
# Welcome to the 9th NHS Integrated Care Conference!

25th June 2025
Leonardo Hotel, Milton Keynes, Midsummer Boulevard, Milton Keynes, MK9 2HP

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# Chair Opening Address

**Dr Gurnak Singh Dosanjh**
GP
LLR ICB


# Keynote Presentation

**Michael Bell**
Chair
South West London ICB and Lewisham & Greenwich NHS Trust


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# Panel Discussion

**Diane Baynham**
Director of Digital Care Pathways
Coventry and Warwickshire ICB

**Belinda Yeldon**
Head of Integration
NHS North East London ICB

**Michael Bell**
Chair, South West London ICB and Lewisham & Greenwich NHS Trust


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# Case Study

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# Case Study

**Tom O'Sullivan**
Consultant
Xytal

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# From Collaboration to Integration

## Top Tips for Effective Multi-Agency MDTs in Neighbourhood Teams

Tom O'Sullivan

Healthcare Improvement Facilitator & Strategic Consultant



T: 020 8016 4607 E: hello@xytal.com www.xytal.com

# Why MDTs Matter Now

- NHS Long Term Plan ➡ INTs & personalised care
- The shift from organisation-centric to person-centred care
- MDTs as a foundation of neighbourhood working


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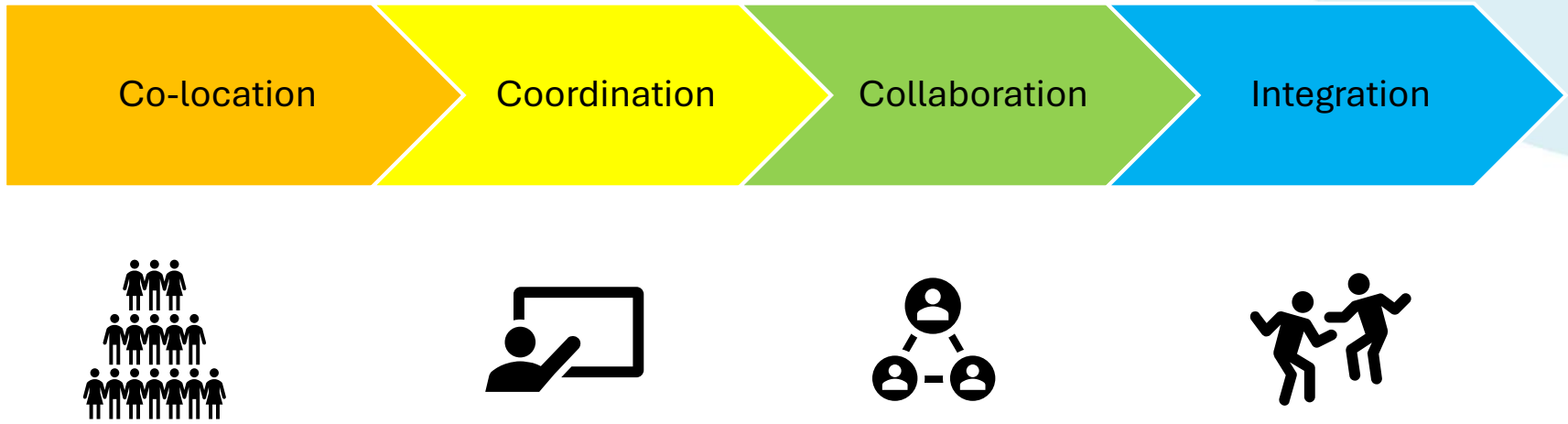
# The MDT Maturity Curve



# Common Pitfalls

- Siloed working despite meetings
- Duplication and meeting overload
- Confusion about roles or escalation
- Misaligned goals and organisational incentives

# Top Tip 1 - Clarity of Purpose

- Ask: What is the **MDT** *for*?
- Shared outcomes vs organisational metrics
- Use of a standard terms of reference or charter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# Top Tip 2 - Psychological Safety

- Norms for respectful challenge
- Equality of voice, including VCSE and social care
- Facilitated spaces, not just chaired meetings

# Top Tip 3 - Role Clarity & Language

- Avoid jargon
- Know each other's capabilities
- Role mapping across the team

# Top Tip 4 - Agile Coordination

- Use of triage huddles, WhatsApp, shared tools
- Flexible attendance, not one-size-fits-all
- Care coordination roles as linchpin


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# Top Tip 5 - Skilled Leadership & Facilitation

- Role of the chair/facilitator in enabling team performance
- Not always the GP or clinical lead
- Value of specialist MDT facilitators

# Skills for the Future

- Relational leadership
- Digital and data literacy
- Cultural competence & trauma-informed care
- Cross-boundary working


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# Final Reflections

- Quick recap of top tips
- Come and talk to us on our stand
- Signpost resources

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Jason Roberts
Commercial Director
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# Refreshments & Networking

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# Chair Morning Reflection

**Dr Gurnak Singh Dosanjh**
GP
LLR ICB

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# Case Study

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freedom to do more


# Case Study

**Laura Thompson**
Director of Marketing
Access Group

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# Neighbourhood Health: From Crisis to Community

## Building Sustainable Healthcare Through Digital-First, Community-Centred Models

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# Supporting Health, Support and Social Care

We are unique in delivering digital transformation solutions right across the Health, Support and Care landscape, with over 850 specialists supporting local government, the NHS, private providers and the third sector

## NHS Trusts

**45+**
NHS Trusts and Organisations using healthcare solutions

**150,000+**
Clinicians use Access Rio EPR

**4,000+**
Social Prescribing Link Workers connecting people to their communities

## Local Authorities

**200+**
Local Authorities using Access social care, education and youth services solutions

**48%**
Councils in England use our Market Management and oversight solutions

**3,000+**
care placements commissioned across local authorities

## Longitudinal Data

**25m+**
Unique patients within our market leading EPR

**4.1bn+**
Patient records, growing by 350m annually

**25+ years**
Of continuous operation in the mental healthcare market

## Preventative Care

**60,000+**
Individuals accessing Technology Enabled Care

**30,000+**
Wearable devices

**687,000+**
Visits carried out using our Social Prescribing solution

## Care Providers

**350,000+**
care workers rostered with Access HSC Software per year

**190m+**
hours of home care managed per year
25% of social care hours in the UK managed

**600,000+**
active recipients of care managed by Access HSC software

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# Significant challenges across the system…

**46%**

**of hospital costs driven by 7% of population with complex needs**

**13.5m**

**hours of clinical time lost annually due to inadequate or disjointed systems**

**7.4m**

**million cases on NHS waiting lists (6.23 million patients)**

**Health and care professionals navigating multiple disjointed systems to go looking for and piece together patient history**

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# Government and NHS England's guidelines are clear about our direction:

1

## Hospital to Community

Moving care closer to home and down the value chain

2

## Treatment to Prevention

Proactive rather than reactive care, planned interventions

3

## Analogue to Digital

Technology-enabled transformation, digital at the heart

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# What are the problems we're trying to solve?

## 01 Sustainable Care

Deliver more care at home or closer to home to:

- improve people's access, experience and outcomes, and
- ensure the sustainability of health and social care delivery.

## 02 Increased complexity

- More people are living with multiple and more complex problems
- The absolute and relative proportion of our lives spent in ill-health has increased*

*Darzi

## 03 Reduce siloes

Too many people experience fragmentation, poor communication and siloed working:

- Results in delays, duplication, waste and suboptimal care.
- Frustrating for people working in health and social care.

## 04 Maintain independence

Create healthier communities, helping people of all ages live healthy, active, independent lives for as long as possible:

- Improving their experience of health and social care, and
- and increasing their agency in managing their own care.

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# Locally led, integrated care focused on earlier interventions, improving outcomes and community services

- A ‘neighbourhood health service’ does not mean shifting a medical model into communities
- It requires a new proactive model of care that works more effectively with communities and wider partners
- This means building on existing community strengths and assets, not replacing them
- Empower residents and communities as equal partners in designing and delivering care, moving from 'doing to' to 'doing with' communities in all decision-making

“We are transforming our approach to care with the focus on using the latest digital technology to enable our residents to continue living their lives independently within the comfort of their own home but with the peace of mind that support is available when they need it.

“The pressures facing our adult social care services show no sign of easing, so I’m proud the Council is taking this forward-thinking approach to find solutions that will reduce the pressure on the system, as well as being beneficial for our residents.”

**Councillor Marian James, Lead Member for People Services at the London Borough of Sutton**

# Delivering the neighbourhood vision

- The evolution of an interconnected portfolio of solutions to support the delivery of high-quality Person-centred care
- Closer integration of health and social care, to enable an individual's condition to be assessed in wider context
- Transformation of health and care delivery, with more focus on prevention, through social prescribing, remote monitoring and assistive technologies
- Better use of data, intelligent platforms and machine learning / AI to drive improved decision making and outcomes

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## *"Being able to heat the house for longer eased my depression"*

## Addressing wider determinants of health prevents or alleviates healthcare demand

**Demonstrating prevention through addressing root causes is always more cost-effective than treating resulting conditions, for example:**

- **Clinical care accounts for only 20% of health outcomes** - While social and economic factors plus physical environment make up 50% of health determinants
- **Home warmth and safety** - Addressing carbon monoxide, fire safety
- **Income maximisation** - Reducing financial stress impacting mental health
- **Energy advice** - Preventing fuel poverty-related respiratory conditions
- **Cross-sector partnerships** - Health boards, housing associations, community and voluntary organisations working together

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# How this is working in practice: the shift from crisis response to organised routine healthcare with care planning rather than reactive interventions

## Technology Enabled Care:

- **Proactive Monitoring**: Activities of Daily Living sensors detect changes before crises
- **Intelligent Response**: 20-25 referrals per month redirected to NHS 2-hour Urgent Community Response
- **Cost Effectiveness**: Right-sizing of reablement care packages through data insights

## Social Prescribing at Scale:

- **Holistic Approach**: Tackling fuel poverty through energy advice, home safety, and income maximisation
- **Measurable Impact**: 71% of individuals feel happier, 74% reduced anxiety, £521,000 return on investment
- **Reduced Healthcare Demand**: People no longer visit GP or hospital as regularly for respiratory conditions
- **Community Partnerships**: Health boards, housing associations, and local authorities working collaboratively

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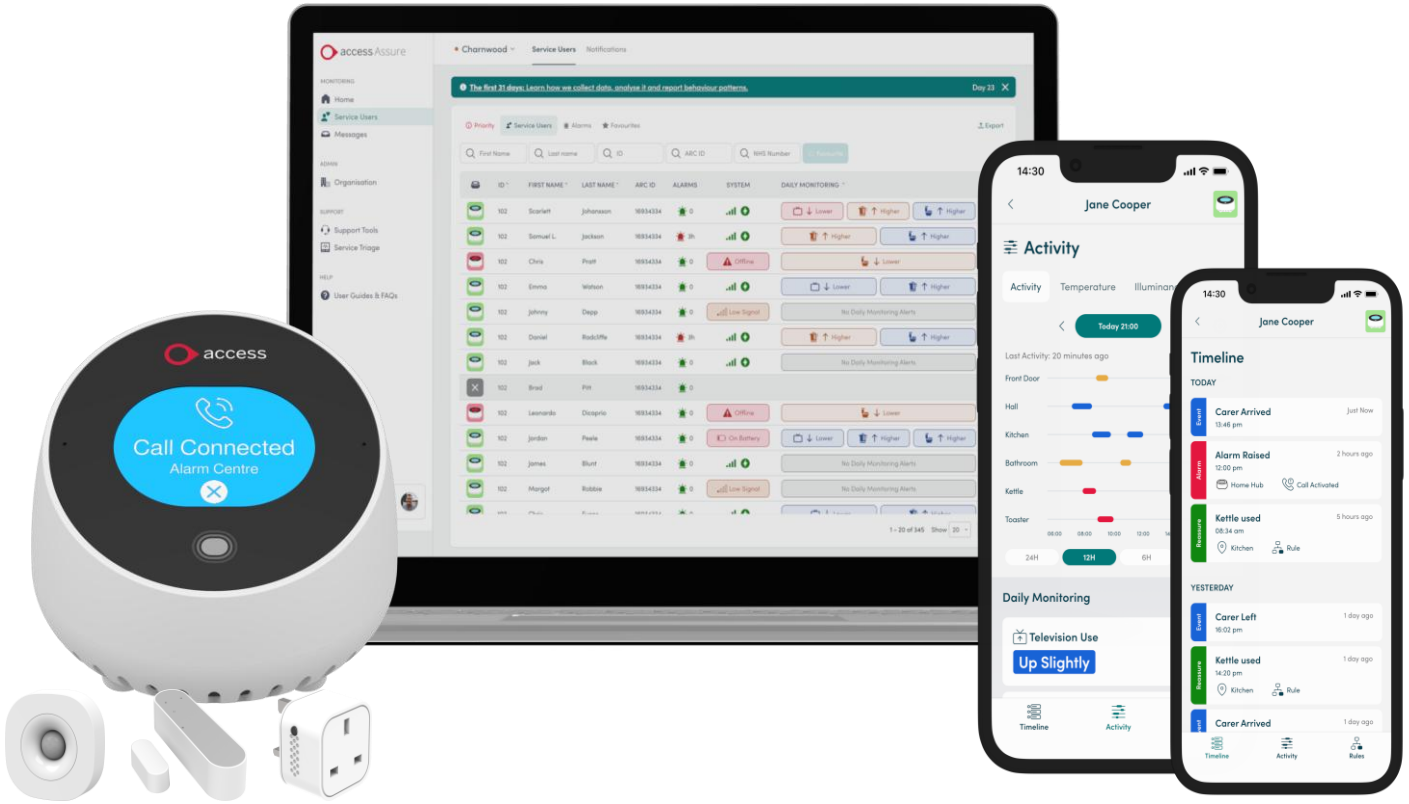
# A fundamental transformation From Reactive to Planned Care Model – Social Prescribing example

- **Link workers** connecting people to community and third sector before crisis points
- **Non-medical interventions** addressing root causes (housing, loneliness, financial stress)
- **Preventative approach** – for example addressing fuel poverty prevents respiratory conditions reaching GP/hospital
- **Data-driven tracking** of health journeys from referral to improved wellbeing outcomes
- **Cross-sector collaboration** making every conversation about health include questions about the home, income, and community connections

"Our study takes the first broad view of **all types of referral pathways, including through primary care, social care, education, charities and self-referrals**... Individuals accessing the service predominantly via non-medical routes, showing the importance not just in investing in GP referrals but also in other diverse ways of referring these individuals to the community resources they could benefit from."

**Prof Daisy Fancourt, Professor of Psychobiology and Epidemiology and Head of the Social Biobehavioural Research Group at UCL**

# A fundamental transformation From Reactive to Proactive Care Model – TEC example




Understand daily activity patterns to identify changes and subtle trends which human observation can easily miss.

Use AI to proactively identify where interventions might precede serious risks relating to falls, mobility, malnutrition, hydration, temperature, UTI onset etc.

Combine with traditional reactive alarm functionality and integrate to other data sources.

## Delivers

- Peace-of-mind from 24x7 monitoring
- Lower costs of healthcare escalation
- Ability to dynamically manage care packages to reduce cost

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Sutton

**Deploying Proactive TEC at scale**

**Improved Resident Outcomes**

**Proven ROI and increased capacity**


"AI has immense potential to make our lives easier and improve public service. The technology we are together sharing with the public today includes shining examples of innovation…helping people live independently."

