	**36%**	**(P<0.001)**
Faster patient email response by	**17% (12 hours)**	**(P<0.001)**
Decreases staff anxiety levels by	**13%**	**(P=0.01)**

Releases **30,000 working days** annually in a large NHS trust

Email KPI dashboard monitors safety

Data 66 Users, 369,899 Emails

www.nhsdigiwell.com

AirEmail

NHS DIGIWELL STUDY FEEDBACK

AIREMAIL HAS MADE ME A **LOT SAFER** IN TERMS OF MISSING PATIENT EMAILS

NHS Consultant

THE CATEGORIES AND **HIGHLIGHTING** NAMES AND ACTIONS WERE MOST HELPFUL.

NHS Manager

IT WILL **IMPROVE PATIENT-RELATED CARE.**

NHS Consultant

LOVE THE HIGHLIGHTER FUNCTION – ENABLES YOU TO **READ EMAILS QUICKLY.**

NHS Consultant

I LIKED THE **AUTOMATIC FUNCTIONS** AS I NATURALLY STARTED TO USE THEM.

NHS Nurse

PRIORITISING CLINICALLY IMPORTANT EMAIL AMONGST THE VOLUME IS ESSENTIAL.

NHS Consultant

AirEmail

AirEmail Outlook Addin Tool

Vision – **Empowering 1.7 million NHS Staff with Smarter inboxes – for healthier teams and better patient care**

- 1st Healthcare Outlook Addin to help NHS Triage and Focus
- 1st Robust Clinical trial: NHS DigiWell
- 1st Email hyperlink to Clinical Systems (Next: Admin, Finance, R&D…)

- **1st Comms Software to improve Clinical Safety, Staff Productivity & Staff Wellbeing**

Potential Impact

- **Reduce harm for >1200 patients a day in NHS**
- Help 1.7 Million NHSmail users (+ 1.6 Million DHSC users)

AirEmail

PARTNERS AND ASSURANCE

We deploy highest data security & security & clinical risk management standards

NHS Royal Free London NHS Foundation Trust

NHS Royal National Orthopaedic Hospital NHS Trust

NHS England

NHS Health Research Authority

NIHR National Institute for Health Research

Blueberry systems

DiCro

NHS Data Security and Protection (DSP) Toolkit

DCB 0129 COMPLIANCE

accenture | avanade | Microsoft

We've joined

COHORT 6 > GROW GLOBAL LONDON

Funded by UK Government | Microsoft | Oury Clark | WILSON SONSINI | SUPPORTED BY MAYOR OF LONDON

2025 cohort member

Grow Digital Health Midlands

AIREMAIL TEAM & ADVISORS

Ameet Bakhai, Director, Clinical Safety Officer

Consultant Cardiologist, NHS NHS

Liba Stones, COO

Previously Head of R&D Kings & Royal Free NHS), ICR, UCB Pharma

Martin Green, CTO

Founder and CEO (Blueberry Consultants)

Leah McCauley, NHS DigiWell study Coordinator

MSc in Neuroscience (UCL)

Jon Pearson, AirEmail Project Manager

Project Manager (Blueberry Consultants)

Jona Metcalf, Data Scientist

MEng (University of Cambridge)

Dhruvesh Patel, AirEmail Development Lead

COO (Blueberry Consultants)

Phil Turner

Senior Systems Designer

(Blueberry Consultants)

Jay Mehta, Advisor

GP (Hillingdon Primary Care, CMIO (Royal Free to 2022)

Prof Jeremy Wyatt, Advisor

Prof of Digital Technology, University of Southampton

Prof Heather Angus-Leppan, Advisor

Consultant Neurologist (Royal Free) Professor of Medical Education (University of East London)

Vashist Deelchand, Advisor

Lead Research Nurse (Royal Free)

Contact:

Liba Stones: liba@airemail.co.uk

Surgfit

Michael Morgan-Curran

CEO, Asclepius Medtech

Surgfit™

Worlds 1st remote
surgical **preoperative** assessment and
postoperative monitoring methodology

Grow
Digital Health Midlands

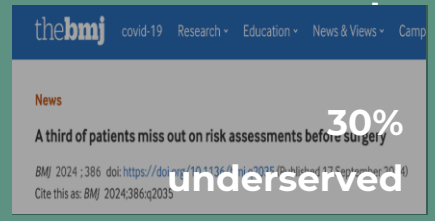
Neighbourhood Health Innovation Showcase

Health Innovation WEST MIDLANDS

Health Innovation East Midlands
Local change, national impact

Asclepius MEDTECH LTD

Why have we created Surgfit?



Improve clinical decision making

Improve **recovery** and **safety** surgery

Care **closer to home**

Reduce hospital visits

Ensure **everyone** gets the **same quality of care**

More **cost-effective**

Meets NHS **10-Year Plan**

Greener technology

Asclepius MEDTECH LTD

What doesn't work well with the current preop assessment?

Resource intensive (£700 cost £289 tariff)

Variation in practice (54% CPET coverage)

Doesn't work for everyone (10% ineligible)

Not accurate (Poor PPV)

System barriers (create health inequalities)

Asclepius MEDTECH LTD

ETHNIC MINORITY RESEARCH INCLUSION

Current hospital-based practice is compounding health inequities and not supporting their engagement

Health Inequalities Research

Demographics

- Age
- Location
- Ethnicity
- Family status

Health Status

- Frailty
- Multiple long terms conditions

Socio economic

- Don’t have adequate transport
- Can't afford to

Confined to

- Place of residence
- Home

Surgfit™

What does the Surgfit look like?

ECG
Resp Rate
Heart Rate
Temp
Activity

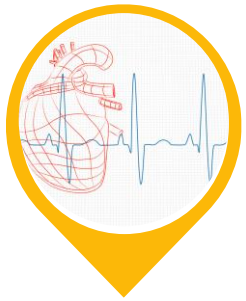
HCP Fitting

Self Install

Class IIa
UKCA, MDR, FDA approved

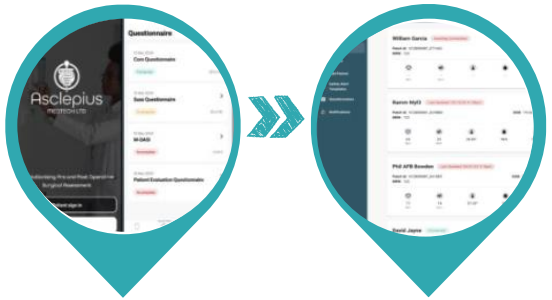
Surgfit™

Remote preoperative assessment



Sensor worn for 1 week to monitor health (heart function etc)

Patient completes questionnaires in the mobile app



The app gathers information using smart prediction software and automatic ECG reading, which is then sent to the preoperative team.

Reduces hospital visits and consultation time. Information is sent to the healthcare team, who check that everything is ready for the surgery.

Eliminates **80%** of the time and **50%** of the cost of preoperative assessment

Surgfit™

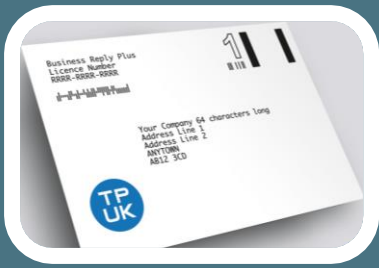
How does it work?

Patients wear **biosensor** for up to **7 days**

Smartphone **app** to **complete functional capacity questionnaires**

Physiological data sets are **produced**, **without** needing to go to the **hospital**

Information is used to **predict how healthy the patient will be** prior and after surgery and if they are likely to **experience any risks**



