WELCOME TO

The Integrated Care Summit: Challenges and Best Practice

Check Out Our Agenda Here...

Wednesday 21st November 2022- 10:50am – 14:30pm – GoTo Webinar

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Conference hosted by Convenzis Group Limited

The Integrated Care Summit: Challenges and Best Practice

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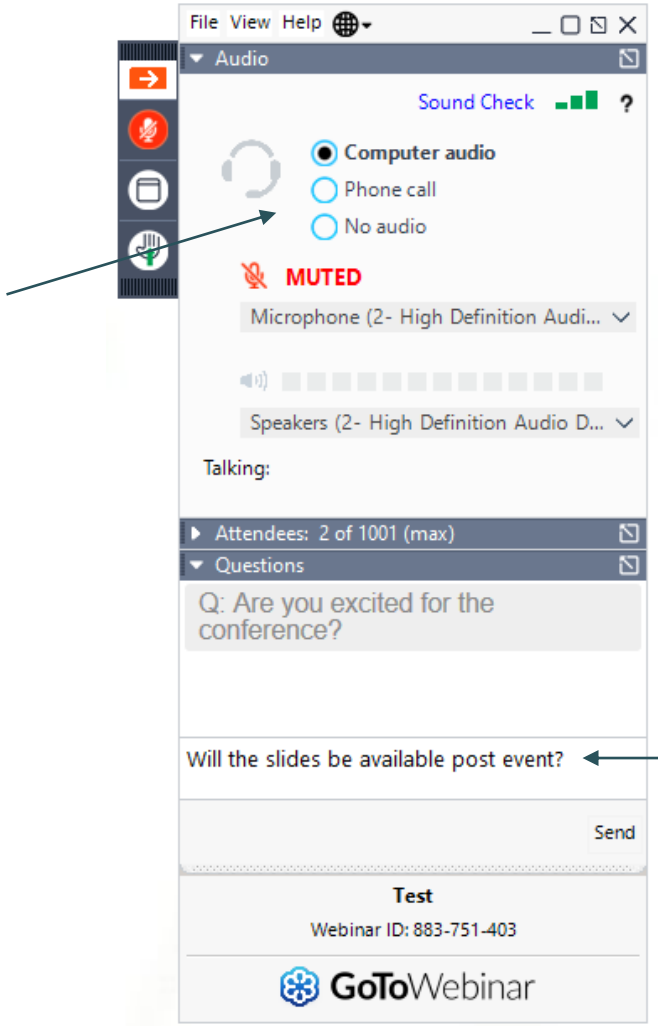
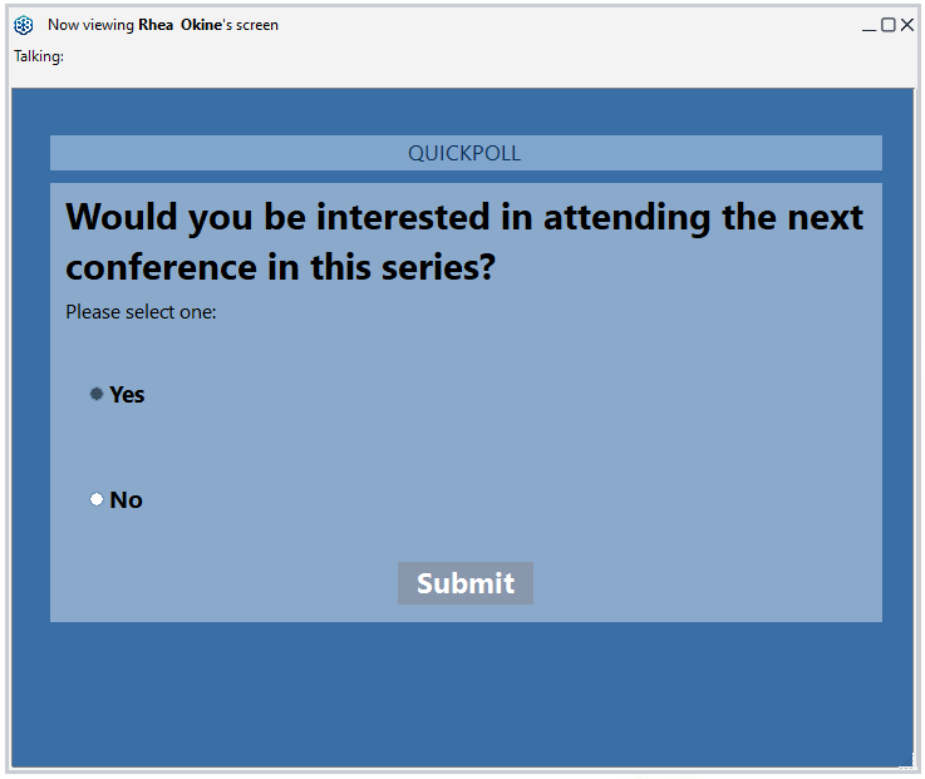


If you have any questions or comments for Speakers across the day, please expand the Questions Section on the GoToWebinar panel. You will not be able to see each others questions.

The Integrated Care Summit: Challenges and Best Practice



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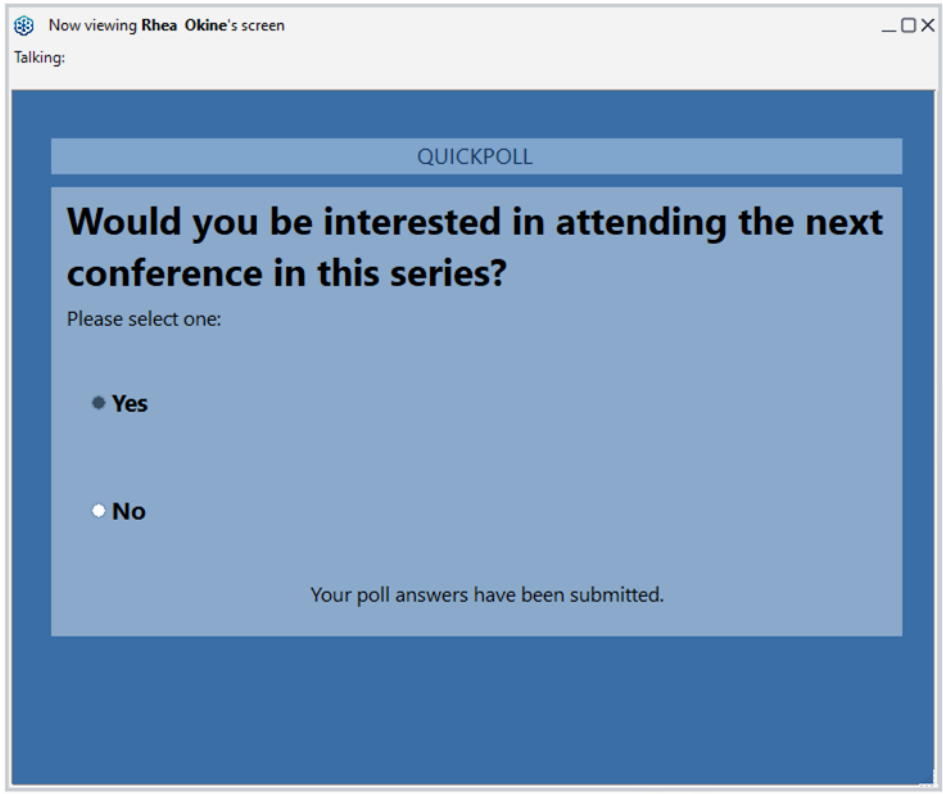

Once **Submitted** your screen will look like this

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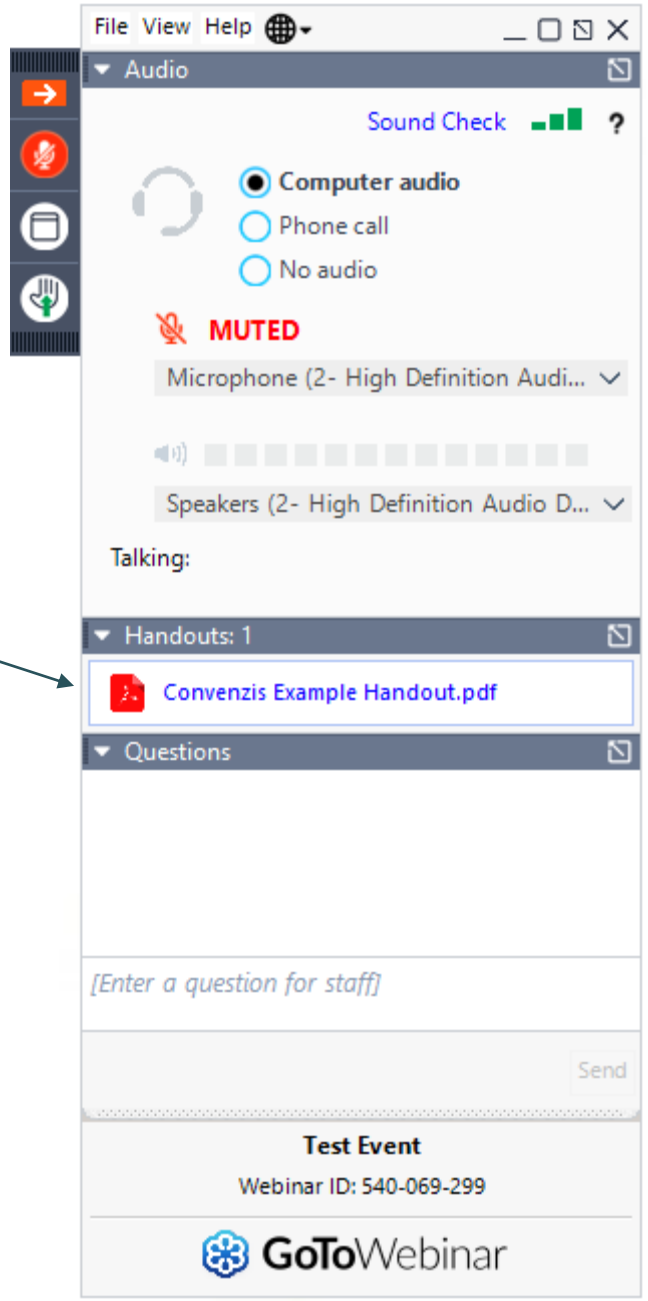
THE INTEGRATED CARE SUMMIT

2022

Expand the Handouts tab, and click on the Hyperlinked PDF. That will then open a document where you can view all of the Sponsor stands. Click on the Sponsor Logo to open their stand. There you will find free demos, downloadable assets and promotional material. You can also arrange meetings with the sponsors.



The Integrated Care Summit: Challenges and Best Practice

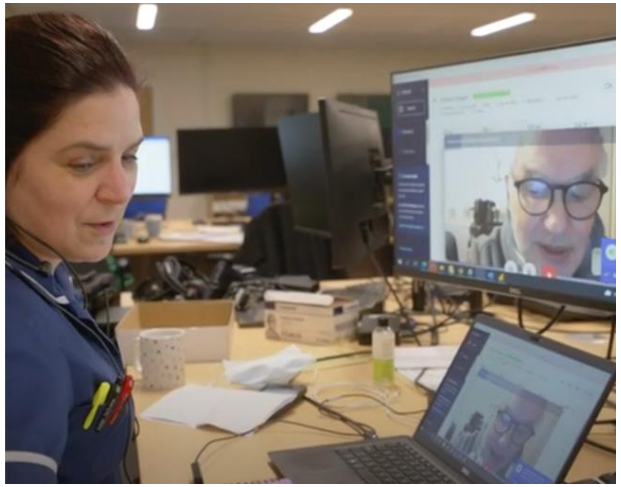
SPEAKING NOW

Dr Vin Diwakar

Medical Director for Secondary Care & Transformation
NHS England and NHS Improvement

I will be discussing…

"Next steps for Virtual Wards"



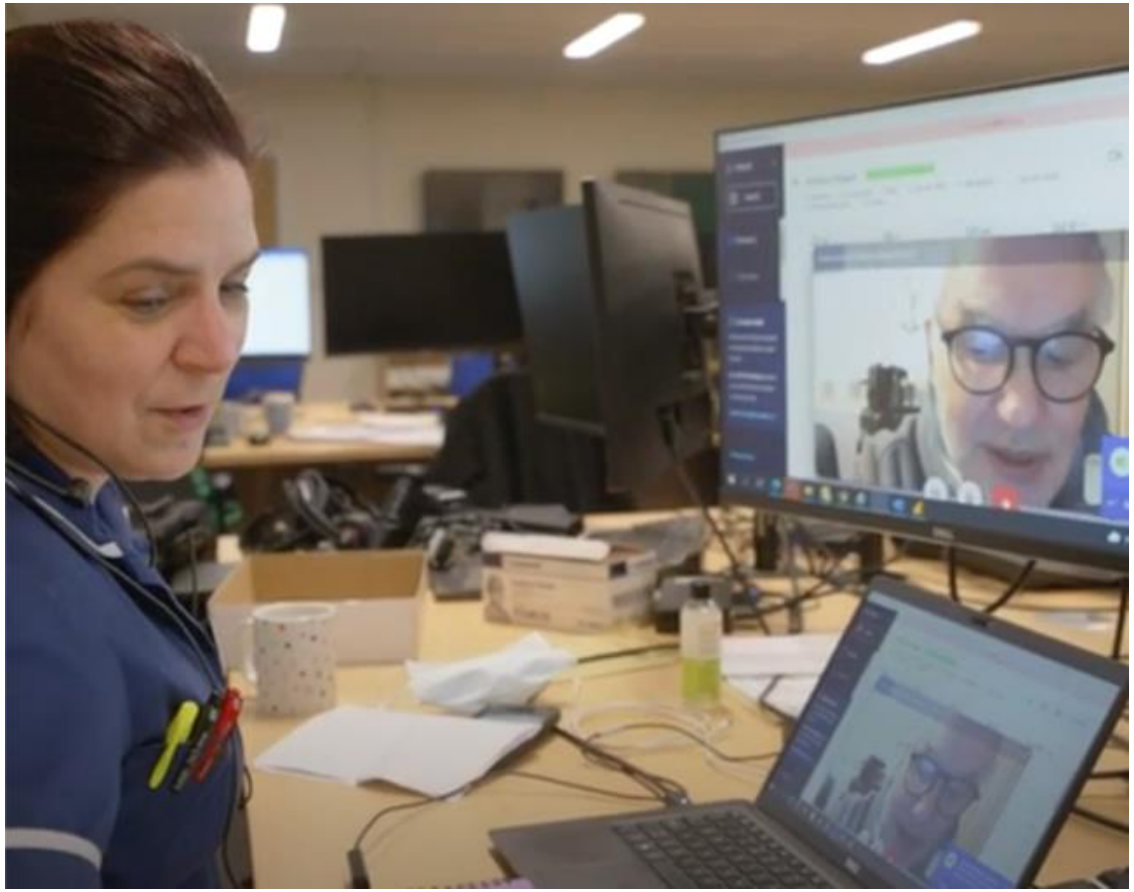

Virtual wards: story so far and what's next?

The Integrated Care Summit: Challenges and Best Practice

Dr Vin Diwakar
Medical Director for Secondary Care and Transformation, NHS England

November 2022

Play short film of NNUH’s virtual ward and patient story:
https://www.canva.com/design/DAFRSI6rm1k/rd_2V8r6DeTQ7S7bN0s0dw/watch?utm_content=DAFRSI6rm1k&utm_campaign=designshare&utm_medium=link&utm_source=publishsharelink



Benefits of virtual wards: summary

Why virtual wards are being developed at scale

There's a growing evidence base

- Virtual wards are supported by a growing evidence base that demonstrates benefits for patients, staff and systems.
- **But** we know that there are gaps that we need to focus on

Patient and staff experience is key in our early learning

- Patients on virtual wards have comparable if not better outcomes than those treated in hospital, including mortality and readmission[1]

We are continuing to evaluate the impact of virtual wards

- Build on work from pilot site evaluations – based on the programme theory of change
- Academic research for publication on NHS virtual wards, with a focus on equity and impact

Sources:
1. Norman, G (2022), Rapid evidence synthesis: virtual wards (hospital at home) for acute admissions, Health Innovation Manchester and National Institute Health Research
2. Leong MQ, Lim CW, Lai YF, Comparison of Hospital-at-Home models: a systematic review of reviews, *BMJ Open* 2021; Comparison of Hospital-at-Home models: a systematic review of reviews | BMJ Open
3. Elliot, S, Winter, G and Ridge, W (2021) Final Evaluation of the Leeds Virtual Ward (frailty) 210813 VW(F) Final Evaluation f1.1 - Virtual Wards Network - FutureNHS Collaboration Platform

Key findings from the evidence ‘review of reviews’

1. Higher levels of **patient satisfaction** (low quality evidence)
2. No significant difference or lower **mortality** (low to moderate quality evidence)
3. Inconclusive results for **length of stay** (moderate quality evidence)
4. Lower or comparable **readmissions** (low to moderate quality evidence)
5. Impact on **costs** was inconclusive (very low to low quality evidence).

Source: Leong MQ, Lim CW, Lai YF, Comparison of Hospital-at-Home models: a systematic review of reviews, *BMJ Open* 2021; Comparison of Hospital-at-Home models: a systematic review of reviews | BMJ Open

“We were over the moon when we realised we could have treatment at home rather than going to hospital.

The service the team provided was second to none and he was so much better when he was discharged”.

Relative of a virtual ward patient, Kent Community Health NHS Foundation Trust

“I am treated as part of the team, they always check that I am coping OK and not being overloaded

"They also check with [my wife] that she is OK with what they're proposing, so it's not being done to her but being done with her”

Unpaid carer and husband to a virtual ward patient

Definition

What a virtual ward is, and what it isn't

virtual ward

ˈvəːtʃʊ(ə)l wɔːd

A virtual ward is a safe and efficient **alternative to NHS bedded care**.

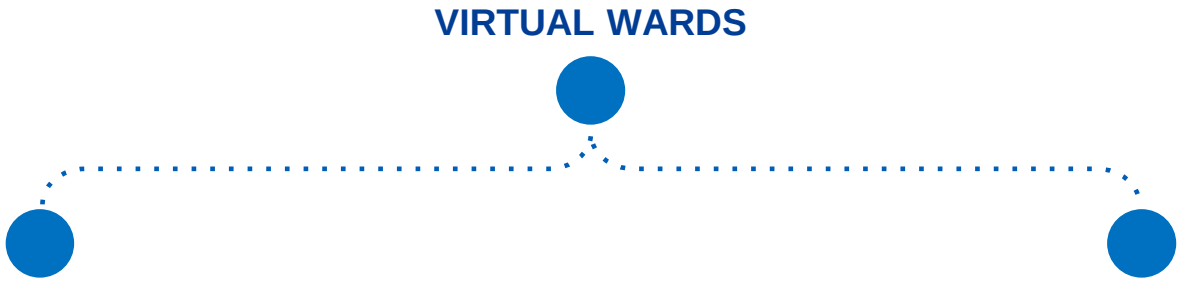
Virtual wards support patients who would **otherwise be in hospital** to receive the acute care and treatment they need in their own home.

This includes either **preventing avoidable admissions** into hospital, or **supporting early discharge** out of hospital.

NB: A virtual ward **is not** a mechanism intended for enhanced primary care programmes; chronic disease management; home intravenous or infusion services; intermediate or day care; safety netting; or proactive deterioration prevention.

Virtual wards in practice

What different models look like, and what happens on a virtual ward



	Mostly remote	Mostly face-to-face
	Based on technology-enabled remote monitoring and self-management, with minimal face-to-face provision	*Based on a blended model of technology enablement with face-to-face provision (Hospital at Home)*
What	• Personalised remote monitoring (that may be digitally enabled), with supported self-management and escalation pathways	• Hybrid service model that blends digital monitoring and face-to-face care to support patients with acute needs
How	• Digital remote monitoring service, or suitable digital alternatives • Early deterioration detection and recognition to trigger clinical input and responses from MDTs • Patient and carer enablement to self-monitor with escalation routes	• Digital remote monitoring and relevant service enablement • Care assessments, intervention planning and face-to-face support with senior clinical oversight and MDT support • Delivering acute-level interventions (i.e. screening, diagnostics, prescription and medicines reconciliation, IV therapies)
Who	**ARI pathway** • Adults with confirmed or suspected acute respiratory infections, who are stable or improving and are not living with moderate or severe frailty, but need ongoing monitoring	**Frailty pathway** • Adults aged 65 and over who have been clinically assessed to be frail and are experiencing an episode that requires acute intervention

National ambition in England

What the national ambition is, and how development and delivery will be supported

AMBITION AND RESOURCE

ICSs are asked to develop comprehensive plans and deliver virtual ward capacity equivalent to:

40-50 virtual ward 'beds' per 100k population

To support this two-year transformation, systems will have access to national SDF funding, covering:

£200m for FY22/23
£250m (match-funded) for FY23/24

Successful implementation will require systems to:

- maximise their overall bed capacity to include virtual wards
- prevent virtual wards becoming a new community-based safety netting service; they should **only be used for patients who would otherwise be admitted to an NHS acute hospital bed** or to facilitate early discharge
- maintain the most **efficient safe staffing** and caseload model
- manage length of stay in virtual wards through establishing clear **criteria to admit** and reside for services
- fully exploit **remote monitoring technology** and **wider digital platforms** to deliver effective and efficient care.