**Feryal Clark, MP**
**AI and Digital Government Minister**

Social Care Premier Supplier Awards – Recognising Excellence in Suppliers to Social Care – Winner 2024

Leaders in Care Awards – Finalist

LGC Awards 2025 – Wednesday 11 June 2025 • Grosvenor House, London – Finalist

NHS What Good Looks Like

Greater London Authority

techUK

Department for Science, Innovation & Technology

Department of Health & Social Care

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# Data into insights and those insights into action – Intelligent Care Platform example

Modern clinical systems enable workflow transformation, but the future lies in intelligent platform layers that not only connect data, but connect teams and make insights actionable:

- **Single dashboard** bringing together data from multiple clinical systems including separate EPRs
- **Real-time alerts** highlighting key risks and gaps in care across community and mental health services
- **Cross-sector integration** - acute, community, mental health, social care, GPs, education, VCSE sectors
- An **intelligent overlay** infrastructure that enables **FHIR standards** and **continuance, not starting again** but building on what exists while connecting everything intelligently

"By adopting this technology, we can see huge potential in improving the breadth and depth of digital clinical information available to community staff at the point of care, strengthening our strategic priorities for digital excellence across Shropshire, Telford and Wrekin.

"It's about making the right information available to the right people, at the right time, and in the right place."

**Jonathan Davies, chief information officer at Shropshire Community Health NHS Trust**

# Joined up approaches will be integral to successful neighbourhoods

- **Children**: **Early intervention** through education, voluntary youth clubs, creating **less crisis points**
- **Adults**: **Long-term conditions** managed through health centres, with adult social care **reducing acute health demand**
- **Elderly**: **Care flagged early** and personalised with Technology Enabled Care **before crisis occurs**
- **Safeguarding**: TEC supporting those with Learning Disabilities, Mental Health Problems, Dementia, or experiencing Domestic Violence can be **more inclusive and less intrusive**
- **'Front door'** wait lists increase risk and likely to be detrimental to wellbeing for the people on those lists. Social prescribing can support people to **'wait well'**

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# Key Considerations in the Left Shift Ambition

1. **Workforce pressure concerns** - more pressure on primary care providers, GPs, mental health services, social services, community elderly care providers and VCSE organisations who are already under huge pressure

2. **Outcome-based models of care** - From activity-based to prevention-focused commissioning; from counting contacts/interventions to measuring population health outcomes, wellbeing improvements, and prevention of crisis

3. **Investment in community assets** - Funding for social infrastructure, community spaces, and local support networks

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# Your next steps

## Start with optimisation

Review current tools and processes, optimise and identify gaps

## Focus on complex needs population

Where and how can you shift from urgent reactive to planned proactive care?

## Invest in intelligent overlays

Build on existing systems with FHIR standards

We can shift from more urgent, less routine to more routine, less urgent - creating a healthcare system that keeps people **healthy, independent, and connected** to their communities

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# The future of healthcare isn't in our hospitals, it's in our neighbourhoods


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# Case Study

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# Case Study


**Graham Beales**
Deputy Director of Data and Analytics
Greater Manchester ICS

**Mohammed Shamraze**
Business Development Director
Aire Innovate


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# Fireside Interview

**Diane Baynham**
Director of Digital Care Pathways
Coventry and Warwickshire ICB


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# Case Study

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# Case Study

**Rob Hurrell**
Senior Business Development Manager – Health
Enovation UK Limited

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# From Patient Discharge to Transfer of Care


Care Network
Social Network
Remote Care
Early detection
Transfer
Registration
Treatment
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# Healthcare around the world

People are getting older.
Proportion of elderly people is growing.
People are living independently for longer.

More care professionals needed to follow demand.

Healthcare systems are not sustainable without innovation.

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# Patient Transfer

# The national discharge picture in England

**Title:** **Timeliness of Acute Hospital Discharges completed within the month**
**Summary:** Acute hospital discharges and bed days after the Discharge Ready Date averaged over a complete month for trusts submitting acceptable data.

**Period:** September 2023
**Source:** SUS (Secondary Uses Service) extract
**Basis:** Provider
**Published:** 9th November 2023
**Revised:** -
**Status:** Published
**Type:** Official statistics - In development
**Contact:** england.nhsdata@nhs.net

Note
Some trusts have a performance that naturally falls outside the Acceptance Criteria.
More information here on acceptance criteria here.
This is most likely the case for trusts providing specialist services (Type 2). In such situations these trusts might be included as exceptions.

| | | | | % of patients discharged after their Discharge Ready Date but discharged within - | | | | | | Total bed days after Discharge Ready Date for patients discharged within - | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Code | Organisation Name | Date of discharge is same as Discharge Ready Date | Date of Discharge is 1+ days after Discharge Ready Date | 1 day | 2-3 days | 4-6 days | 7-13 days | 14-20 days | 21 days or more | 1 day | 2-3 days | 4-6 days | 7-13 days | 14-20 days | 21 days or more |
| **National** | **ENGLAND** | **86.4%** | **13.6%** | **33.1%** | **23.9%** | **16.1%** | **15.3%** | **5.5%** | **6.2%** | - | - | - | - | - | - |
| RCF | AIREDALE NHS FOUNDATION TRUST | 81.3% | 18.7% | 27.5% | 18.8% | 11.9% | 21.6% | 9.6% | 10.6% | 60 | 98 | 129 | 447 | 354 | 774 |
| RTK | ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST | 90.8% | 9.2% | 38.4% | 30.1% | 15.1% | 11.6% | 2.7% | 2.1% | 56 | 99 | 110 | 144 | 62 | 82 |
| RXL | BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST | 88.3% | 11.7% | 32.1% | 23.8% | 16.9% | 15.2% | 5.9% | 6.2% | 93 | 170 | 242 | 404 | 290 | 683 |
| RAE | BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST | 70.5% | 29.5% | 64.7% | 19.2% | 7.9% | 4.5% | 2.3% | 1.4% | 503 | 353 | 284 | 331 | 301 | 476 |
| RXQ | BUCKINGHAMSHIRE HEALTHCARE NHS TRUST | 84.6% | 15.4% | 14.8% | 16.3% | 16.7% | 24.5% | 11.3% | 16.3% | 38 | 103 | 214 | 587 | 479 | 1,531 |
| RWY | CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST | 88.8% | 11.2% | 10.0% | 22.4% | 23.6% | 24.3% | 8.5% | 11.2% | 26 | 142 | 290 | 605 | 361 | 967 |
| RGT | CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST | 81.4% | 18.6% | 45.0% | 20.2% | 13.2% | 13.8% | 5.2% | 2.6% | 276 | 296 | 406 | 750 | 532 | 472 |
| RQM | CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST | 87.8% | 12.2% | 36.2% | 22.3% | 13.9% | 17.2% | 3.9% | 6.5% | 122 | 185 | 226 | 543 | 229 | 752 |
| RJR | COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST | 90.3% | 9.7% | 14.4% | 12.2% | 12.2% | 33.8% | 9.4% | 18.0% | 20 | 40 | 82 | 427 | 210 | 964 |

# The national discharge picture in England

- In Sep 23, across England, 84% of Discharges occurred on Discharge Ready Date
- Dig into the other 16% and you find:
  - 33.1% were 1 day after (95)
  - 23.9% were 2-3 days after (68)
  - 16.1% were 4-6 days after (46)
  - 15.3% were 7-13 days after (44)
  - 5.5% were 14-20 days after (16)
  - 6.2% were 21 days or more after (18)

# Not a ‘nice to have’, but an urgent priority

Urgent care worse than pre-pandemic, think tank says

Hugh Pym
Health editor
@bbchughpym

28 April 2025 · 35 Comments

**A leading health think tank says urgent and emergency care in England is performing "far worse" than before the pandemic.**

The Health Foundation argues that the NHS was "in distress" this winter with A&E waiting times reaching a record high.

The group says it would be wrong just to blame relatively high levels of flu.

The government is due to publish an urgent and emergency care plan soon.

The Department for Health and Social Care said that hospitals were "feeling the strain" but that it was taking "decisive action" to prevent winter crises.

Home / News & comment

News

Tough winter continues for NHS with discharge delays keeping patients stuck in beds

Pressure on social care funding, a lack of care home beds and delays to discharge packages is slowing the flow of patients

20 February 2025



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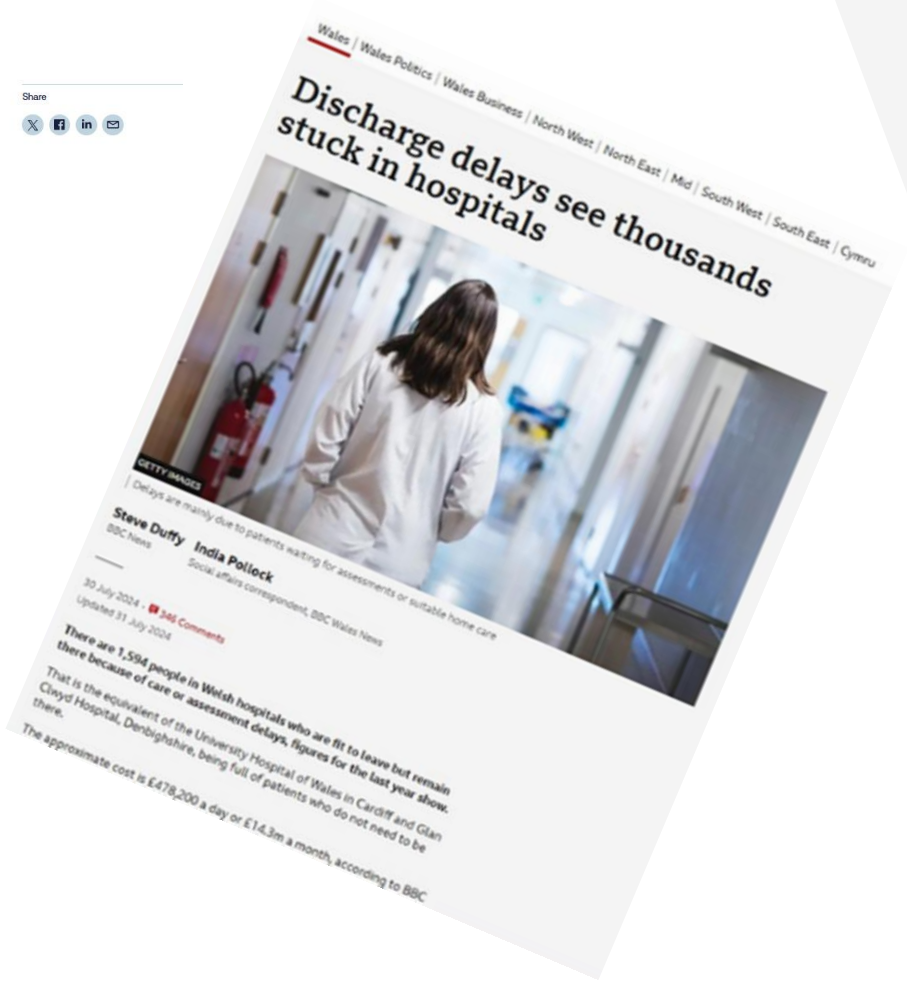

Wales | Wales Politics | Wales Business | North West | North East | Mid | South West | South East | Cymru

Discharge delays see thousands stuck in hospitals



GETTY IMAGES

Delays are mainly due to patients waiting for assessments or suitable home care

Steve Duffy
BBC News

India Pollock
Social affairs correspondent, BBC Wales News

30 July 2024 · 346 Comments
Updated 31 July 2024

**There are 1,594 people in Welsh hospitals who are fit to leave but remain there because of care or assessment delays, figures for the last year show.**

That is the equivalent of the University Hospital of Wales in Cardiff and Glan Clwyd Hospital, Denbighshire, being full of patients who do not need to be there.

The approximate cost is £478,200 a day or £14.3m a month, according to BBC

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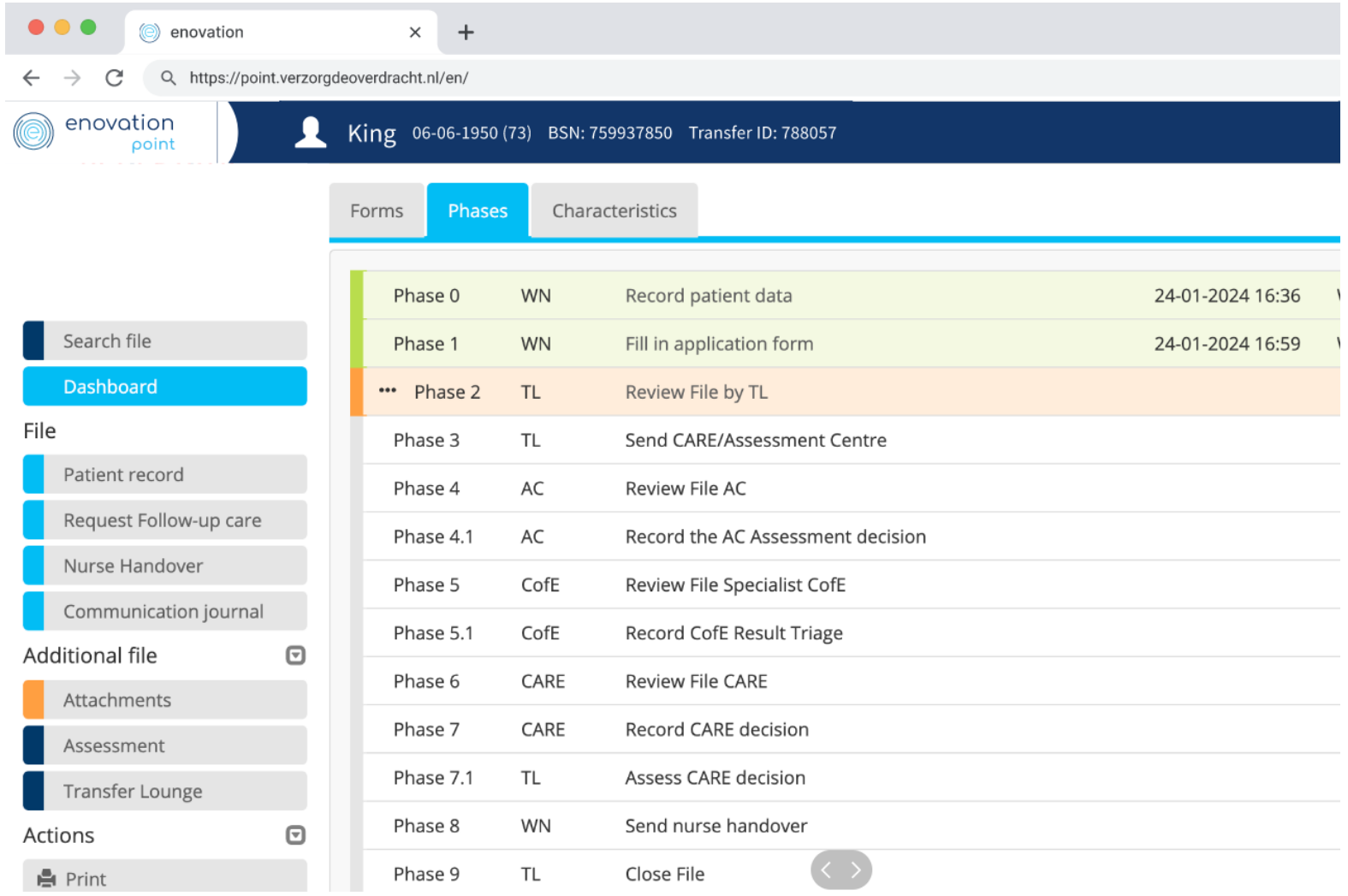
# What is the challenge?