Asclepius MEDTECH LTD

Initiation + in primary care to avoid the need for hospital attendance entirely

Hospital out patients

Current Practice

Surgfit™

GP Practice

Place of residence

Pharmacy

Surgfit™

Preferred by patients and clinicians

Reimagined
PreOp Assessment

Michael Morgan-Curran
Chief Executive Officer

mm-c@asclepius-medtech.com

+ 44 (0) 7540 737188

asclepius-medtech.com

Population Health Management / Live Well in the Community

Frank Botfield

Assistant Director of Digital Strategy & Walsall Together
Digital and Data Lead

Walsall Together

Neighbourhood Health
Population Health / Live Well in Community

Midlands Neighbourhood Health Innovation Showcase

Frank Botfield – 22nd January 2026

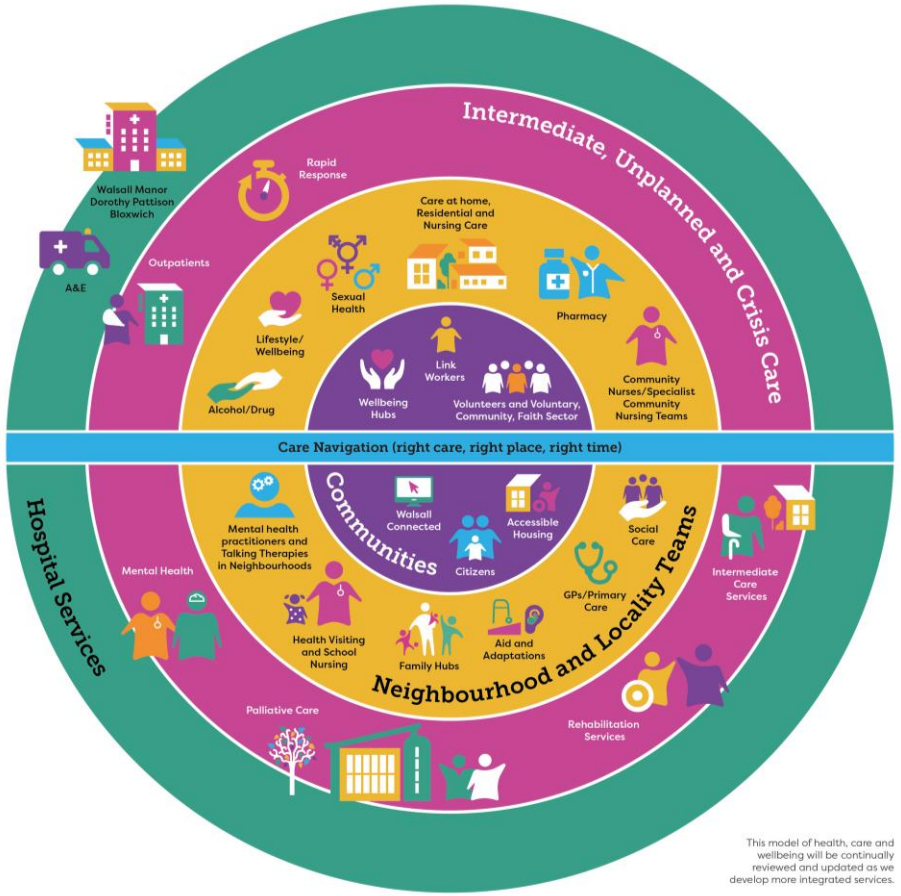
Collaborating for happier communities

NHS 10 Year Plan - National Policy Context

- Neighbourhood Health Guidelines published February 2025
- NHS Plan published in July 2025
- Three key shifts:
  - Hospital to Community
  - Analogue to Digital
  - Treatment to Prevention

Walsall Together

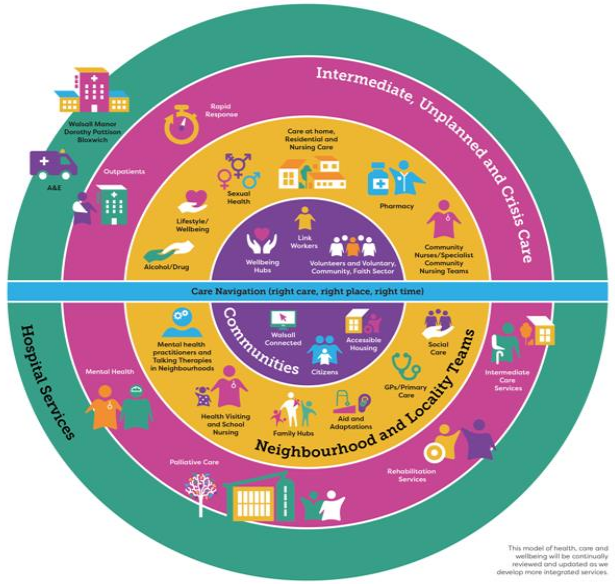
- Partnership aimed at improving the health, care and wellbeing of Walsall residents through **integration since 2019**
- We integrate services, pathways and support in line with our **Model of Health, Care & Wellbeing**
- We measure improvement against the Walsall **Wellbeing Outcomes Framework** (WWOF)



- Prioritisation of resource and effort where collective action is required to 'shift the dial'
- Recognising the fundamentals of wellbeing, influence wider partnerships and areas of service and support
- Enable connections and relationships

Vision

Communities	Prevention, early intervention, proactive self-care and wellbeing support services, are organised at individual and community levels. There is a strong emphasis on fairness and equitable access to services and opportunities.
Neighbourhood and Locality Teams	Building integrated teams at neighbourhood and locality levels for adults, children, young people and families. Bringing together teams and professionals from multiple providers to work together, share resources and information, and form multidisciplinary teams (MDTs) dedicated to improving the outcomes of a local community and tackling health inequalities.
Intermediate, Unplanned and Crisis Care	Joined up health, mental health, social care and other specialist services at the Borough level, to manage chronic and complex needs, provide crisis support and hospital avoidance as well as intermediate care.
Hospital Services	Access to high quality acute hospital services for patients when they need specialist intervention, available through both the Black Country Provider Collaborative and Mental Health Lead Provider.
Care Navigation	Health, care and wellbeing access, navigation and coordination, including triage and service directories, to ensure citizens can get to the right part of the system, to the right service and to the right professional in an efficient and timely manner.



whg

Walsall Healthcare NHS Trust

NHS Black Country Healthcare NHS Foundation Trust

healthwatch Walsall

Walsall Council

NHS Black Country Integrated Care Board

WALSALL COMMUNITY NETWORK

Walsall Primary Care Collaborative

What it will mean for adults and children and young people

The [Walsall Wellbeing Outcomes Framework] provides the infrastructure for a **cultural change** in everything we do and deliver as a partnership, so Walsall people are supported to become more resilient, happy and healthy.

Adults

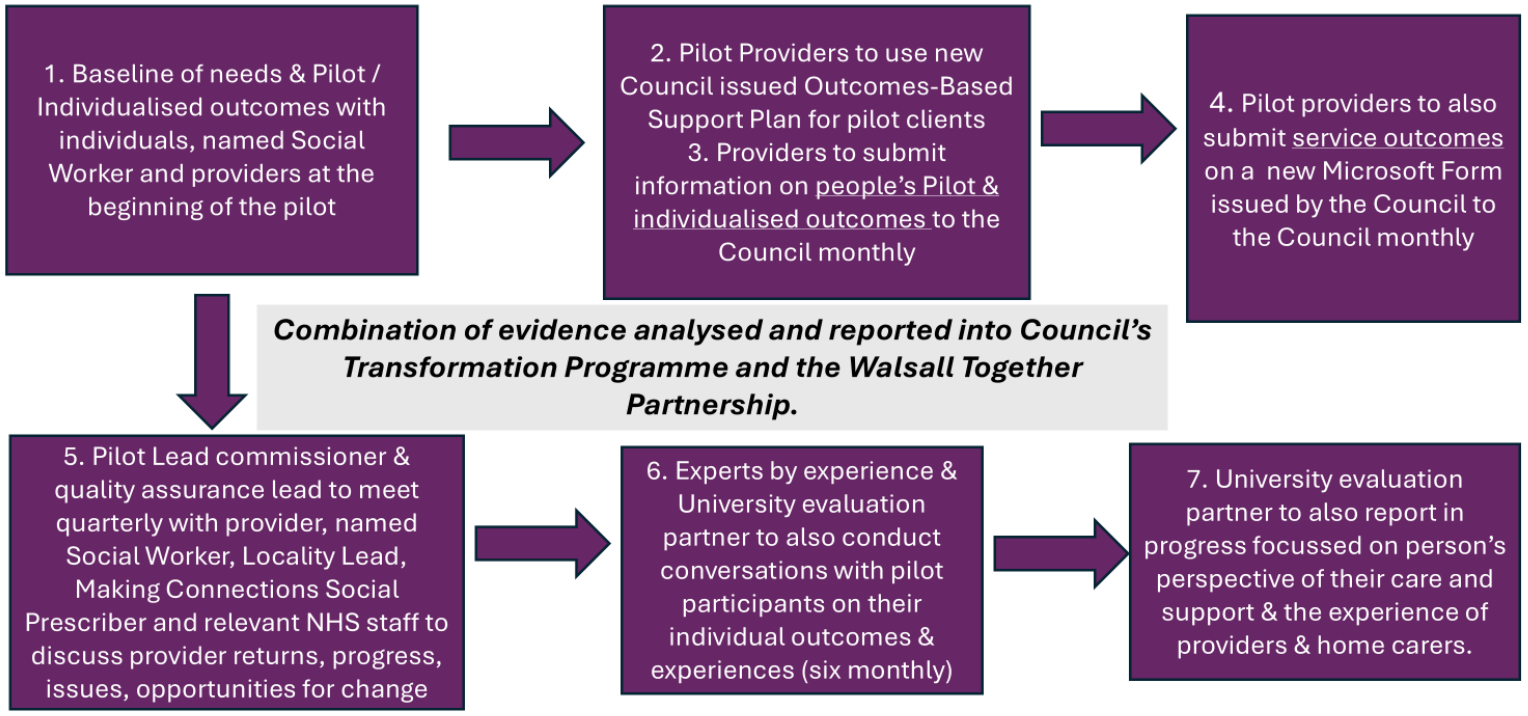
- I can get to the places and people that matter to me
- I live in a safe, secure and comfortable place
- I am able to influence what is important to me
- I am confident in applying my knowledge skills and abilities
- I have people in my life who make me feel happy and safe
- I have the knowledge and skills to get online
- I feel good and well
- I have enough money to live comfortably
- I have a sense of identity and purpose

