Welcome to the NHS Continuing Healthcare Conference

30th June 2026
etc.venues, Prospero House, 241 Borough High St, London, SE1 1GA

CHCFuture

FEATURED ORGANISATIONS

Visit every stand for your chance to win a £100 voucher!

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Global Policy Network

Eden Brown Synergy | PUBLIC SECTOR TALENT SPECIALISTS

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CONVENZIS TRAINING

Please scan the QR Code on the screen below to register your interest for our accredited training courses.

HESUK

Powered by - CONVENZIS

Join the Healthcare Engagement Society (HES)

- **What it is** – A secure, year-round platform bringing NHS professionals together across six specialist communities.
- **Why it matters** – Stay connected beyond today's event, share challenges, and learn from peers facing the same priorities.
- **Your benefits** – Exclusive access to interviews, insights, best practice, and real-time discussion threads with colleagues nationwide.
- **How to join** – Simply scan the QR code, choose your community, and start connecting today.

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Stay Connected Beyond Today

Join the **HES Primary & Long Term Care WhatsApp Community** to stay connected with the people, ideas and conversations shaping this space. Receive relevant updates, access focused peer discussion groups, share practical insight and be first to hear about future events, resources and opportunities.

Scan the QR code to join the Community

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Chair Opening Address

James Crowe
Independent Chair for CHC
NHS Wales

Keynote Presentation

Jess McGregor
Executive Director, Adults & Health
London Borough of Camden

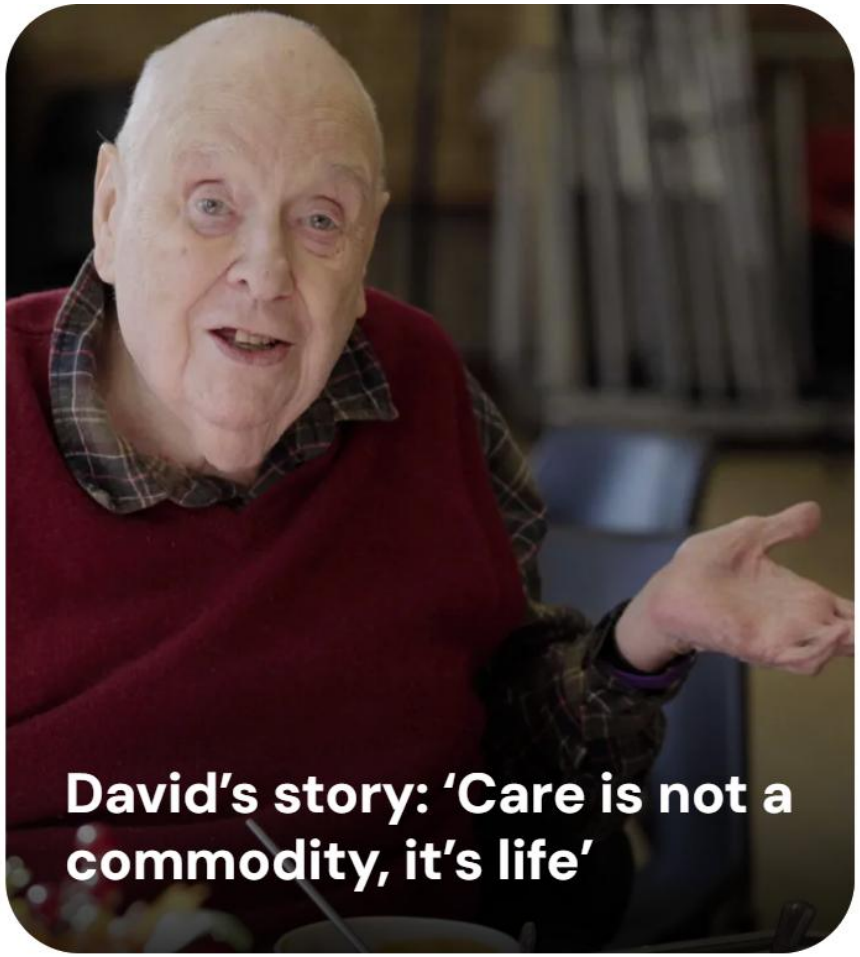
CHC Eligibility and Assessment – Applying Robust Frameworks Across MDTs

Jess McGregor
Executive Director Of Adults and Health – Camden Council
Association of Directors of Adult Social Services – Immediate Past President

National Context

Context – ADASS Members' principles

- Keep the policy position rooted in people's rights and lived experience
- Take a strong national line on NHS and ICB funding behaviour
- Push for a clearer disputes and escalation framework:
- Protect what works while reducing unwarranted variation
- Promote the practical ingredients of effective local models
- Keep CHC and Section 117 distinct but linked
- Use wider system levers without diluting the core issue
- Be open to a more radical long-term reform model



The core tension

At its best, CHC assessment is:

- Evidence-based
- Multidisciplinary
- Person-centred

In practice, there is often drift towards:

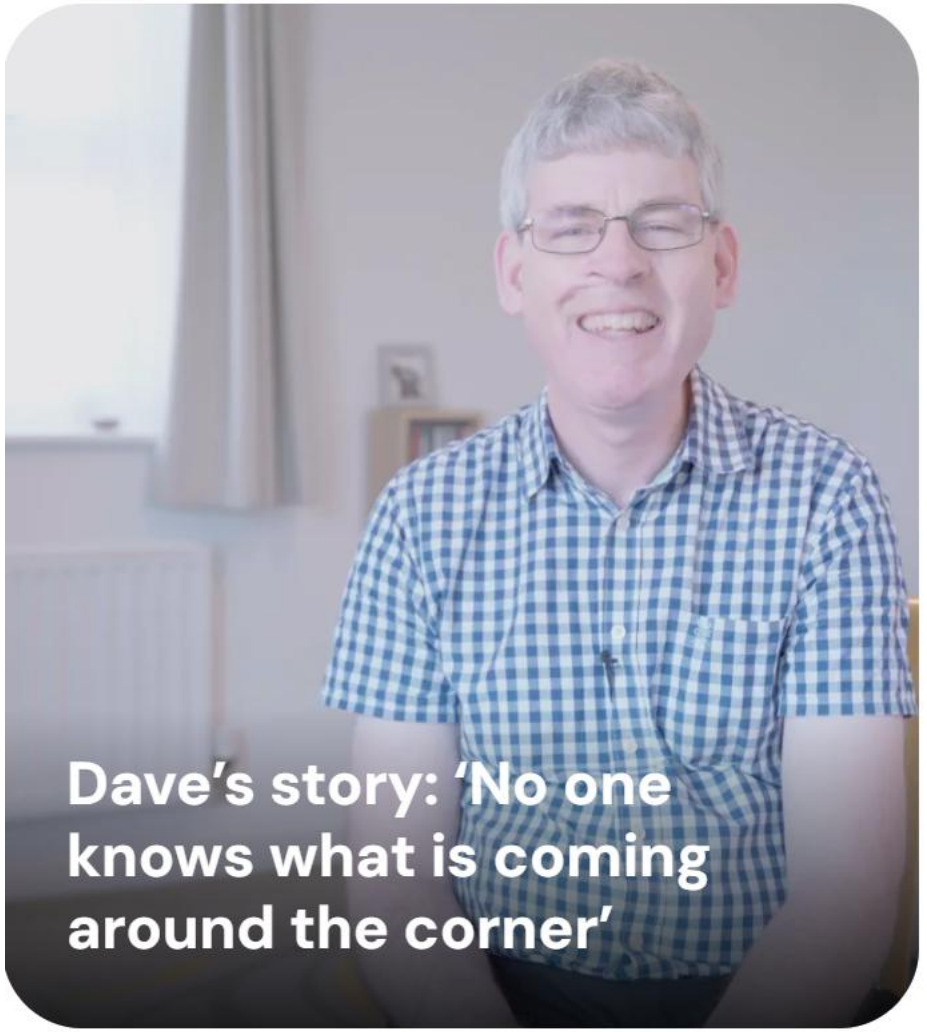
- Process compliance over professional judgement
- Organisational defensiveness over shared analysis
- Completion of the DST over clarity of rationale

The leadership challenge is not choosing between rigour and person-centredness —

it is **holding both at the same time**.

Where eligibility and assessment go wrong

- The Person becomes secondary to the process
- Inconsistent application of the framework
- MDT decision-making drifts into negotiation
- Rational is not always explicit or accessible
- Use of external companies to support the assessment and review process



Reasserting Person-Centred Assessment

Robust eligibility decisions depend on:

- **A coherent understanding of the person as a whole**
- A clear articulation of how needs **present, interact and fluctuate**
- Explicit linkage between needs and **their real-world impact on care, risk and outcomes**

Person-centredness is not supplementary —
it is fundamental to accurate application of the framework.

Without it, there is a real risk of:

- Underestimating complexity
- Fragmenting needs
- Producing decisions that are procedurally sound but clinically and practically weak

What robust application looks like

- Strong MDT leadership
- Disciplined use of the four characteristics
- Transparent and defensible rationale
- System-wide calibration

Leadership challenge

- For senior leaders, the key questions are:
- How consistent are our MDT decisions in practice?
- How confident are we in the quality of rationale, not just process compliance?
- Are our assessments genuinely person-centred, or primarily process-driven?
- Do our decisions stand up to scrutiny — clinically, legally, and crucially experientially?