Updated Winter Resilience focus

- The NHS's recent letter on a winter resilience plan has a specific focus on managing demand and capacity.
- This includes a commitment to work with local areas to develop more bed capacity across the country, including through the use of virtual wards.
- As a result, the NHS has committed to working with local areas to increase the number of virtual wards
- ICSs are in the process of developing an additional 2,500 virtual ward 'beds' to support this winter, building on the current provision of virtual wards that already exist

Critical success factors when designing and scaling virtual wards across ICS footprints

Appropriate **clinical leadership and governance** in place at a system and provider level

A **competency-based approach**, avoiding assumptions about professional boundaries and early investment in workforce development and training

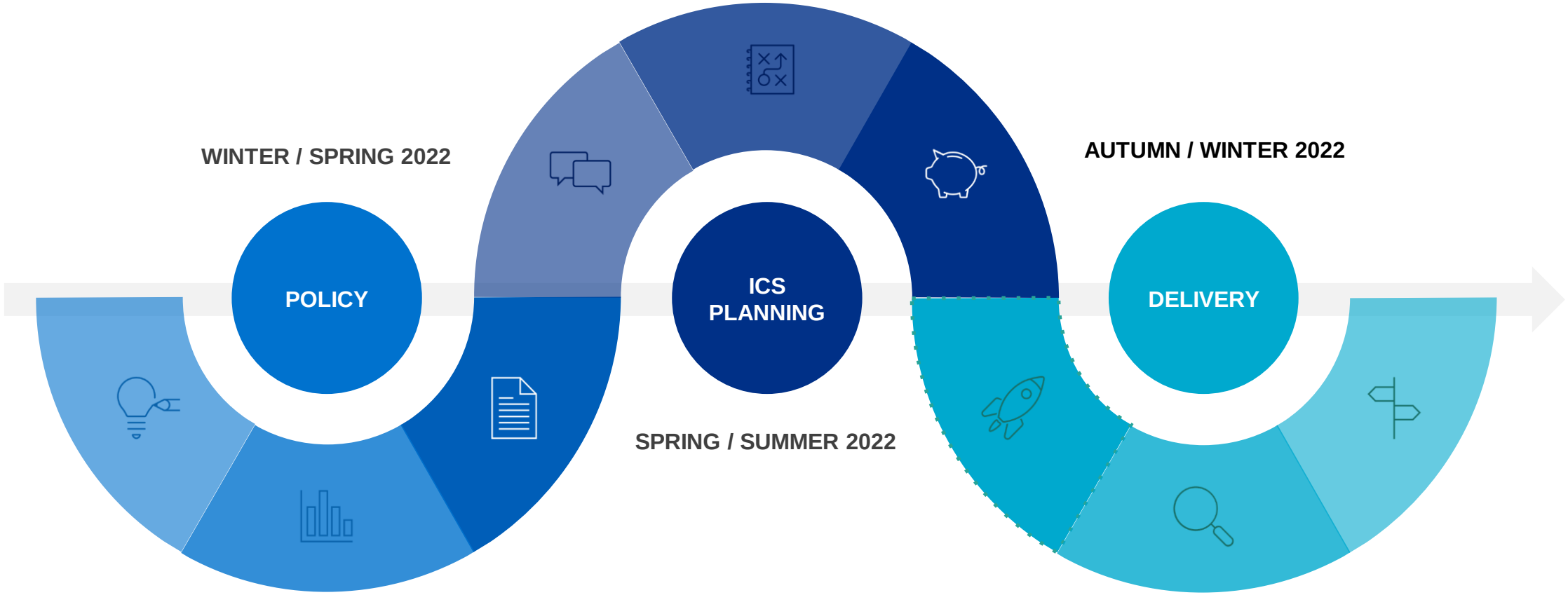
Integrated ICS and place based working across health and social care considering use of provider collaboratives

Remote monitoring technology and **wider digital platforms** to deliver effective and efficient care..

An **incremental approach to improvement** and growth

Virtual wards plans are in place in every ICS and we are collectively supporting more people each month

Around 10,000 people a month are being supported currently	Over 6,900 VW ‘beds’ in place currently	Over 200 services reporting activity	We are aiming that by December 2022 this increases to nearer to 20,000 people



What next?

Stabilise	• Continued focus on virtual wards with no change to commitment in 22/23 planning guidance • Connected ways of working • Develop a sustainable approach to virtual ward for the future
Energise	• Shared Learning through Communities of Practice and Clinical Summits • Creating the right resources to support implementation • Development of future virtual ward pathways
Realise	• A focus on embedding virtual ward into system capacity and extending pathways • Development of national virtual ward evaluation strategy • A focus on workforce development

Get involved and share your stories

- Visit our website: england.nhs.uk/VirtualWards
- Community of practice – every Thursday at 12 noon
- Clinical summits – next is 24 November 2022
- Tweet using #VirtualWards
- Speak to our team: england.virtualward@nhs.net
- FutureNHS: future.nhs.uk/NationalVirtualWards/

The Integrated Care Summit: Challenges and Best Practice

UP NEXT...

The Integrated Care Summit: Challenges and Best Practice

SPEAKING NOW

Dr Simon Wallace

CCIO

Nuance Communications

Dr Jay Mehta

GP Registrar and CMIO

NHS

We will discuss…

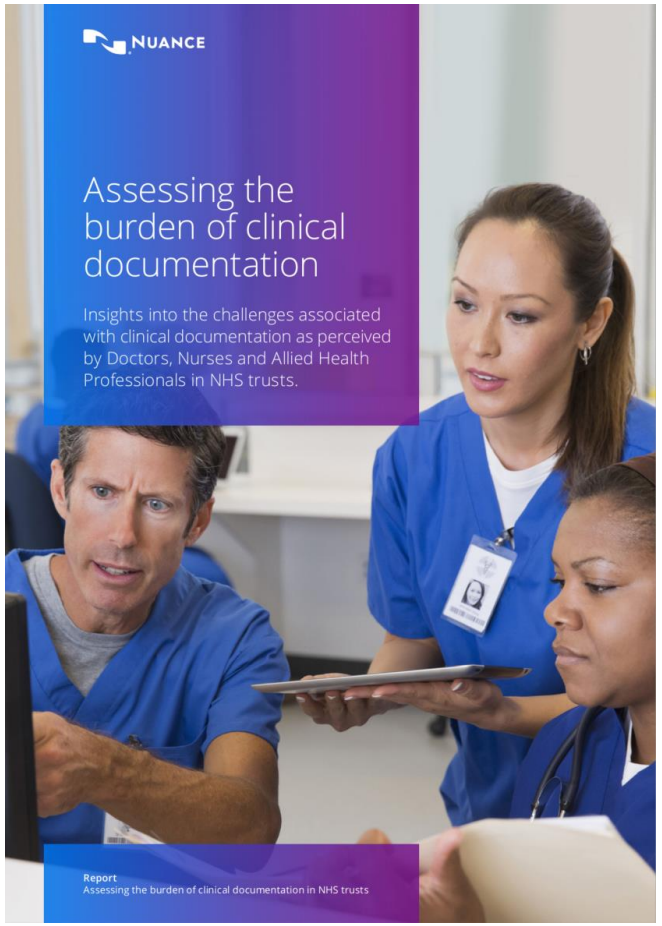
"Assessing the burden of Clinical Documentation"

New Research: Challenges of NHS Clinical Documentation

Presenter:
Dr Simon Wallace, CCIO at Nuance

2022 Nuance and Ignetica Study

Assessing current challenges and how clinician's perceptions have changed in the last 7 years



Our study was developed to assess the current challenges working with clinical documentation for clinicians in NHS England trusts.

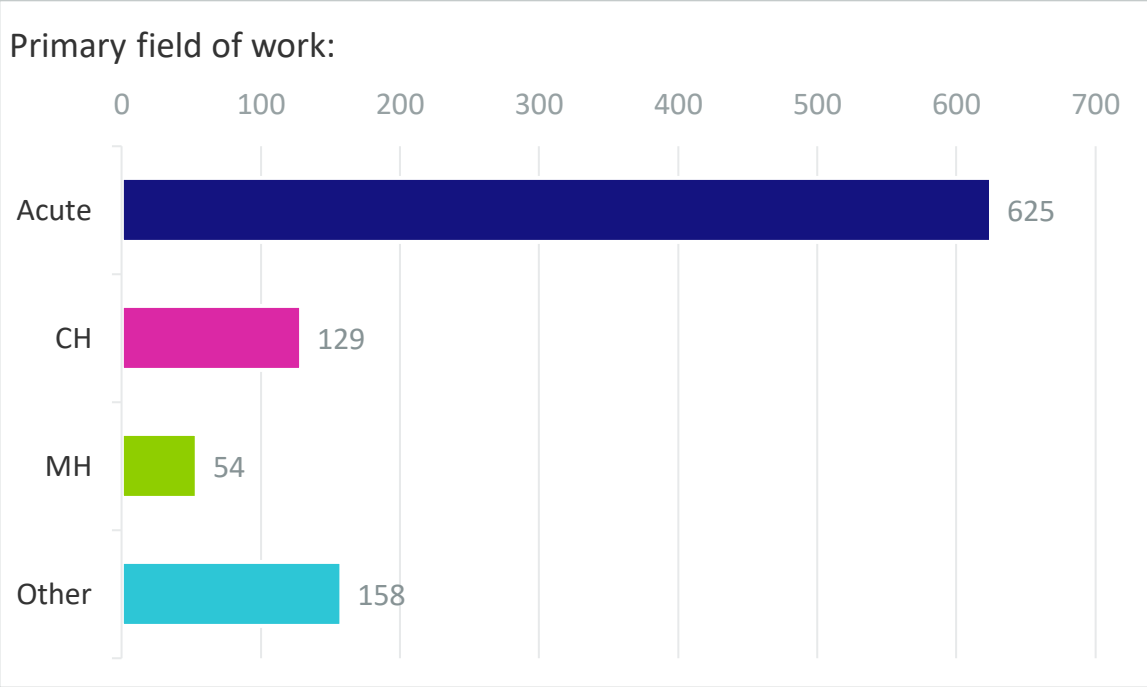
- How much time are Doctors, Nurses and Allied Health Professionals (AHP) spending on clinical documentation?
- How often is clinical data not available, sufficiently accurate, or complete?
- How do these findings compare to a very similar study undertaken in 2015?

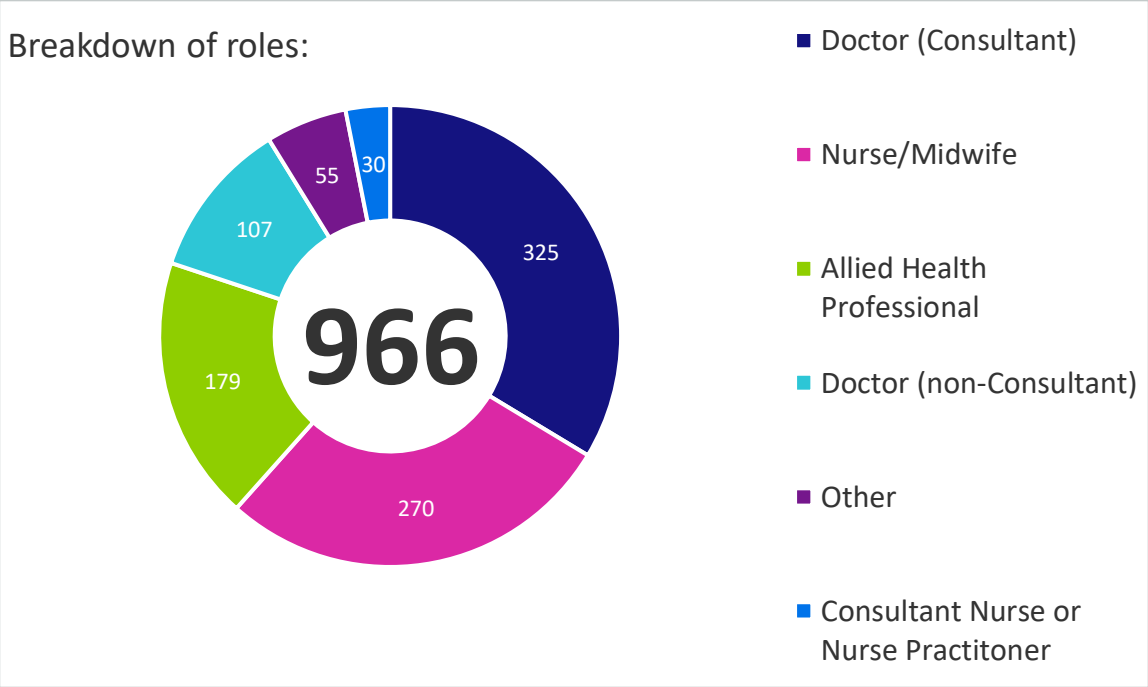
www.nuance.co.uk/report

ignetica

Survey demographics

Five NHS trusts participated in the survey between April and July 2022





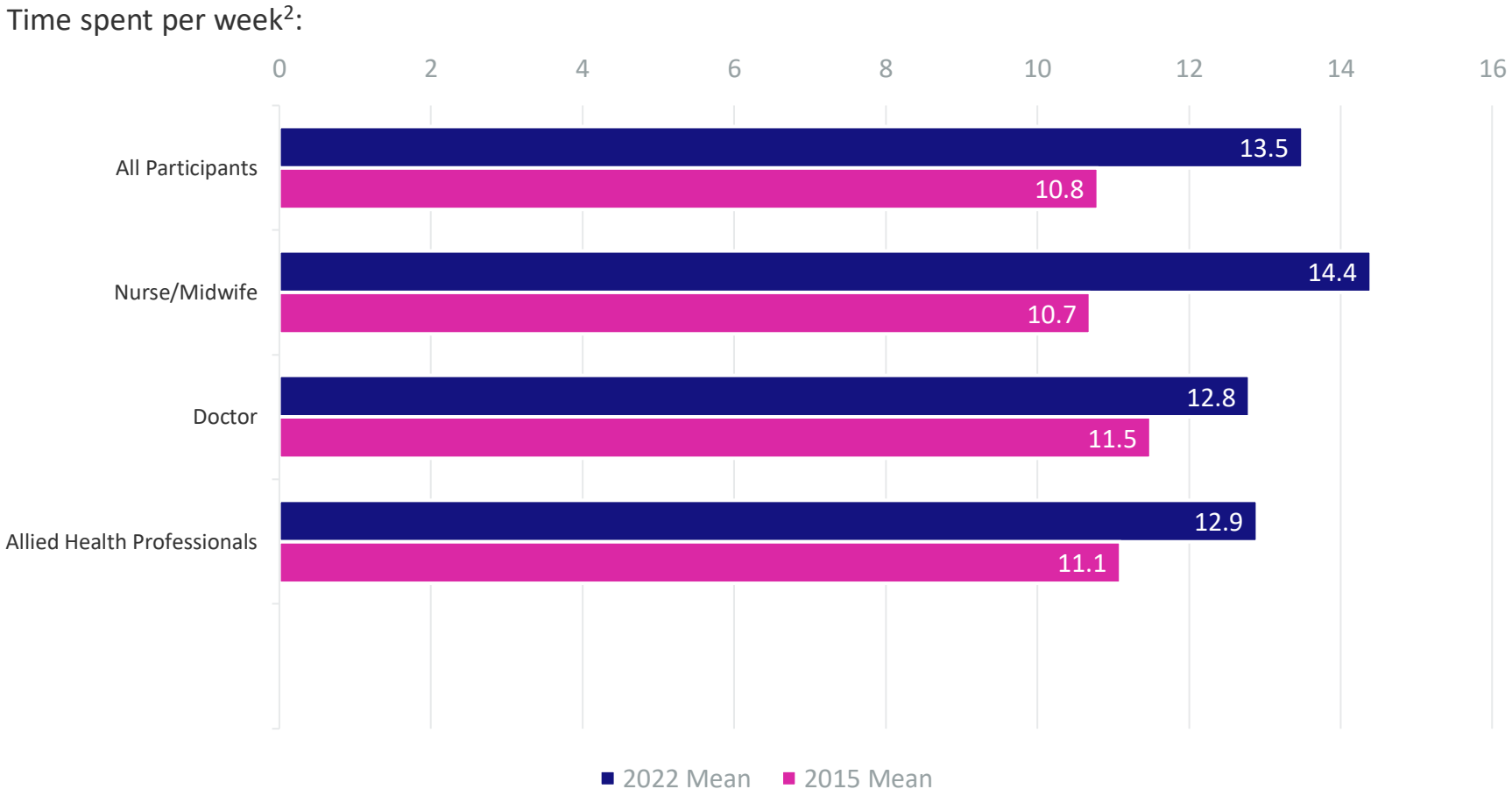
- Participating Trusts had stable electronic noting systems in place. (Either best-of-breed or trust wide EPR.)
- The published study data is aggregated and anonymised.
- ‘Other’ option incl. specialist Nursing (31%), different types of therapist (21%) and clinical imaging (13%)

25% more time on clinical documentation than 7 years ago

Clinicians spend a third of working hours[1] on clinical documentation

- Healthcare professionals spend an average of 13.5 hours per week on clinical documentation[2]

1. 37.5 Average working hours per week.
2. Adjusted for WTE.



Use of pen and paper has halved in the last 7 years

In the 7 years since the last study, the use of electronic systems has increased substantially

- Pen/paper has reduced from over 80% to around 40%
- Keyboard & mouse has risen from 55-63% to now 90-95%
- Tablet and touch has not materially changed in IP or OP.
- Those indicating use of speech (note this could be any type of speech recognition) is significantly higher than in the 2015 study, particularly in Outpatient settings.

Share of respondents..

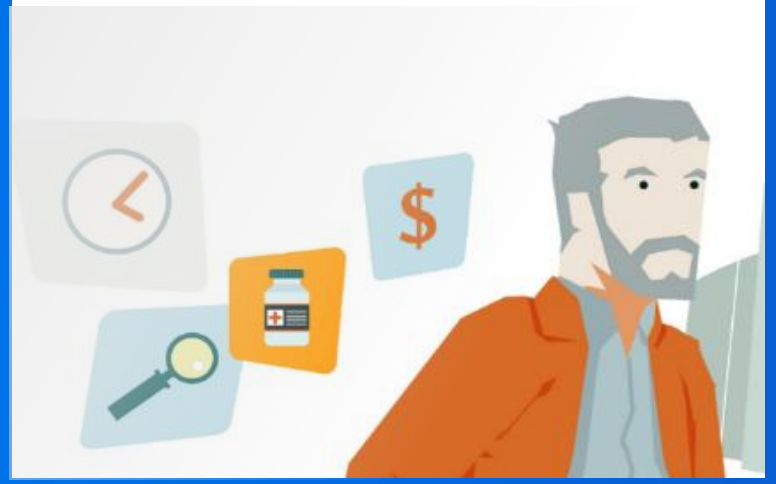
Modality (in inpatients)	2022	2015
Pen & Paper	41.0%	89.4%
Keyboard & Mouse	95.0%	55.3%
Tablet & Touchscreen	13.7%	12.8%
Dictation & Transcription	8.9%	17.0%
Speech Recognition	13.0%	0.0%
n=	439	94

Modality (in outpatients)	2022	2015
Pen & Paper	37.9%	81.0%
Keyboard & Mouse	90.5%	63.3%
Tablet & Touchscreen	6.6%	5.1%
Dictation & Transcription	35.6%	38.0%
Speech Recognition	37.5%	3.8%
n=	317	79

More key findings from the survey

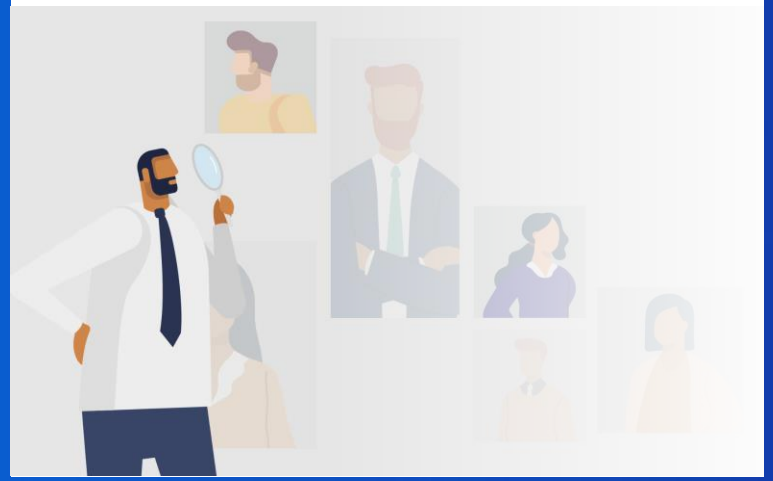
3.2

hours per week spent out of hours on clinical documentation (Consultant Doctor average was 4.7 hrs.).



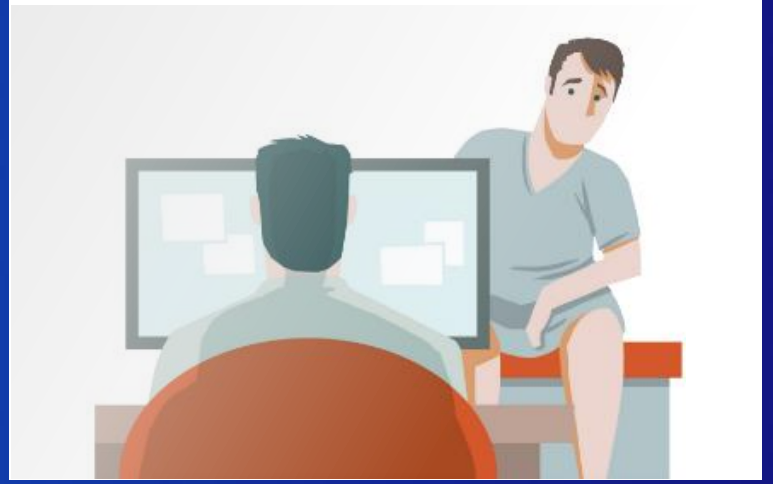
62

minutes per day spent searching for information.



68%

felt it was likely or very likely their notes would be more complete with more time.



Verbatim comments

Factors impacting the time spent on clinical documentation

"Move to paperless"

"Typing takes significantly longer than writing in notes"

"Slow IT systems/access to computers etc."

"Significant time is wasted searching through EPR for relevant clinical information"

"Trying to find information on computer is significantly slower than looking for it in paper notes."

"Lack of personalised secretarial support adds significantly to administrative tasks"

"Multiple different platforms used"

The Challenge of Clinical Documentation

85% of NHS healthcare professionals think the burden of clinical documentation is a significant contributor to burnout

Reference: Nuance clinician burnout survey, 2020

US research, such as this April 2021, the Journal of the American Medical Informatics Association article has linked clinician burnout to increased documentation, following the adoption of the EHR (Electronic Health Record) in the US.

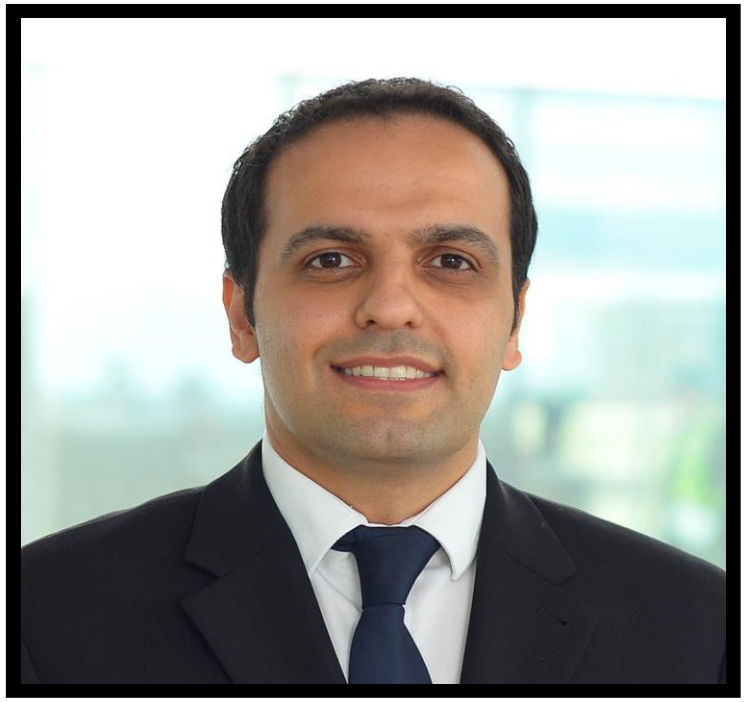
Q&A with Dr Jay Mehta

Thank you, any questions?