Children and young people

- I am happy, health and well
- I am safe in all spaces
- I have a voice, and I am heard
- I am hopeful and excited for the future

Live Well in The Community

Pilot Monitoring and Quality Assurance Process



The approach

- Ensure the reduction in **health inequalities** is front and centre
- Use and build on **existing assets** and offers
- Build connections and understanding **between** the different offers
- Work out the best ways to position these offers **alongside** primary care
- Ensure we can demonstrate the **impacts** simply and effectively
- Improve the sustainability of the **funding**

Walsall Together

Thank you

frank.botfield@nhs.net

Grow
Digital Health Midlands

Innovator Presentations

Part 2

Health Innovation East Midlands
Local change, national impact

Health Innovation WEST MIDLANDS

Appt Chronic Condition Management

Hector Smethurst

Founder & CEO, Appt Health

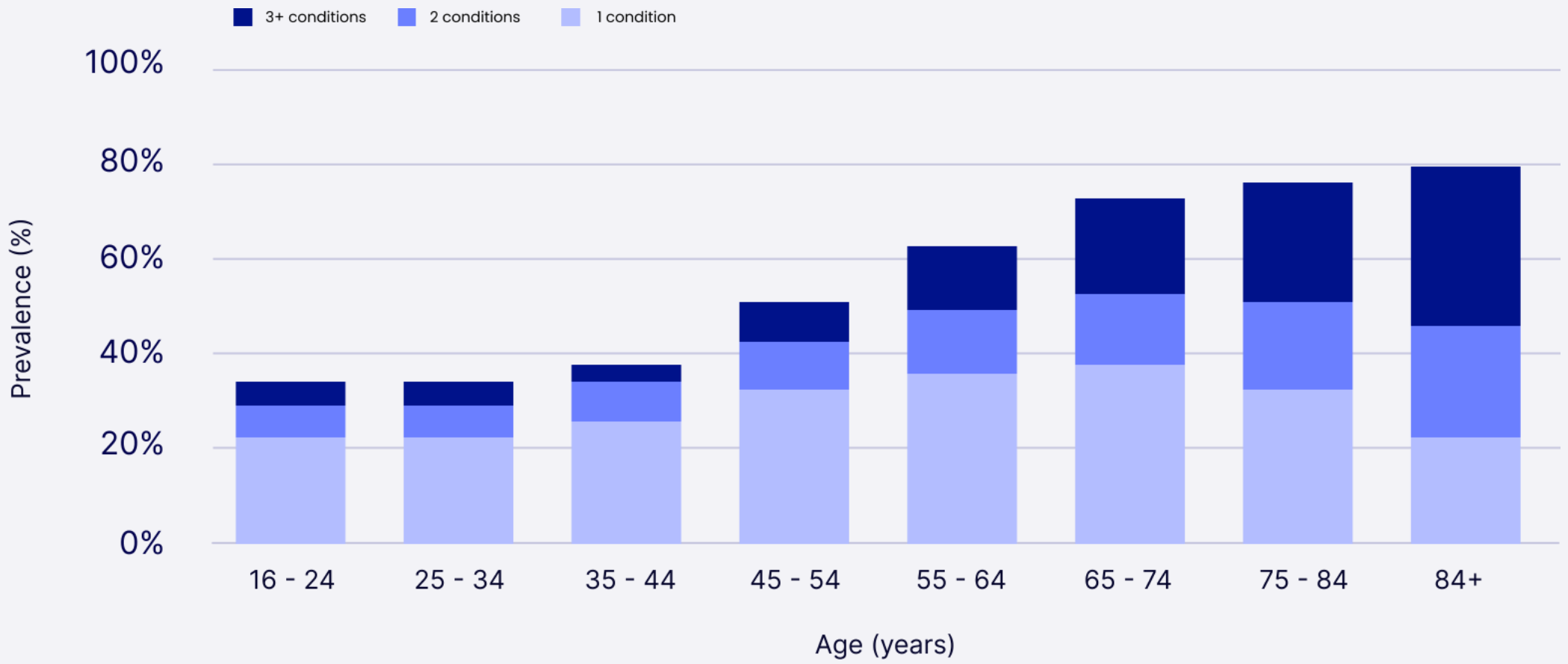
apptheath

Making Neighbourhood Health Work in Practice

Appt Health | Grow Midlands

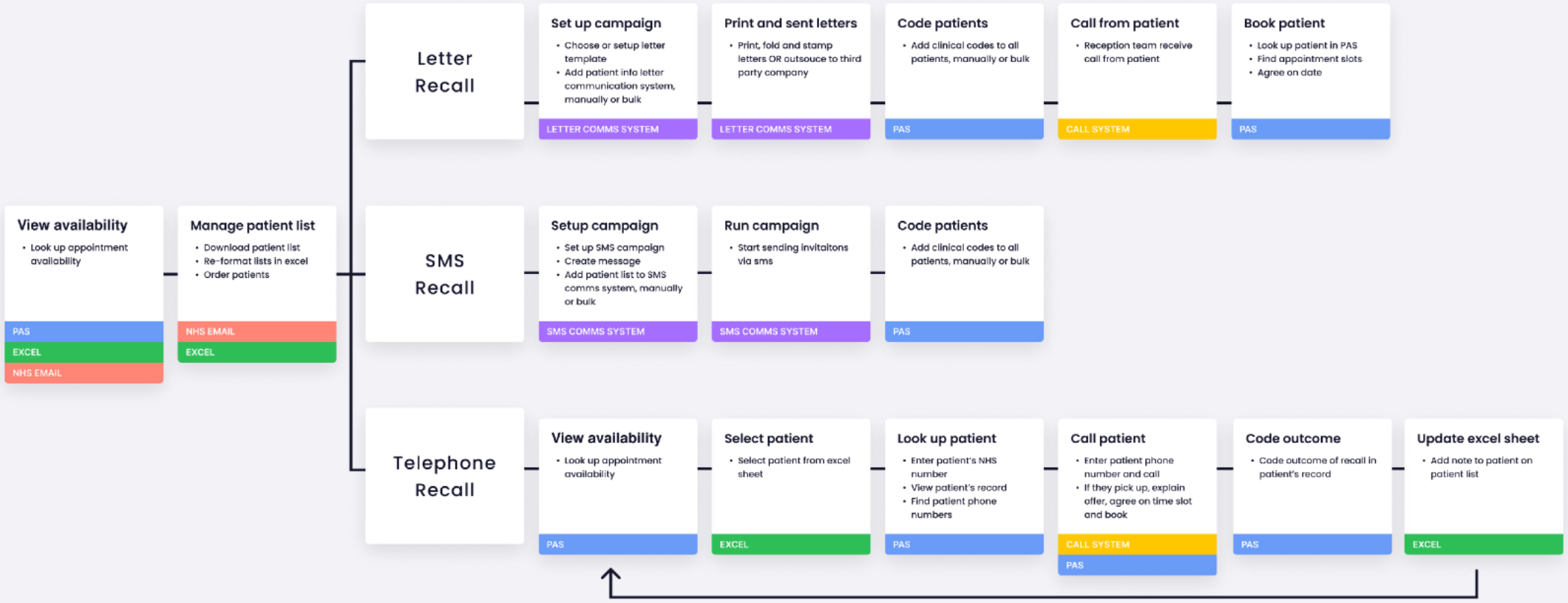
22nd January 2026

The growing burden of patients with multiple long-term conditions



Reference: Major Conditions Strategy, GOVUK 2023

The status-quo is a fragmented patchwork of tools




Making Waste Segregation Simple

Appt's multi-agent system for care coordination in primary care

Eligibility Agent

Identifies which patients are diagnosed with one-or-more long-term condition and whether any NICE recommended care needs are due.