Let’s get this right for the people who need us to

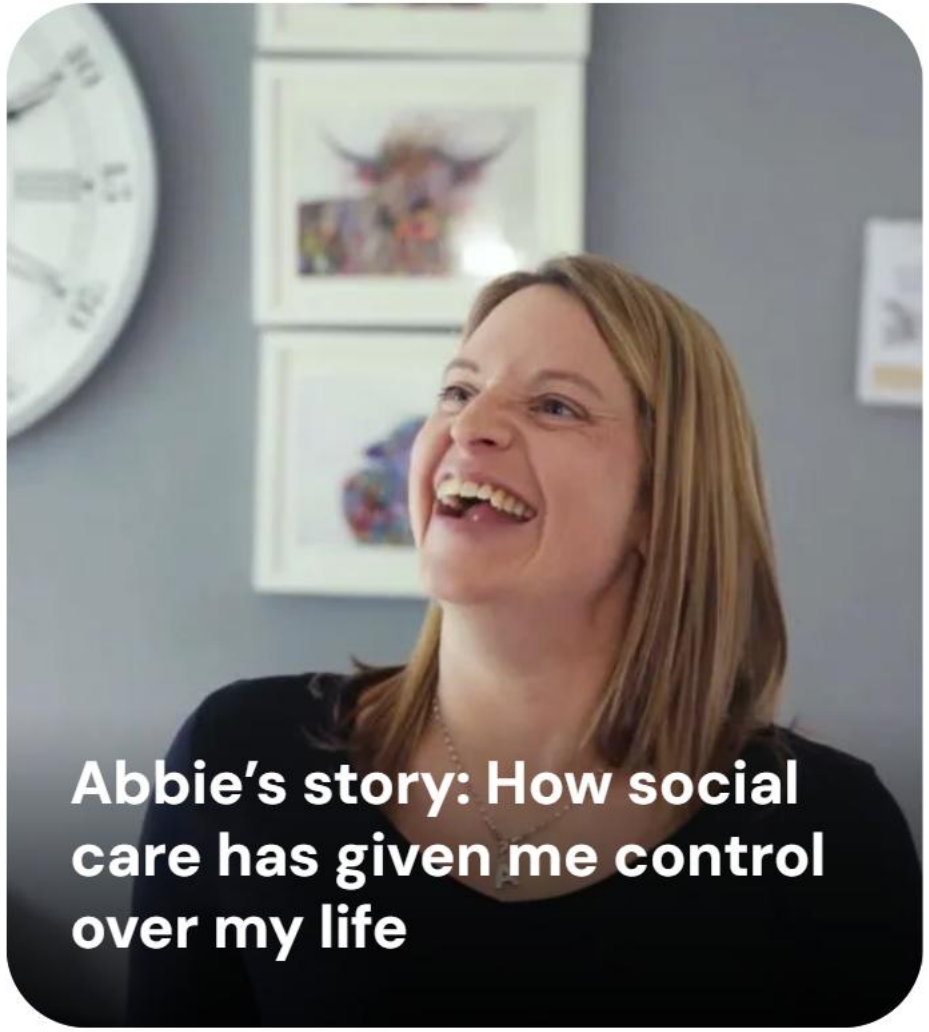
Structured framework is there to be used

Not accept being overly process-driven and fragmented, and reconnect to the lived experience of people with profound and complex disabilities and health issues

Understand how our assessments are experienced

The priority for us as senior leaders is clear

- Strengthen consistency of application
- Improve the quality and transparent of decision-making
- Ensure person-centredness is evident, not assumed



Questions

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Skills Clinic

Juliet Mtada
Senior Clinical Lead-Deputy Head for AACC
South West London ICB

Bose Adegbola
Independent CHC Nurse

Rachel Melton
Deputy Associate Director, All Age Continuing Care
Lancashire & South Cumbria Integrated Care Board

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Refreshments & Networking

Chair Morning Reflection

James Crowe
Independent Chair for CHC
NHS Wales

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Case Study

Case Study

Matt Culpin
Chief Product Officer
IEG4

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Case Study

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Case Study

Maddy Dadson
Project Management Lead
Evondos

Can we deliver medication support differently while maintaining safety?

Maddy Dadson

13.7.2026

Is our current medication model sustainable?

- Long drives to people's homes
  - Highly trained individuals spend significant amounts of time driving when they could be delivering care.
  - Cost of driving & environment

- Medication times can often be constrained by staff availability rather than what is clinically optimal.

- Morning and evening **peak times** require high staffing levels.

- If care teams are unavoidably delayed, time-critical medication may not be given at the right time.

- A person's ability to manage their own medication is **restricted,** forcing them to rely on others for their medication.

- By **2037**, around two-thirds of people over 65 are expected to be living with multiple long-term conditions (NHS England)

What can we learn from the Nordics & Netherlands

- People who need support to take their medication correctly are supported in the **least restrictive** way possible.
- Medication is delivered when it is **clinically optimal.**
- Medication is **securely stored** and can not be accessed when it is not due.
- The person is alerted and supported to independently take their medication when it is due, and care teams are alerted if they do not take their medication on time.
- Care teams can observe and support those who need it remotely via a two-way camera.