Email: info.healthcare@nuance.com

The Integrated Care Summit: Challenges and Best Practice

SPEAKING NOW



Wes Baker

Director of Strategic Analytics, Economics & Population health Management - Mersey Care NHS Foundation Trust

I will be discussing…

"Population Health Management"

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NHS Foundation Trust

Community and Mental Health Services

System P - A preventative, predictive, precise approach to population, patient and person in a joined-up intelligence led system

“Enabling us to programme equity, rather than tackle inequality”

Wes Baker | Director of Strategic Analytics, Economics and Population Health Management

What is System P?

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Community and Mental Health Services

CIPHA uses a wide range of detailed and mostly real-time data*

REAL-TIME OPERATIONAL DATA FEEDS

GP Practices

GP Practices

Patient / Citizen

- Survey data
- About me

Summaries

- Cancer
- Urgent Care
- Mental Health

Administration	Contraception & HRT	Smoking	Problems List	Diabetes Diagnosis
Alcohol Exercise Diet	ECG Pulmonary	Urinalysis	Social History	Contraindications
Allergies	Family History	Immunisations	Physiology Tests	Recent Tests
Glucose / HbA1C	Heamatology	Active Problems	Investigation Admin	Active Problems
Blood Chemistry	Height & Weight	Encounters	OTC Prophylactics	Encounters
Blood Pressure	Medication Issues	Obstetric Procedures	Medication Admin	Repeat Medications
Cervical Cytology	Other Diagnostics	Operations	Referrals	Microbiology
Child Health Data	Other Therapeutics	Cytology	Admissions	
Chronic Disease Data	Pregnancies.	Other Pathology	Past Problems	

ANONYMISED DATA

PSEUDONYMISED DATA

IDENTIFIED DATA

EXTERNAL DATASETS

- NHS Test and Trace
- NIMS (Vaccinations)
- Commissioning datasets
- Record-Level Secondary Uses Service (SUS) da
- SITREP (Strategic Information Platform)
- UK Health Facts published data
- 111 queries
- Reference
- Care home bed availability
- Social determinants
- Johns Hopkins' risk assessments

MPI	Theatre Visits	Alerts
Waiting Lists	Orders / Results	Contacts
ADT	Reports	Diagnoses
Referrals	Medications	Procedures
Appointments	Correspondence	Involved Profession
A&E Attendances	Clinical Summary	

Acute Care

MPI
CPA Details
Diagnoses
Clinical Notes
MH Act
Risks
EIP

Mental Health

MPI
Immunisations
Care Plans
Problems
Interventions
Diagnoses
Medications

Community

MPI	Contacts
Referrals	Professionals
Events	Services
Case Details	Care Plans
Risks/Hazard/Alerts	Disabilities
Protection Notices	

Social Care

MPI
Clinical Summary

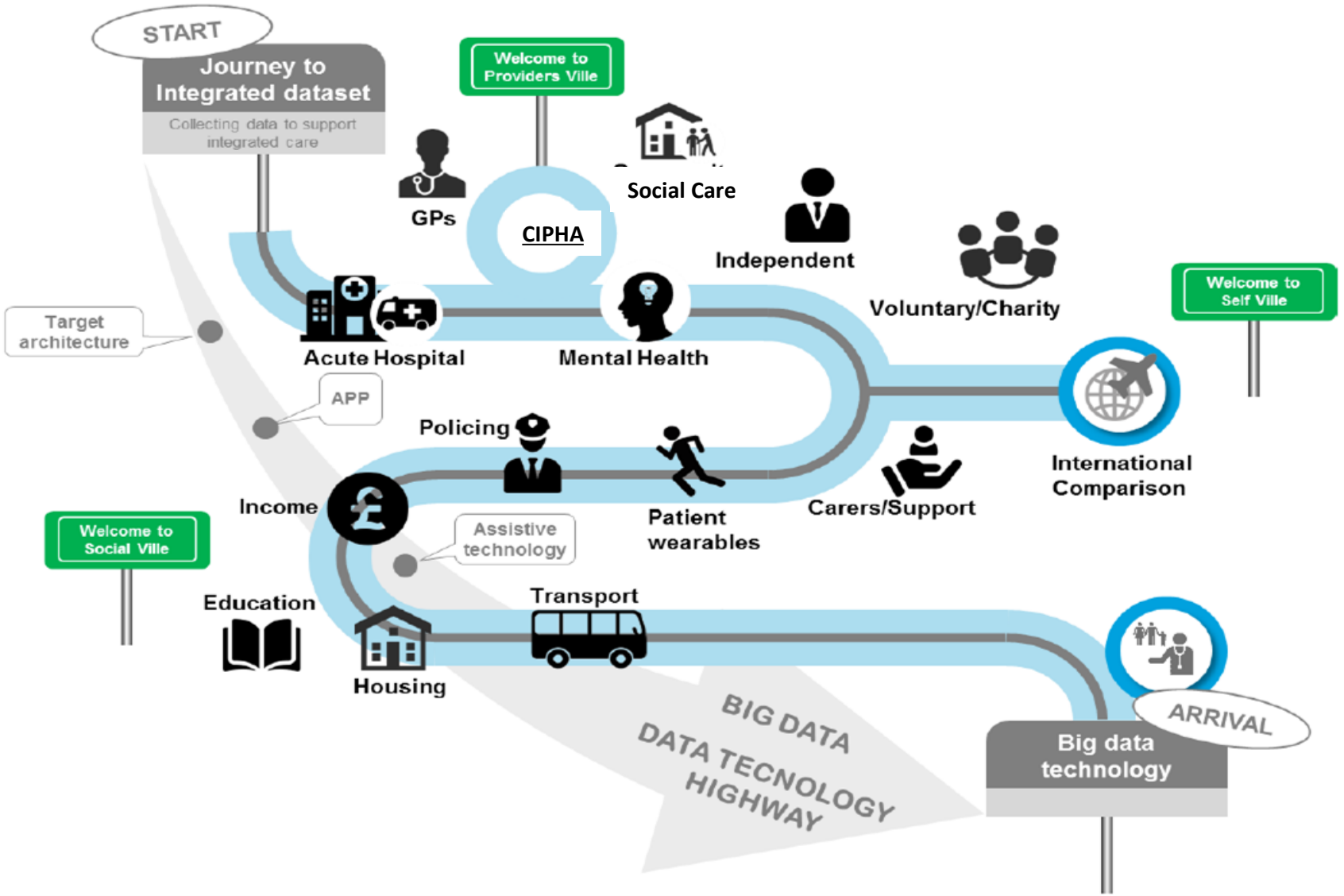
OOH / ITC

Note: not all care systems have all data feeds yet, but the majority are in place.

Population Health Management relies on integrated data taken from a wide range of sources

NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services



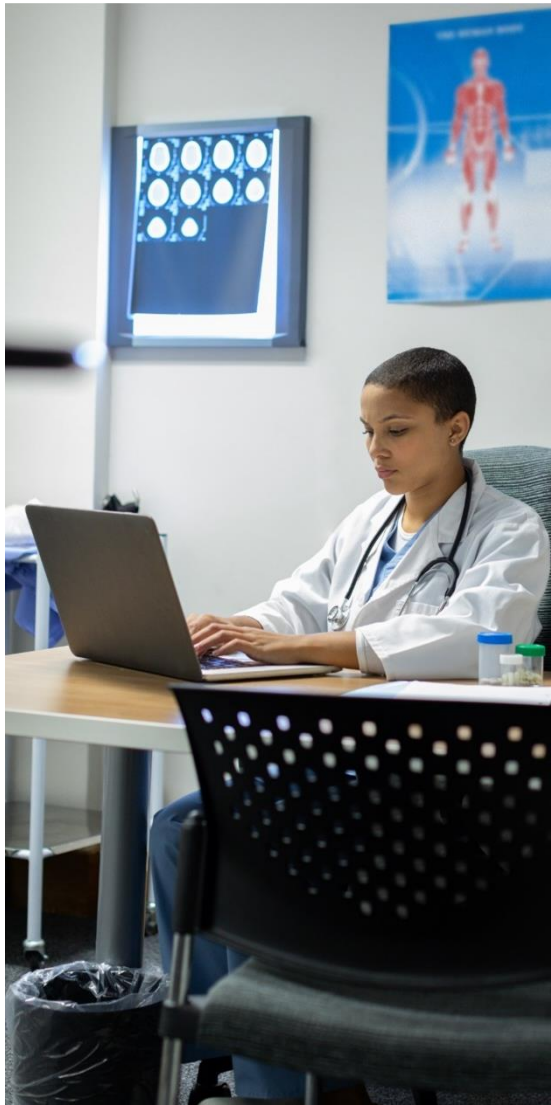
System P – Hackathon

NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

1. Hackathon – 10 November 2021

1. **Hackathon – 27 April 2022**



PA Bringing Ingenuity to Life

How are the Complex Lives segment defined

Mersey Care NHS Foundation Trust

Community and Mental Health Services

In Cheshire and Merseyside ICS 11,857 individuals (0.6% of the population) were identified as belonging to the Complex Lives segment. In this pack we describe the characteristics of people in this segment, before moving on to describe their other healthcare issues and how they use services.

Patient characteristics

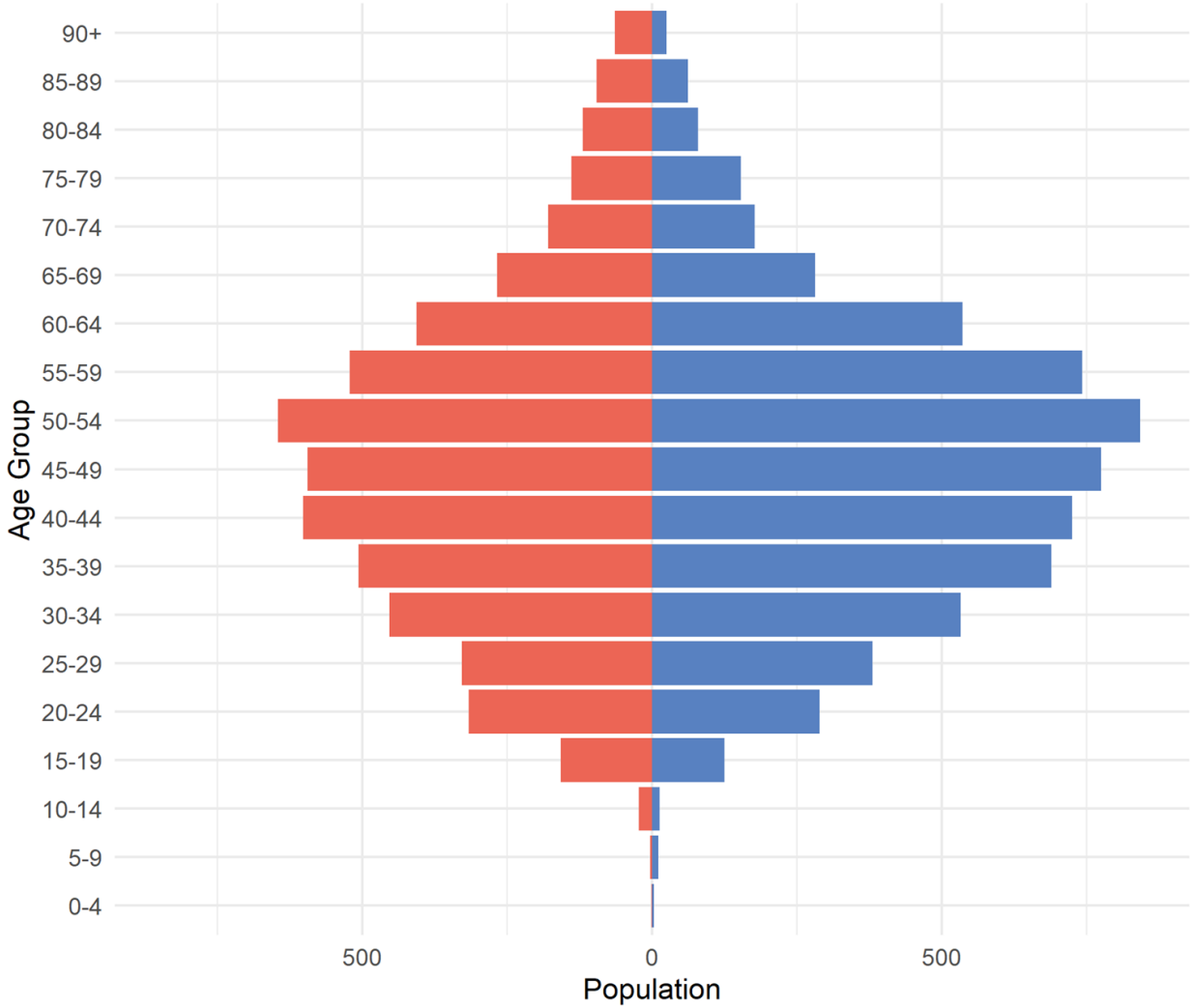
Age and gender

Mersey Care
NHS Foundation Trust

Community and Mental Health Services

- For the Complex Lives segment the mean average age of these patients is 48 (interquartile range from 36 to 58)

- Gender splits within the segment are 54% male and 46% female.



Patient characteristics

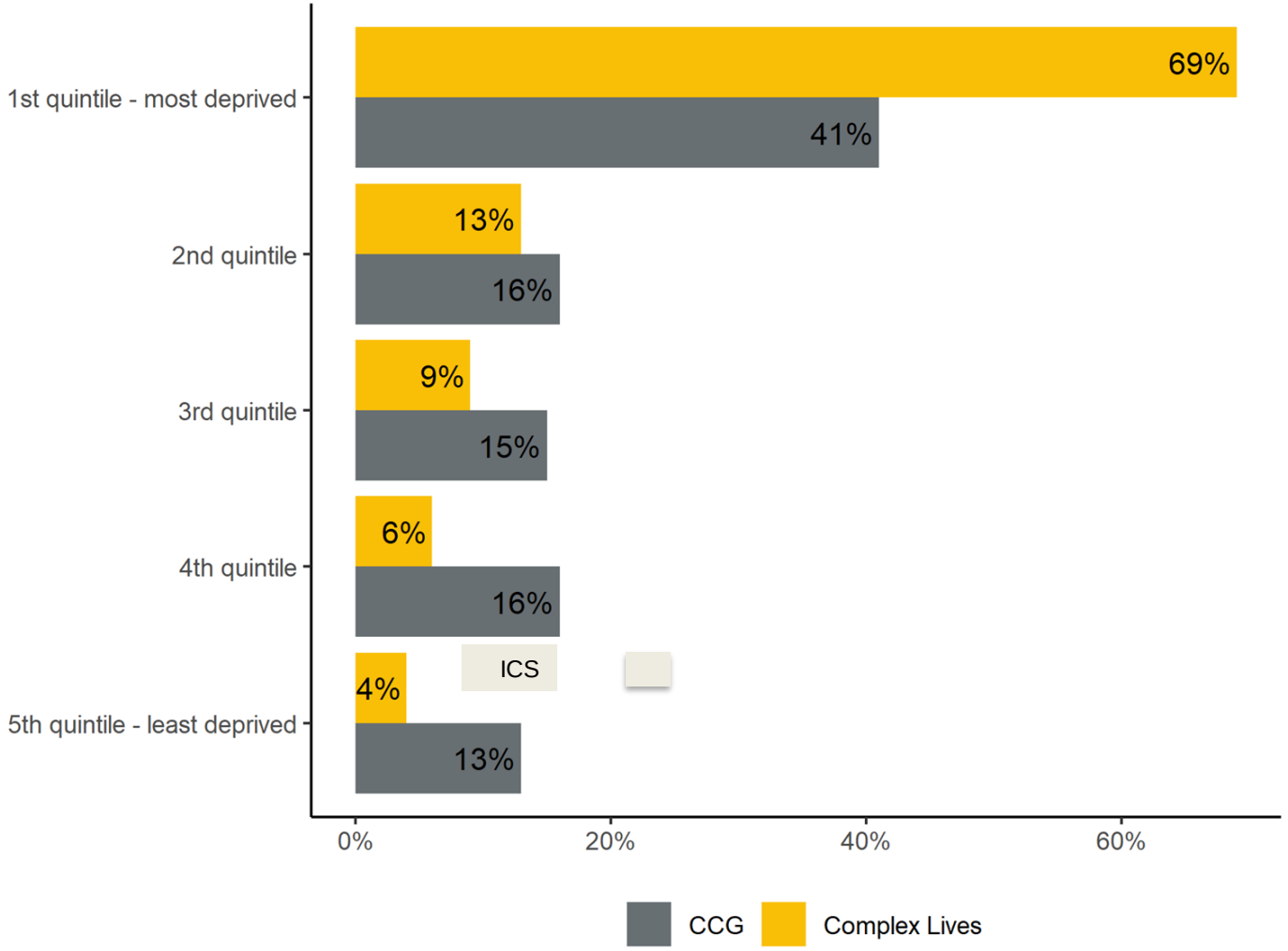
Deprivation

Mersey Care NHS Foundation Trust

Community and Mental Health Services

Those with Complex Lives are more likely to reside in areas of higher deprivation. 69% of the segment live in the most deprived quintile.

Proportionately, this is 1.7 times the share of the CCG population living in the most deprived quintile.



Patient characteristics

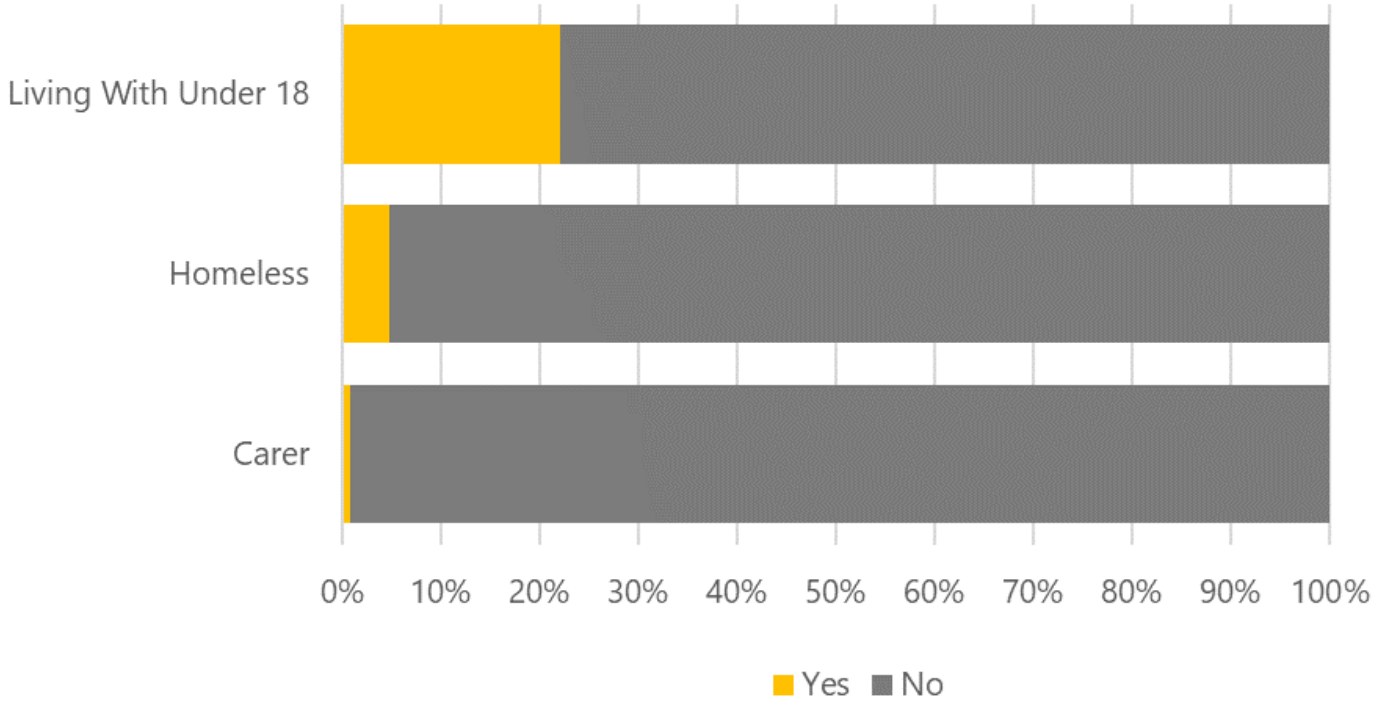
Living arrangements

Mersey Care
NHS Foundation Trust
Community and Mental Health Services

Those in the Complex Lives segment are found to be living with, on average, 1.6 other people. Therefore, beyond the Complex Lives individuals already identified, an additional estimated 18,473 people are also affected by Complex Lives. A number of these will be children.

For the Complex Lives segment 2,424 people (22%) are identified as living in a household with someone under 18.

5% of the segment have experienced homelessness in the last 2 years and 1% have caring responsibilities.
44 people were found with a status of asylum seeker.