Capacity Management Agent

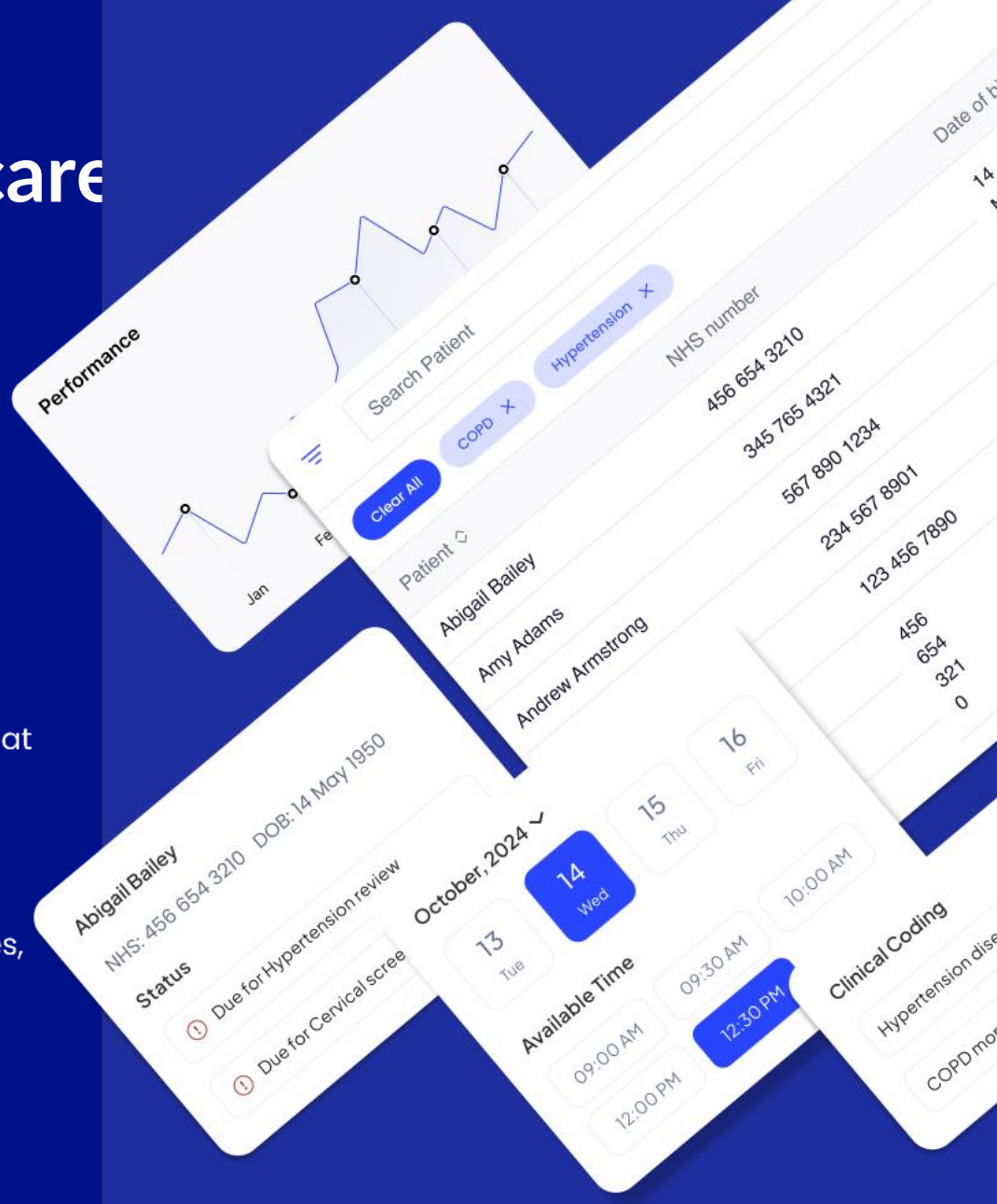
Senses available appointment capacity in the GP system and interprets what each slot can be used for based on the skill mix of available clinicians.

Patient Management Agent

Automates essential patient management tasks like sending questionnaires, reducing manual work and improving care coordination.

Patient Engagement Agent

Automates patient engagement with targeted, personalised invitations, behaviourally informed messaging, and automated follow-ups.



Appt is an AI-enabled care coordination service

1

	Hypertension	Diabetes	Asthma
Patient 1	**Practitioner:** HCA **Duration:** 30 min **Activity:** Blood pressure, bloods, urine test	**Appointment 1** **Practitioner:** HCA **Duration:** 20 min **Activity:** Blood pressure, Bloods, Weight **Appointment 2** **Timing:** Within 6 weeks of results **Practitioner:** Nurse **Duration:** 20 min **Activity:** Review results	**Practitioner:** Nurse **Duration:** 15 min **Activity:** questionnaire, medication review and spirometry.

Appt extracts clinically coded data from EHRs (EMIS, SystmOne) and follows a rules-based approach to identify the care needs for each patient.

2

	26/03/24	27/03/24	28/03/24
Nurse Skill 1 Skill 2 Skill 3	10:00 - 10: 20 10:20 - 10: 40 10:40 - 11: 00 12:10 - 12: 30	10:00 - 10: 20 10:20 - 10: 40 10:40 - 11: 00 12:10 - 12: 30	10:00 - 10: 20 10:20 - 10: 40 10:40 - 11: 00 12:10 - 12: 30

Through a second API, Appt identifies availability and skill mix of appointment slots available in practice and from other approved local sources.

3

	BP	Bloods	Weight	Vaccine	Results
Appointment 1 HCA 30 min	✓	✓	✓	✓	✗
Appointment 2 Nurse 20 min	✗	✗	✗	✗	✓

Appt's proprietary Machine Learning algorithms help to prioritise patients and consolidate their care needs into the smallest number of appointments.