- Discharge historically seen as the end of the pathway: ‘get patients out of hospital’
- **Lack of collated information** about ongoing care needs
- Lack of system integration means discharge notes are ‘sheets in the wind’ – **clinical risk**
- Lack of information about **capacity** leads to the dreaded ‘call round’.

# The Hague (NL)

# The Hague (NL)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File
Patient record
Request Follow-up care
Nurse Handover
Communication journal
Additional file
Attachments
Assessment
Transfer Lounge
Actions
Print
Phase 0 WN Record patient data 24-01-2024 16:36
Phase 1 WN Fill in application form 24-01-2024 16:59
Phase 2 TL Review File by TL
Phase 3 TL Send CARE/Assessment Centre
Phase 4 AC Review File AC
Phase 4.1 AC Record the AC Assessment decision
Phase 5 CofE Review File Specialist CofE
Phase 5.1 CofE Record CofE Result Triage
Phase 6 CARE Review File CARE
Phase 7 CARE Record CARE decision
Phase 7.1 TL Assess CARE decision
Phase 8 WN Send nurse handover
Phase 9 TL Close File

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# Sussex ICS

# Stockport

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# Lessons

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# Lessons

- There is really good national guidance for what holistic transfer of care could / should look like
- Trusts and other care providers have put staff in place to support effective pathways
- Despite this, technology is siloed and doesn't meet staff or patients where they are.
- Need to integrate existing systems so right information can be accessed in right place at the right time
- Then (and only then) can a holistic transfer of care pathway truly succeed in improving patient care

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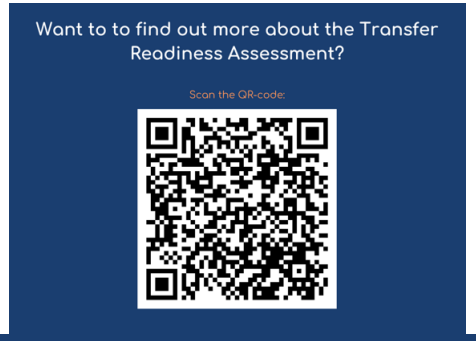
# Where do I start?

- Talk to us - we have created quite an active forum for sharing ideas and best practice around approaches to patient transfer, and we'd love to hear your experiences.
- We are offering a transfer readiness assessment to help care organizations benchmark where they are, where they could be, and what they might need to get there – see us downstairs, or simply scan the QR code on screen for a brochure.



# Questions?


Want to to find out more about the Transfer Readiness Assessment?

Scan the QR-code: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**Those with a yellow lanyard attending todays roundtable please meet at the registration desk**


# Lunch & Networking

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# Chair Afternoon Reflection

**Dr Gurnak Singh Dosanjh**
GP
LLR ICB

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# Case Study

blinx healthcare


# Case Study

**Dr Simon Bowers**
Chief Medical Officer
Blinx Healthcare

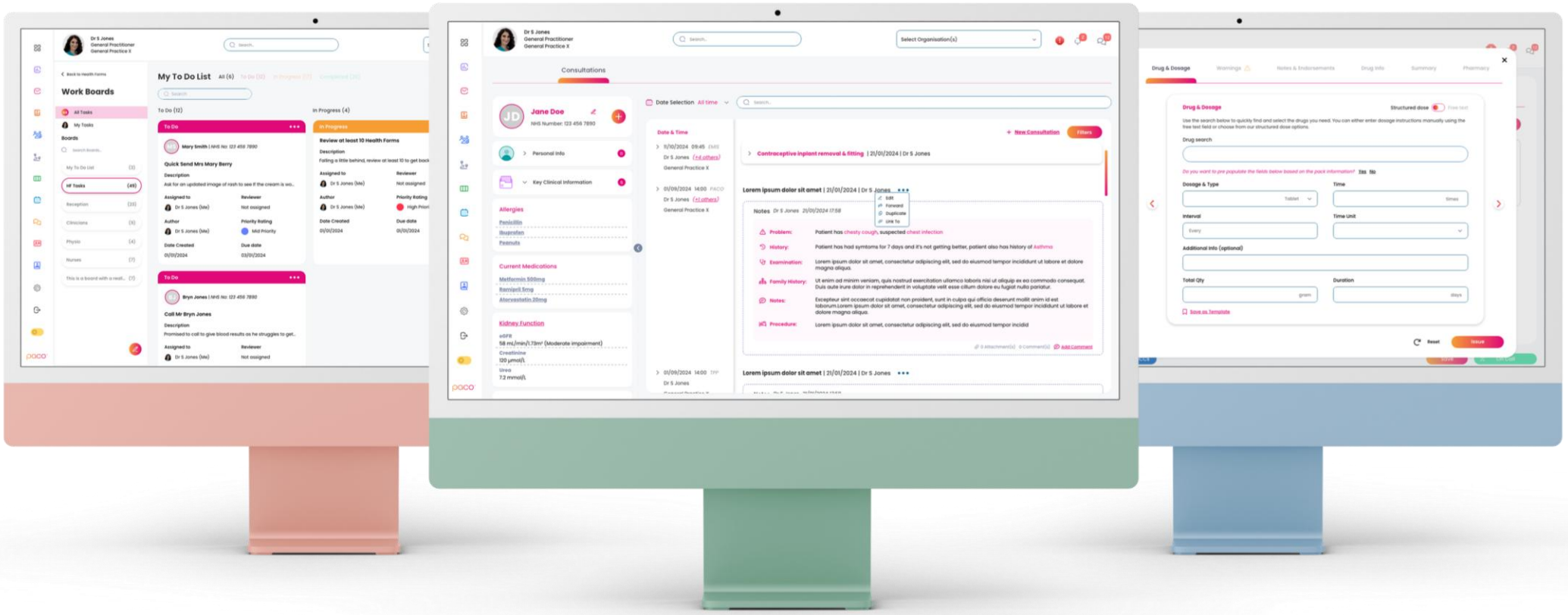
paco® Patient And Care Optimiser

blinx healthcare

# Welcome to our Neighbourhood

## Dr Simon Bowers

Chief Medical Officer



# Background: Building the Future of Clinical Systems

## Blinx: Built with the Front Line to Power the Next Generation of Care

### Flexible, Stepwise Transformation
- Integration
- Mobilise the record
- Scalable
- An end to workarounds

### Frontline Co-Design
- Clinically Led
- 3 years of development with GPs, nurses, and urgent care teams

### Only Cloud-Native, End-to-End Platform
- Built for neighbourhood, PCN & system-wide models
- Supports joined-up care across all settings

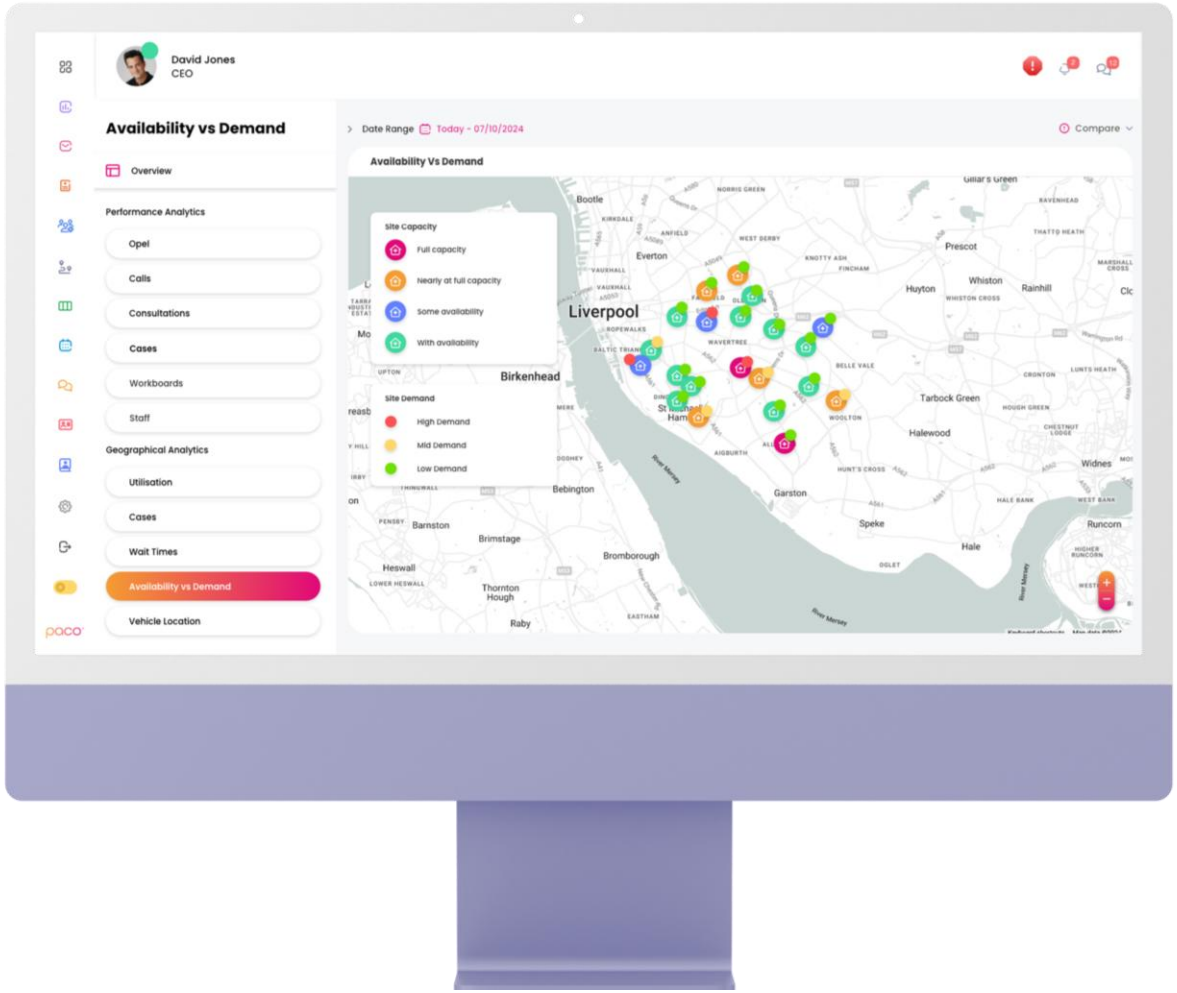
### Blinx DNA
- Deep roots in data, UX, interoperability
- Designed to streamline workflows and reduce admin

### Enabling a New NHS Operating Model
- More than replacement: PACO unlocks a **scalable, modern, joined-up system** for today and tomorrow

At the heart of our Architectural design

**Safety First**

Clinical | Cyber

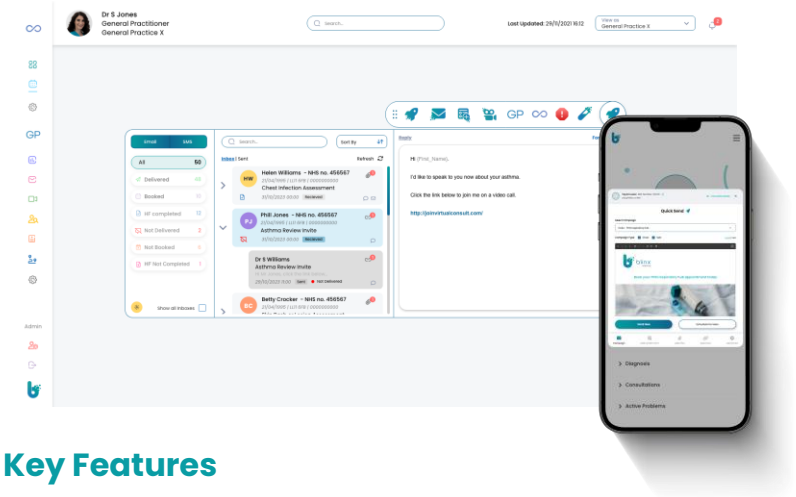


# Our Product Story

## paco GP

### A single Primary Care Platform

Paco GP is an all-encompassing digital platform for Primary Care. From Online consultations and Care Navigation to Appointment Booking, Patient communications, Digital Healthcare data capture, and Population Health Analytics, it addresses every facet of primary care seamlessly, all in **one place.**



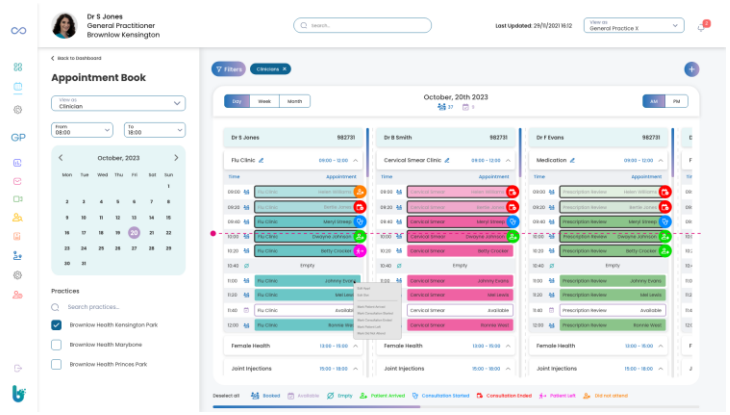
### Key Features

- Compatible with EMIS and TPP
- Auto Translations of all communications
- Highly Configurable Care Pathways
- Health Form Design tool
- NHSE IM1 approved
- Boasts 25+ integrations with EMIS
- Integrated with ICE for test management
- Rocket Bar

## paco connect

### Neighbourhood healthcare platform

Paco Connect extends the capabilities of PACO GP to support Healthcare delivery at scale. It supports functionality beyond Primary Care borders, empowering Primary Care Networks, Localities, Neighbourhoods, Federations, or ICBs to operate efficiently at scale and distribute demand across all available resources. Including mixed **EMIS and TPP** teams.




### Key Features

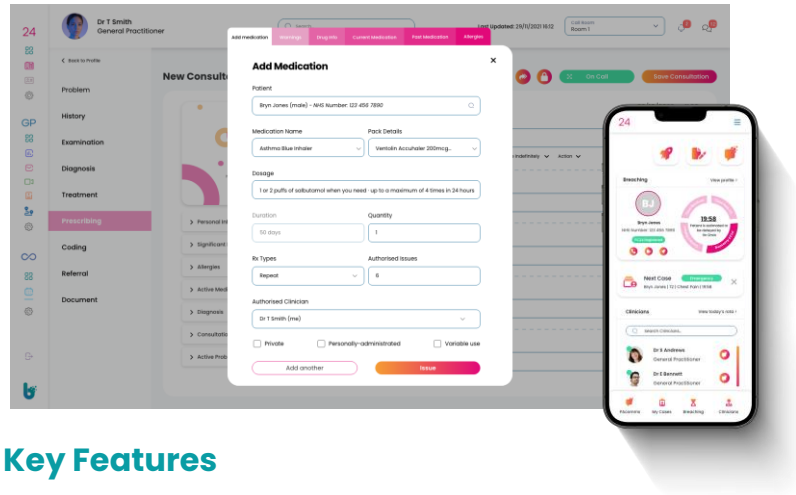
- Publishable Appointment books for cross org “Neighbourhood working
- Single Sign On (vs. multiple smartcard logins) for cross org consulting
- Mapping of HealthCare Professional Skills to patient demand
- Patient Self booking into Neighbourhood/locality/PCN services

## paco 24

EPR **New Market Entrant**

### EPR for Urgent Care Providers

Paco 24 is a cloud-based full clinical urgent care platform, facilitating the entire patient journey from '111' call request to consultation, prescription, and integration into the patient's medical record. With integrated Telephony, it supports mobile consultations for remote consultations and home visits, ensuring a comprehensive Urgent Care/Out of Hours experience.