Patient characteristics

Geography

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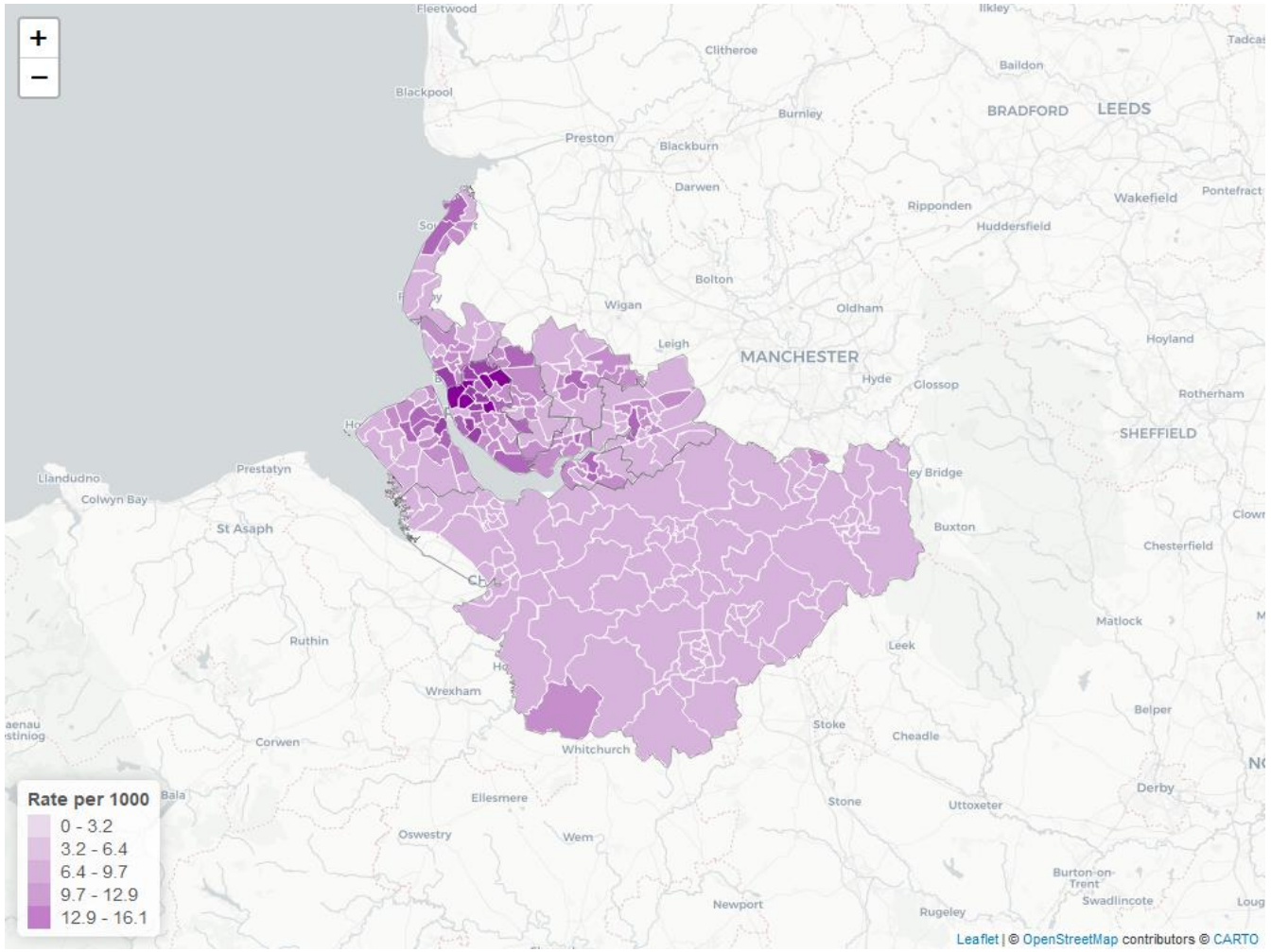
NHS Foundation Trust

Community and Mental Health Services

The map shows, for wards within the ICS, The rate of Complex Lives individuals per 1,000 population.

Areas with some of the highest density for Complex Lives are:

- Norris Green (Liverpool)
- Everton (Liverpool)
- Kirkdale (Liverpool)



Due to the low sign up of practices in Cheshire CCG rates in this area will be artificially low.

Patient characteristics

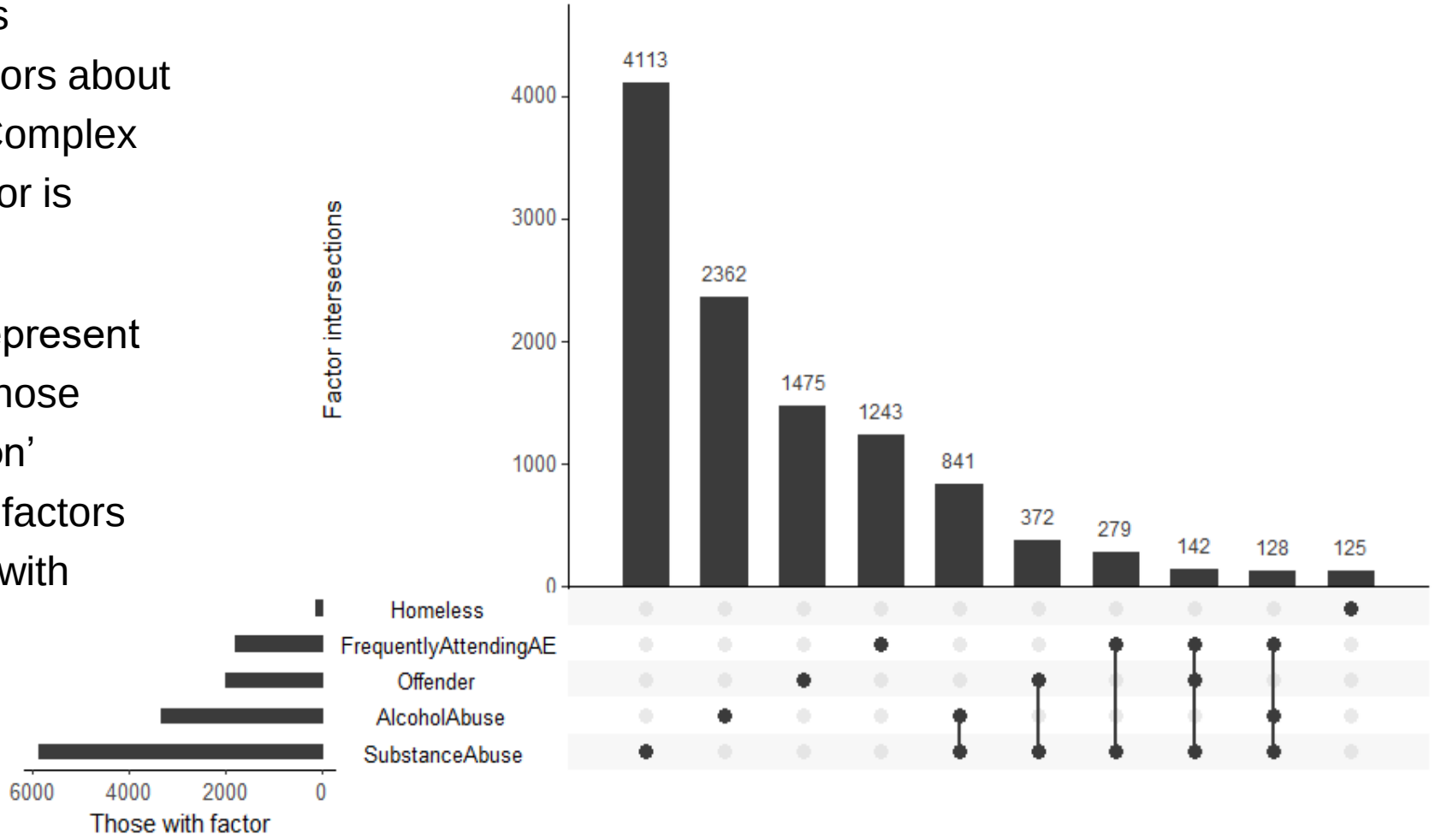
Factors

Mersey Care
NHS Foundation Trust

Community and Mental Health Services

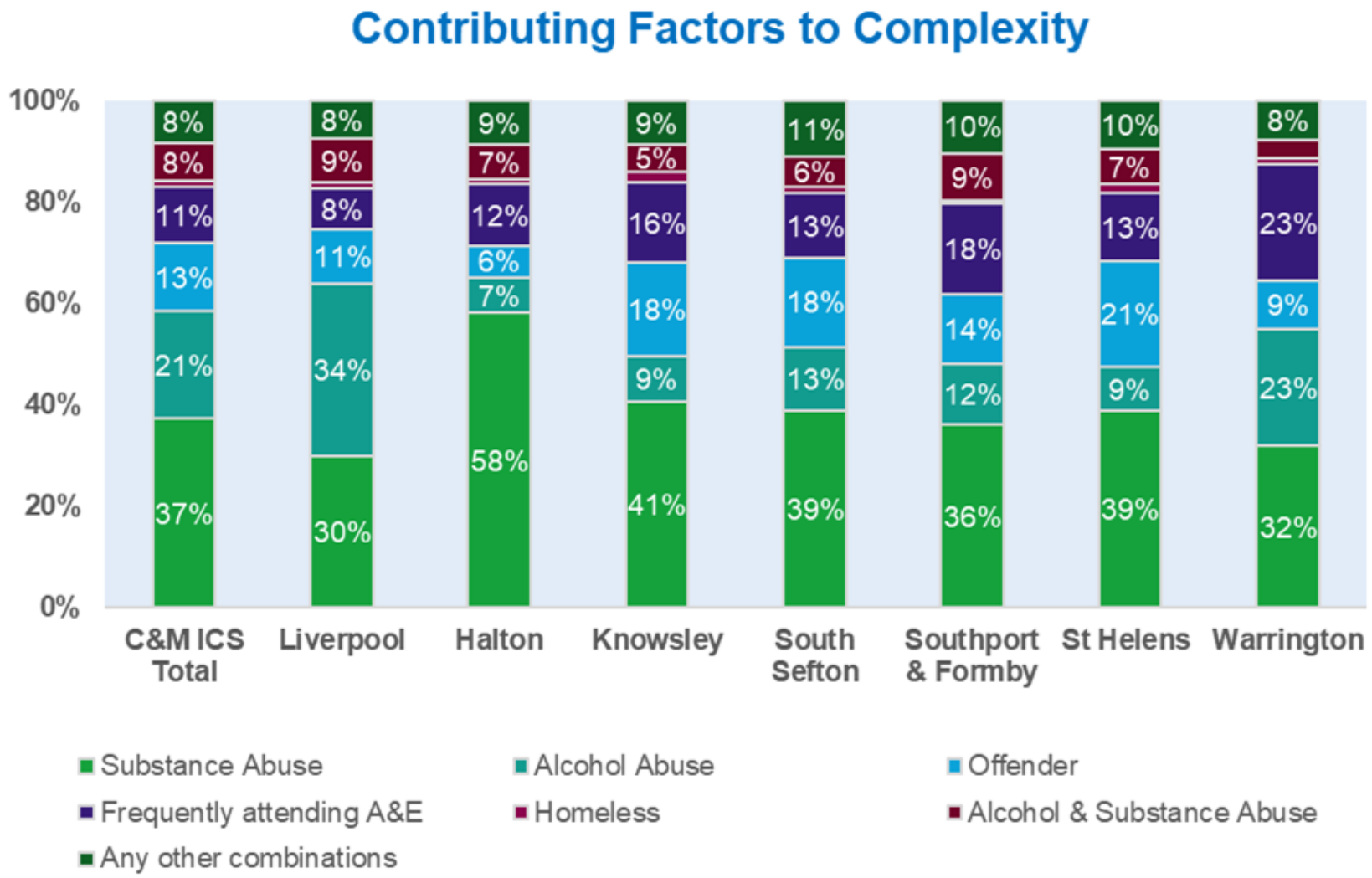
The definition for a individual to be assigned to the Complex Lives segment relates to certain factors about that person. For those in the Complex Lives segment the largest factor is substance abuse.

The ‘Those with factor’ bars represent all those in the segment with those factors. The ‘Factor intersection’ represents the combination of factors and the number of individuals with those combinations.



Characteristics
Contributing factors

Mersey Care NHS Foundation Trust
Community and Mental Health Services

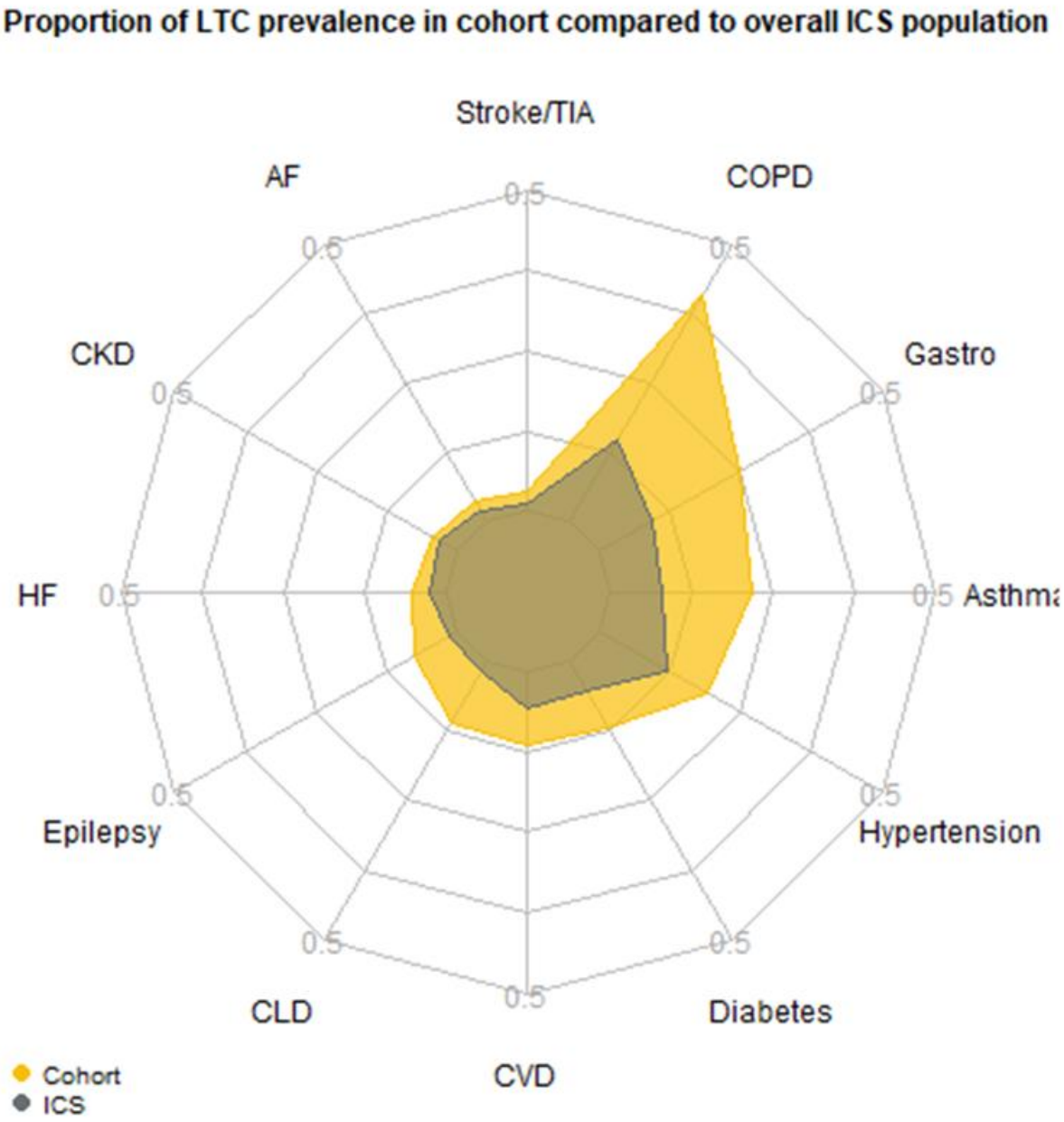


Health Care Conditions

LTCs in the population

- For the specified long term conditions a comparison of prevalence rates is made between those in the Complex Lives segment and the total population (aged 15+). This indicates the scale of the difference in these disease areas between the segment and the total population.

- The scale shows the rate per person so 0.5 represents prevalence of 50% of people.



Health and care use

A&E services

Mersey Care
NHS Foundation Trust
Community and Mental Health Services

- Those in the Complex Lives segment attend A&E services on average **2.9** times per person, per year. This is much higher than the total population who attend A&E services **0.4** times per person, per year. Emergency Departments are the most used A&E service and also the service where there is the greatest disparity in use between segment and total population. In a year **61%** of people in the Complex Lives segment attend an A&E service. For the total population the same figure is **22%**

- When attending A&E services the average cost per attendance is **£153** for those in the Complex Lives segment. This is **10%** higher than the average cost per attendance for the total population

- Where a clinical reason for attending A&E has been recorded this identifies that for the Complex Lives segment common reasons for attending A&E relate to *Trauma / musculoskeletal* or *Psychosocial / Behaviour change* problems.

Cost information is derived from 21/22 national prices. Activity without a national price is excluded when calculating average costs. There is no national price for Walk in centre attendances.

Health and care use

Emergency admissions

Mersey Care NHS Foundation Trust

Community and Mental Health Services

- On average those in the Complex Lives segment have 1.1 emergency admissions per person, per year. This is again much higher than the total population who have on average **0.1** emergency admissions per year

- **40%** of people in Complex Lives segment have an emergency admission in a year. For the total population the same figure is lower at **7%**.

- The average emergency admission cost is **£2,152** for Complex Lives compared to **£2,141** for the total population.

- When those in the Complex Lives segment are admitted as an emergency common reasons for admission relate to *Poisoning Toxic Effects Special Examinations Screening and Other Healthcare Contacts* and *Treatment of Mental Health Patients by Non-Mental Health Service Providers*.

Cost information is derived from 21/22 national prices. Activity without a national price is excluded when calculating average costs. Maternity admissions are excluded from analysis on emergency admissions

Health and care use

Planned care

Mersey Care
NHS Foundation Trust

Community and Mental Health Services

- Those in the Complex Lives segment use more planned admissions, both as electives and as daycases, on average per person, per year. They also use more outpatient attendances

- In a year **15%** of people in Complex Lives segment have a planned admission. For the total population the same figure is **7%**. For outpatient attendances **63%** of those in the Complex Lives segment attended at least one outpatient appointment in a year compared to **35%** for the total population

- For elective planned care the Complex Lives segment are often admitted with a reason of *Orthopaedic Non-Trauma Procedures* . In daycase admissions their main reason for admission is related to *Digestive System Endoscopic Procedures*. For outpatients their most common clinical specialty is *Gastroenterology* (first attendances) and also *Gastroenterology* (follow-up attendances).

Planned admissions are elective admissions with an overnight stay. Daycase admissions are planned admissions with admission and discharge on the same day. Regular Attenders are excluded from this analysis due to inconsistent coding. Cost information is derived from 21/22 national prices. Activity without a national price is excluded when calculating average costs.

Health and care use

Mental health

Mersey Care NHS Foundation Trust

Community and Mental Health Services

- On average those in the Complex Lives segment have **7.7** mental health contacts per person, per year. This is much higher than the total population who on average have **0.3** contacts with mental health services per year

- **53%** of people in the Complex Lives segment have an contact with mental health services in a year. For the total population the same figure is only **4%**

- When those in the Complex Lives segment are in contact with mental health this most commonly involves contacts with *Community Mental Health Team – Functional* or *Crisis Resolution Team/Home Treatment Service* teams.

No cost information is available for mental health data.

Health and care use

Community services

Mersey Care
NHS Foundation Trust

Community and Mental Health Services

- On average those in the Complex Lives segment have **7.2** contacts with community services per person, per year. This is higher than the total population who, on the same basis, have **1.7**

- **30%** of people in the Complex Lives segment are in contact with community services in a year. For the total population the figure is **21%**

- The most used community service for the Complex Lives segment is *District Nursing Service*.

Health and care use

Social care

Mersey Care
NHS Foundation Trust
Community and Mental Health Services

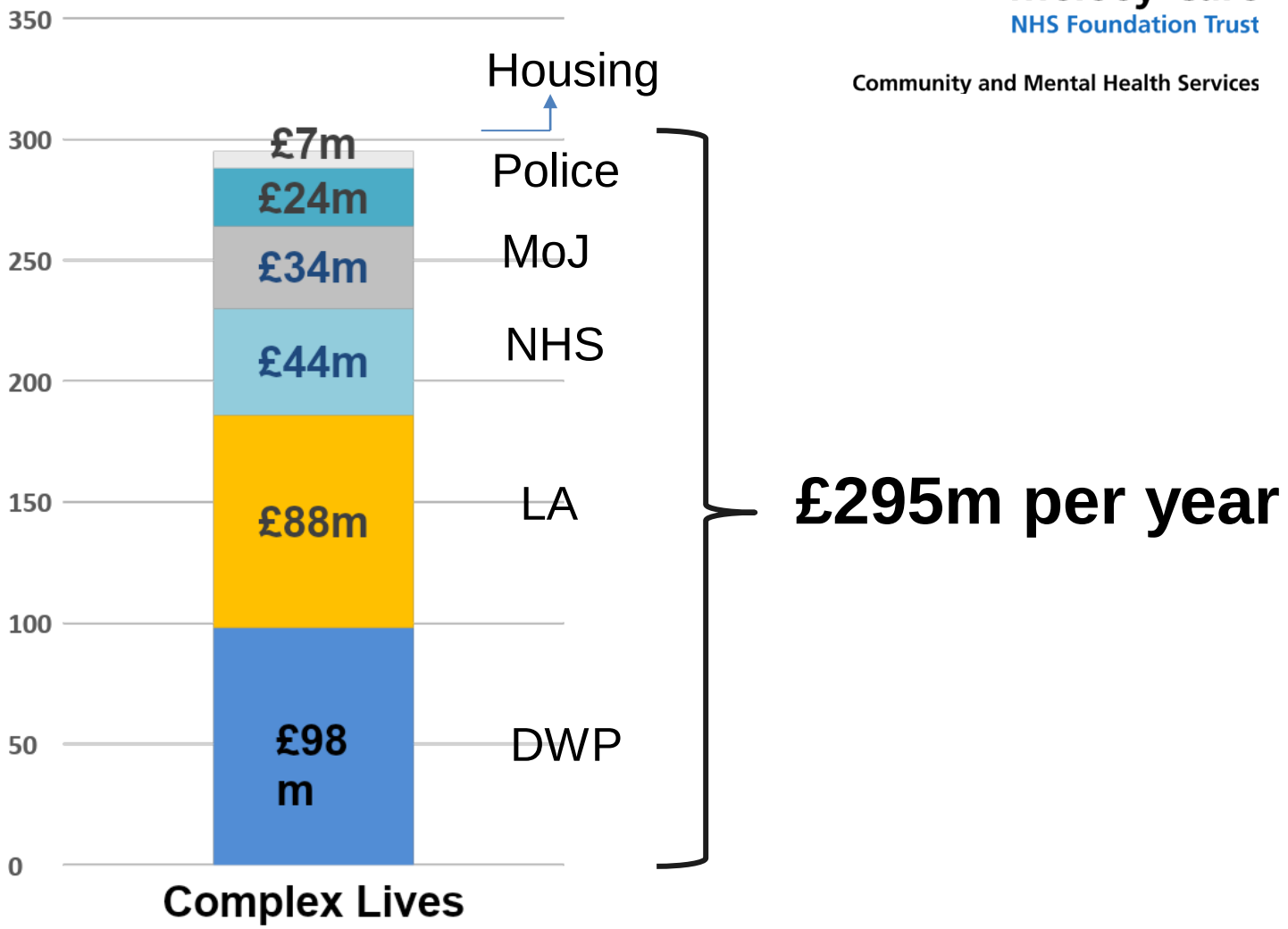
- From available data there were on average **0.15** of the Complex Lives segment known to social services in the last year. More than the total population where the same figure is **0.02**. However, social services data should be viewed as indicative and treated with caution. A recent review of the data indicated concerns with the data and further work is already underway to improve the consistency and quality of social care data

- Social services data includes information collected by councils and does not include services purchased directly by patients or provided by the voluntary sector.

The CIPHA platform gives us the opportunity to network intelligence consistently across C&M.