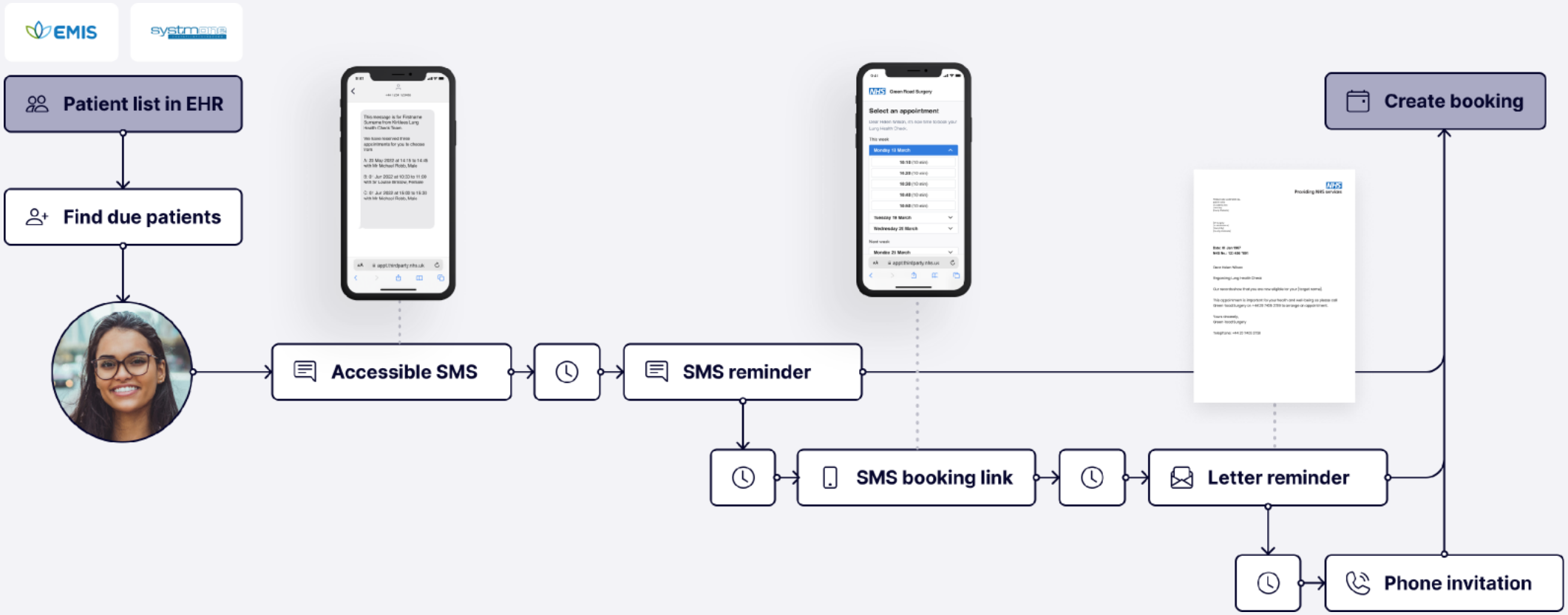
4

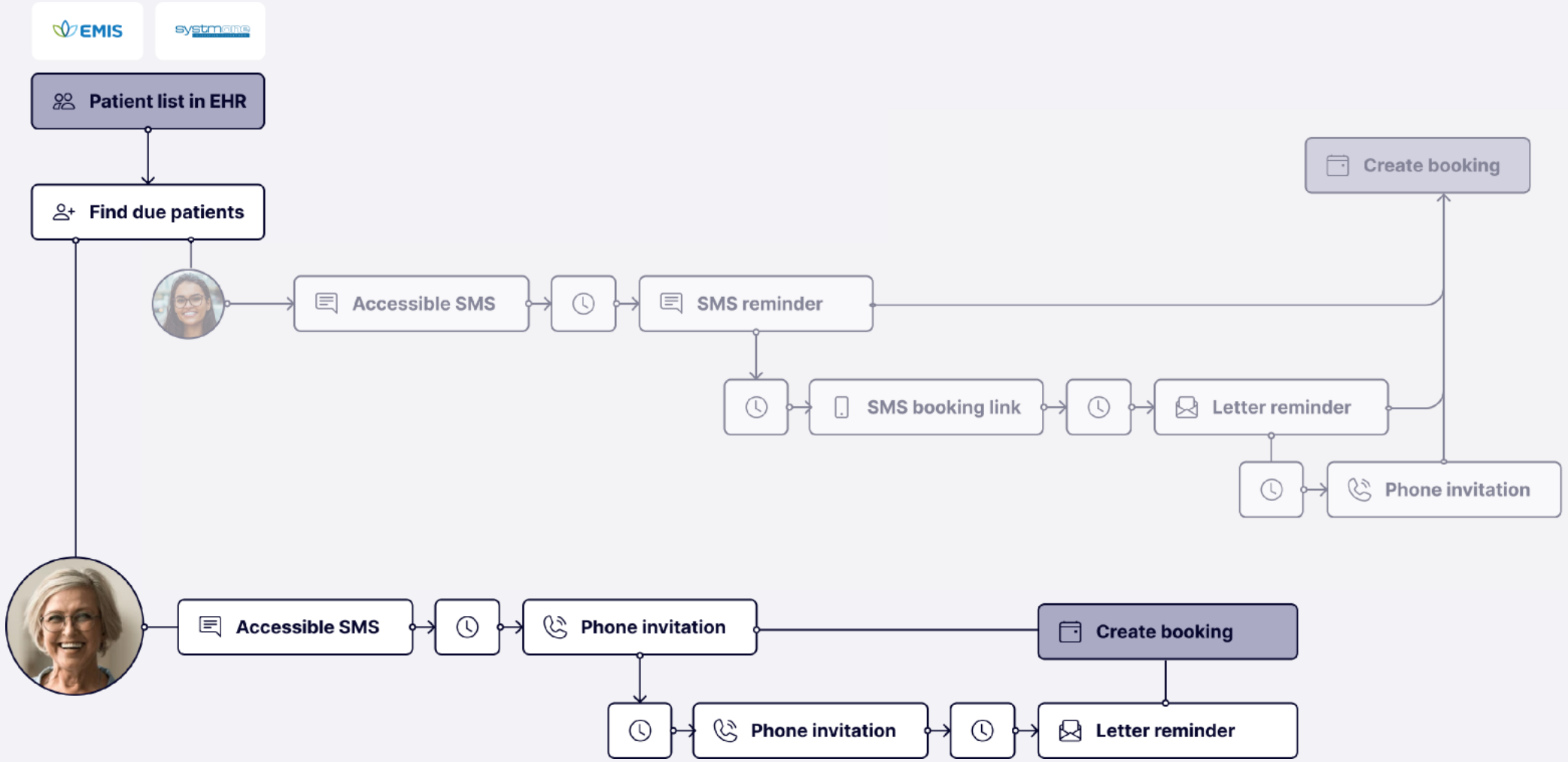
	1	2	3	4
Patient 1 Appointment 1 & 2				

Appt automatically schedules appointments via SMS, postal letter and phone calls, using further ML techniques to increase patient response rates.

PPIE and co-design workshops with low uptake subgroups are central to our approach

Appt moves patient engagement away from a one-size-fits all approach




EMIS
Patient list in EHR
Find due patients
Accessible SMS
SMS reminder
SMS booking link
Letter reminder
Phone invitation
Create booking
Accessible SMS
Phone invitation
Create booking
Phone invitation
Letter reminder

Demonstrated Success: transformed a lung cancer screening programme into the best in England

£883k

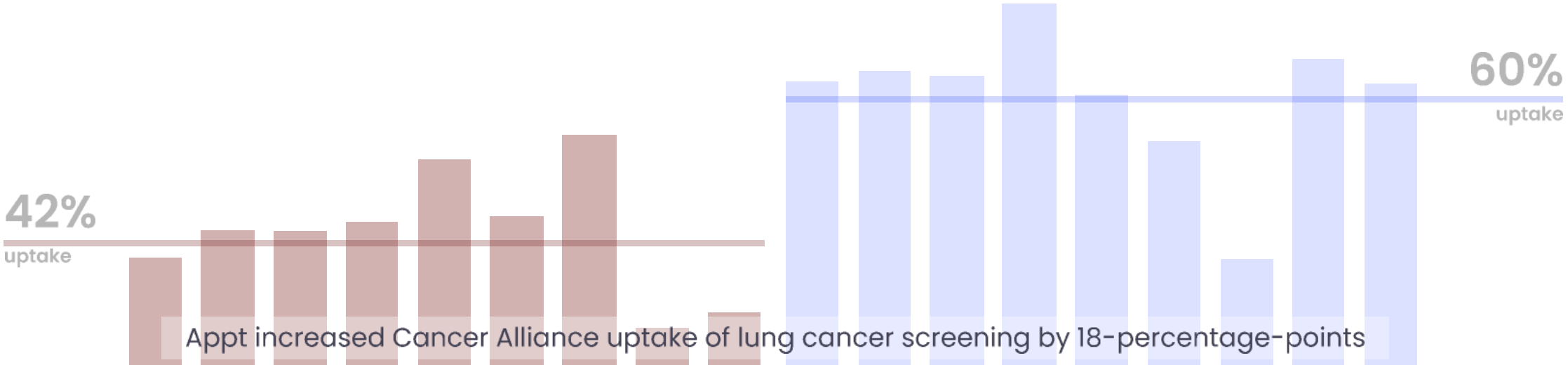
increase in revenue earned by the Cancer Alliance by using Appt on one programme

35

additional diagnoses of stage 1-2 lung cancer, with health economic value of £1.2m, per year

↑18%

Increase in uptake of lung cancer screening amongst current smokers (high risk group)



Appt increased Cancer Alliance uptake of lung cancer screening by 18-percentage-points

Neighbourhood health succeeds or fails in day-to-day practice delivery

- **Overstretched practice teams**

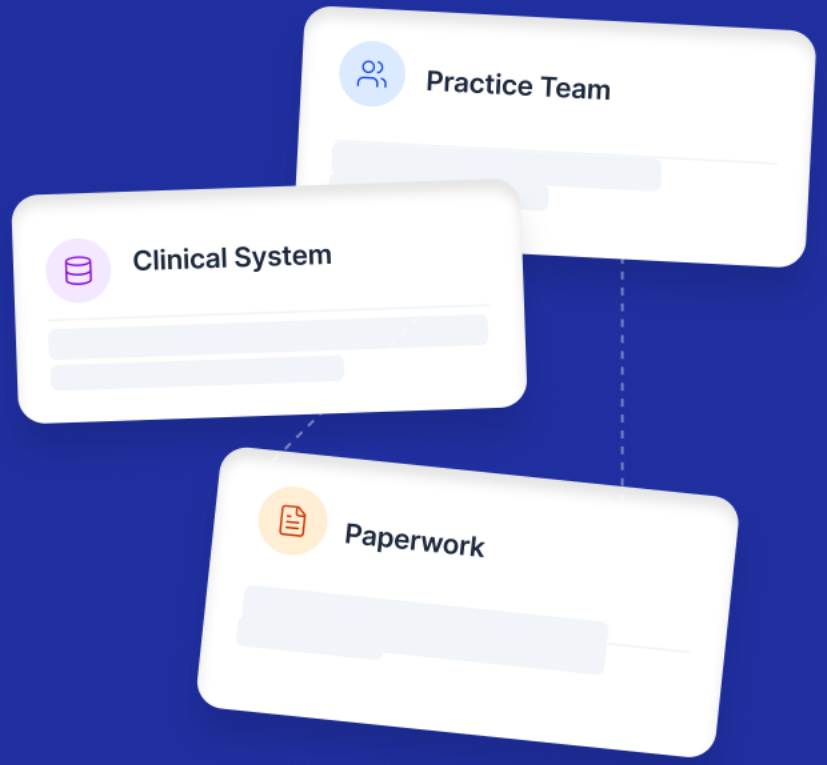
  Delivery relies on practice teams that are already at capacity.

- **Fragmented processes**

  Workflows are disconnected across systems, roles, and locations.

- **Overstretched practice teams**

  Coordination work is the primary bottleneck for scaling.