### Key Features

- Cloud based architecture for scale and resilience
- Smart case management and allocation based on priority and staff skillset
- Telephony Integration with auto-calling
- Appointment books for UCCs
- Patient Comfort Calling & Quick Send (SMS/Email)
- Health Forms for data capture

# Primary Care e2e

## Analytics

- Identify Patient Cohorts to target proactive actions and create **Healthier Populations**
- See and act on **Clinical** and **Workforce** data insights such as **Access/Capacity & Demand** to improve access and patient outcomes
- Aggregate views at **Practice, PCN, Federation or ICS**

**Quick Send**

Direct patient messaging

Patient **SMS and Email**

## Comms Hub

- Batch **Email & SMS Campaigns** for Appt. Invites & Health Forms
- Automation of **Call/Recall searches, invites and coding automated**
- Auto translated to **patient's native language**
- Direct patient messaging (**Quick Send**) with invite links
- Insert videos to **personalise patient comms**

**Quick Form**

Staff entered Health Forms

**Mobile Consultations** for Home visits and Care Home ward rounds

## Health Forms

- Digital Health Forms for **patient recorded data capture. Health diaries, questionnaires, Consent forms etc.**
- All data **coded back to the patient record**
- Code any type of question, econsent providing full **digital signatures**

NHS England

Integrations

## Virtual Consultations

- Host virtual consultations  Web Chat and Video. **Add multiple colleagues or multiple patients!**
- Directly **Code patient notes** within the PACO video/chat
- All integrated to the patient record **without logging into your clinical system**

## Scheduler

- Patients self book and complete digital Health Forms, **No App download! No account creation!**
- Reduced inbound calls
- Practice/PCN controlled configuration ensuring **patients see the right staff member**

**Care Navigator**

Staff led triage pathways.

**Configure your own pathways**

## Digital Front Door

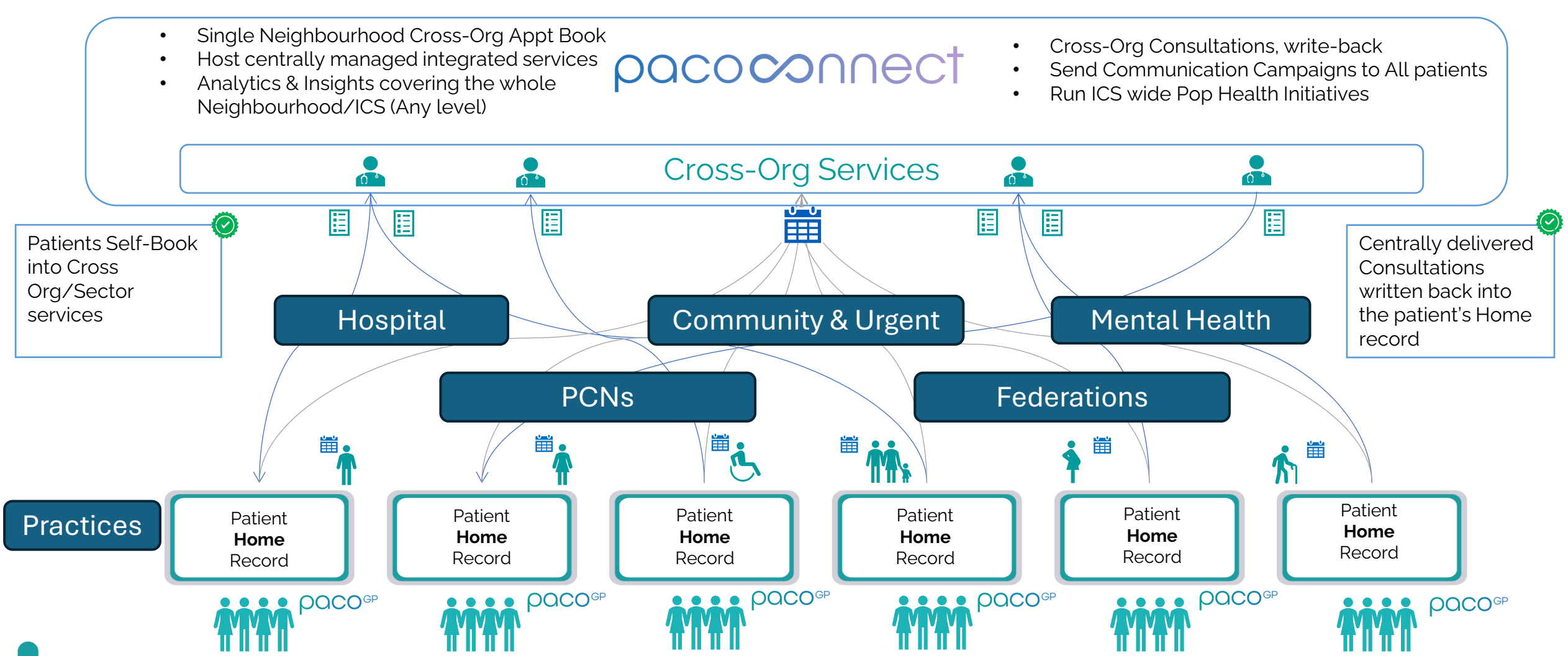
- Digital Access point for patients to **self book, make admin and clinical requests or record patient data through our Health Forms**
- Configurable by practices, PCNs, Feds etc
- OCVC Triage, Consent, Care Home integration

# paconnect Integrated Neighbourhoods

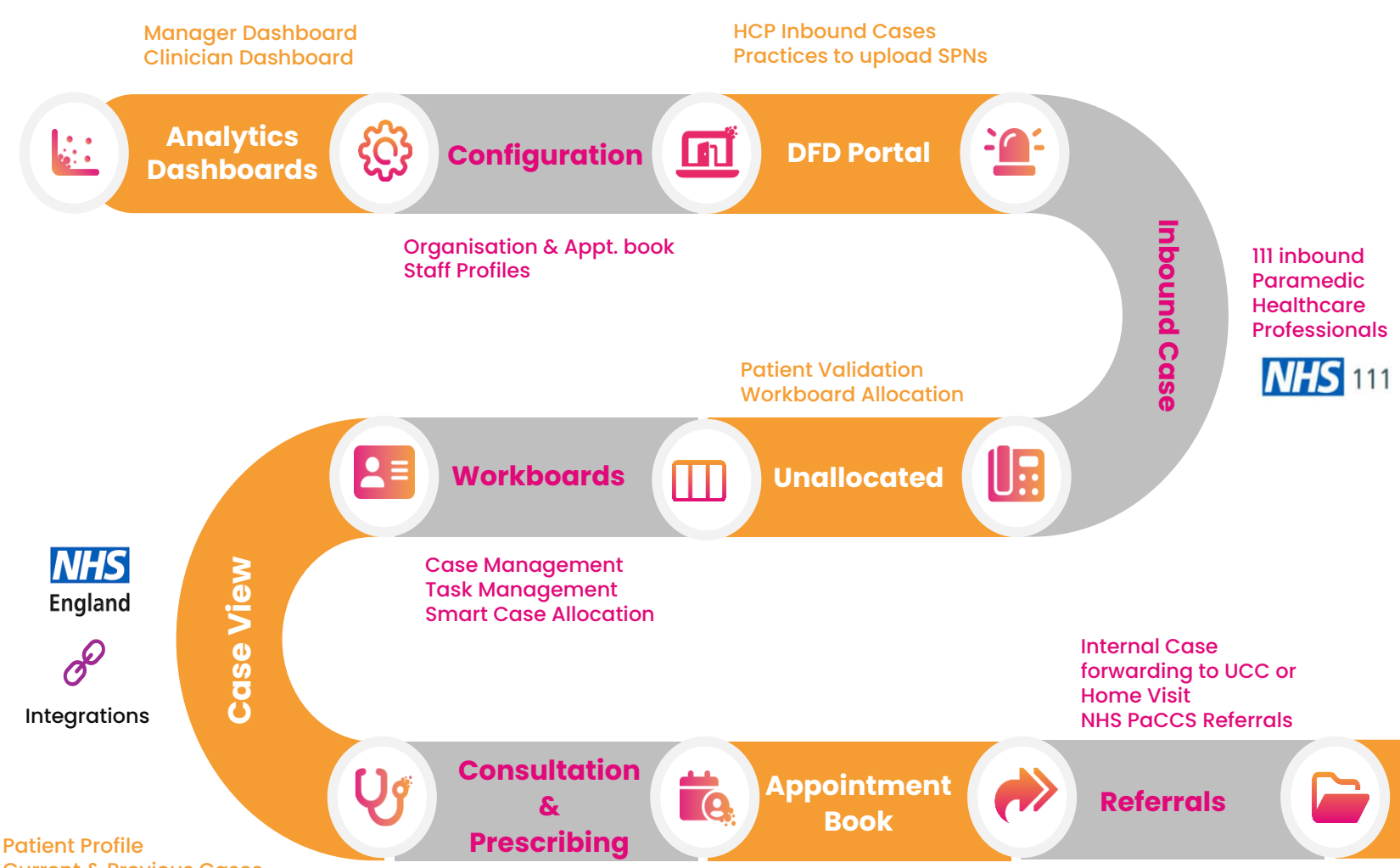
- Single Neighbourhood Cross-Org Appt Book
- Host centrally managed integrated services
- Analytics & Insights covering the whole Neighbourhood/ICS (Any level)

paconnect

- Cross-Org Consultations, write-back
- Send Communication Campaigns to All patients
- Run ICS wide Pop Health Initiatives




**Integrates with** emisWeb **and/or** systmone




## Quick Send

Direct patient messaging
Patient SMS and Email
Add health forms and booking links

## Quick Book

Book Patients into the UCC with quick book, based on locations, clinicians and session availability

## Telephony

Integrated telephony for consultations, comfort calling.
Dial in additional callers
Virtual waiting rooms
Telephony reporting

## Health Forms

Ability to capture consent or additional information to assist sent via SMS or Email.

## PAComms

Internal Messaging with online staff members.

# PACO: Not Just a System. A New Way of Connecting Care

blinx healthcare

General Practice | Pharmacy | Dentistry | Urgent Care | Community & Mental Health | Social Care | Acute


### Document Management
Easily manage, store, and find clinical documents

### Quick Send & Comms Hub
Send messages, emails, and texts to patients fast. Automated translations. Automated coding.

### Health Forms & Quick Forms
Digital forms for capturing patient info efficiently. (Automated Coding)

### Self Booking
Empower Patients With Flexible Appt. Booking

### RocketBar
Fast access to key tools and shortcuts in one place.

### Quick Pay
Collect payments or fees quickly and securely.

### Appt Book
A Modern Booking System For Practices & other Neighbourhood Teams (single appt book)

### Case Load Management
Track and manage patients by clinical case or need. Automated Skill based Case allocations

### PACO Analytics
Capacity & Demand, Meds Mgmt. Population Health Data For Single and Multi-Site Organisations for CVD prevention etc. Automated recall and Clinical Trials solution

### Telephony
Intelligent Cloud based telephony for Patient Communications

### Digital Control Room
Population Health/Capacity & Demand Analytics At Scale. With intelligent automations for proactive outreach & intervention

### Consultations & Quick Script
Modern & Efficient structured Consulting and Prescribing Experience

### Virtual consultations
Video Call & Web Chat structured consultations

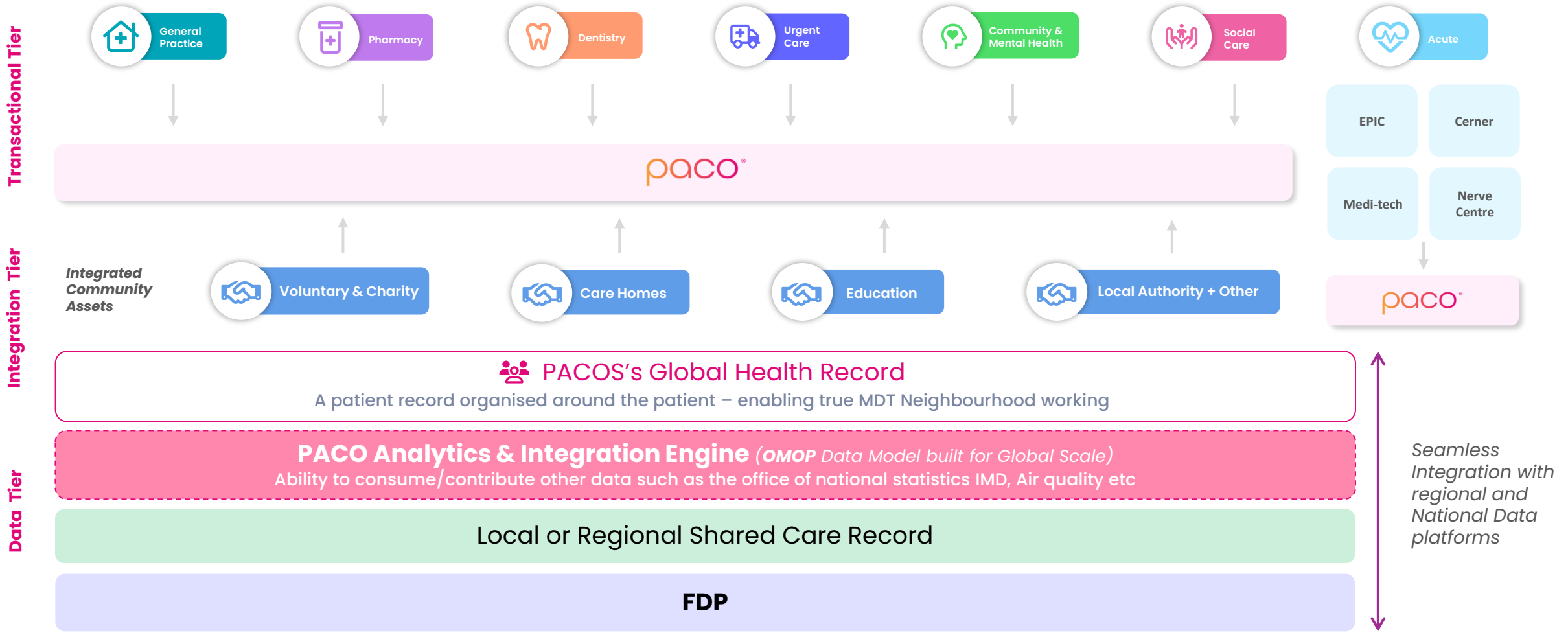
### Care Navigation
Helping Teams Guide Patients Through Pathways