System P provides the methodology and approach to using this practically to effect change.

Each year C&M ICS, we spend c.£295m to support c.11,857 people with complex lives

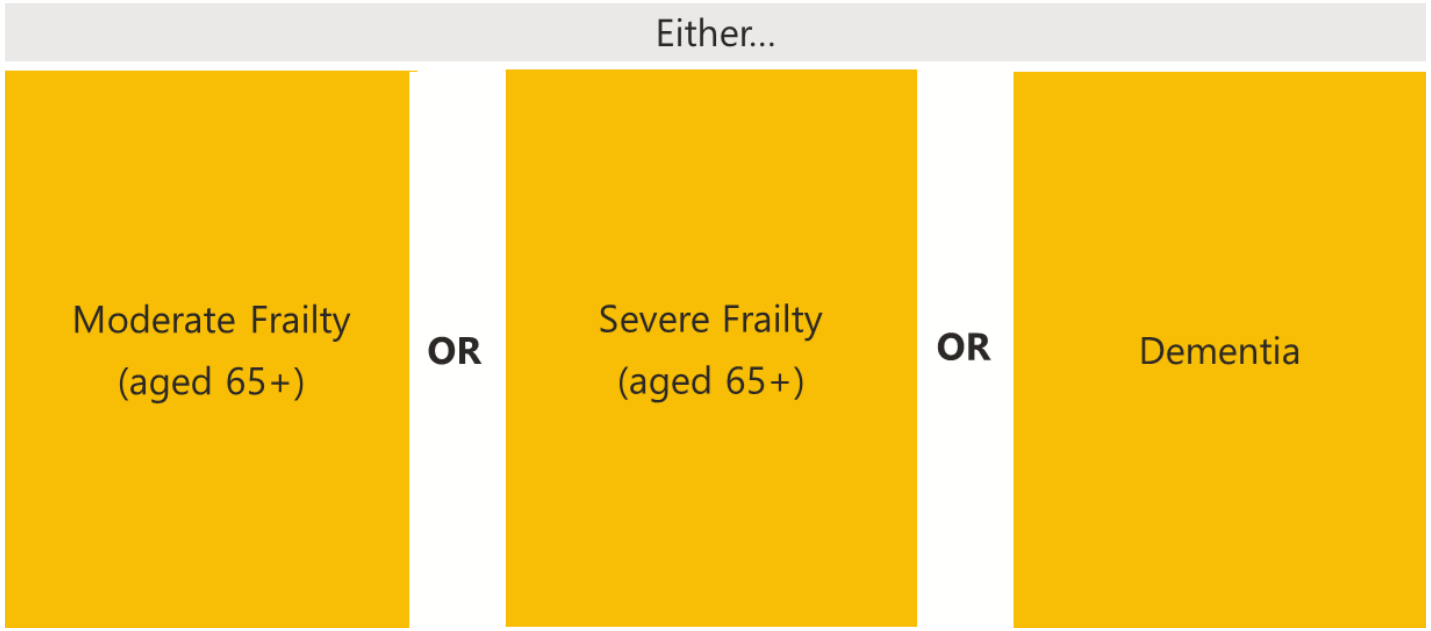


Data source: New Economy Manchester Unit Cost Database.

How are the Frailty and Dementia segment defined?

Mersey Care NHS Foundation Trust
Community and Mental Health Services

People are defined as belonging to the Frailty and Dementia segment if they have:



In Cheshire & Merseyside ICS 117,243 individuals (5.6% of the population) were identified as belonging to the Frailty and Dementia segment. In this pack we describe the characteristics of people in this segment, before moving on to describe their other healthcare issues and how they use services.

Patient characteristics

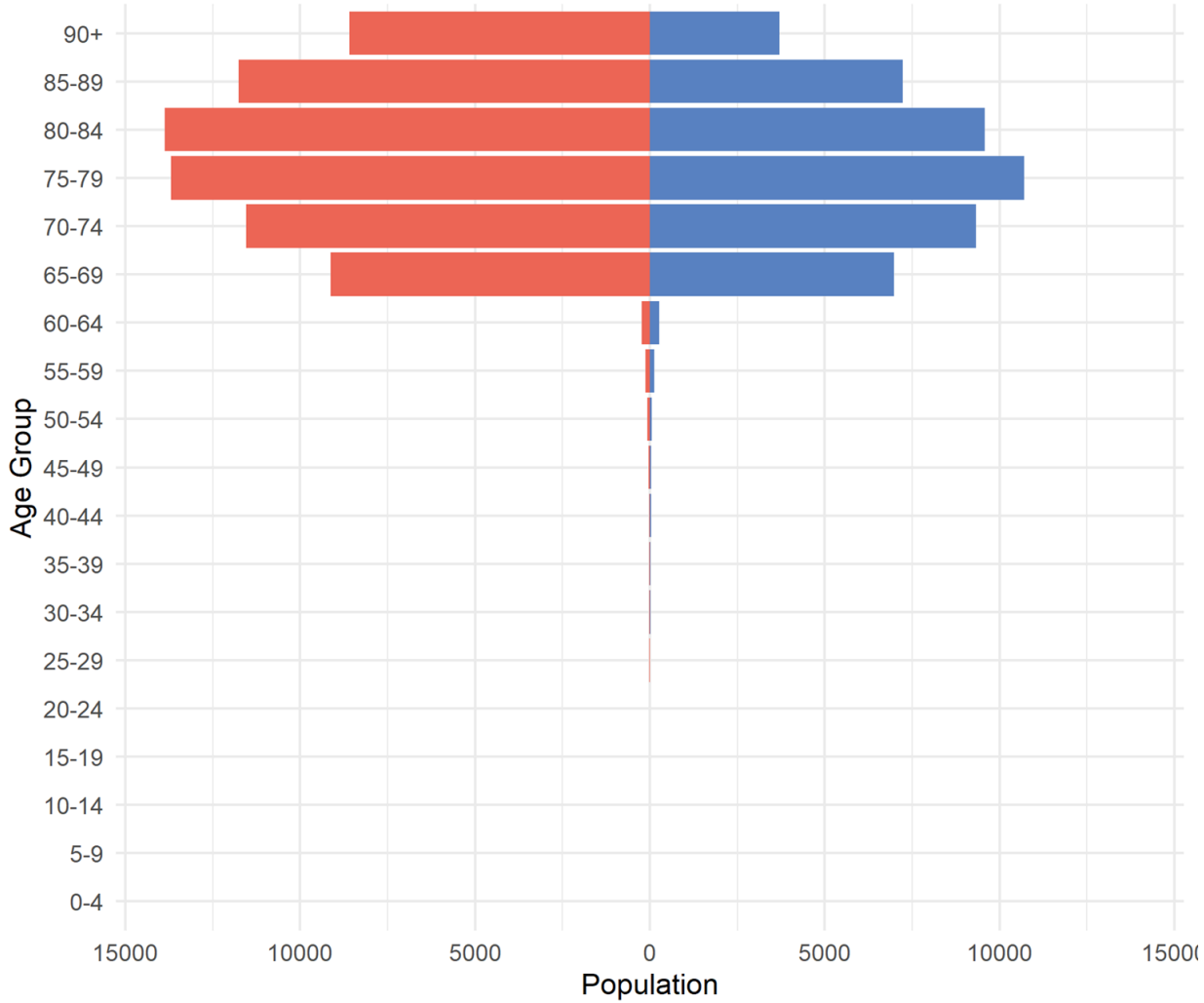
Age and gender

Mersey Care
NHS Foundation Trust

Community and Mental Health Services

- For the Frailty and Dementia segment the mean average age of these individuals is 79 (interquartile range from 73 to 85)

- Gender splits within the segment are 41% male and 59% female



Patient characteristics

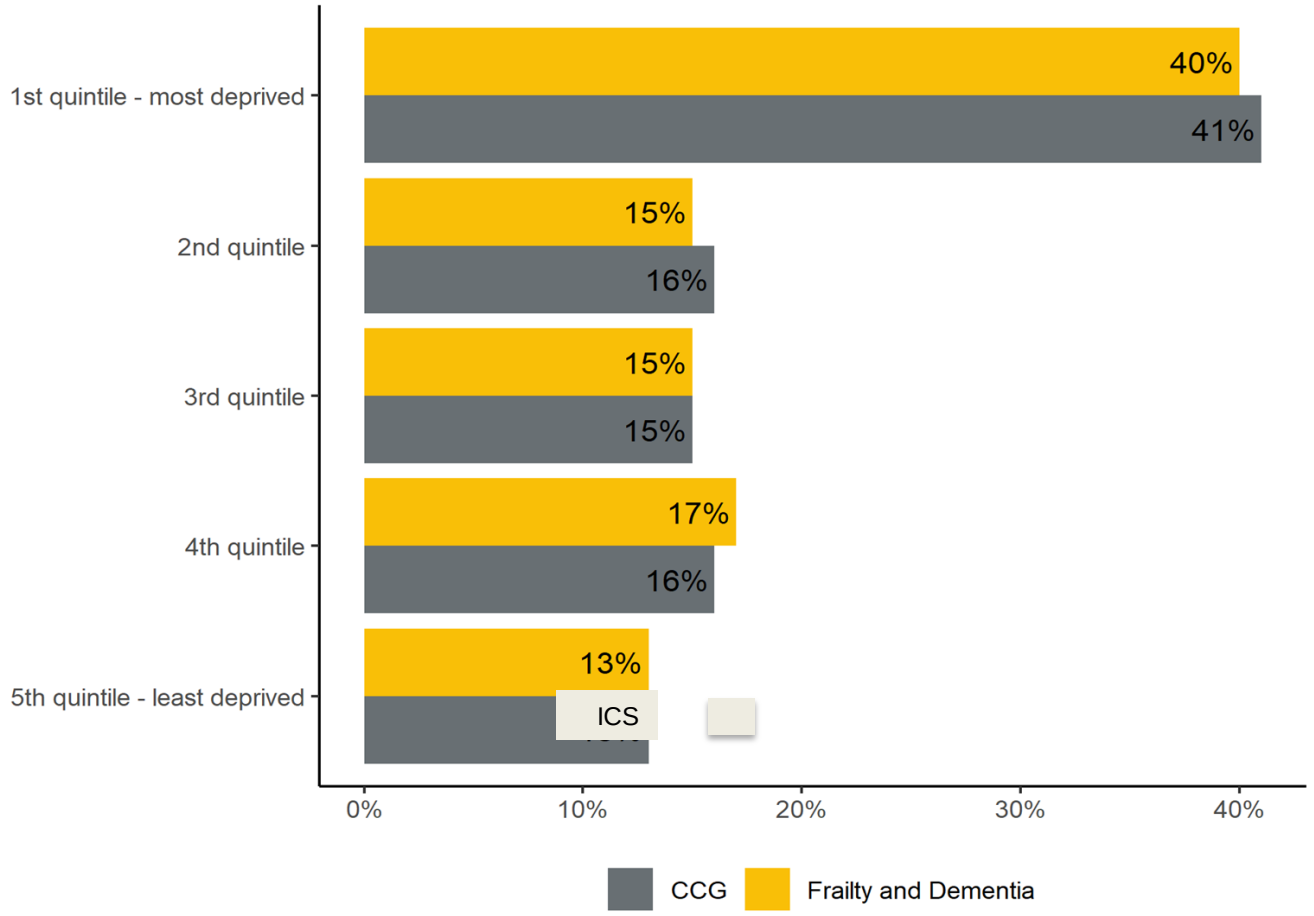
Deprivation

Mersey Care NHS Foundation Trust

Community and Mental Health Services

Those with Frailty and Dementia are more likely to reside in areas of higher deprivation.

40% of the segment live in the most deprived quintile.



This analysis excludes a small number of people for whom no deprivation was recorded. ICS figures based on practices with signed DSA.

Patient characteristics

Geography

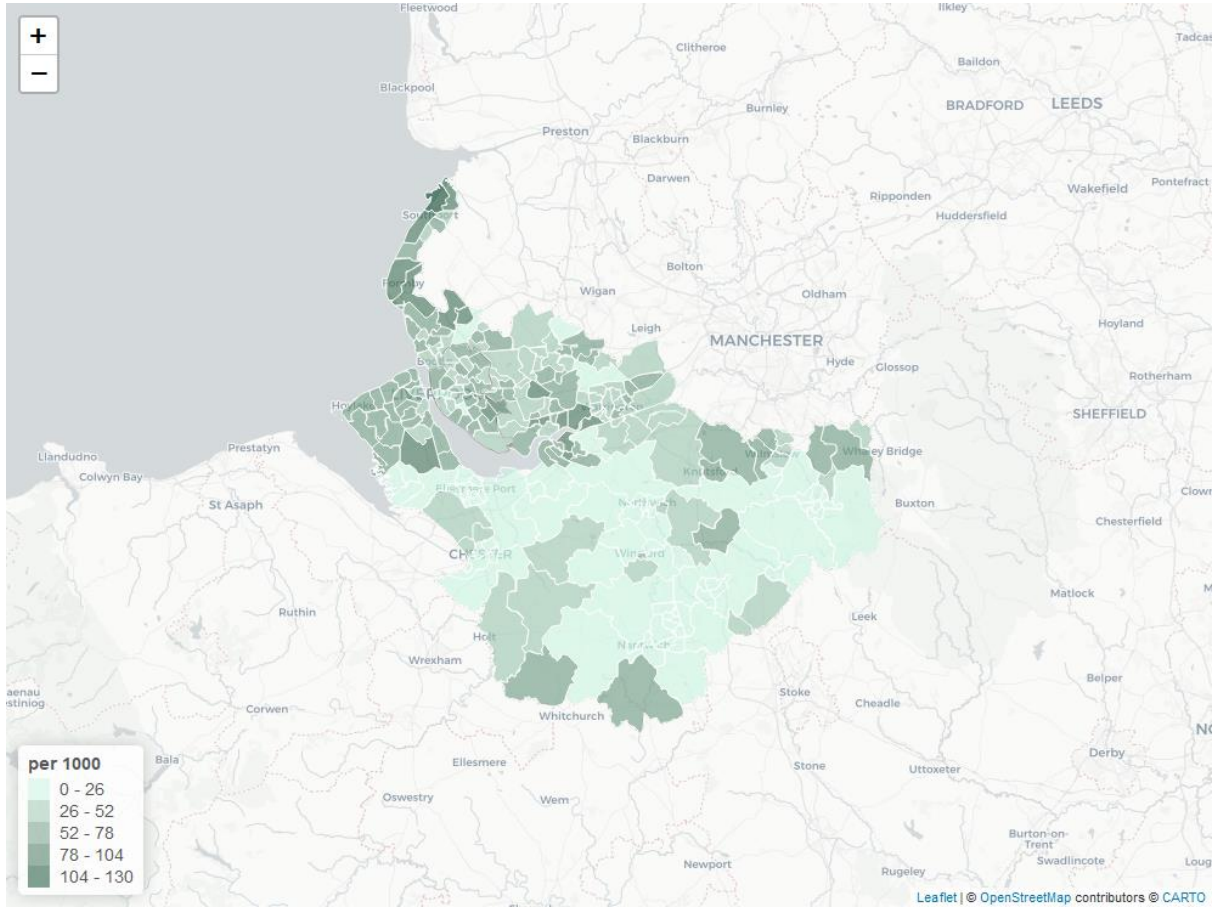
NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

The map shows, for wards within the ICS, the rate of Frailty and Dementia individuals per 1,000 population.

Areas with some of the highest density for Frailty and Dementia are:

- Bankfield (Halton)
- Duke's (Southport & Formby)
- Cambridge (Southport & Formby)



Due to the low sign up of practices in Cheshire CCG rates in this area will be artificially low.

Health Care Conditions

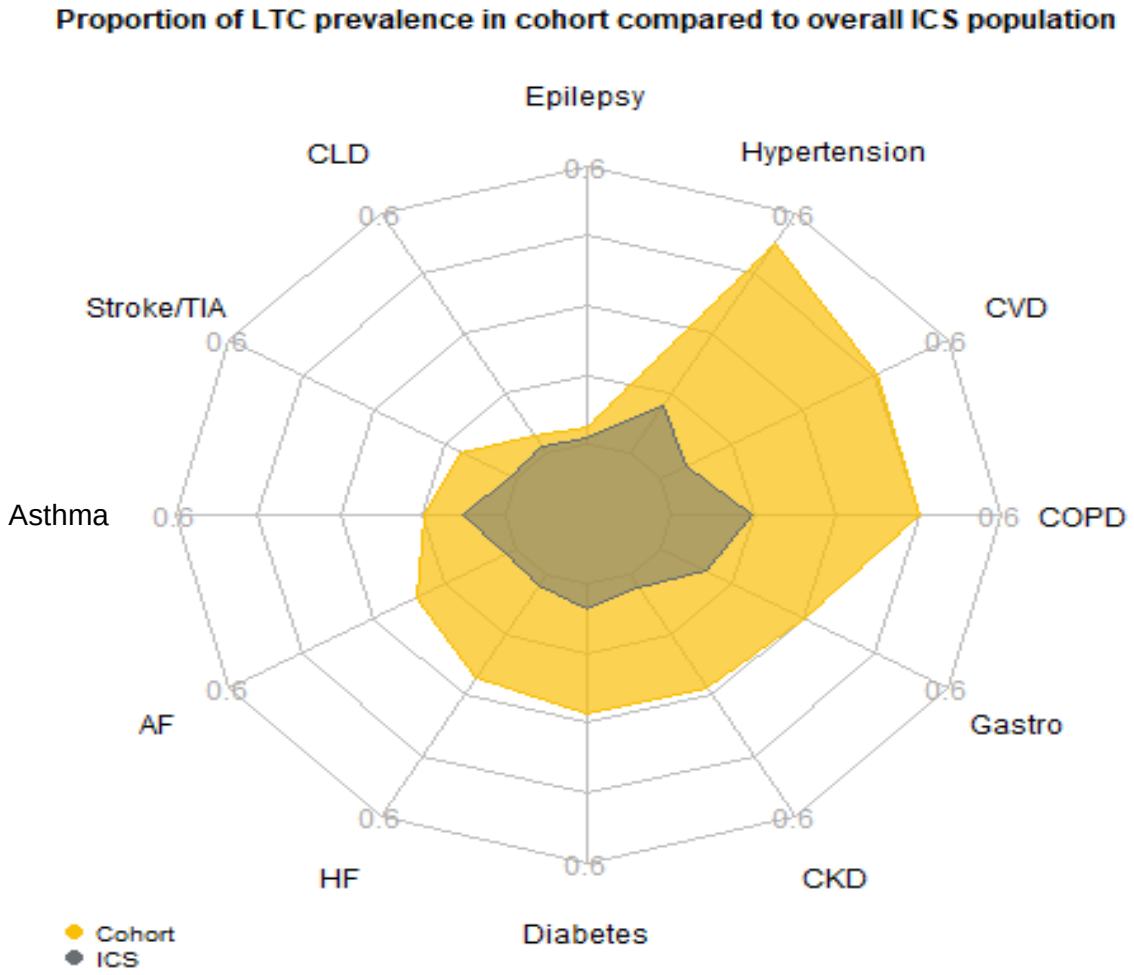
LTCs in the population

Mersey Care NHS Foundation Trust

Community and Mental Health Services

- For the specified long term conditions a comparison of prevalence rates is made between those in the Frailty and Dementia segment and the total population (aged 15+). This indicates the scale of the difference in these disease areas between the segment and the total population.

- The scale shows the rate per person so 0.6 represents prevalence of 60% of people.



Patient characteristics

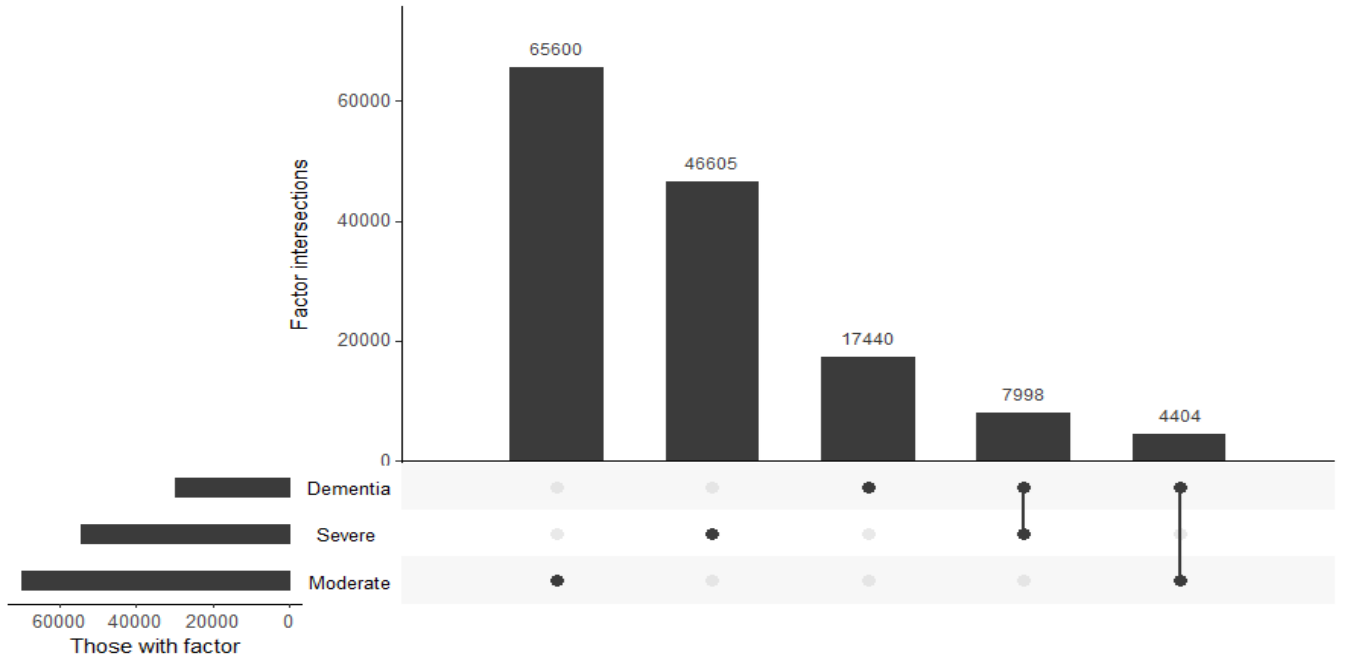
Factors

Mersey Care NHS Foundation Trust

Community and Mental Health Services

- For an individual to be assigned to the Frailty and Dementia segment depends on factors for the level of frailty (moderate or severe) or a clinical code for dementia. Numbers are larger frailty alone but some individuals do have both frailty and dementia.

- Although not a factor, there was interest in identifying those prescribed an anticholinergic. In the last year 80% of those in the segment were prescribed these at least once, and where prescribed there were on average 2.4 different types.