Traditional model vs New model

Traditional	Technology-enabled
Multiple daily visits	Medication delivered when due
Staff travel	Remote oversight
Reactive care	Automated alerts
Dependence	Supported independence

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James (Age 75), South East

- Advanced dementia and Parkinson’s disease
- Requires medication at multiple intervals through the day, including some meds that are time-critical medications
- Averaging 3 acute admissions a months due to, medication mistakes and falls
- Pre-intervention: ~£13,370

evondos®

James (Age 75), South East

- Takes his medication independently
- Has one physical visit per month and one video check-in each week
- Medication adherence has increased to **99%**
- **No acute admissions** in the last 3 months
- Reduced anxiety from waiting for carers to attend
- **Net saving: ~£11,700 per year**

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Sarah, Age 63 – South UK

- Complex mental health needs who was discharged under Section 117
- 24/7 supported living
- Feels her independence is being taken restricted, resulting in low mood
- Pre-intervention: 24/7 supported living cost £93,600 p.a

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Sarah, Age 63 – South UK

- The video camera is used to remotely carry out observed medication administration multiple times a day.
- More flexible, **self-directed lifestyle** with increasing independence.
- Post-intervention: 08:00 – 17:00 supported care £26,000
- **Net saving: £65,380 savings per year p.a**

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What have we learned for using the model in the UK?

- The increases in independence are often valued more than anything else by our patients.
- Technology should not replace human interaction and care, but rather optimise it and **release time** for personal care.
- Patient selection is critical.
- The clinical value of taking medication when it's **clinically optimal** rather than operationally is often overlooked.
- Patients' appetite and ability to embrace technology are often underestimated

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Thank you!

Maddy.dadson@evondos.com

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Interview Session

Juliet Hammond
CHC Clinical Lead
NHS Frimley Integrated Care Board (ICB)

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Case Study

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Case Study

Aoife Clarke
Partnerships Lead: Healthcare
Beam

Matilda Crowfoot
Strategic Lead - Healthcare
Beam

Marta Szczot
Deputy Head of Business Development
Hampshire and Isle of Wight Integrated Care Board

What if AI was actually built for CHC?

A Case Study

MATILDA CROWFOOT

General Manager - Healthcare

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MARTA SZCZOT

Deputy Head of Business Development

NHS
Hampshire and Isle of Wight

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Beam is a social impact company using AI to **free up** frontline time in health and social care.