What practices need to engage with neighbourhood health

- **Very low setup effort**

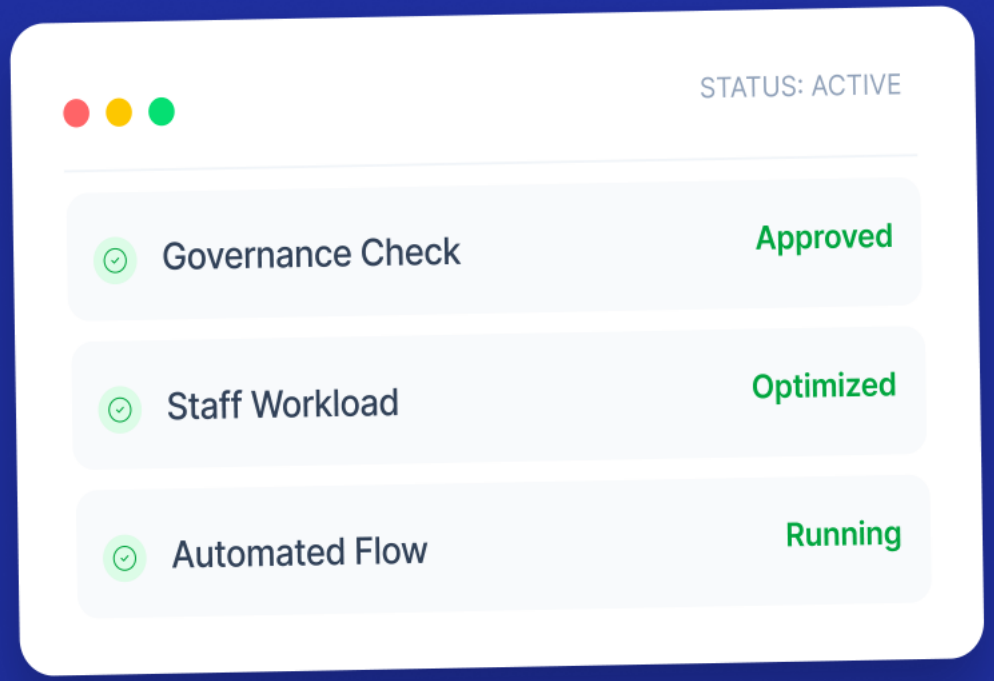
Must require near-zero setup time and minimal ongoing effort from staff.

- **Low /well managed clinical risk**

Zero additional clinical or information governance risk for the practice.

- **Administration a key limiting factor**

Confidence that the system will run reliably without constant checking.



Where Appt Health fits in neighbourhood health delivery

Appt Health provides the operational infrastructure that allows neighbourhood health initiatives to run reliably inside general practice, without adding workload.

- Connects fragmented systems
- Automates patient outreach
- Manages capacity intelligently

Reliable delivery enables neighbourhood health outcomes

Consistent Participation

More reliable practice engagement across the neighbourhood.

Underserved Reach

Better penetration into hard-to-reach patient populations.

Strategy to Action

Neighbourhood strategies that actually translate into delivery.

We've had a measurable impact on our users

"

Appt's determination to disrupt preventative healthcare and consistently deliver with excellent acknowledgement of feedback is impressive.

Osman Bhatti
Chief Clinical Information Officer
North East London CCG

NHS
North East London

"

The implementation has been one of the most successful I've experienced in the NHS. Appt has had a hugely positive impact on our programme.

Stephen Lees
Program manager
Lung cancer screening West Yorkshire.

Targeted Lung Health Check Programme

Thank You!

Hector Smethurst
CEO and Founder

Email
hector@appt- health. co. uk

Phone
+44 7817 875431

Website
www.appt-health.co.uk

Heidi AI Medical Scribe

Gus Lyon

Primary Care Lead, Heidi Health

Heidi

Neighbourhood Health Innovation Showcase

Heidi Health

January 2026

The Documentation Challenge in *Neighbourhood Teams*

The average clinician spends a third of their working week on admin today. The rise of the multi-tasking clinician has led to rising admin burden.

Admin Burden

Each service uses different documentation formats with varying consistency and completeness. This variation blocks automation and makes cross-team working inefficient.

Standardisation Gap

Time shifts from patients to admin, increasing burnout, turnover risk, and reducing care continuity.

Clinician Impact

Each organisation uses different EHRs, lacking the integration and interoperability required for timely sharing of information and completeness of records.

Information Lag

Product

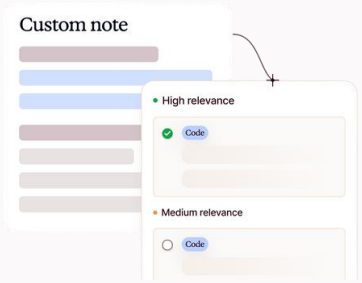
Clinicians lose valuable time to documentation -Heidi gives it back with automated clinical notes

1. Transcribe

Simply press transcribe on your computer or phone, and Heidi instantly begins capturing your consultation with precision

2. Customise

Choose from versatile note templates which work for any specialty

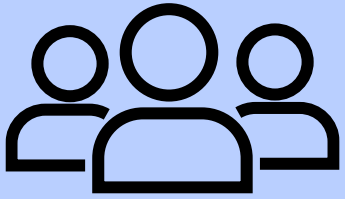


3. Create

Ask Heidi to create anything you need next - letters, adding medical codes or a patient summary

Product

Where Heidi can help neighbourhood teams today

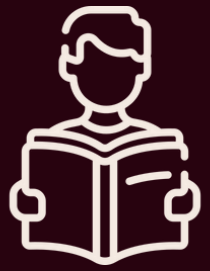


Neighbourhood MDTs

Custom templates capture MDT meetings in real- time, ensuring standardised documentation with clear action points and tasking across all team members

Modern General Practice

Heidi helps practices cope with rising volume and increasing complexity in need through saving clinicians up to an hour a day.



Cross- team continuity

By using Heidi across all settings, patient records stay consistent, contemporaneous and comprehensible - increasing continuity as patients move between GP, community, acute and hospice services.

Enabling care closer to home

Mobile- ready documentation works wherever care happens - GP surgeries, home visits, care homes, community clinics. Contemporaneous capture eliminates information lag and keeps care in the community.

CHCP - Community Health Partnership deploying across multiple disciplines

GPs, Consultants, Allied Health Professionals, Advanced Practitioners, Specialist Community Teams and Nursing staff

Challenge

- Implementing AI Scribe in a highly regulated, risk-averse healthcare environment, where benefits in complex settings remain unproven at scale. Administrative burden continues to hinder patient flow and clinician satisfaction.
- Hypothesis: Co- designed workflows and rigorous evaluation enable AI Scribe to improve note quality and clinician satisfaction across multiple clinical disciplines.
- The UK healthcare institution aimed to pioneer and measure AI' s impact on clinical efficiency, documentation accuracy, and workforce wellbeing in high- volume care settings.

Solution

- We built clinician advocacy by appointing departmental champions to drive frontline adoption and peer support.
- We mapped tailored workflows across disciplines, ensuring alignment with existing clinical practices.
- We customised training materials designed collaboratively with clinicians to accelerate adoption and minimise workflow disruption.
- Article published here: Link.

KPIs

~180
Additional patients per year

15-20 mins saved
Per patient on frailty assessments

>25%
Improvement across care, home, and virtual settings

97%
Activation and adoption with pilot users

50%
Reduction in spelling errors per consultation

Heidi

ExpertCare

David Immleman

Founder & CEO, DXS International

Neighbourhood Health Innovation Showcase

Grow
Digital Health Midlands

ABOUT DXS

- Clinical decision support to NHS GPs – SMART Referrals, Pathways, Medicine information and more.

- Developed a unique solution, **ExpertCare,** for the medicine management of long-term conditions.

HM Government G-Cloud Supplier

NHS Digital

NHS GP IT futures

NHS Shared Business Services

bsi ISO/IEC 27001 Information Security Management CERTIFIED

MHRA Certified

DTAC

THE DXS PROPOSITION MEETS NEIGHBOURHOOD INITIATIVE CORE COMPONENTS

- **Enable Population Health Management.** ✓
- **Incorporating a modern general practice approach.** ✓
- **Integrating intermediate care with a 'Home First' approach.** ✓
- Standardising community health services.
- Neighbourhood multidisciplinary teams (MDTs).

WHAT WE ARE OFFERING

Our ExpertCare digital solution will:

- Enable hypertension and cholesterol medicine reviews across the nine QoF CVD domains in half the normal time.
- Reviews conducted virtually with most patients at home.
- Reduce GP consultation time by automating repetitive tasks on behalf of non-GP prescribers.
- Help prescribers meet QoF targets and reduce CV events and costs.

OPPORTUNITY - REDUCING STROKES & HEART ATTACKS

If PCN achieves QOF targets for a **50,000 patient PCN** then over three years:

19 heart attacks, strokes and CV events avoided

8 deaths avoided

£296, 000 saved on heart attacks and strokes

Size of the Prize

UCLPartners Health Innovation

THE NHS IS NOT ACHIEVING ITS CVD CONTROL AMBITIONS?

The Reasons:

- Ageing population with increasing multimorbidity.
- 34% (17,000) plus of all registered patients across each 50,000 registered patient PCN will fall into one or more of the nine CVD QoF domains.
- Resources required to move patients to controlled BP from base of 69% (England June 25) to 85%.
- Exacerbated by lack of clinical resources.