The ‘Those with factor’ bars represent all those in the segment with those factors. The ‘Factor intersection’ represents the combination of factors and the number of individuals with those combinations.

Frailty and dementia

Mersey Care
NHS Foundation Trust
Community and Mental Health Services

The cumulative effect of taking one or more medicine with anticholinergic properties (anticholinergic burden) increases the risk of:

Delirium and falls (short-term adverse outcomes)

Hospitalisation

Dementia, loss of physical function, loss of independence (long-term adverse outcomes)

Mortality

NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

Questions?

The Integrated Care Summit: Challenges and Best Practice

UP NEXT...

Capita

The Integrated Care Summit: Challenges and Best Practice

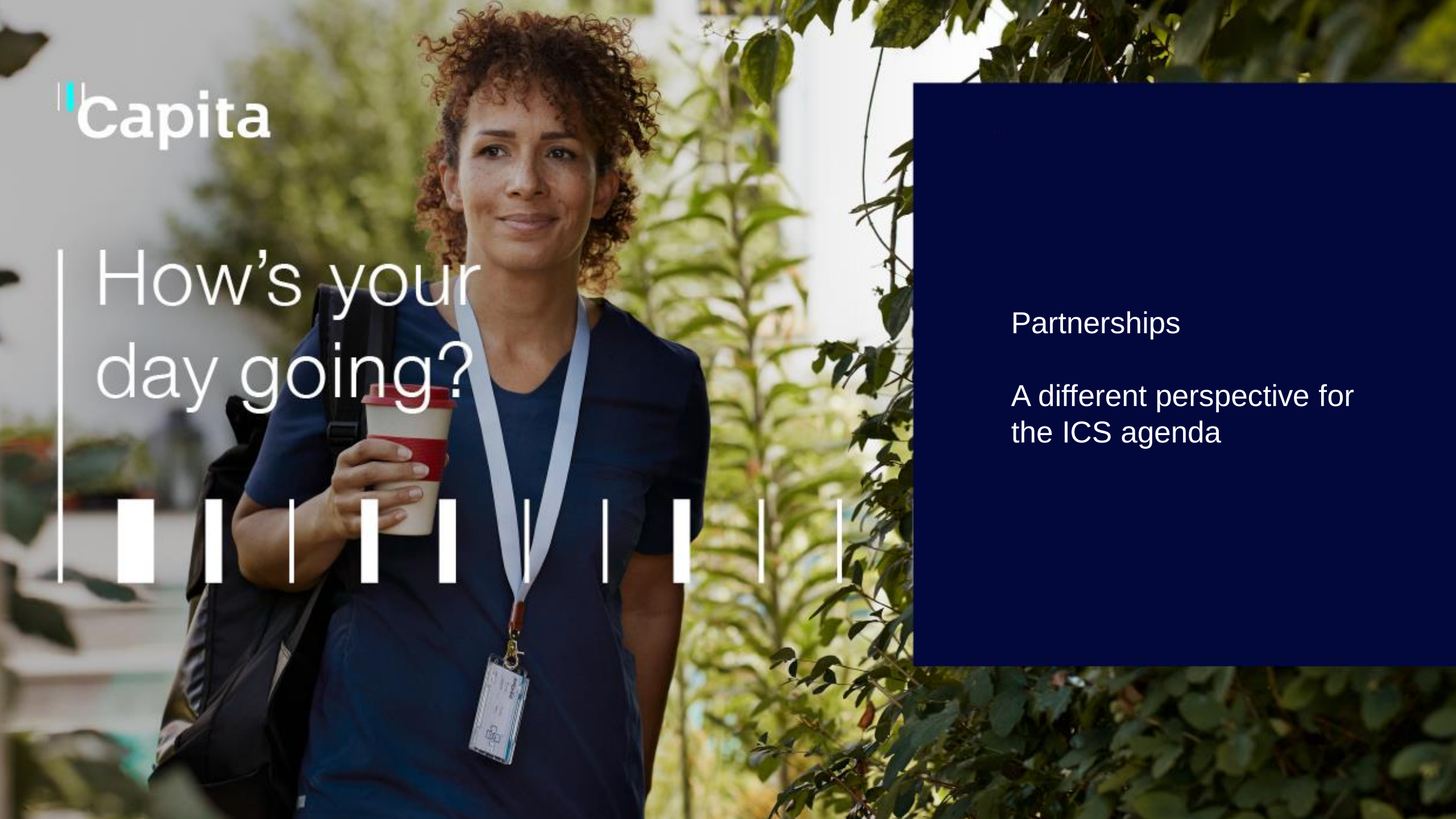
SPEAKING NOW

Tim Coney

Health and Welfare Engagement Director
Capita

I will be discussing…

"Partnerships: A different perspective for the ICS agenda"



Partnerships

A different perspective for the ICS agenda

Creating better and more sustainable healthcare

Support Every NHS

GP, Pharmacy, Dentist & optician practice in England

100 million

encounters managed globally by Capita technology

1.3 million

health assessments carried out since 2012

50,000+

healthcare workers & volunteers trained to deliver LFT device testing during the COVID 19 pandemic

- Capita deliver results not talk
- For one NHS body we delivered over £145M in savings in a 5-year period while improving engagement and quality scores
- We are currently transforming the administrative services of multiple ICS organisations
- Our national contract to provide networking across all of health, social and wider the public sector in Scotland has a CSAT score of 98% across 6000 sites
- We provide services to healthcare and clinical administration. We do not provide direct clinical care

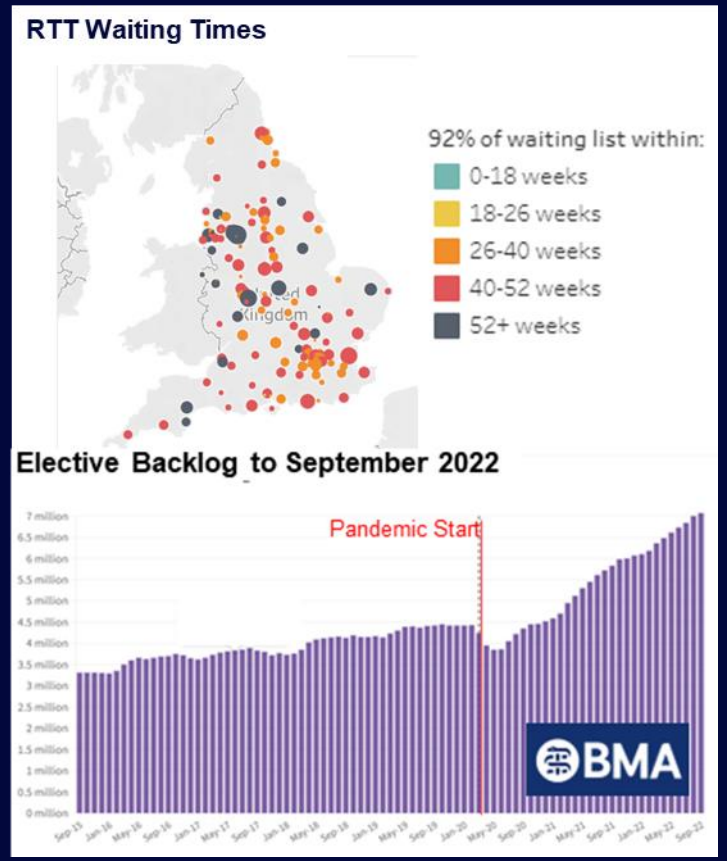
Challenges and levers

Funding → Resources → Operational Performance →

132,139 * Increasing vacancy rate in key areas **

~40% of NHS staff are in support roles

"The persistent understaffing of the NHS now poses a serious risk to staff and patient safety both for routine and emergency care". ***



The scale of the challenge requires ICSs to consider every 'lever', examples

- Focus on Need
- Population / Activation
- Early Years
- Integration
- Primary Care / Social Care / Neighbourhood / VCSE
- Staff Development

Partnership is an additional key lever

- Between providers in the care system
- Between public, VCSE and private sectors

*/** : NHS Digital
*** : Health and Social Care Committee 2022

Partnership and integrated systems

Individual organisations

A collection of organisations coming together

A collection of common values

A care eco-system based on partnership and shared values

NHS (Public) Local government Voluntary Private

- Care systems have constantly evolved
- Partnership is an intrinsic part of how they deliver
- Partnership gives them many things, including;

Ability to Adapt

Ability to Respond

- For patients, citizens and their families, partnership works successfully because of trust and pride

London 2012

Benefits and past pitfalls

Partnerships underpin care delivery – many with non-public sector bodies – VCSE and private sector

This approach delivers significant benefits to the care system, including improved care, better outcomes / experience, and operational effectiveness

We know this because we are a proven operational partner of the NHS and local government at scale

- Experience / Engagement
- Training / Skills Development
- Administration / Administrative Healthcare
- Estates and Infrastructure (inc. digital and data)

We support the public sector to help it achieve more

Many of the historic issues with external contracts are due to the nature of the commercial relationship

Major areas of weakness include;

Measurement

KPI's, volumes and milestones, not outcomes.

Structure

Inflexible Operations

Solios vs. collaboration / fluidity

Good partnerships have common goals and ethos
They start with the patient, citizens and their carers

The relationship has the patient, citizen, their carers and care professionals at its heart

Underpinning a good partnership

Capita believes a good partnership is based four things

Values

1. Shared common non-commercial goal/s e.g., helping patients and citizens

Collective

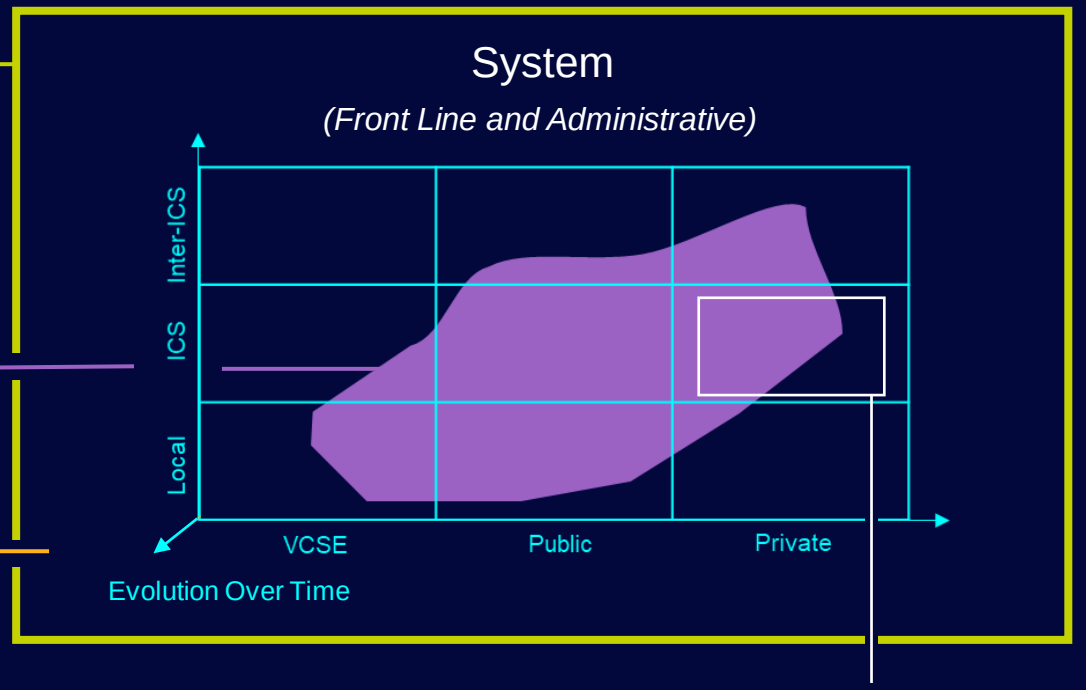
2. A clear view of what the whole care eco-system can enable in partnership

Evolution

3. A clear set of principles owned by the local system to guide the partnership

Measure

4. A clear set of measures aligned to ‘system’ priorities e.g., patient outcomes, citizen experience, effectiveness and efficiency



A model that starts with a contract, specification and “KPI” measurement regime around part of the system in isolation will likely struggle

Building partnership to enable better solutions

Previous ‘solutions’ might not work in the current climate;

- Buying Additional Capacity – too expensive and unsustainable
- “Big” Tech – often too slow and expensive
- Traditional Advisory – expensive and limited operational capability
- Monolithic Programme – Focus on contracts, not outcomes

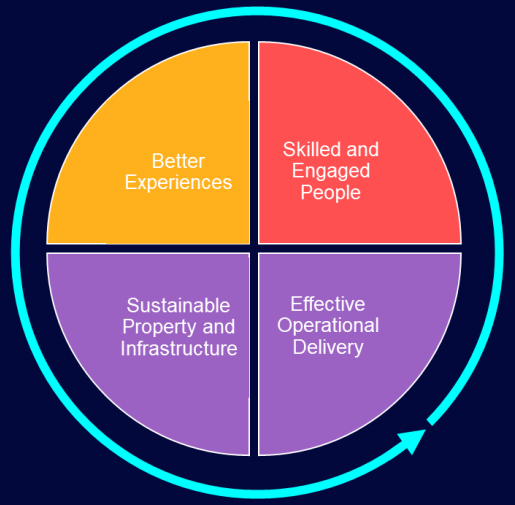
In the current climate there is the risk that harms become normalized.
“we must stop normalizing the unacceptable” – Academy of Royal Colleges (2022)

Partnerships are not a silver bullet, however, they are a valuable lever which should be re-evaluated in the context of the integrated care agenda

- They can enable wider thinking, provide new capacities / capabilities, scale and investment
- They can help with enabling the ‘front line’ as well as administrative and infrastructure

The challenge is how to get the right partnerships based on outcomes and guiding principles

It starts with patients, their carers and the care professional community and a joint conversation in the care eco-system, the right guiding principles and measures and not a procurement



Capita

Contact us

If you would like further information, please contact Tim Coney at tim.coney@capita.com


Capita

The Integrated Care Summit: Challenges and Best Practice

COMFORT BREAK

Please remain logged into the platform, we will resume shortly.

The Integrated Care Summit: Challenges and Best Practice

SPEAKING NOW

Mark Wilkinson

Cheshire East Place Director
NHS Cheshire and Merseyside

I will be discussing…

"The future integration of health and care - taking a lead on tackling health inequalities within our communities"

#BecauseWeCare
Cheshire East Partnership

The integration of health and care – tackling health inequalities
22 November 22

Mark Wilkinson, Cheshire East Place Director
NHS Cheshire and Merseyside

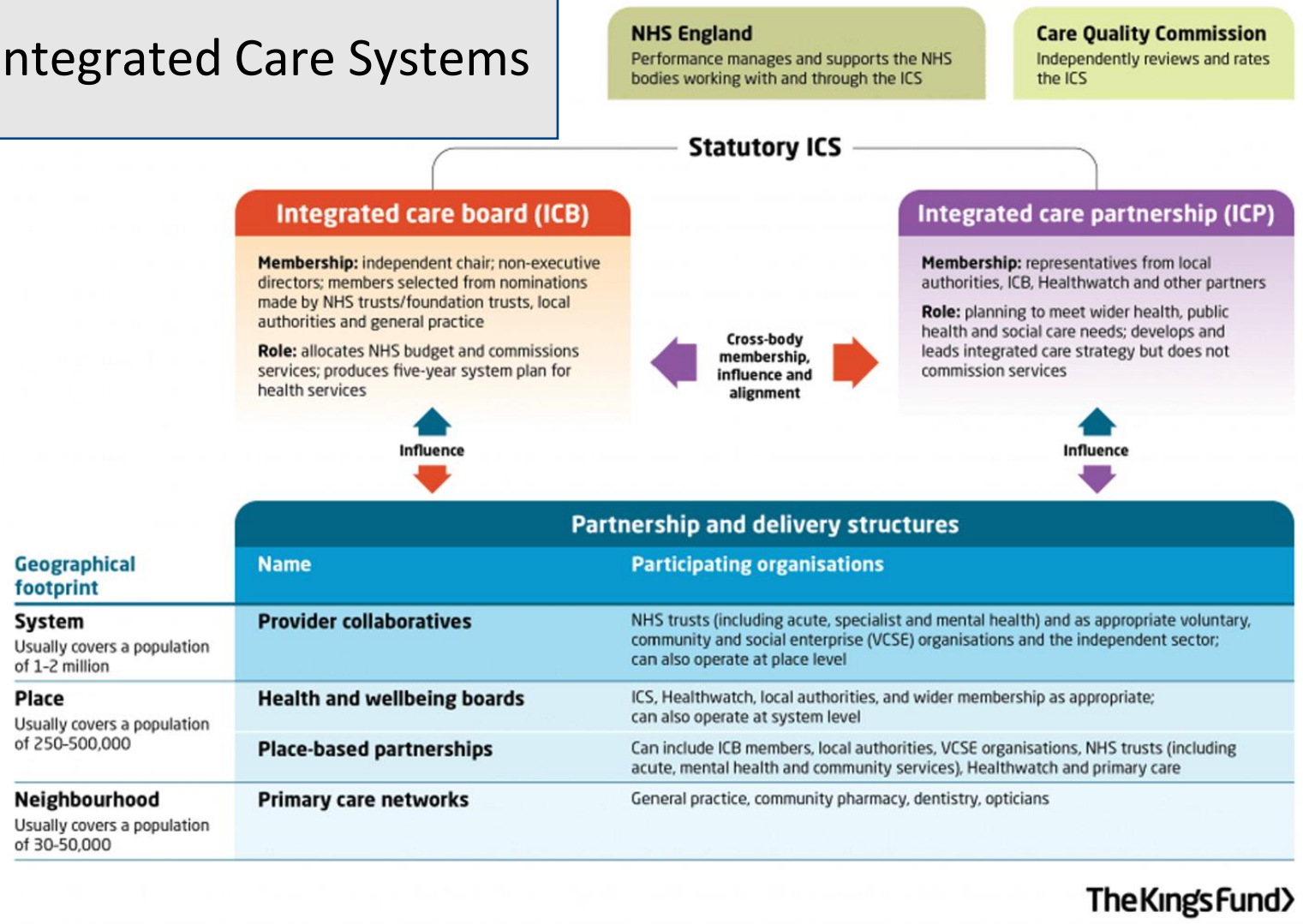
Objectives for this session

- How to develop effective place partnerships
- Share customer segmentation for health services
- Progressing implementation – thinking about capabilities
- Approaches to place organisational development

#BecauseWeCare
Cheshire East Partnership

#BecauseWeCare
Cheshire East Partnership

Integrated Care Systems



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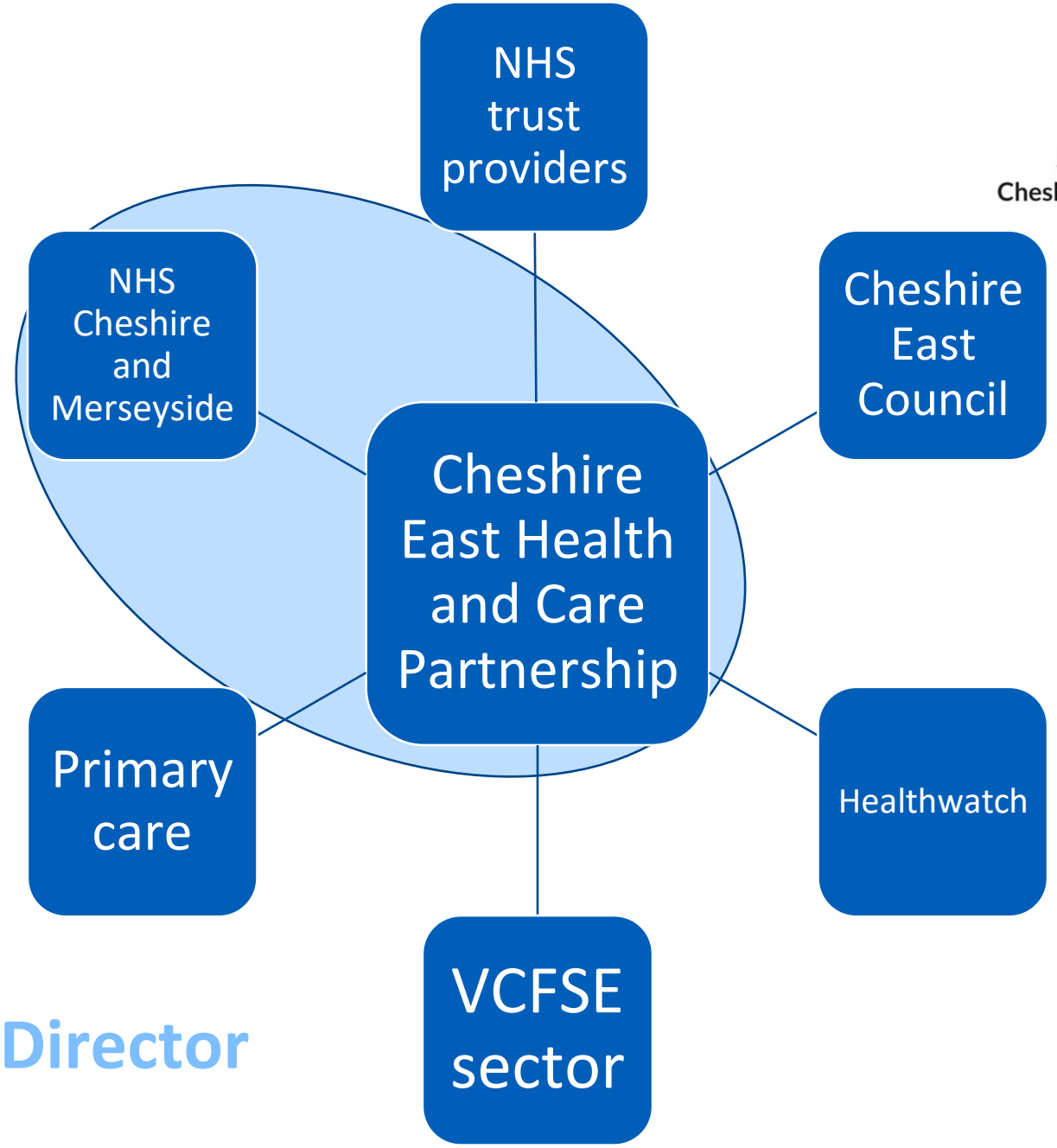
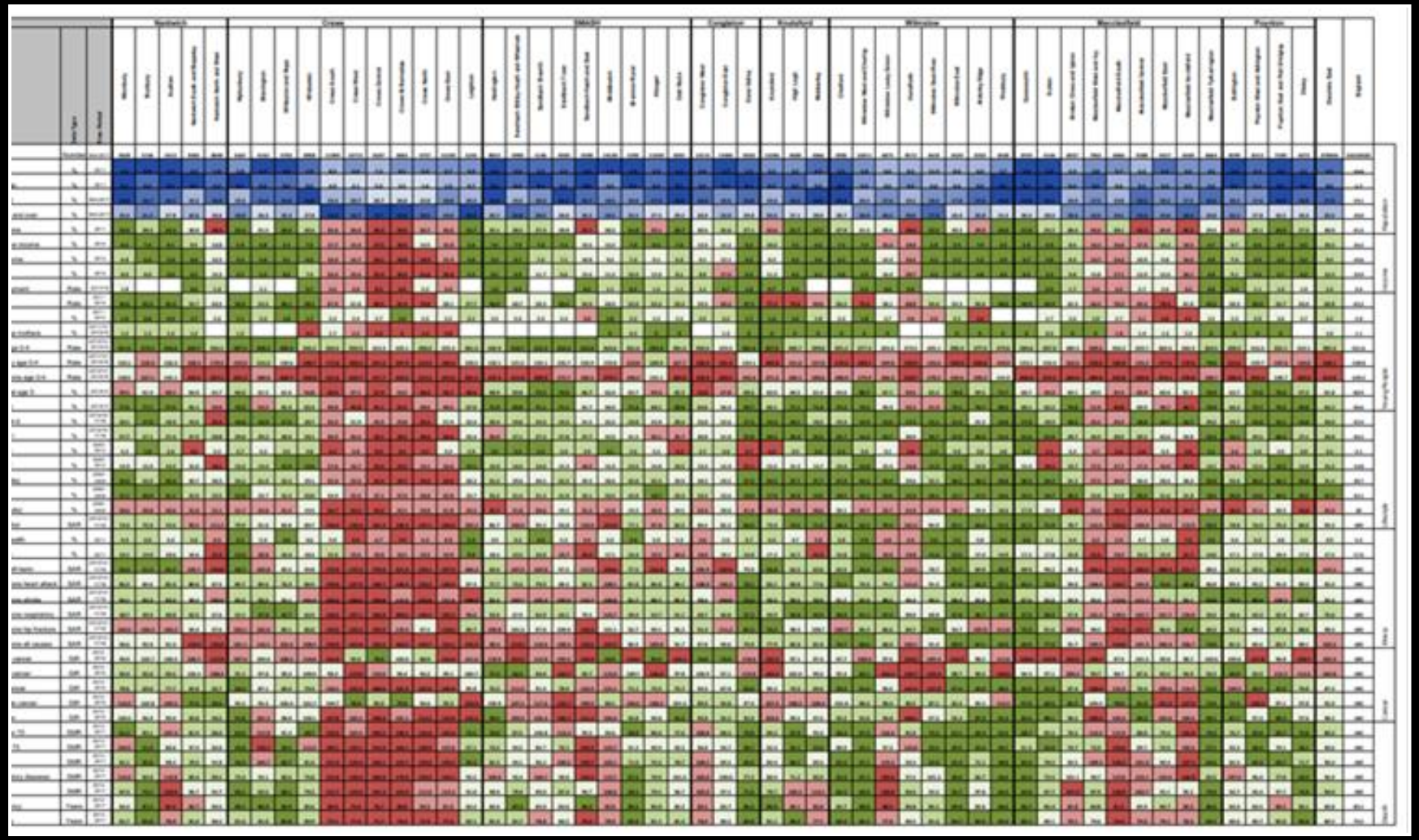
Cheshire East Partnership



Place Director

The Cheshire East Place Partnership: Who are we?