### Digital Front Door
Patient Self-Serve Access To Services

### PACO Assist
Blinx's AI 'PACO Assist' will support you with a number of functions. Including suggest coding

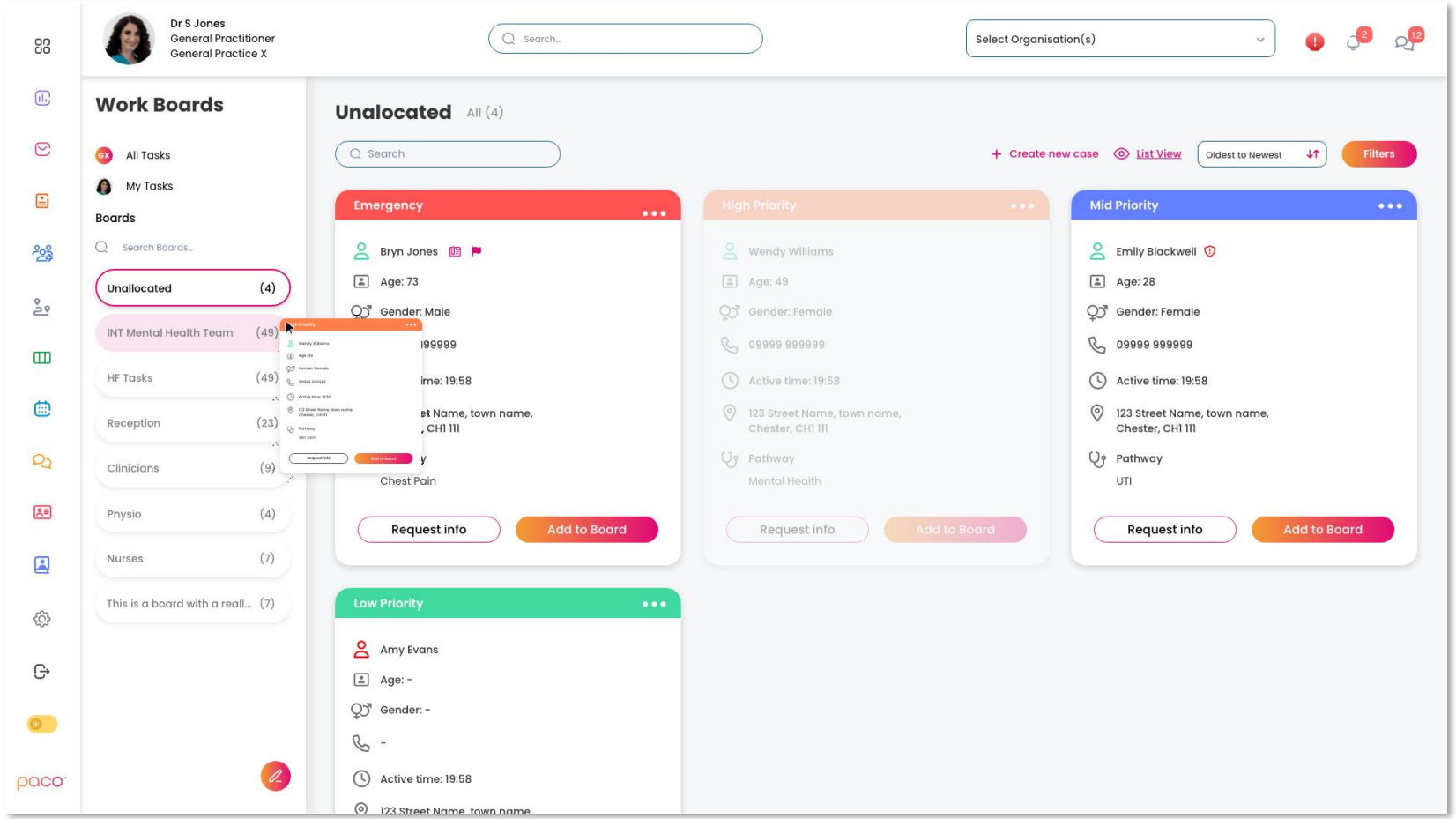
### Workforce Optimisation
Rostering/rota/talent optimisation

# Neighbourhood Health with PACO




**PACO** Offers the option to **Integrate** or **Replace** across the Neighbourhood in line with your strategic timing. PACO operates as the Neighbourhood Middleware enabling data flows seamlessly across organisation via a single Global Patient Record (**GPR**) that organisations can contribute to or consume

# **Caseload Management** – Seamless, Patient-Centric, and Actionable.

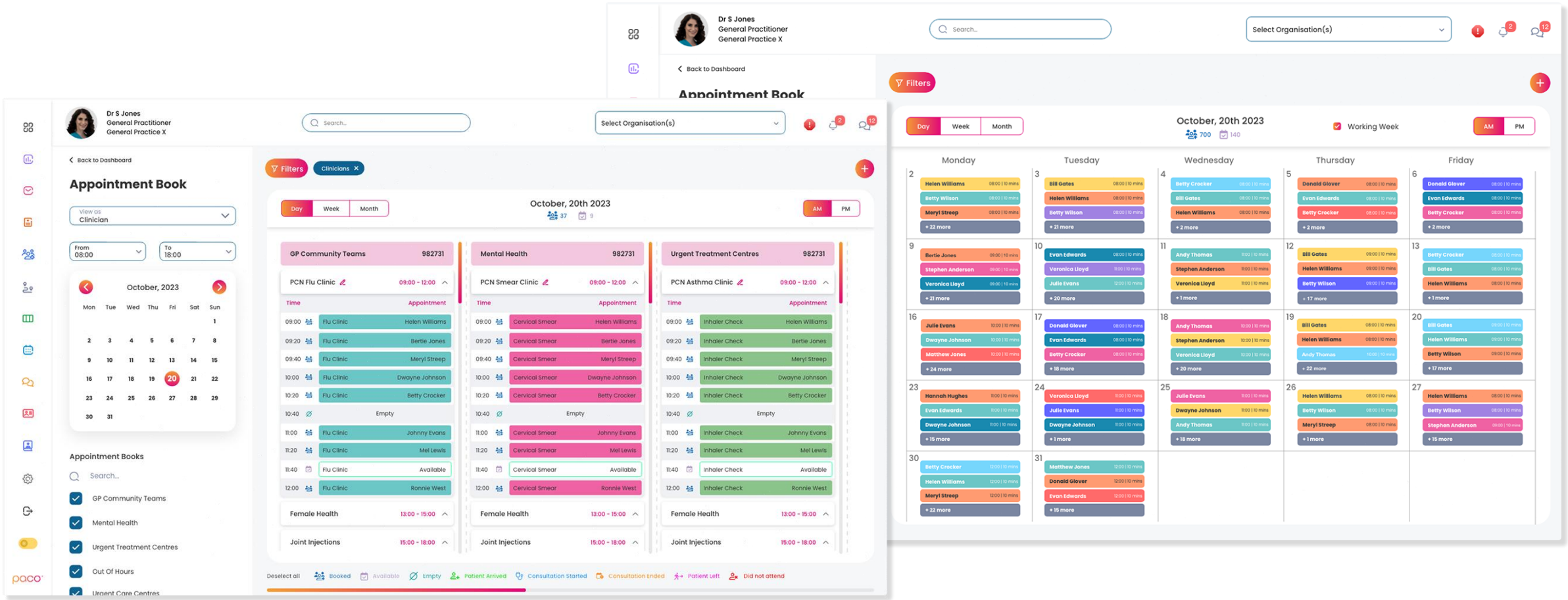



PACO puts Caseload Management at the heart of the Neighborhood Global Patient Record.

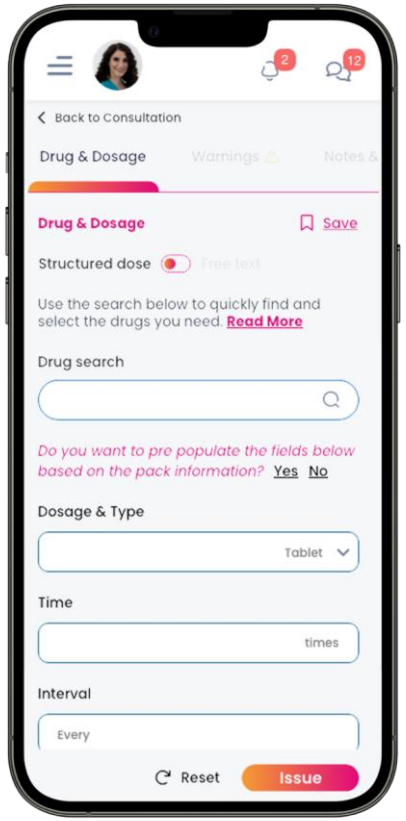
In this example, a patient case is transitioned effortlessly (Drag & Drop!) from the Neighbourhood view to the Mental Health Workboard — **in just one click.**

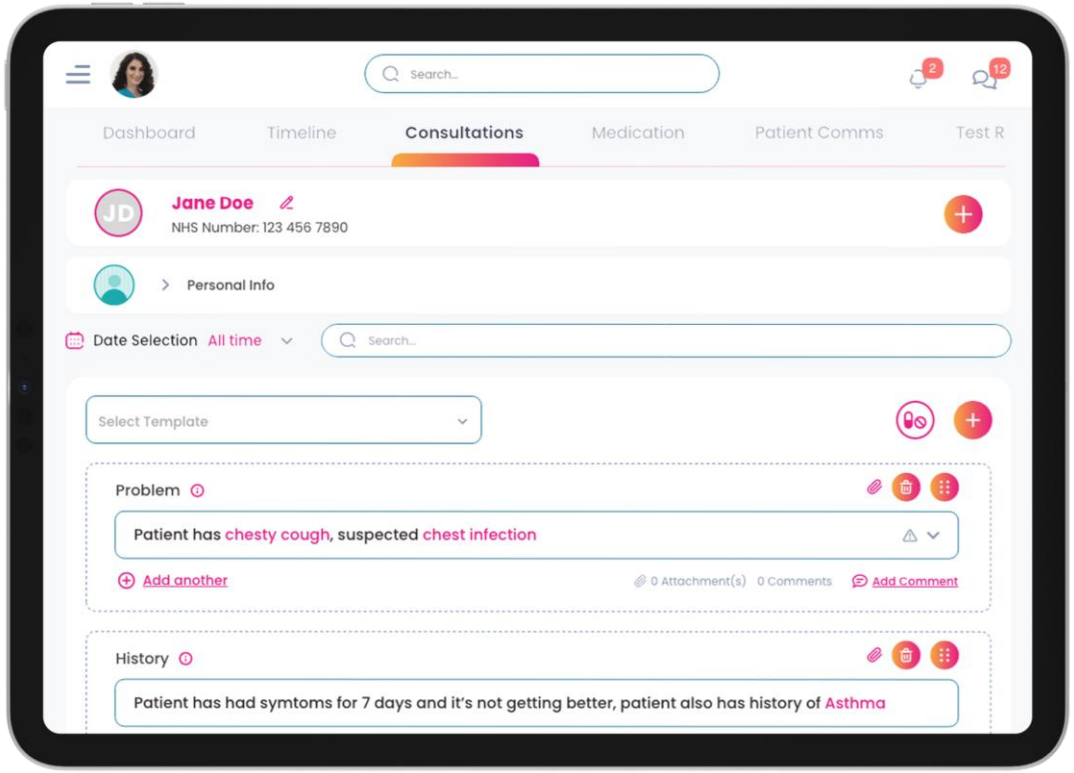
*One shared record. One coordinated response. One PACO.*

# Smart Booking Functionality



# Mobile & Tablet Consultations & Prescribing



Patient And Care Optimiser

paco®

# The Global Health Record


blinx


# Slido

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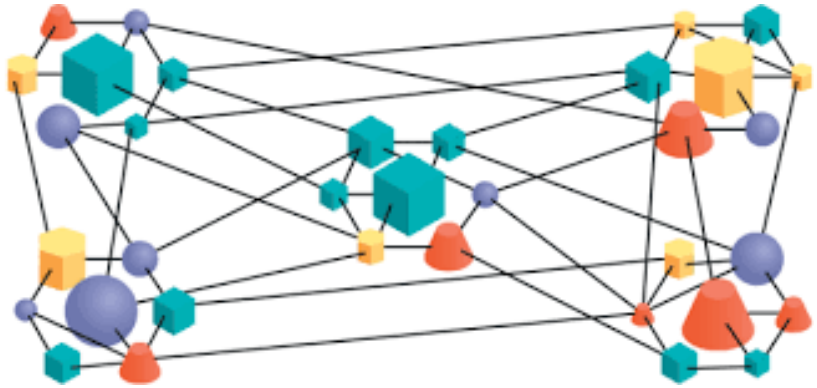
SCAN ME


# Workshop

**Jason Greasley**
Leadership Consultant & Head of Coaching and Leadership Transformation
Buckinghamshire Health & Social Care Academy

# A ‘Team of Teams’ approach to Integrated Neighbourhood Teams


*Health Coaching cohort, 2024*



Jason Greasley

Head of Coaching and Leadership Transformation,
*Buckinghamshire Health and Social Care Academy*

Buckinghamshire Health & Social Care Academy

The Coaching and Mentoring Pool

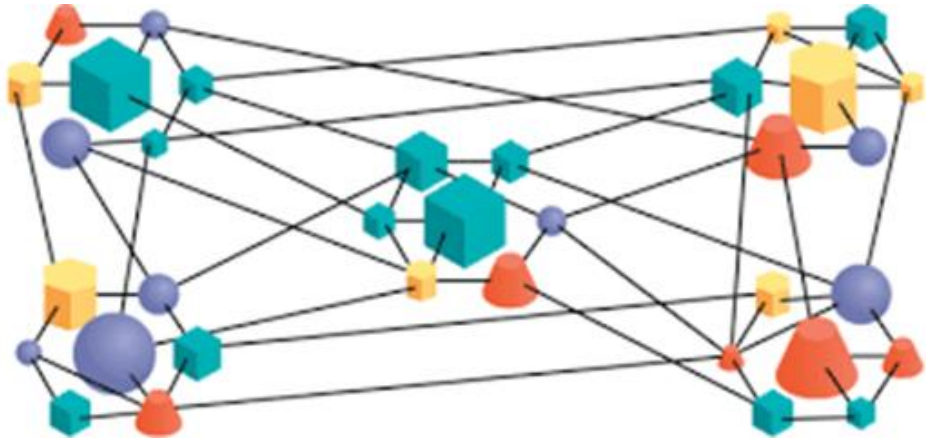
part of the Buckinghamshire Health & Social Care Academy

# Integrated Neighbourhood Teams (INT's)

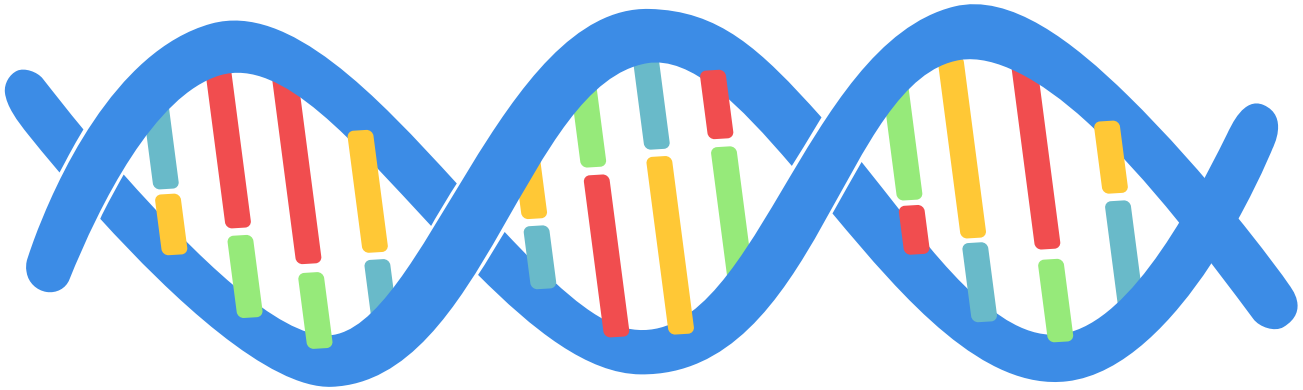
- Integrated Neighbourhood Teams (INT's) are one of the many shifts in health and social care to support improving outcomes, prevention and shifting resources into the community, whilst improving health inequalities.
- For INTs to work, all stakeholders will need to let go of old models of working and build strong relationships and trust across their systems.
- Those we are serving need to be at the heart of every decision and be involved in the decision making; it's their life and their community.
- We will need a multidisciplinary approach from all services, in all sectors and move towards a 'team of teams' approach.