A SOLUTION - INTRODUCING EXPERTCARE

Automating the “heavy lifting” for busy expert NHS staff:

01 Analysis

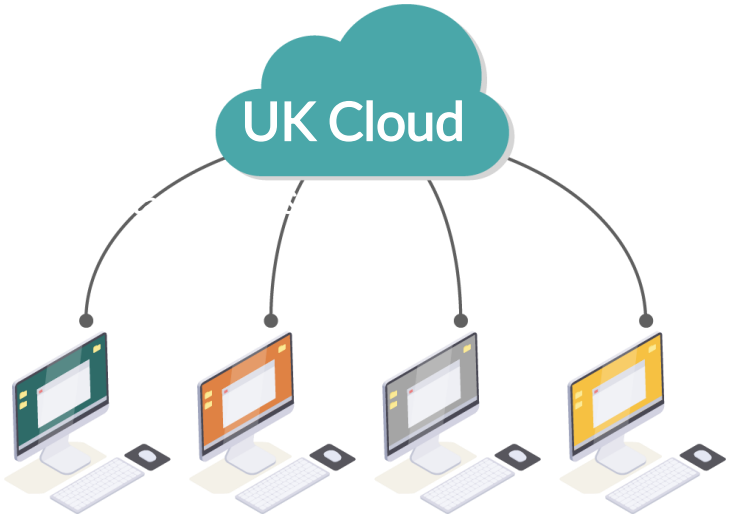
Information 02

03 Compliance

01 Analyses the coded GP record in seconds

02 Automates relevant prescribing information and advice

03 Ensures optimum medicines management in compliance with NICE



EMIS, SystmOne

40 000 clinical scenarios processed in seconds

HOW EXPERTCARE IS USED

FTE for a 50,000 patient PCN over 12 months

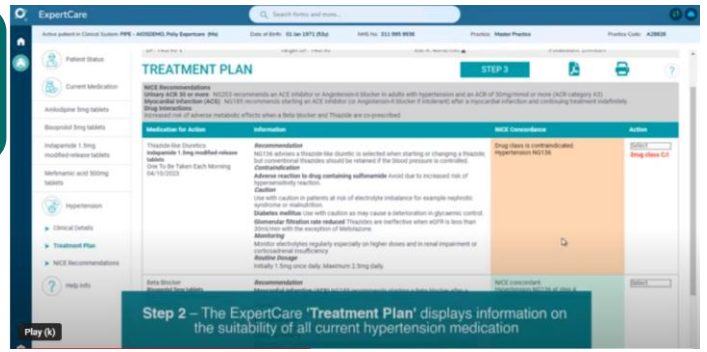
- Admin - 0.8
- Prescribing Pharmacists - 1.6
- Estimated GP time - 0.3

1. Identify patients requiring a BP / Cholesterol test — Eclipse / CVD Into Action
2. Use SMS / Calls to get updated BP/Chol readings — Eclipse / AccuRx
3. Save updated readings to patients records
4. Conduct medicines reviews for patients with uncontrolled readings — ExpertCare
5. SMS/Call patients for permission to make meds changes
6. Make meds changes
7. Review reminder

Patient at home

Assessed and proven to cut time by 50%

YHEC
York Health Economics Consortium



THE BENEFITS ARE CLEAR

In an Innovate UK project, reviewing hypertensive patients and completed in July 2025, the outcomes were:

- 50% patient response to SMSs and 50% called.
- Over 7 months patients with uncontrolled BP improved from 29% to 58% (100% improvement).
- The average number of meds review cycles to achieve control was 1.4.
- NICE compliance increased by 21%.
- Thousands of GP hours were saved.
- Overall resource time was cut by approximately 50%.
- A YHEC evaluation showed that NHS resource costs could be cut by up to 60%.
- Excluded the savings on heart attacks and strokes, GP appointments, wider workforce savings and CO2.
- Achieving QoF CVD targets equates to £245,000 p.a. across a 50,000 patient PCN with 5 practices.

YOUR INVESTMENT FOR A 50,000 PATIENT PCN

Year One (PCN)

• Setup & Training of ExpertCare plus 120 hours of a DXS Mentor	-	(£16,500)
• Potential saving to PCN on resources	-	£160,000
• Total benefit to PCN (excluding CVD savings & other)	-	£143,500

Year Two (PCN)

• ExpertCare License fee	-	(£7,500)
• Potential saving to PCN on resources	-	£145,000
• Total benefit to PCN (excluding CVD savings & other)	-	£137,500

- Excludes a potential £20,000 grant in year one from Grow Digital which would be split 50/50 between DXS and PCN.

THE CLOCK IS TICKING - EVERY 3 MINUTES...

someone in the UK dies of a heart attack or stroke

THANKS FOR LISTENING

Grow
Digital Health Midlands

Suvera

Ivan Beckley

CEO & Co-founder, Suvera

Health Innovation East Midlands
Local change, national impact

Health Innovation WEST MIDLANDS

NHS
Providing NHS services

suvera

Creating one seamless virtual experience in the neighbourhood

Neighbour health is about moving care from the patient to the population

These are the components:

Population health management

1. Neighbourhood MDT

Team of professionals focused on the population not just individual patients

2. Standardise community services

One point of access with a consistency of support and utility

3. Home-first intermediate care

Where possible taking care out of buildings and into people's homes

4. Community urgent care

Catching immediate need where patients overspill from A&E

Yet there is a massive gap going from patients to the population

	Patient focused model	The GAP	Population focused model
Access	Patients come to you		You go to the patient
Care	Infrequent and discontinuous		Frequent and continuous
Intervention	Medications		Medications + Behaviour change

Suvera exists to fill this gap for every neighbourhood in the country

	Patient	suvera	Population
Access	Patients come to you	Risk stratification and automated recall	You go to the patient
Care	Infrequent and discontinuous	Remote monitoring and async care	Frequent and continuous
Intervention	Medications	Personalised patient app	Medications + Behaviour change

Introducing suvera

The essential virtual layer for Neighbourhood care

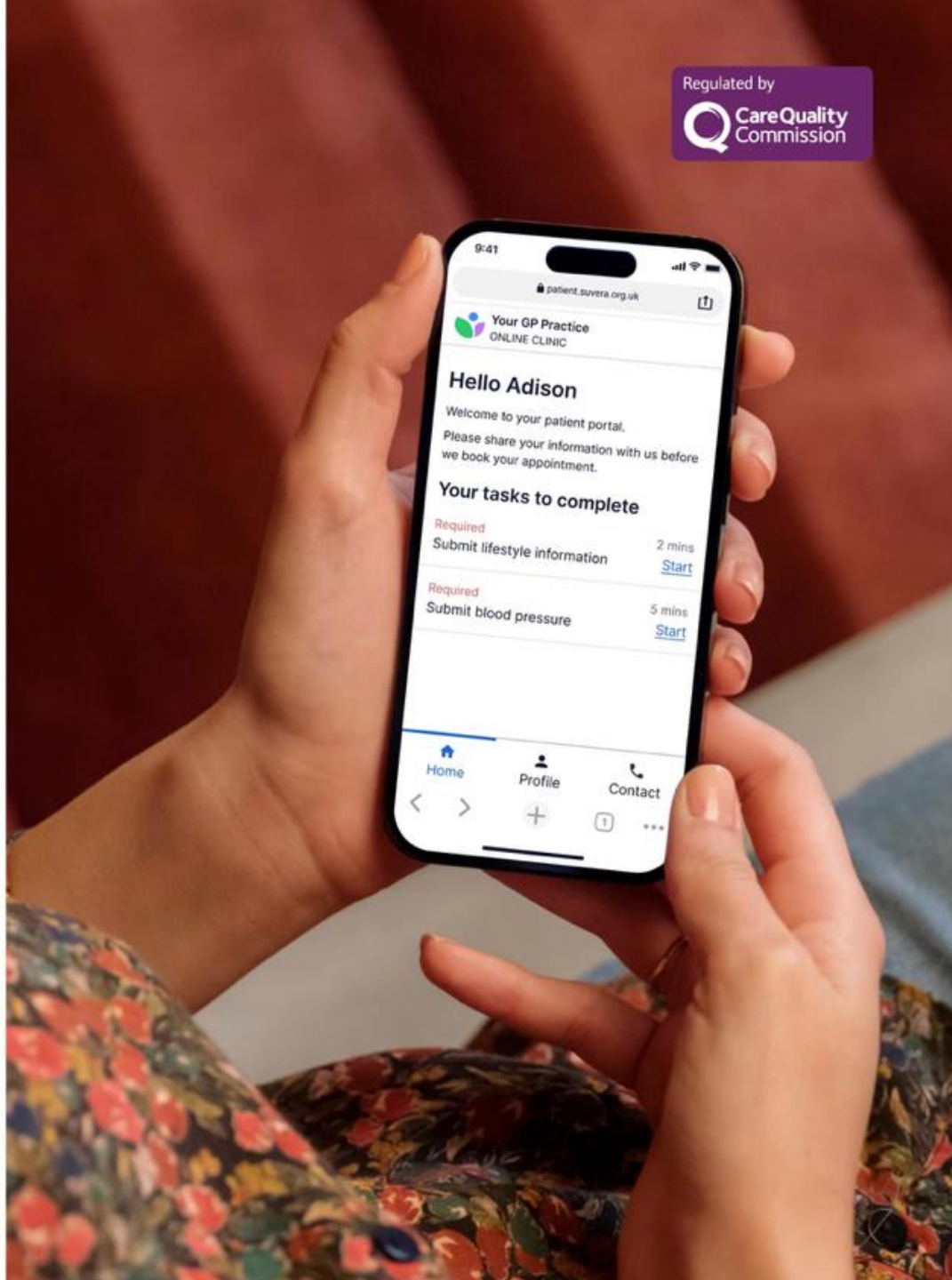
Using EHR data, our online clinic creates a **single experience** for condition management in the community