- The people we serve
- Care Communities (neighbourhoods)
- Healthwatch
- The voluntary community faith and social enterprise sector
- Cheshire East Council
- Primary Care
- Mid Cheshire Hospitals NHS Foundation Trust
- East Cheshire NHS Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Cheshire East Integrated Care Board (ICB) Team



The Tartan Rug

The case for Care Communities / neighbourhood working

- Structural reorganisation will only create the conditions for change.
- Hyper-local change best placed to make tangible difference to exclusion.
- Risk of supply-led demand consumes workforce, funds and attention.
- Leaning into neighbourhood working offers a threefold benefit: reducing demand on the health and care system, developing community resilience and enabling retention through delivering new models of care. Focusing on underlying determinants motivates staff.
- Builds on councillors' kerbside insights and wider understanding of inclusive growth and housing.
- In sporting parlance, neighbourhoods need a squad not a team. Steps which should unlock possibilities: analysis, immersion, and promotion.

Putting neighbourhoods at the heart of integrated care - NHS Providers

Recognition of Joint Functions and Working Principles

- shared vision, mission and purpose
- joint strategy
- joint priority setting,
- fair and defensible allocation of resource
- joint stewardship of resource,
- joint operational delivery,
- joint accountability
- mutual accountability

Shared vision mission and purpos

#BecauseWeCare
Cheshire East Partnership

Health and Wellbeing Board

- A statutory board of the Council.
- Gathers information on wants and needs to set the Health and Wellbeing Strategy including crucially working on the social determinants of health.
- Influences the Partnership Board.

Cheshire East Health and Care Partnership Board

Implementation of strategy set by the Health and Wellbeing Board with a particular focus on integration of health and social care and our contribution to the broader determinants of health

Four distinct types of want for our people

#BecauseWeCare
Cheshire East Partnership

		Service Proposition	What do patients look for?	Attributes	Key success factors	
Fix me!	 Wonderful service! I was back on my feet quickly. Great, courteous and efficient.	• Focused care to 'fix patient' following a definitive diagnosis. • Clinical innovation to deliver good outcomes	• Accessibility • To be seen quickly • Reputation for quality • Expert care • Rapid return to normal life • Pleasant environment	• Predictable activity • Minimal variation • Volume based • Higher turnover of patients • Outcome based	• Cost competitiveness • Recruitment and retention • Capacity • Patient journey management	We provide medical and surgical services to treat our patient and deliver optimal outcomes
What's wrong with me?	 I can really rely on the Trust to help me and provide the care I need.	• Expert diagnostics and pathway co-ordination to provide patients with shortest and most effective route to diagnosis and plan of care	• Access to specialist expertise • Convenience • Predictability • Quick resolution • Customer service	• Collaborative care, single clinical coordination • Centralised with satellite locations e.g. diagnostics • Activity based	• Capacity • Responsiveness • Patient journey management • Specialist equipment and resources	We provide the expertise, access and convenience to diagnose and develop treatment plans for our patients
Help me stay well	 The CARE is always there for me. I do not know how I would cope without them.	• Integrated care network • Services geared to support patients to manage their wellbeing and exacerbations • Patient to patient support networks	• Service fits around their life • Trust and compassion • Availability • Support for self management • Long term relationship	• Distributed and decentralised model • Care coordination hub across primary, community, secondary, tertiary and social care • Outcome based	• Level of integration and co-operation • Multi-skilled resources • Communication and engagement	We provide integrated care and work with carers, patients and their local community to keep them well in an environment that meets their needs.
End of life	 My father was able to live the last days in comfort and get closure.	• Holistic and personalised care enabling dignified end of life care and support for family and carers	• Empathy • Trusted advice • Approachability • Recommendation • Convenience • Please environment	• Care coordination • Network of services • Distributed service • Heavy personalisation • Flexible	• Personalisation of care • Patient experience management • Continuity of care • Multi-skilled resources	We provide the best possible end of life care

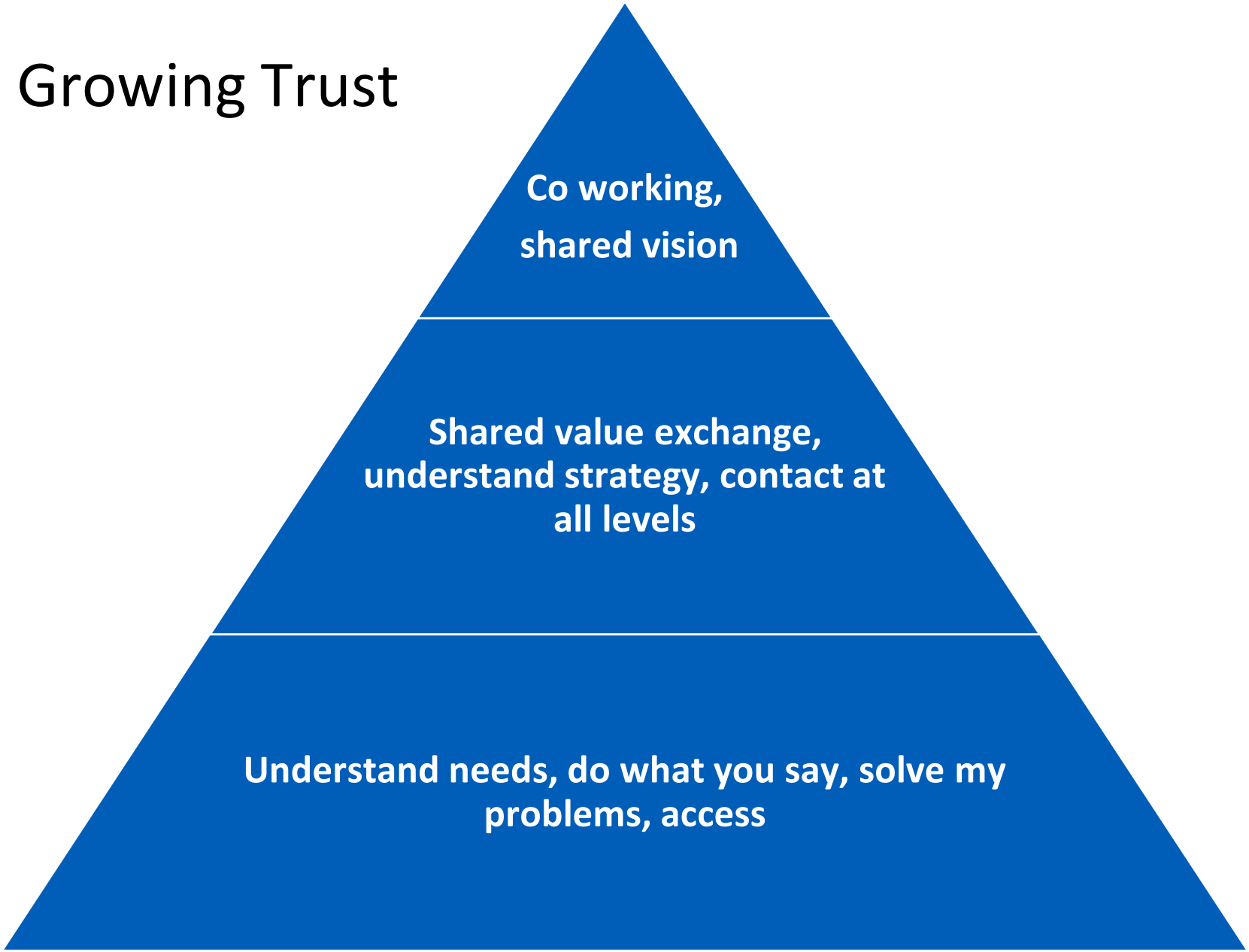
The capabilities required to deliver…

#BecauseWeCare
Cheshire East Partnership

Applied intelligence	Quality improvement and culture	New business model	Service portfolio optimization
Backlog and restoration	Workforce welfare and capacity	System innovation	Patient access, flow and equality
Digital health	Professionalisation of business units	Talent management	Knowledge management
Future workforce	Digital operating model	Collaboration management	Infrastructure optimization

Community contribution

Growing Trust



System wide organisational development

- 100 leaders chosen: primary care, VCFSE leaders, trusts and local authority
- Cheshire Business School
  - The art of being brilliant: one system, one vision – inspiring, rejuvenating, real
  - Bouncebackability – Mojo, recovery, resilience
  - Adaptive leadership for our people across all systems
  - Work, earn, learn, it's all about leadership in the 21st-century

CBS

CHESHIRE BUSINESS SCHOOL

VENI - VIDI - VICI

Moving forward,

Place based partnerships

Key: Function | Meeting

#BecauseWeCare
Cheshire East Partnership

Care Communities in Bollington Disley and Poynton, Chelford Handforth Alderley and Wilmslow, Congleton and Holmes Chapel, Crewe, Knutsford, Team Macclesfield, Nantwich and Rural, Sandbach, Middlewich, Alsager, Scholar Green and Haslington.


Any Questions ?

The Integrated Care Summit: Challenges and Best Practice

SPEAKING NOW

Louis Holmes

Policy Manager
Care England

I will be discussing…

"The role audit social care has within an ICS"

CARE ENGLAND

Representing independent care providers

The role adult social care has within an ICS:

What adult social care can do for you

Presented by:
Louis Holmes, Policy Manager
Care England
lholmes@careengland.org.uk

CARE ENGLAND
Representing independent care providers

About Care England

Care England is the largest and most diverse representative body for adult social care in England. Our members include residential care, supported living and homecare providers and also mental health. We work on behalf of small, medium and large independent care services.

Care England speaks with one voice for the sector and its members and seeks to create an environment in which providers can continue to develop and deliver the high quality care that service users require and deserve.

Our core mission is to support user choice, empowerment and quality services.

CARE ENGLAND
Representing independent care providers

ICSs and the adult social care sector: what are the current issues facing adult social care and ICSs?

Adult social care is at a tipping point:

Funding

Continuous changes in reform make long term business strategies unworkable

Cost of Living

The energy and cost of living crisis could cripple and ultimately shut down care settings across the country

Workforce

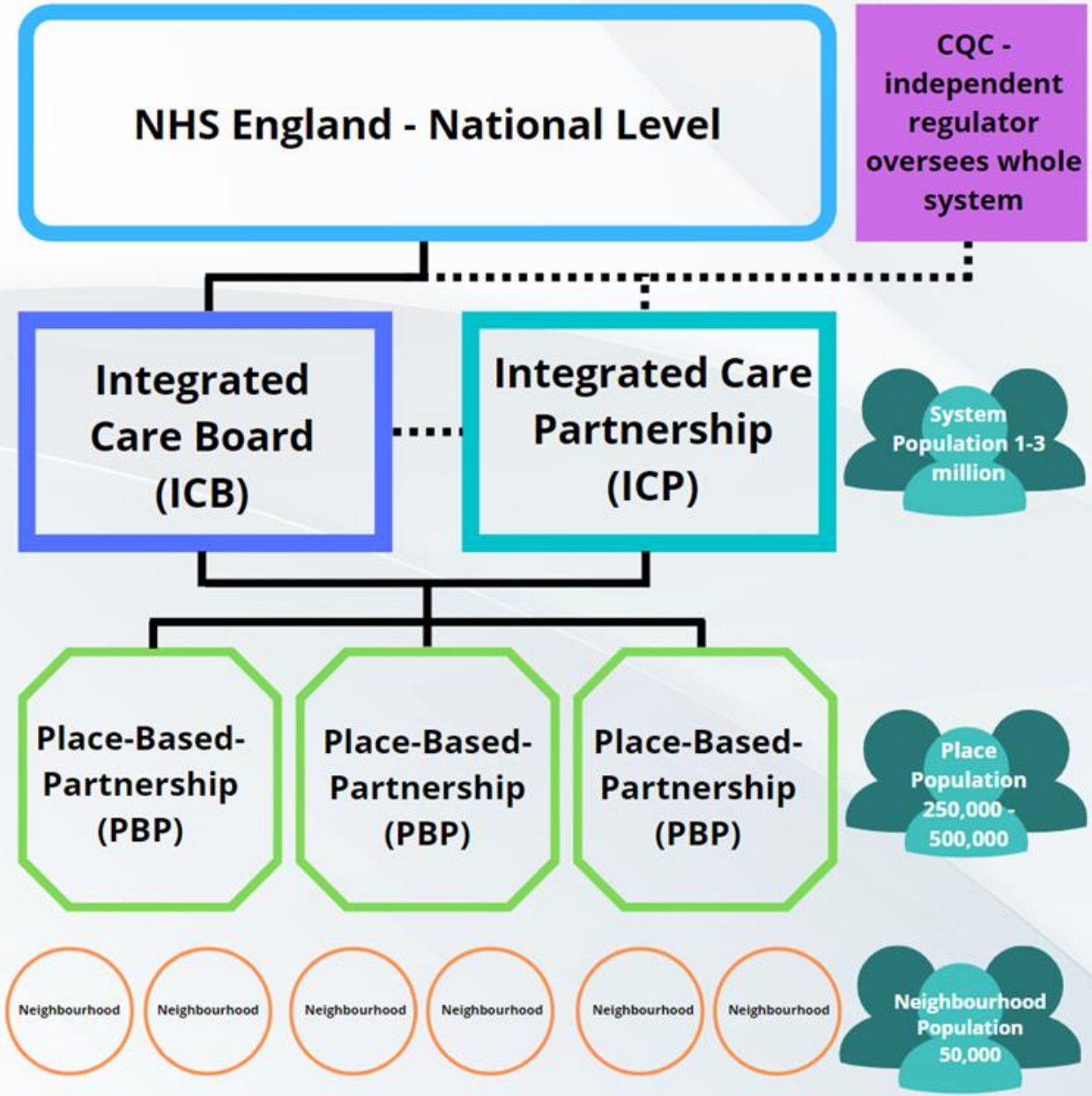
Workforce in turmoil with 165,000 vacancies an increase of 51% since October 2021 (Skills for Care)

The Impact

South East Social Care Alliance (SESCA) outlined that 45% of provider in the South East have considered exiting the sector

CARE ENGLAND
Representing independent care providers

Care England's ICS Guide



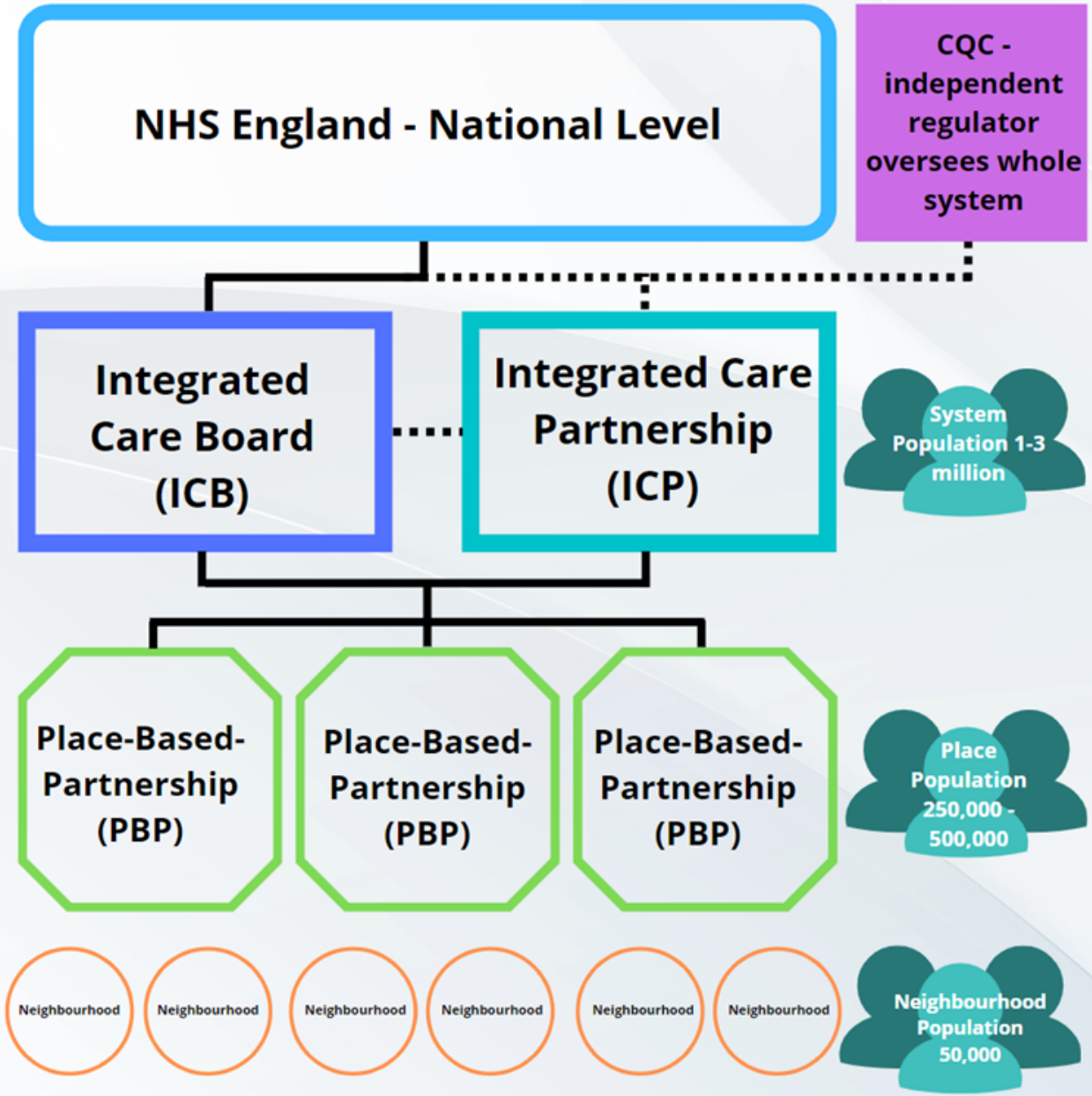
ICSs and the adult social care sector: what are the current issues facing adult social care and ICSs?

Representation - How will care providers be represented/engaged at system level?

Winter resilience – how will ICSs address discharge pressures?

CARE ENGLAND
Representing independent care providers

Care England's ICS Guide



ICSs and the adult social care sector: what are the current issues facing adult social care and ICSs?

Representation – *Good Practice*

<u>Frimley ICS</u>

No upper limit for the ICP membership

<u>Nottingham and Nottinghamshire ICS</u>

The two local authorities have nominated two care providers to sit on the ICP

ICSs and the adult social care sector: Care England's Winter Resilience Key Asks

- ✓ Importance of joint strategy planning
- ✓ Importance of transparency in funding
- ✓ Importance of shared learning

These key asks can be used in the short-term to address Winter issues, but also long-term strategic planning.

What Adult Social Care can do for you: Improve outcomes in population health and healthcare

What is the issue? ***Delayed discharge – increase in backlog and fewer hospital beds***

What is the solution? ***Working collaboratively with care providers and utilising care home and other services capacity***

How is it achieved?

- Winter pressure units have been proven to benefit both health and care.
- There must be some form of consistency across the various region.
- Imposing a national or regional tariff to help provide business continuity.
- Joint partnership and sharing best practice between ICSs is key.

What Adult Social Care can do for you: Improve outcomes in population health and healthcare

What is the issue? ***An increase in ageing population will impact health inequalities***

What is the solution? ***Increasing the use of adult social care datasets***

How is it achieved?

- In the CQC's state of care report, it was noted that around half a million people are potentially waiting for either an ASC assessment for a direct payment to begin for a review of their care.'
- Utilising Data within care homes will be paramount to tackling inequalities.
- Learnings from the Vivaldi project will help ICSs better understand infection in care homes.