The concept of a "team of teams" in INTs refers to a collaborative approach where multiple smaller teams work together as a cohesive unit. This structure aims to:

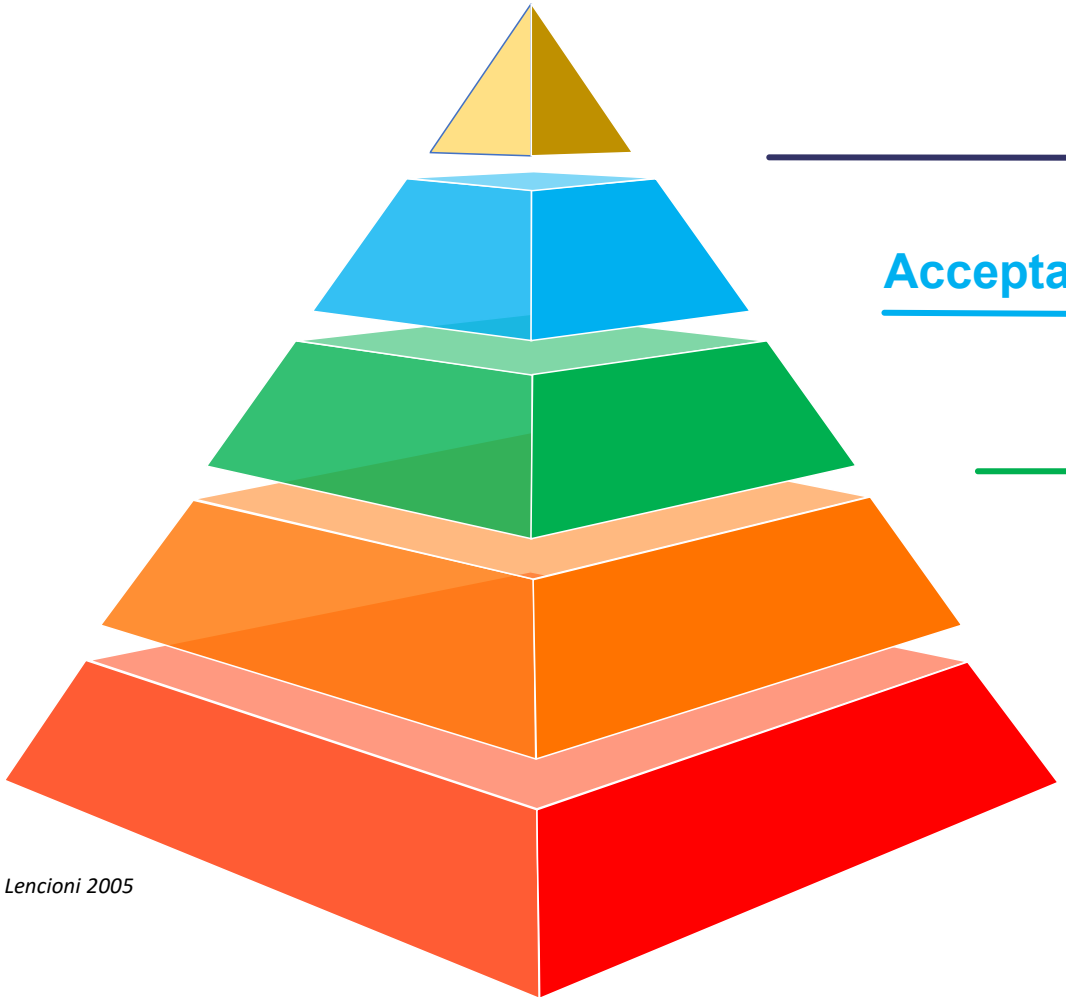
- **Enhance Collaboration:** By bringing together various professionals from different disciplines, INTs foster better communication and teamwork.
- **Streamline Processes:** Simplifying referral and administrative systems reduces barriers to care and improves efficiency.
- **Improve Patient Outcomes:** Coordinated care ensures that service users receive comprehensive and timely support, addressing both medical and social needs.
- **Leverage Expertise:** Teams can draw on specialist knowledge from various fields, providing more holistic and specialised care.



This approach helps create a more integrated and effective healthcare system, benefiting both service users and providers, whilst putting those we serve first.



# Five functions of a team



*Lencioni 2005*

Attention to RESULTS

Acceptance of ACCOUNTABILITY

Clear open COMMITMENT

Productive CONFLICT

Building TRUST

# What next?

Trust is the foundation for any relationship both at home and work; absence of trust across teams and in systems is the most severe dysfunction a team can have.

Doing more with less means we **MUST** work better across systems and build the foundations for the future.

If we do not trust each other, will we share knowledge, will we learn from each other?

- What's within your control to change this?
- Who do you need to build trust / relationships with?


# Slido

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# Keynote Presentation

**Liz Ashall Payne**
Founder
ORCHA Health

ORCHA

# Revolutionising Patient Flow
## Integrating Digital Health to Address NHS Capacity Challenges

**Liz Ashall-Payne**
**Founder**

DIGITAL HEALTH. **UNLOCKED**.

# THE Capacity Challenge

A Growing Challenge **7.5M+ people are currently on NHS waiting lists**
Mental Health and elective care delays impact millions

As at Feb 2025
MSK (Trauma & Ortho): 853K
Ophthalmology: 589K
Cardiology: 413K
General Surgery: 408K
Dermatology: 404K

**Mental Health** Waiting List Snapshot:
**2.3M open referrals**
**345K+ waiting over a year**
16.5K+ waiting over 18 months
393K children & young people in queue

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**Waiting list data as of December 2024 – NHSE RTT data*

# Digital health is critical to solving the healthcare crisis in the NHS

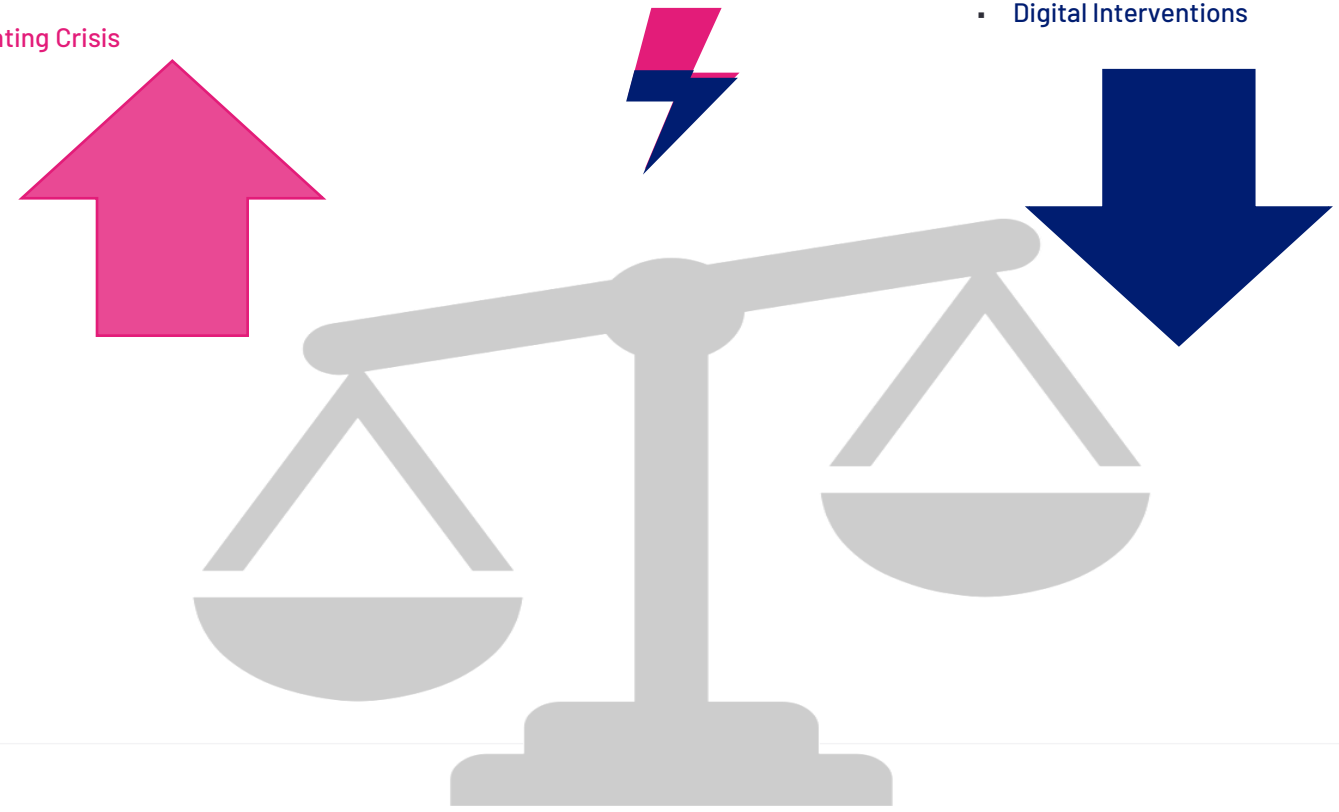
**Digital Health drives demand and capacity**

**Demand Drivers**

- Self care and self management approach to healthcare
- Better control on disease
- Appropriate use of resources
- Preventing Crisis

**Capacity Drivers**

- Automation
- Decision support
- 'Virtual Wards'
- Digital Interventions



# THE DIGITAL OPPORTUNITY

**6.6 billion**

**People across the world have a smart phone**

**That's more people than own a toothbrush**

## Top countries for health app downloads:


**5m**

People download a health app every day.

**93%**

of clinicians believe digital technologies can help.

**65 %**

of people aged 65 years and above want to engage with Digital Health

# THE DIGITAL PROBLEM

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Only

**20%**

**of the 365,000 apps to choose from meet quality thresholds.**

*How do people or healthcare systems know which ones are safe and effective and therefore which to buy?*

# Step 1
# Build Trust and Transparency

# Example Digital Health Assessment Frameworks

There are multiple digital health frameworks globally ,

The DTAC

ISO-82304-2

Mindex

DiGA

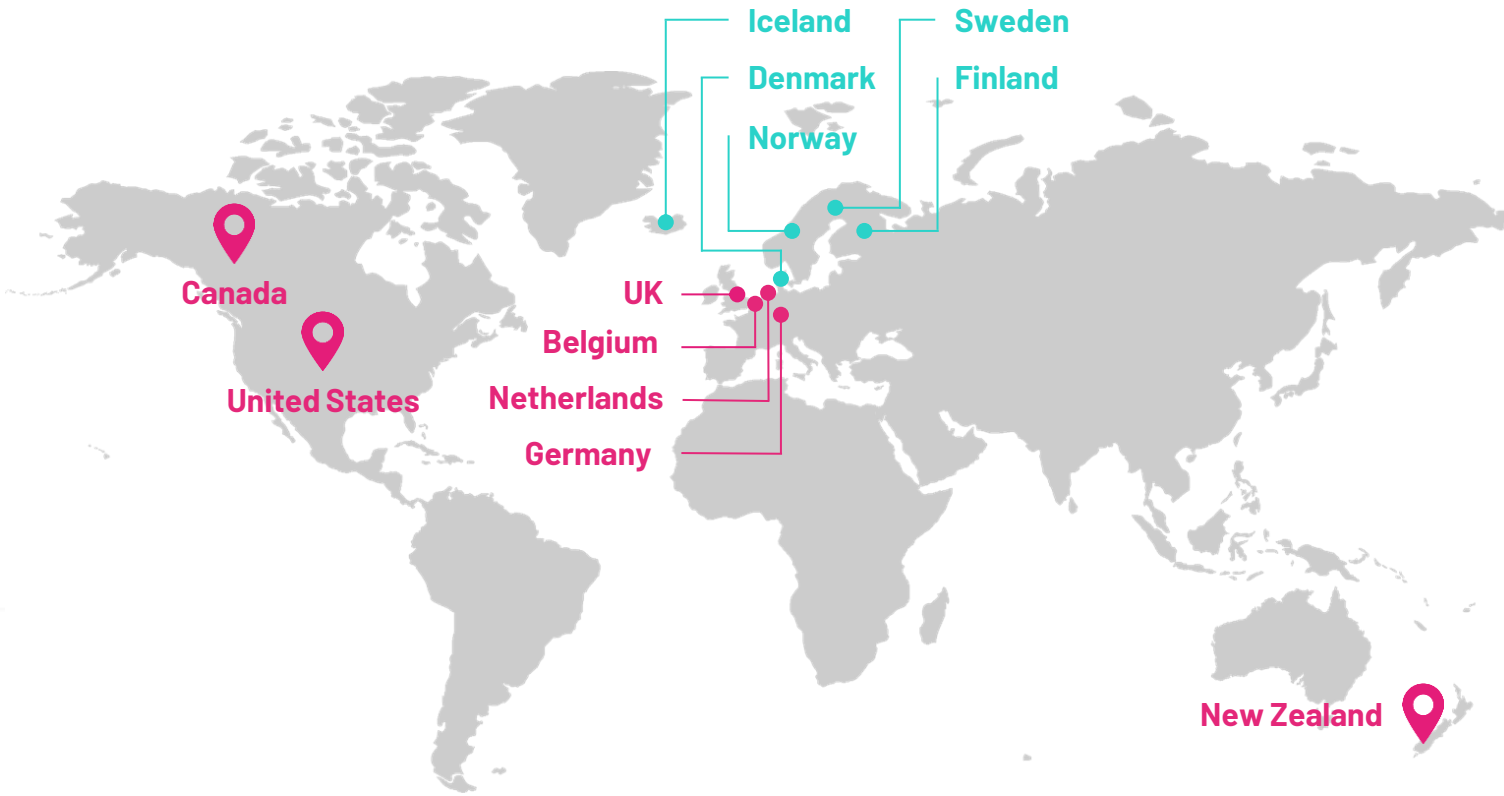
mHealth Belgium - Validation Pyramid

NORDIC Baseline Review

USA DHAF

Belgium

Canada



# Huge amount of convergence

***HAVING HELPED CREATE MANY OF THEM, ORCHA work to passport compliance data raising efficiency and reducing cost***

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| | US Digital Health Assessment | EU ISO 82304-2 | NHS DTAC | Canadian MHCC | German DiGA | Netherland GGZ/Mind | 5 NORDIC Nations | NZ -Health Navigator |
|---|---|---|---|---|---|---|---|---|
| **ORCHA Enhanced Review** | | | | | | | | |
| Enhanced Evidence Analysis | | ✓ | | | | | | ✓ |
| Commercial and Financial | | | | | | | | |
| Interoperability | | | | | | | ✓ | |
| Clinical Safety | | ✓ | ✓ | | ✓ | | | ✓ |
| Technical Stability | ✓ | ✓ | ✓ | ✓ | ✓ | | | |
| Security | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | |
| Enhanced Data Analysis | | | ✓ | ✓ | | | | |
| User Experience | ✓ | | | | | ✓ | ✓ | |
| Clinical Assessment | | | | ✓ | | | ✓ | |
| **Global Baseline Review** | | | | | | | | |
| Clinical Assurance | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Usability & Accessibility | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Data & Privacy | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Rapid Assessment** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

# GLOBAL BASELINE REVIEW (OBR)

ORCHA

| | |
|---|---|
| **Data & Privacy** | • GDPR HIPPA<br>• Privacy Policy<br>• Data Use<br>• Data Storage<br>• Existing Standards (ISO 27001) |
| **Professional Assurance** | • Medical Device Status and Conformity<br>• Evidence and Effectiveness<br>• NICE Evidence Standards Framework<br>• Clinical Involvement |
| **Usability & Accessibility** | • Apple HIG / Android App Quality<br>• WCAG 2.0 AA / WCAG 2.1 AA<br>• ISO 9241<br>• Bug Management |

ORCHA CERTIFIED

This Global Review has been adopted globally and has been used to assess 27,000 products and has been through 7 iterations.