4.5 million

BEAM NOTES RECORDED

100,000+

USERS ACROSS BEAM'S TOOLS

Certified B Corporation

Certified Social Enterprise – Business for Good

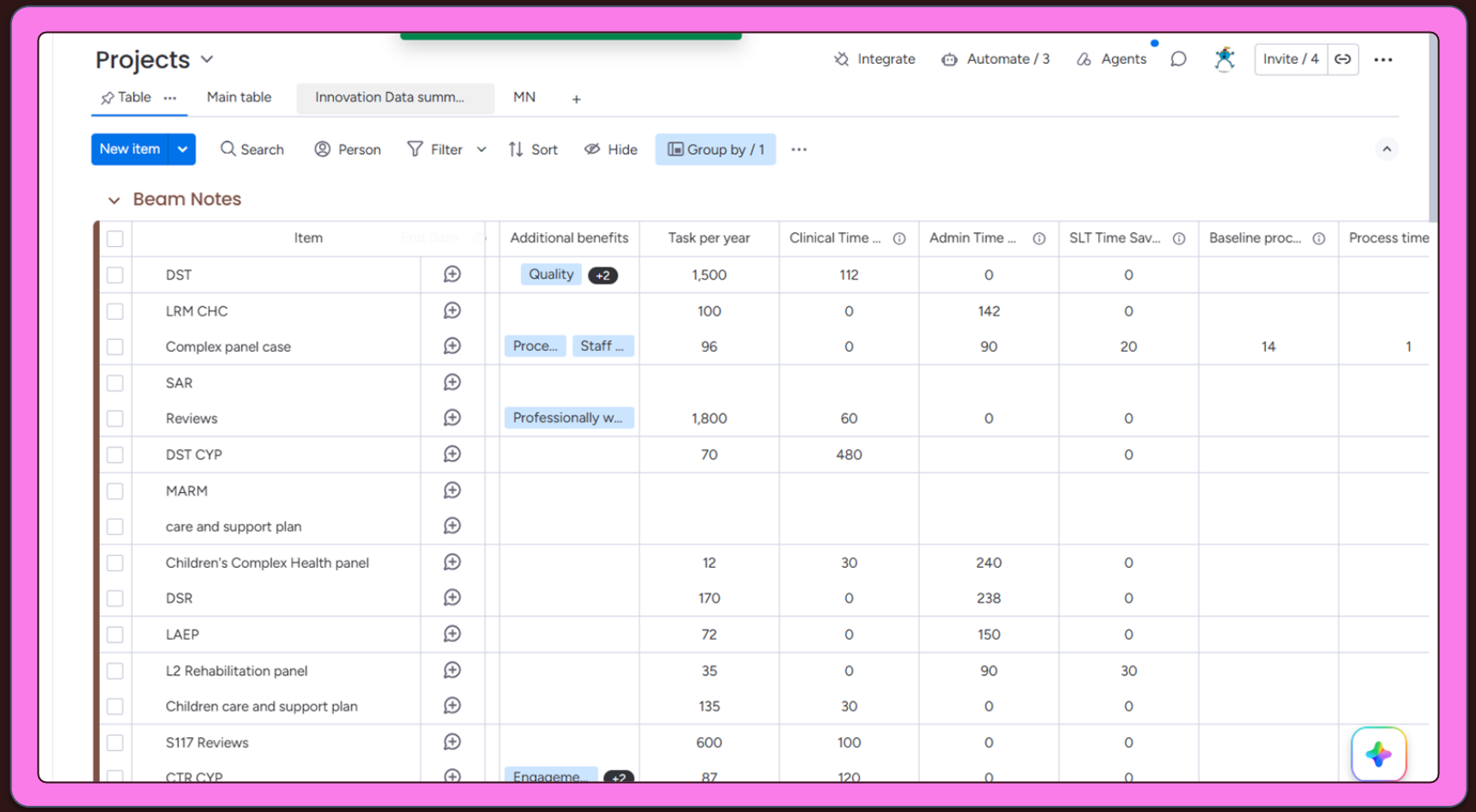
200+ health and social care partners

- NHS West and North London
- NHS Hampshire and Isle of Wight
- PRIORY
- NHS Northamptonshire Healthcare NHS Foundation Trust
- your healthcare
- NHS Avon and Wiltshire Mental Health Partnership NHS Trust
- CareQuality Commission
- GIG CYMRU NHS WALES – Bwrdd Iechyd Prifysgol Cwm Taf University Health Board
- NHS Hampshire and Isle of Wight Healthcare NHS Foundation Trust
- NHS Norfolk and Suffolk Integrated Care Board
- Berkeley Psychiatrists CONSULTANT PSYCHIATRY SERVICES

Discussion

beam

Measured live, not estimated after the fact



Item	Additional benefits	Task per year	Clinical Time ...	Admin Time ...	SLT Time Sav...	Baseline proc...	Process time
DST	Quality +2	1,500	112	0	0		
LRM CHC		100	0	142	0		
Complex panel case	Proce... Staff ...	96	0	90	20	14	1
SAR							
Reviews	Professionally w...	1,800	60	0	0		
DST CYP		70	480		0		
MARM							
care and support plan							
Children's Complex Health panel		12	30	240	0		
DSR		170	0	238	0		
LAEP		72	0	150	0		
L2 Rehabilitation panel		35	0	90	30		
Children care and support plan		135	30	0	0		
S117 Reviews		600	100	0	0		
CTR CYP	Engageme... +2	87	120	0	0		

ICB-built dashboard tracking the time saved on every Decision Support Tool - from day one

Results: From 6 users to Business as Usual

June 2025 - 6 users (pilot)
December 2025 - 60 users
June 2026 - 172 users · 20+ live templates · BAU

*"**I feel like I can be a nurse again**. When I'm not sitting typing the whole time, I can show empathy and maintain eye contact - something that we didn't always get time to do."*