THE OUTSTANDING SOCIETY

UCL

Scan the QR code to find out more about the Vivaldi project:

CARE ENGLAND
Representing independent care providers

What Adult Social Care can do for you: Enhance productivity and value for money

What is the issue? ***Adult social care is a fractured digital landscape***

What is the solution? ***Increasing funding to address basic digital infrastructure***

How is it achieved?

- The Government have committed to digitising 80% of the sector by 2024 through digital care records.
- Be transparent with the remit of the Adult Social Care Digital Transformation Fund!
- Reach out to Digital Social Care for support and how to engage with your local care providers.
- Invest in digital infrastructure and digital skills.

Digital Social Care

CARE ENGLAND
Representing independent care providers

What Adult Social Care can do for you: Help the NHS support broader social and economic development

What is the issue? ***A ever growing workforce demand within health and social care***

What is the solution? ***Unifying the two sectors under one workforce banner***

How is it achieved?

- The adult social care sector contributes £50.3 billion to the English economy and employs 6% of the total UK workforce – Skills for Care
- Economic and workforce contribution will continue to increase as the population ages and long term specialist care develops. To meet this demand there needs to be an increase of 27% (480,000) in the workforce by 2035.
- The health and social care workforce is 'one workforce'

Conclusion

Reach out to your local care providers and encourage:

Importance of joint strategy planning

Importance of transparency in funding

Importance of shared learning

Allow care providers to sit and engage at all levels, including at system!

Want to continue the conversation?

to discuss anything raised within the presentation further, contact me on:

08450 577 677

lholmes@careengland.org.uk

www.careengland.org.uk

CARE ENGLAND
Representing independent care providers

The Integrated Care Summit: Challenges and Best Practice

UP NEXT...

The Integrated Care Summit: Challenges and Best Practice

SPEAKING NOW

Nick Western

Chief Commercial Officer

Lilli

Fiona Brown

Chief Care Officer

Lilli

We will discuss…

"ICS's - Where and how to deploy care technologies to positively impact the whole system"

ICS's - Where and how to deploy care technology to positively impact the whole system.

Nick Weston
Chief Commercial Officer

Fiona Brown
Chief Care Officer

Nick Weston

Chief Commercial Officer

Former Head of Enterprise System Integrators and Partnerships Nick at O2, and has worked on securing multi-year contracts with the Co-operative, Heath Lambert and Swinton Insurance as Head of Partnerships at Simplyhealth.

Fiona Brown

Chief Care Officer

Former Executive Director for Neighbourhood at Sunderland City Council, public sector executive leader with over 30 years experience in strategic leadership and business development.

Implementing profound transformation to fully leverage the opportunities of digital technologies and their impact. Extensive experience of leading and managing large multi million pound investment programmes in the public sector whilst reducing costs to drive out substantial efficiencies.

The system is overwhelmed

- Growing demand as the population ages
- A shrinking workforce
- Constrained budgets
- Increasing ambulance wait times
- Bed-blocking/ delayed discharge
- Unprecedented pressure in primary care
- Elective care wait list backlog
- Those who have been shielding throughout the pandemic

BBC NEWS

Care-worker shortage: Woman appalled by lack of support for dying mum

THE TIMES

Only two in five people can leave hospital when they are ready, according to CQC report

The Telegraph

NHS general practice has passed the point of no return

THE TIMES

Social care waiting list soars 40% in a year

THE TIMES

Record seven million patients on NHS waiting list in England

The Telegraph

Fix social care to head off an NHS winter calamity

The Telegraph

'Perilous' shortage of homecare workers leaves patients trapped in hospitals

The Telegraph

The key to ending the vicious NHS circle

BBC NEWS

Social care: 'The worst it's been in my 36 years in care'

What if there was a different way?

Whole System Impact

↑ **Social care**

Health ↓

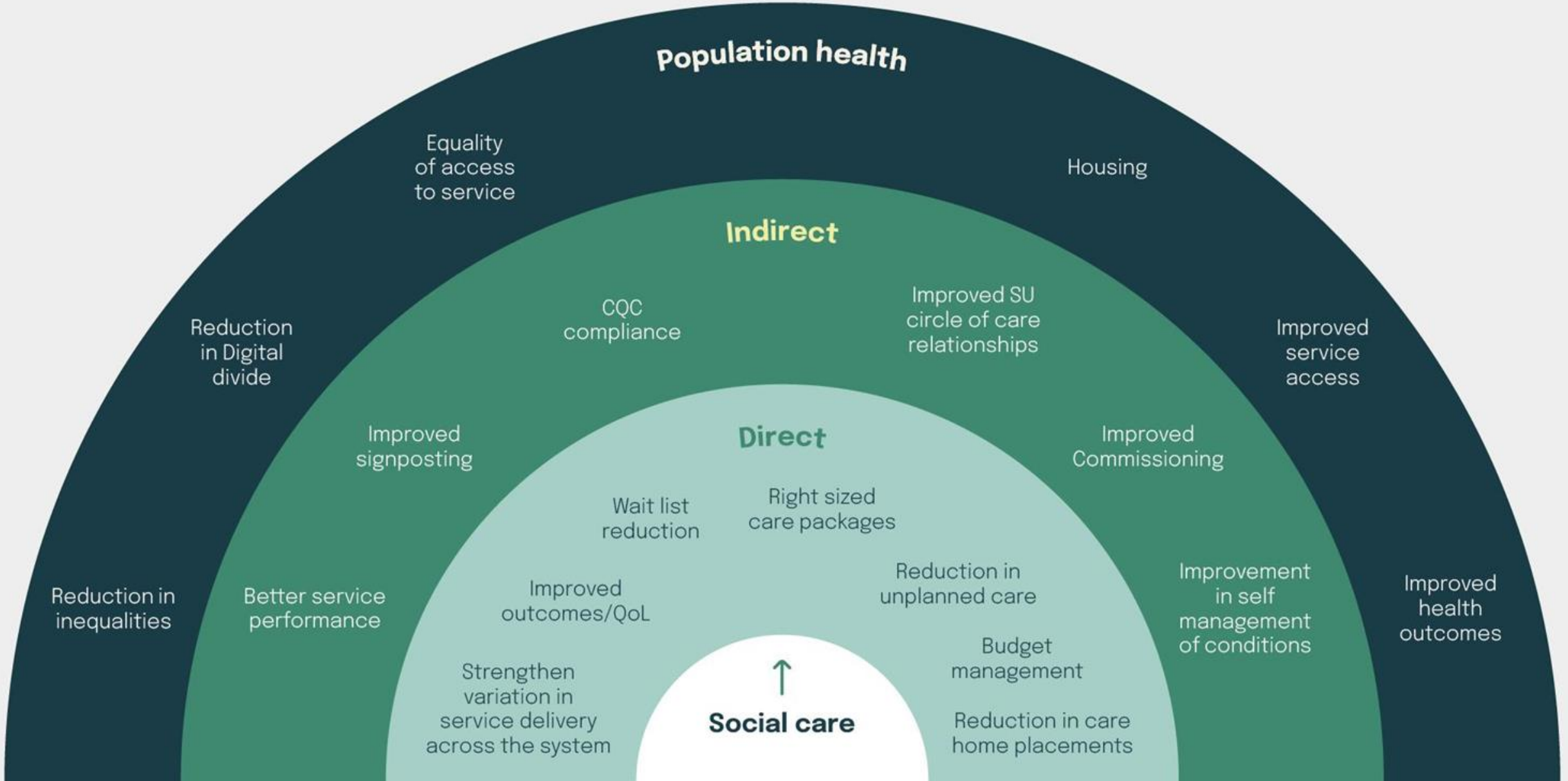
Whole System Impact

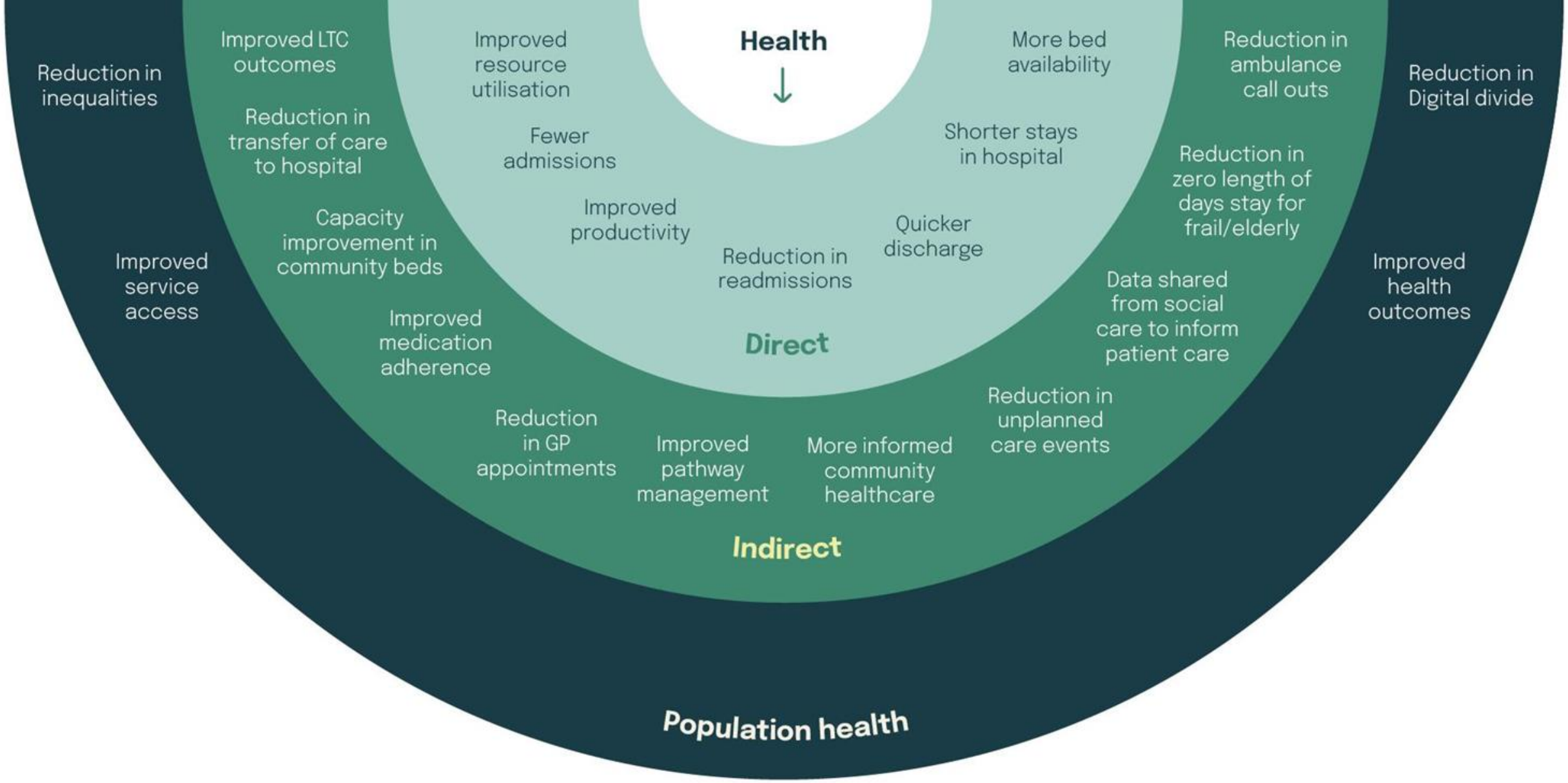
How can deploying technology in social care impact the whole system?

- Creates an opportunity to identify and manage needs associated with health deterioration
- Deliver proactive preventative steps to minimise crisis events in the community setting
- Slow patient deterioration down to reduce demand on services throughout the ICS system

Technology has the potential to:

- Prevent hospital admissions and deliver reductions in readmissions
- Support safer and quicker discharge
- Support more patients to be re-abled at home
- Increase capacity in the system


Population health
Equality of access to service
Housing
Reduction in Digital divide
Improved service access
Reduction in inequalities
Improved health outcomes
Indirect
CQC compliance
Improved SU circle of care relationships
Improved signposting
Improved Commissioning
Better service performance
Improvement in self management of conditions
Direct
Wait list reduction
Right sized care packages
Improved outcomes/QoL
Reduction in unplanned care
Budget management
Strengthen variation in service delivery across the system
Reduction in care home placements
Social care


Health
Improved LTC outcomes
Improved resource utilisation
More bed availability
Reduction in ambulance call outs
Reduction in inequalities
Reduction in Digital divide
Reduction in transfer of care to hospital
Fewer admissions
Shorter stays in hospital
Reduction in zero length of days stay for frail/elderly
Capacity improvement in community beds
Improved productivity
Quicker discharge
Improved service access
Reduction in readmissions
Improved health outcomes
Data shared from social care to inform patient care
Improved medication adherence
Direct
Reduction in GP appointments
Improved pathway management
More informed community healthcare
Reduction in unplanned care events
Indirect
Population health

CASE STUDY

Edna

Edna is 99 years old and currently resides in sheltered accommodation in Nottingham close to her son and granddaughter.

She receives social care support through 3x30 minute visits a day from carers.

Unfortunately she has been in hospital 4 times in the last year for a range of issues stemming from falls.

Her family are concerned that the number of falls are increasing and that Edna may need to move to residential care.

Outcome: Lilli has enabled Edna to remain in her own home receiving community based care and support. Recently a potential hospital admission for a UTI was avoided through proactively identifying changes in her bathroom and nighttime activity.

CASE STUDY

Kate

Hospital Discharge Social Worker, Nottingham City Homes

"I really like the clarity of the information provided on the Lilli platform"

Roger

The patient

71 years old

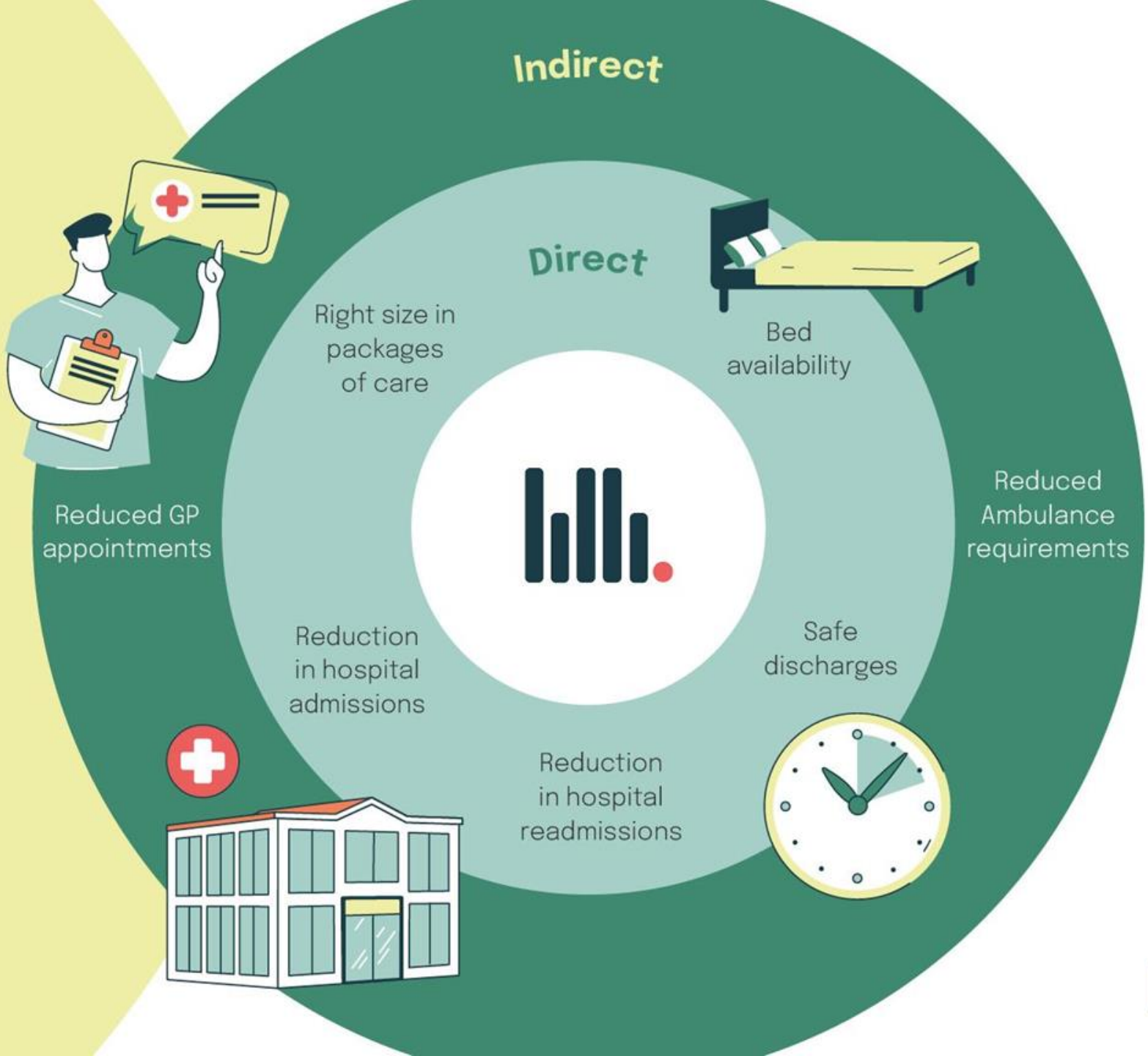
Called an ambulance out 5 times in last 6 months for frailty related incidents.

Kate identified Roger as a patient who she could use Lilli to support his discharge to a reablement program. The insight and support that Lilli offers gave Kate the confidence that in discharging him home Roger would be safe and supported if required.

Kate's colleagues in reablement were able to utilise the insight on the Lilli platform to evaluate his care needs throughout the reablement period and right size his care appropriately.

Outcome: Through using Lilli as part of the discharge process Kate was able to support a quicker safer discharge with a smaller package of care than without Lilli.

Outcomes


Indirect
Direct
Right size in packages of care
Bed availability
Reduced GP appointments
Reduced Ambulance requirements
Reduction in hospital admissions
Safe discharges
Reduction in hospital readmissions

Whole System Impact

How implementing technology in social care can positively impact the whole ICS ecosystem.

WEBINAR

30th November 2022

10am - 11:30am GMT

Pilot Scheme

- We are currently taking applications for our next pilot from ICSs now
- The pilot project has to start in the next 3 months
- 3 month duration
- Up to 50 patients
- Purpose is to create a business case at the end to support the procurement and roll out of Lilli or similar technology at scale
- Co-design, co-creation, collaboration
- Training and support provision for front line teams

To find out more email

nick.weston@intelligentlilli.com

Thank you for listening

Any Questions?

To find out more email
nick.weston@intelligentlilli.com

@LilliSays

intelligentlilli

The Integrated Care Summit: Challenges and Best Practice

SPEAKING NOW

Stephen Timmons

Professor of Health Services Management, Centre for Health Innovations, Leadership & Learning, Nottingham University Business School

I will be discussing…

"Integrated Care: Lessons from Global Experience"

Integrated Care: Lessons from Global Experience

Professor Stephen Timmons

Centre for Health Innovation, Leadership and Learning

Nottingham University Business School

Systematic Reviews

- A comprehensive, transparent review of the available research evidence
- Rigorous methodology
- Developed for reviews of interventions (treatments)
- Cochrane Collaboration
- Widely used by NIHCE
- Now more widely used

McKinsey

- The evidence for integrated care (2015)
- Systematic review of randomised controlled trials only
- “Integrated care programs were associated with a 19 percent reduction in hospital-admission rates, compared with usual care. For diabetes, we found that integrated care was associated with a mean 0.5 % point reduction in HbA1c compared with usual care. We also looked at the elements commonly found in successful programs. We found that four elements appear to be important: patient education and empowerment, care coordination, multidisciplinary teams, and individual care plans”

Baxter et al 2018

- The effects of integrated care: a systematic review of UK and international evidence. Baxter et al. BMC Health Services Research (2018) 18:350
- “Evidence of perceived improved quality of care;
- increased patient satisfaction;
- improved access to care.”
- But: “Evidence was rated as either inconsistent or limited regarding all other outcomes reported, including system-wide impacts on primary care, secondary care, and health care costs.”

Baxter et al 2018

- “There were limited differences between outcomes reported by UK and international studies, and overall the literature had a limited consideration of effects on service users.”
- “Indications of improved access may have important implications for services struggling to cope with increasing demand.”

Liljas et al

- Liljas, AEM, et al. Impact of Integrated Care on Patient-Related Outcomes Among Older People – A Systematic Review. International Journal of Integrated Care, 2019; 19(3): 6, 1–16.
- Smaller study than Baxter et al
- “Integrated care may reduce hospital admission rates and lengths of hospital stay. However due to lack of robust findings, the effectiveness of integrated care on patient-related outcomes in later life remain largely unknown.”

Rocks et al

- Rocks et al. Cost and effects of integrated care: a systematic literature review and meta-analysis. The European Journal of Health Economics (2020) 21:1211–1221
- “relatively low average quality score”
- Meta-analysis
- “significant decrease in costs and significant improvement in outcomes for integrated care.”
- “Results were significant in studies lasting over 12 months, with both a decrease in cost and improvement in outcomes for integrated care interventions. These associations were not significant in studies with follow-up less than a year.”

Hughes, Shaw & Greenhalgh

- Rethinking Integrated Care: A Systematic Hermeneutic Review of the Literature on Integrated Care Strategies and Concepts. Milbank Quarterly 2020
- I think this review shows why the extensive literature has not reached any definitive conclusions
- “Contrary to much of the current literature, our findings show that integrated care is not a unified concept but is better understood as an emergent set of practices, such as multidisciplinary case management and strategic partnership working. Integrated care programs are shaped by contextual factors, such as payment systems for health services, and therefore are unlikely to reliably affect a predetermined set of outcomes”

How does IC work ?

- Aunger, J, Millar, R, Rafferty, A, Mannion, R, Greenhalgh, J, Faulks, D & McLeod, H 2022, How, when, and why do inter-organisational collaborations in healthcare work? A realist evaluation *PLoS ONE*,17;4
- “Leadership behaviours, including showing vulnerability and persuasiveness, acted to shape the core mechanisms of collaborative functioning. These included our prior mechanisms of trust, faith, and confidence”

Conclusions

- It’s hard to define integrated care, which makes it hard to study
- Despite an extensive international literature, it’s not been shown conclusively that integrated care is better for all groups of patients
- There is some evidence that it can improve certain indicators for certain groups of patients
- This overall picture is best explained by the Hughes, Shaw and Greenhalgh review
- Last thought: Might IC have sustainability/$C0_2$ benefits ?

THANKS FOR ATTENDING

The Integrated Care Summit: Challenges and Best Practice

CONVENZIS

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NHS Elective Care Conference 2022

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Outpatient Transformation Conference 2022

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Understanding Genomics in the NHS 2022

Sign Up Here...