# Digital Technology Assessment Criteria (DTAC)

**The Digital Technology Assessment Criteria (DTAC) is an assessment criterion for the commissioning of digital health technologies across the NHS and social care services.**

## The DTAC includes criteria covering:

- Clinical safety DCB0129
- Data protection DPIA GDPR
- Technical assurance including Pen testing Cyber Essentials + ISO 27001, 9001 etc
- Interoperability SOC2
- Usability and accessibility

For a digital health product to pass the DTAC, it must meet all requirements in each of the above areas.

It is designed as a continuous evaluation as your product(s) develops.

DTAC CERTIFIED

NHSX Digital Technology Assessment Criteria

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# Navigating the Digital Health Maze: Key Challenges

ORCHA COMPARE

- **High Compliance Costs & Complexity** – Assessing regulatory and security standards is time-consuming and resource-intensive.
- **Costly compliance checks**,
- **Duplicate assessments** are being conducted across the NHS
- **Inefficient Product Comparisons** – Manually evaluating and comparing slows down decision-making.
- **Risk of Non-Compliant or Ineffective Solutions** – Without robust assessment, organisations risk investing in tools that fail to meet requirements.
- **Procurement Bottleneck**s – Without a streamlined way to approve solutions, the adoption of digital health tools is delayed.

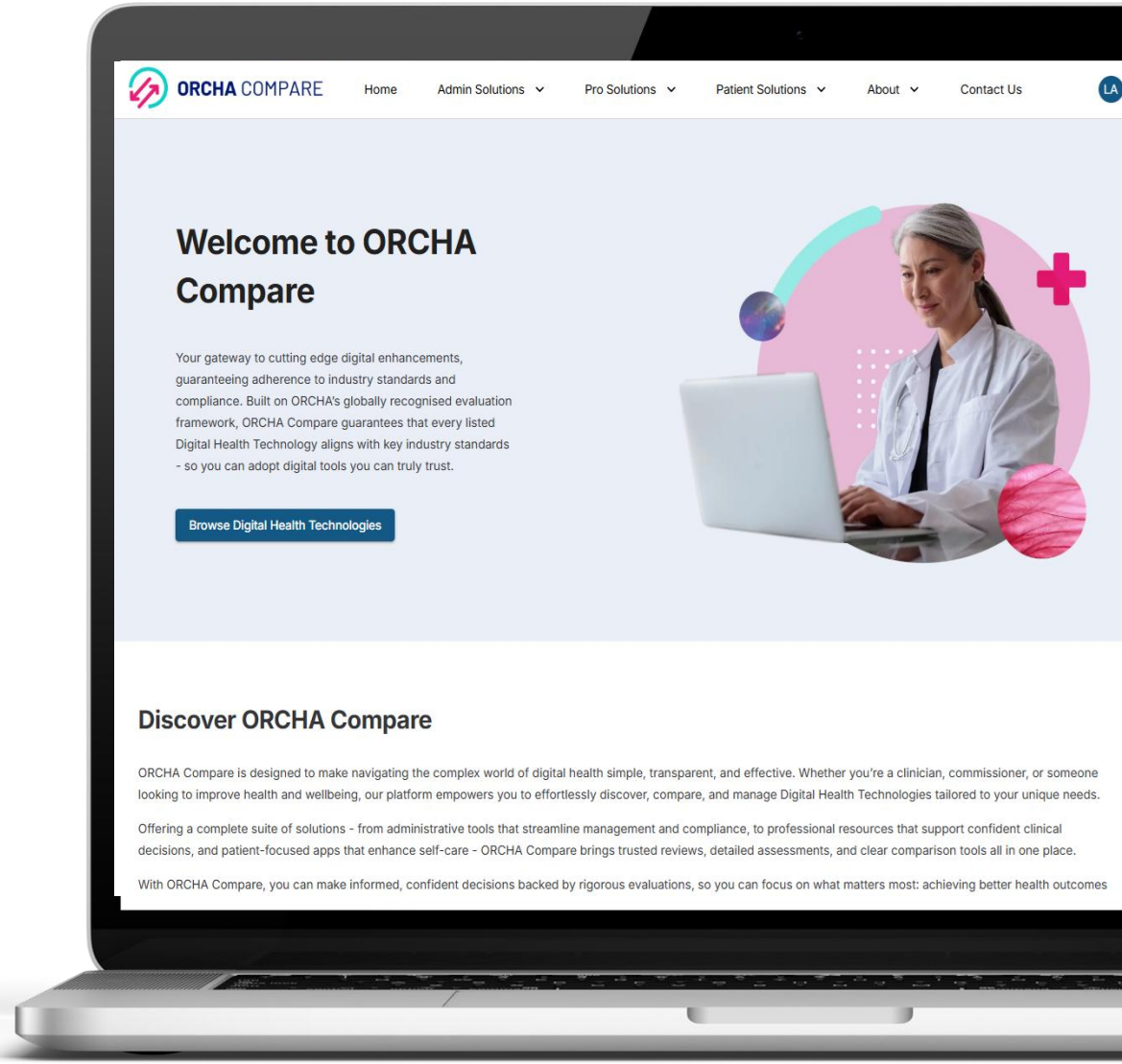
# ORCHA COMPARE

## We can help you...

- **Compliance Burden -** you gain instant access to over **2,600 assessed products** and can easily request a compliance check for any missing solutions.

- **Market Scan & Insight** –Compare provides a **comprehensive, regularly updated database**, enabling NHS teams to quickly **search, filter, and assess** available options.

- **Streamlined Procurement** – Compare accelerates decision-making **by offering structured comparisons** across compliance, functionality, usability, and cost—helping NHS teams **find the right solution faster** and with greater confidence.

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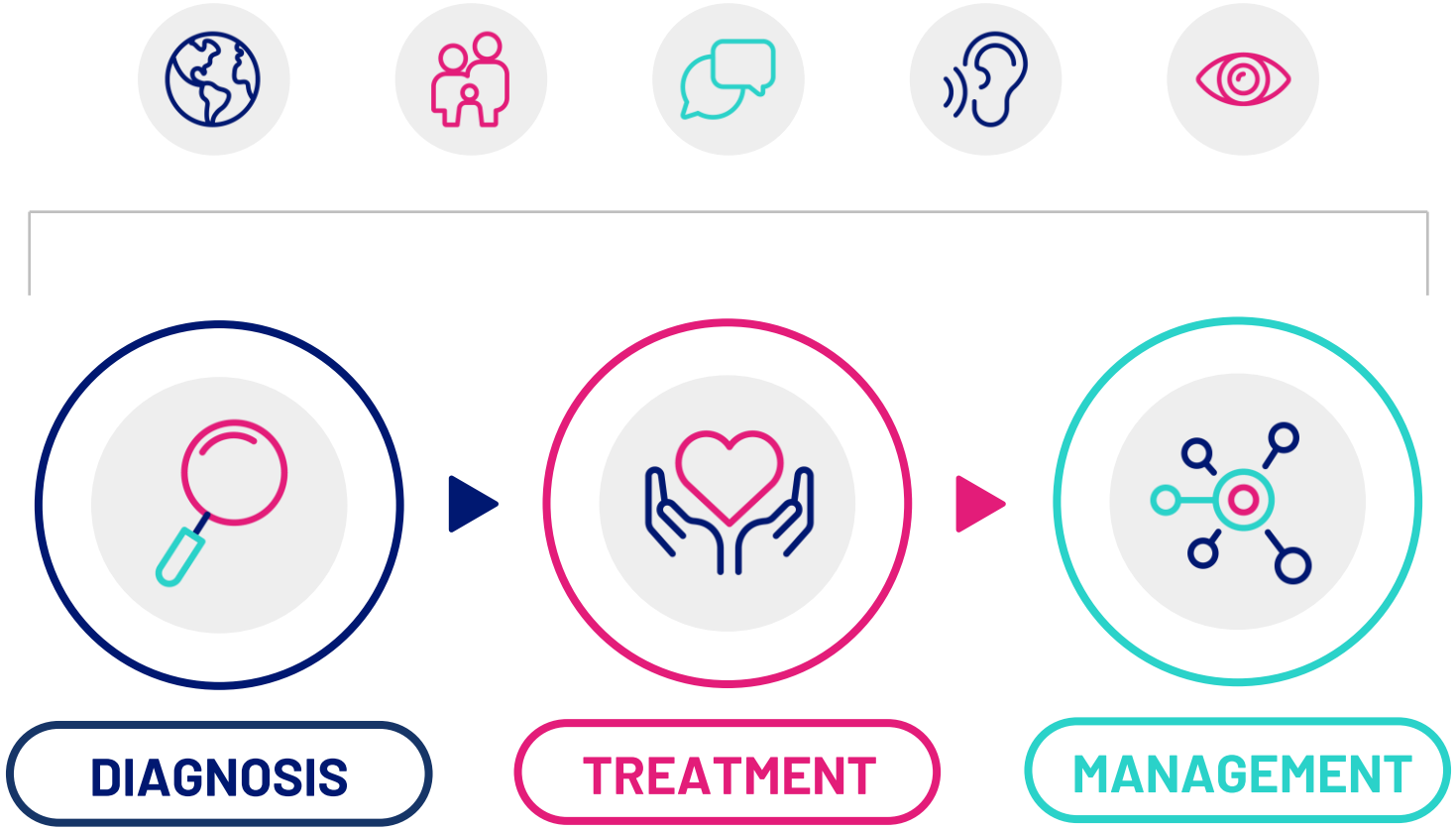
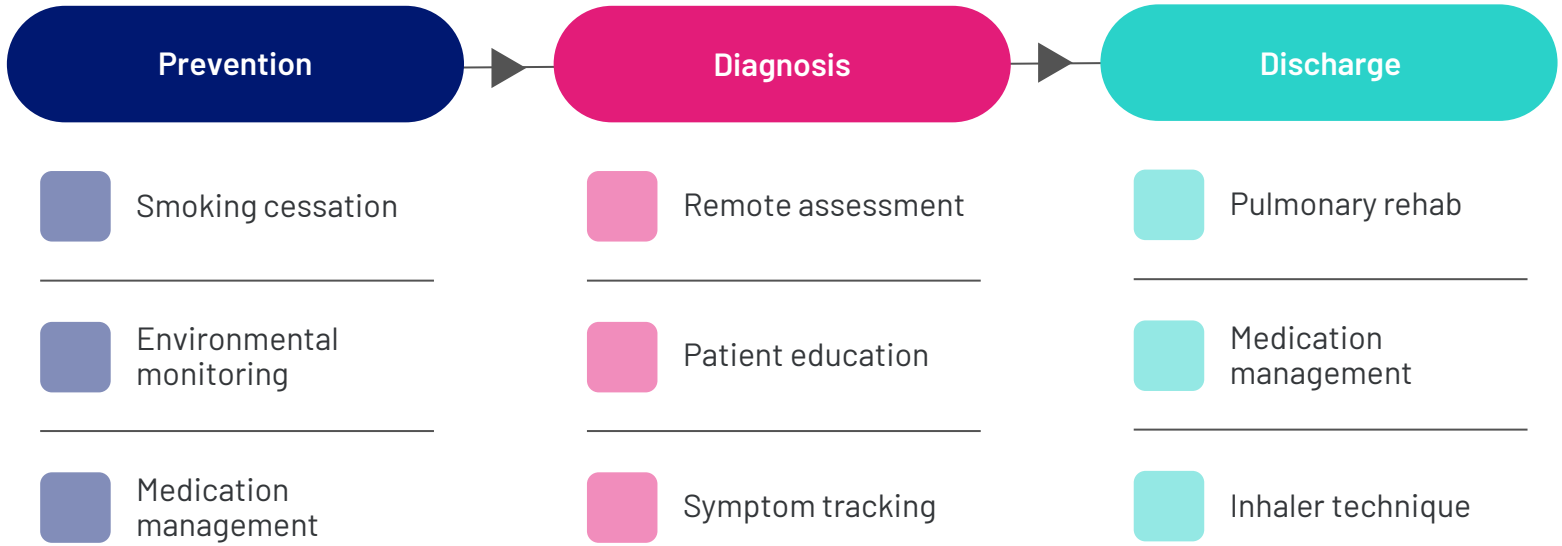
# Step 2
# Think Pathways not products