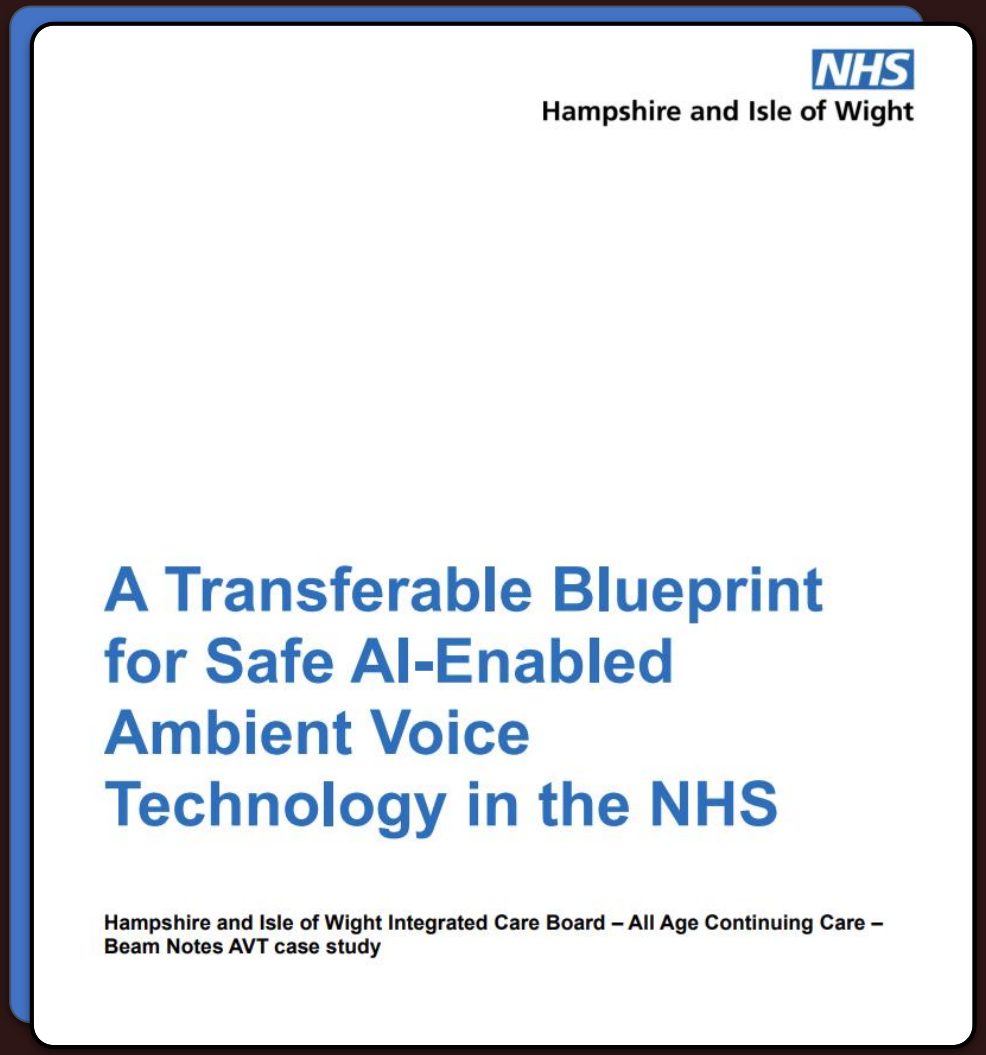
3hrs
SAVED PER DST

92%
28-DAY KPI PERFORMANCE, UP FROM 35.5%

4.2WTE
CLINICAL CAPACITY RELEASED

100%
FOUND IT EASY TO USE & WANTED TO KEEP USING IT

From one ICB to a transferable blueprint



"The main message is not that one organisation used one tool successfully, but that sustainable AVT implementation depends on the right conditions: clear governance, responsible and ethical use of AI, clinician co-design, phased rollout, practical training, ongoing support, and a service model willing to redesign workflow rather than simply add technology on top of existing processes".

Beam Plan for CHC

AI built for the complexity of CHC

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healthcare@beam.org
BEAM.ORG

BOOK A CALL

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Lunch & Networking

Chair Afternoon Address

James Crowe
Independent Chair for CHC
NHS Wales

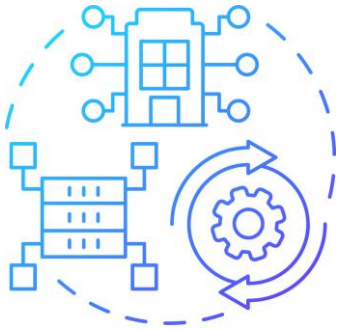
Keynote Presentation

Michelle Kelly
Operations and Commissioning
Programme Lead AACC
BSOL ICB

Rebecca Dale
Data and Performance Manager
BSol

Birmingham and Solihull Integrated Care System
Caring about healthier lives

NHS
Birmingham and Solihull



From Trackers to Transformation

How Birmingham and Solihull ICB Digitised Continuing Health Care with Power BI

Presented by

Michelle Kelly Operations and Commissioning Lead AACC &
Rebecca Dale Data and Performance Manager AACC

Introduction

- Who we are
- Why we used trackers
- What prompted change
- Impact of digital shift

The Starting Point – Life with Trackers

Trackers used in CHC for

- Assessments
- Referrals
- Appeals
- DST deadlines

Issues:

- Manual input & errors
- Poor visibility & reporting
- Version control problems

Why We Needed Change

Drivers for transformation:

Volume & complexity of CHC data

NHS governance & audit standards

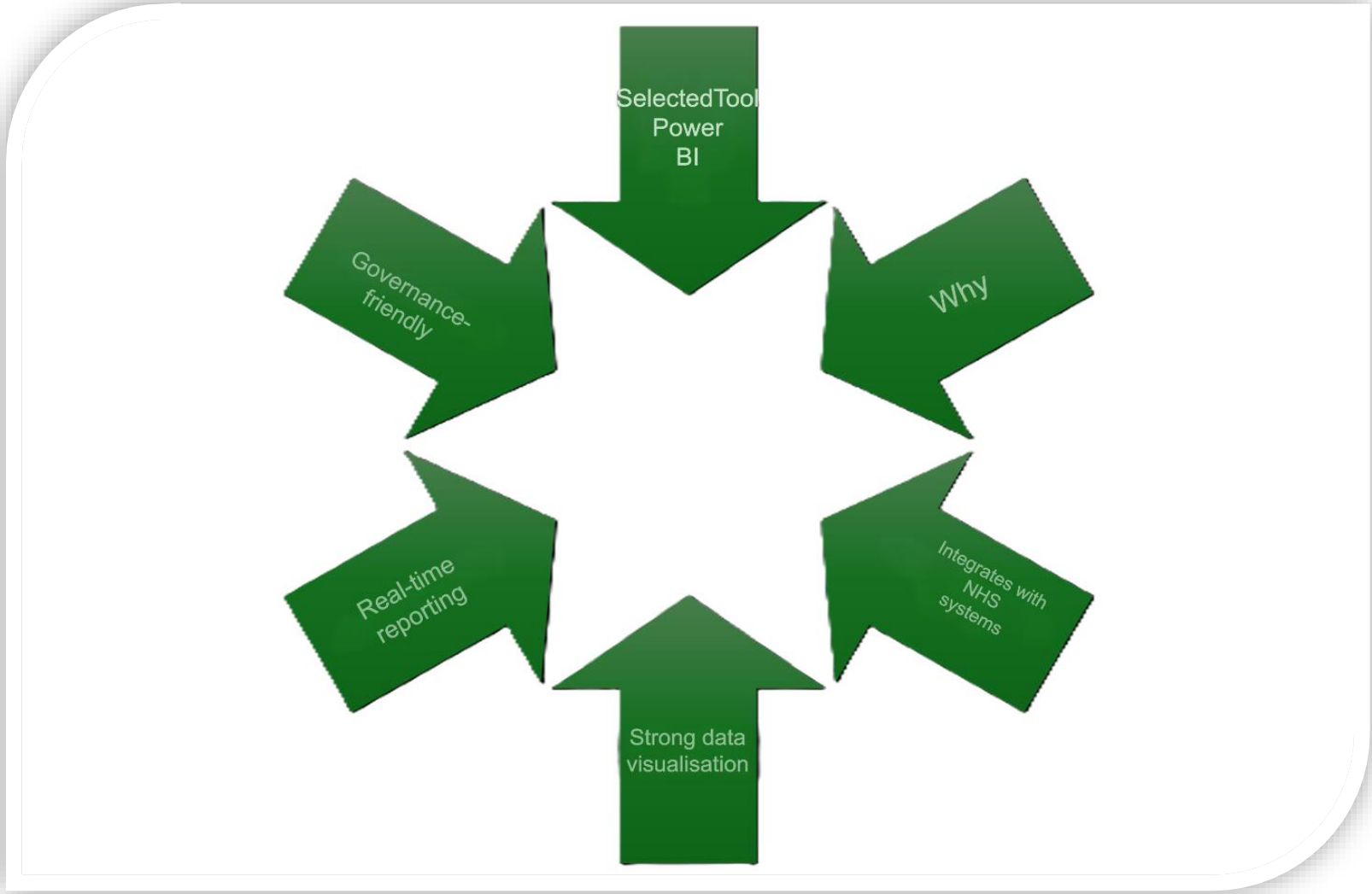
Need for real-time insights & automation

Reduce burden on staff

Exploring options

- Internal vs external solutions
- Engagement with CHC teams, BI, IG
- Criteria:
- Secure, NHS compliant
- Easy to use
- Scalable & report-ready

The Chosen Digital Solution



Building the Solution

APPROACH:

- AGILE DEVELOPMENT WITH PILOT USERS

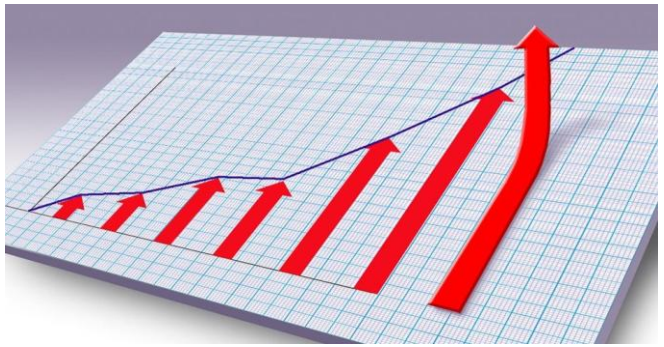
- POWER BI DASHBOARDS FOR EACH CHC PROCESS