350+
partnered GP practices

148,000+
active under management

4.1/5
patient experience score

82%
of patients invited engage in the model



Overlaying the EHR, we deliver a full solution, not a point solution

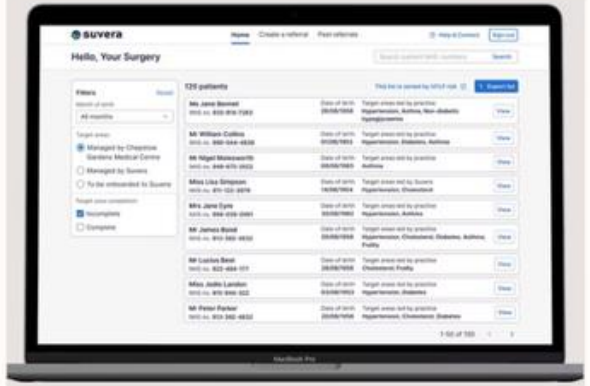
NHS
Providing NHS services

1 Identify

Automatic risk-stratified patients in real-time

Using the patient records we automatically list patients for Suvera and the practice to review separately

tpp planner EMIS

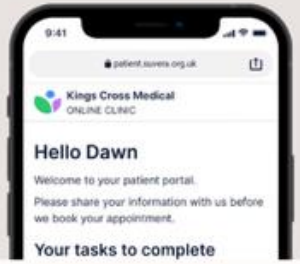


2 Engage

Automatic invite to the Virtual Clinic

Patients receive a personalised SMS inviting them to join the virtual clinic

app

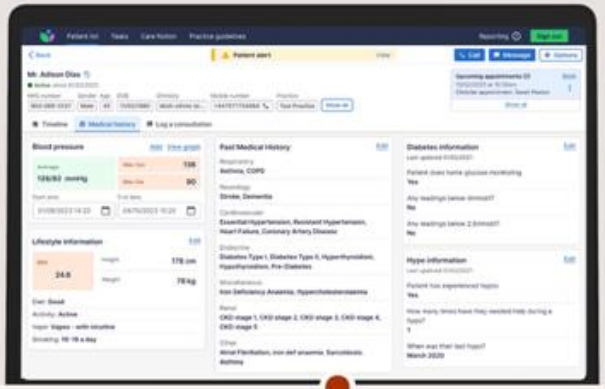


3 Automate

Triaging of clinical data

Clinician reviews clinical information and technology automatically sets up sequences of care

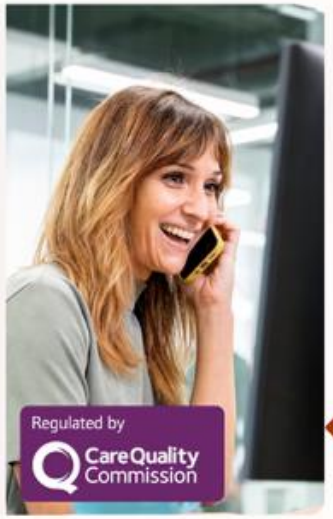
tpp dashboard EMIS



4 Care

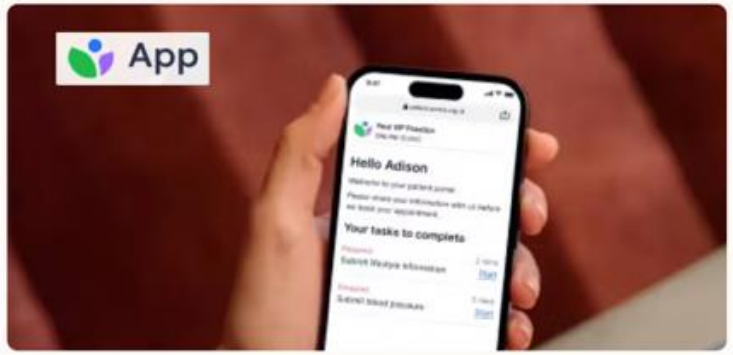
Sync clinical review with patient

Patient telephone or video consultation to discuss test results, treatment and goals with our pharmacist team, supervised by GPs.



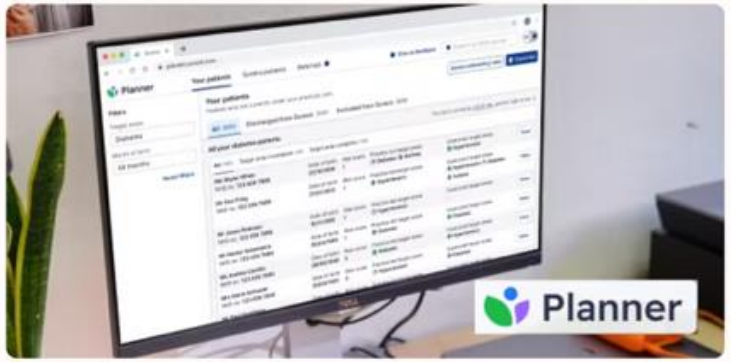
We focus on delivering the best outcomes for patients

Better engagement: 87% of patients engage with Suvera



2/3rds of patients complete their condition and treatment reviews via the **patient web application**

Better co-ordination: 60% of partners use our software weekly



From recalling patients to tracking progress to completion, we **save hours of time** for your team to stay on track with care

Better quality: 91% of are targets hit with Suvera care

We deliver control up to **11 weeks faster** than traditional general practice via our asynchronous and risk-based care model

While taking away the administrative burden of care in the community

Clinical and operational integration

Delivering a **unified care experience** alongside the practice via Planner

Audit and performance tracking

Regular monthly checks on the **quality and progress** of care across all targets

Governance and reporting

7
Incident

15
Resolution

Incidents and complaints are **organised and streamlined** by us, so you don't have to

We are excited to announce suvera is leading one of the first National Neighbourhood Health Implementation Programme (NNHIP) in England

in partnership with

Cornwall and Isles of Scilly Integrated Care System

vsf cornwall

*Focused in the North and East Cornwall ICA


NHS
Providing NHS services
suvera
Creating one seamless virtual experience in the neighbourhood
9:41
Cancel
suvera.co.uk
Record your blood press
If you're experiencing a medical emergency, please dial 999 immediate
Take your first reading
SYS
128
DIA
80
PULSE
70
Wait 1 minute, then take your second reading
SYS
128
DIA
80
PULSE
70
Wait 1 minute, then take your third reading
SYS
128
DIA
PULSE
ivan@suvera.com

Neighbourhood Health Innovation Fund

Dawn Plummer – Digital Health Innovation Lead

Health Innovation East Midlands

What is the innovation enabling fund?

- Pots of up to £20k available to organisations seeking to deploy one of today's innovations
- **Only eligible** to the innovations you have seen today
- Must be novel to the organisation (i.e. not an extension of an existing project with one of these solutions)
- Applications should have an exec level sponsor and there should be a plan for longer term sustainability
- There can be more than one application per region/organisation, each application is scored on its own merit
- Open to all Midlands health and care organisations

Timeline

- Opens today!
- Organisations have until **COP on Thursday 5th February** to apply through our Awardforce competition platform
- EOI initially for stage 1
- Detailed documentation will be requested for projects progressed to stage 2
- Projects selected from stage 2 will be invited to an interview to enable a final decision on allocation of funding

Interested and want to know more?

- Drop in session for Q&As - applicants can sign-up to join us on Thursday 29th January 11.30 – 12.30
- Email us with any queries:
  - dawn.plummer@nottingham.ac.uk
  - nick.hamilton@nottingham.ac.uk

Tell us what you think!

Grow Digital Health: Midlands Neighbourhood Health Innovation Showcase (22.01.2026)

Grow Digital Health Midlands

Health Innovation East Midlands
Local change, national impact

Health Innovation WEST MIDLANDS

Further information

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