- ITERATIVE FEEDBACK FROM CHC TEAMS

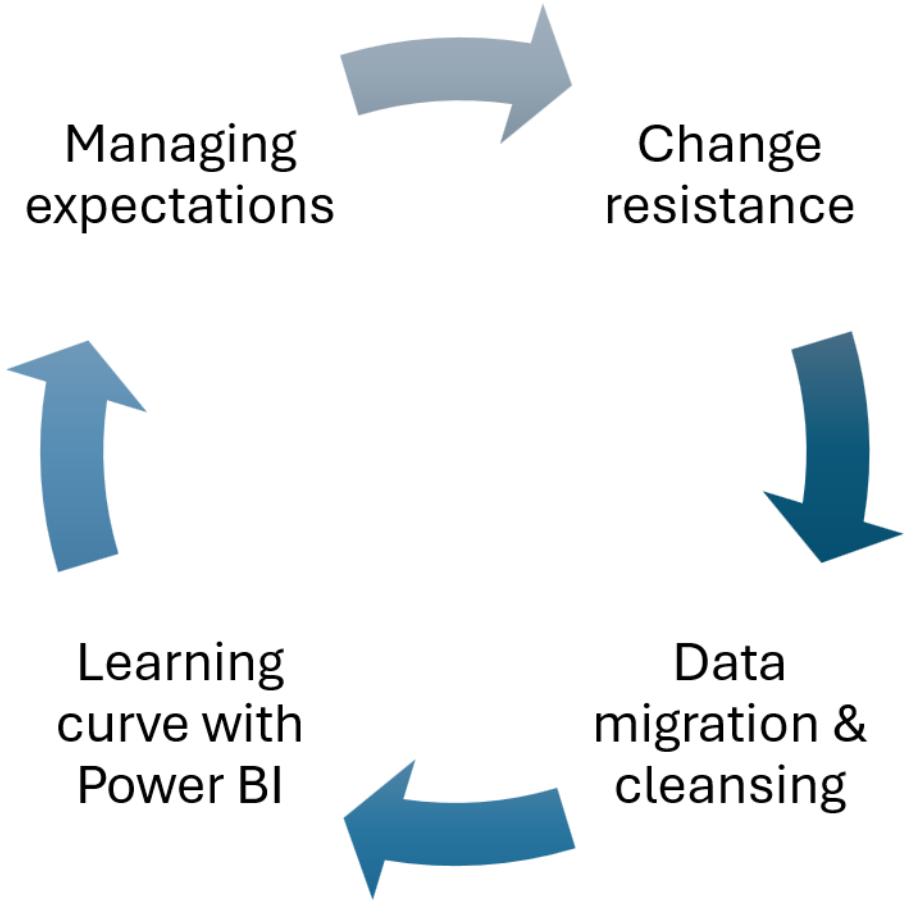
- TRAINING AND ADOPTION SUPPORT

What Improved

- Faster reporting and insights
- Fewer errors
- Easier collaboration across teams
- Clearer visibility of KPIs and backlogs



Challenges We Faced

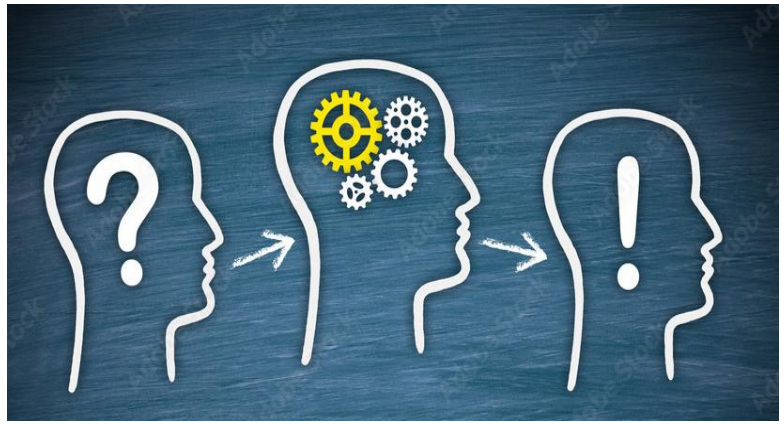


Lessons Learned

INVOLVE USERS EARLY

START SMALL, SCALE FAST

EMBED GOVERNANCE FROM THE START



COMMUNICATE CONSTANTLY

Next Steps and Future Plans

Expand Power BI even further

Automate alerts & reminders

Link to national datasets for benchmarking

POWER BI DEMO LIVE

Questions, reflections, and feedback welcome!

Contact Details

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Rebecca Dale

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Birmingham and Solihull ICB

Power BI Expert Details

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Systems and Data Improvement Specialist
chiragnathvani@gmail.com
Mobile 07717005939

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Keynote Presentation

Art Calder
Nurse Consultant | Individualised Commissioning
Multi Health Specialists Ltd

MENTAL HEALTH ACT 2025: KEY IMPLICATIONS FOR COMMISSIONERS ACROSS MENTAL HEALTH AND NHS CONTINUING HEALTHCARE

WE EITHER WIN OR WE LEARN (MANDELA,N.)

“Now is your time…..”

Calder, A (2026) Arthur.calder1@nhs.net https://www.linkedin.com/in/art-calder-a762b6aa/

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Rachel Hutchings
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June Jones
Complex Discharge Team Lead
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