# THE MYTH -
# THERE IS ONE BEST TECHNOLOGY



# WHAT ARE THE OPPORTUNITIES?

*Take the example of a 58 year old male with COPD...*

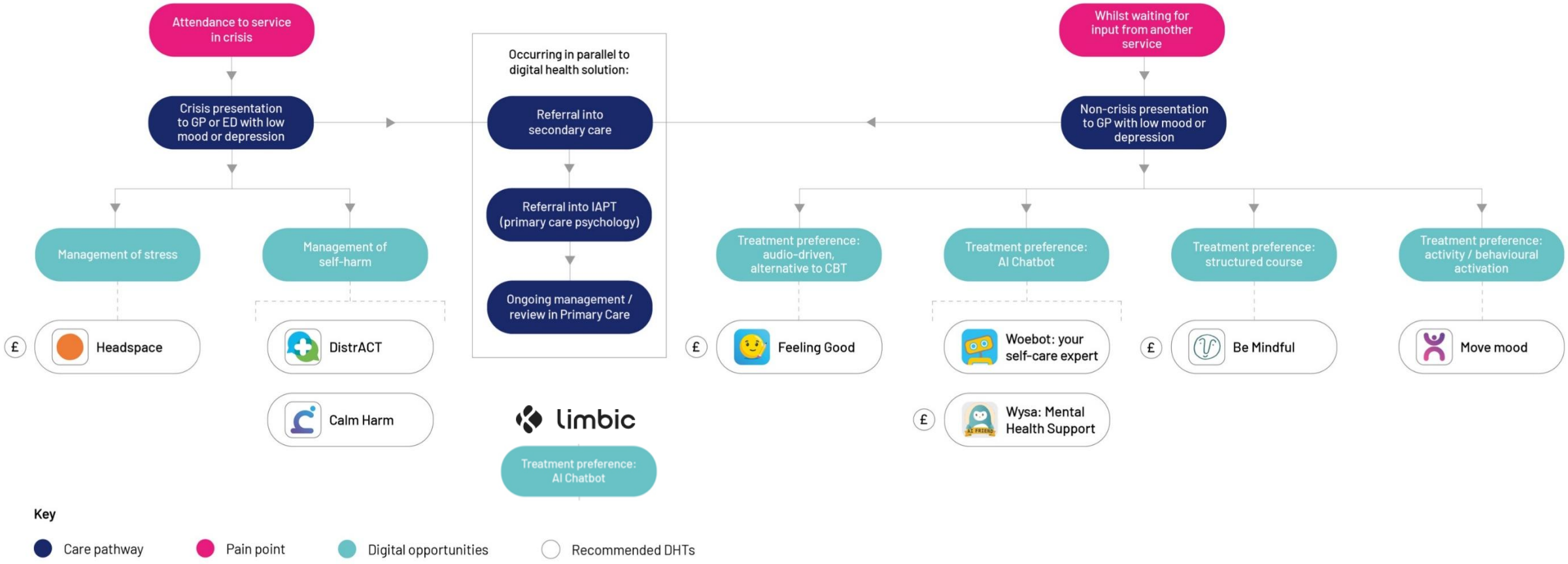


# WHAT ARE THE OPPORTUNITIES?

*Take the example of a 75 year old woman awaiting a hip replacement*

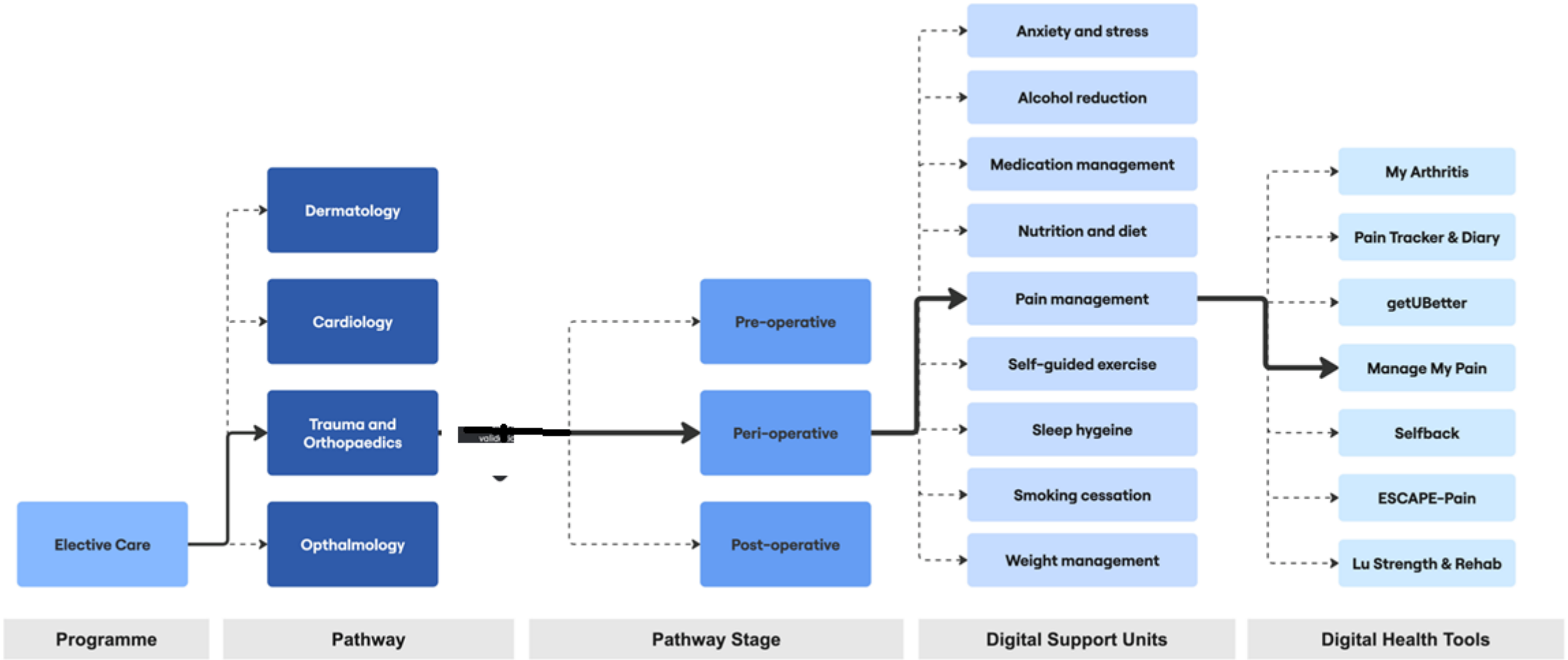
| Optimise | Streamline | Discharge |
| --- | --- | --- |
| Weight loss | Remote pre-op assessment | Remote rehab |
| Digital Health Coaching | Patient education | Medication management |
| Pain management programme | Remote monitoring | Care coordination |

# Offering different solutions to meet different needs. Mental Health Example:



# Step 3
# Implement a System that Operates Independently of Clinician Time

# Example Flow Elective Care Programme

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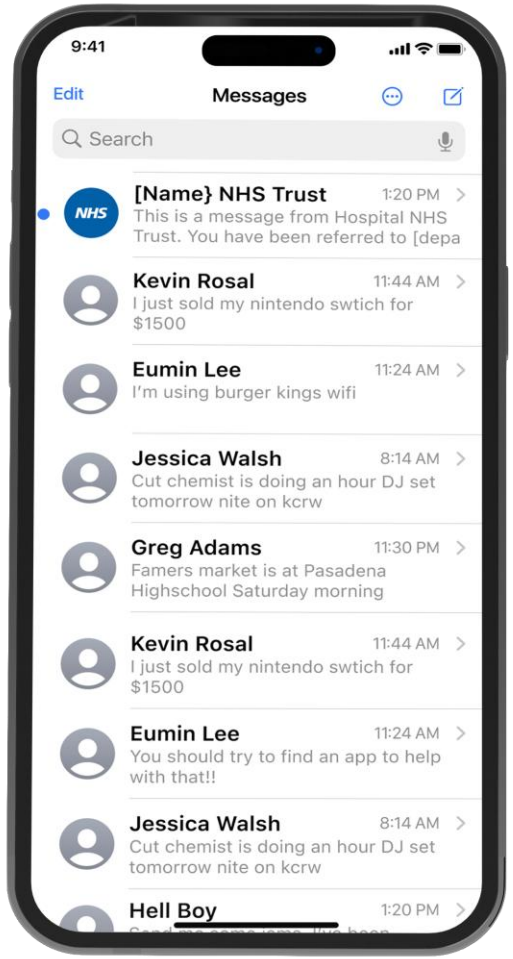
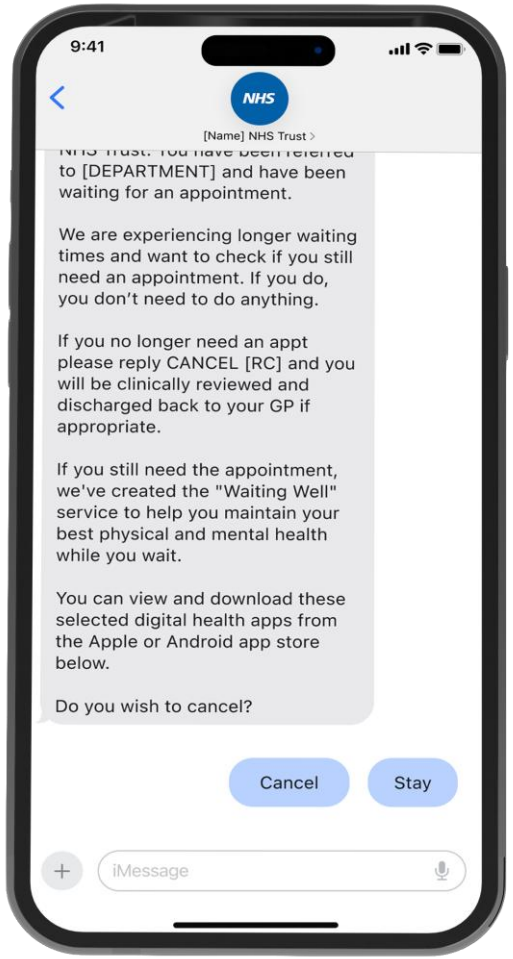
# Introducing CareQ

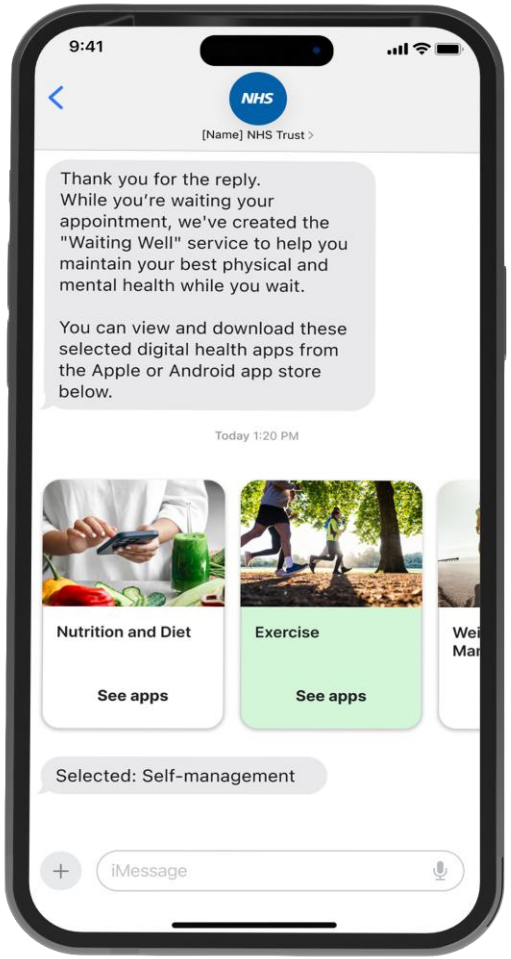
All technologies are certified by ORCHA

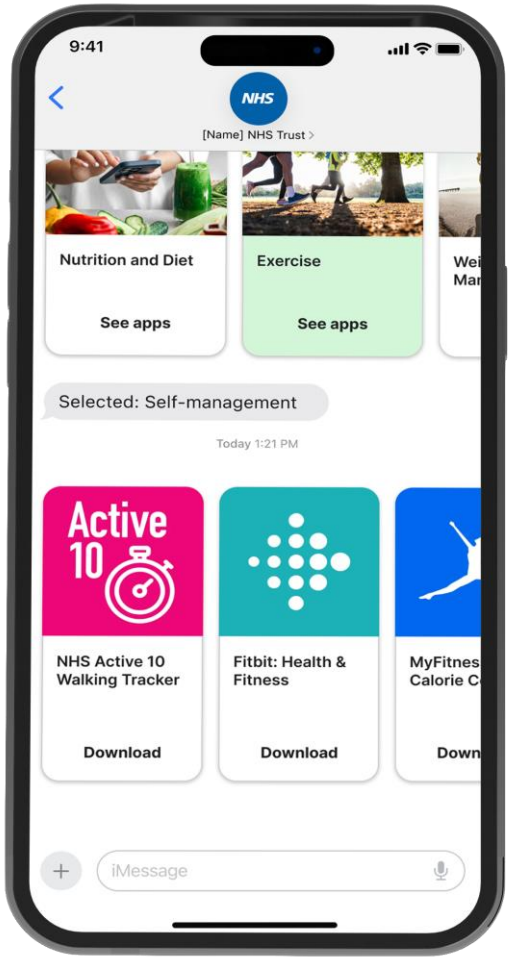
All delivered without human interaction

## Patients receive automated digital technologies via SMS or RCS message

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## Delivering Tangible Results and Productivity Gains

Early work suggests that around **30% of the waiting list population are benefiting from this initiative, leading to significant productivity improvements**. By validating patient needs upfront, healthcare providers can more effectively allocate resources, streamline care delivery, and reduce inefficiencies within the system.

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# 3 KEY STEPs

1. **Use compliance work once.** Share it widely to reduce burden and speed up innovation.

2. **Think Pathways** not products- One size does NOT fit all

3. Deploy **Clinician-Free Solutions** That Fit Into the Current Tech Stack

# *THANK YOU and QUESTIONS*


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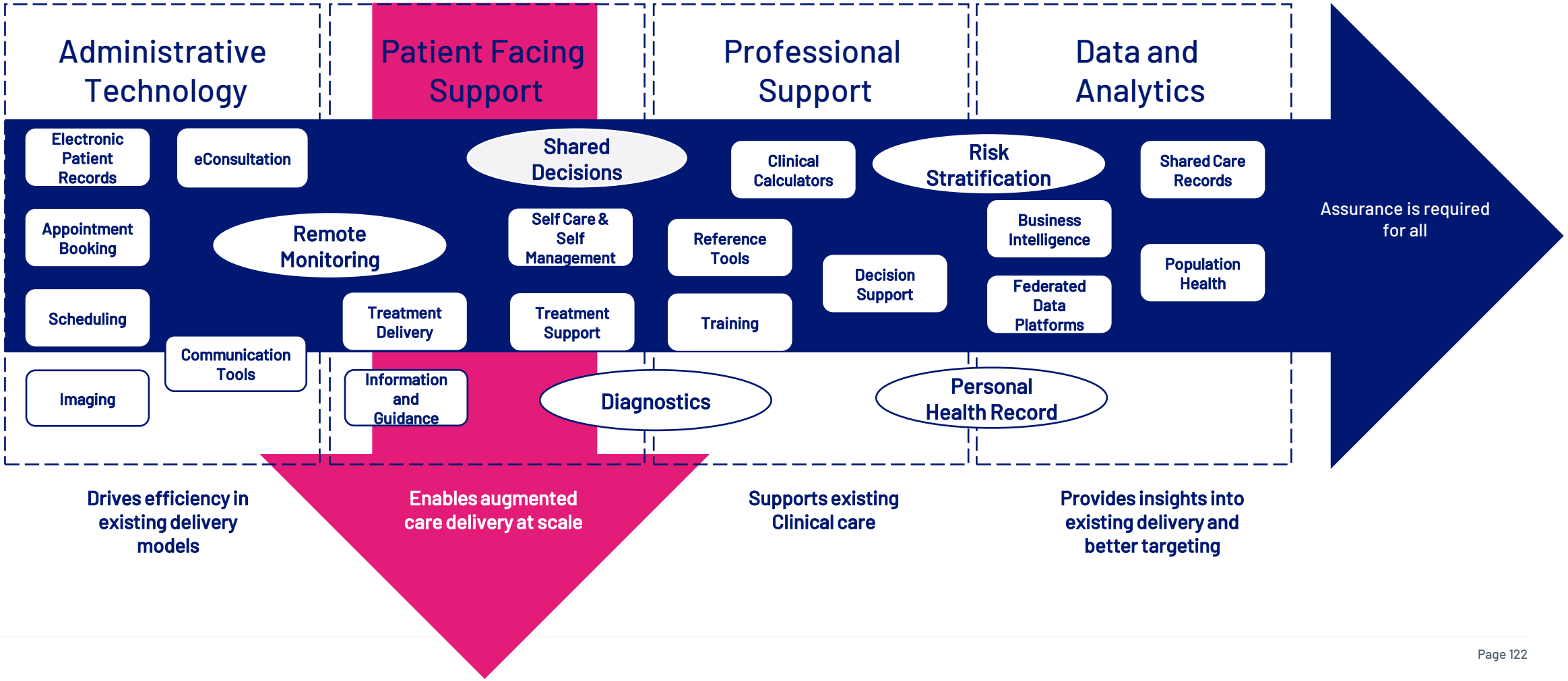
@OrchaHealth

@Orcha

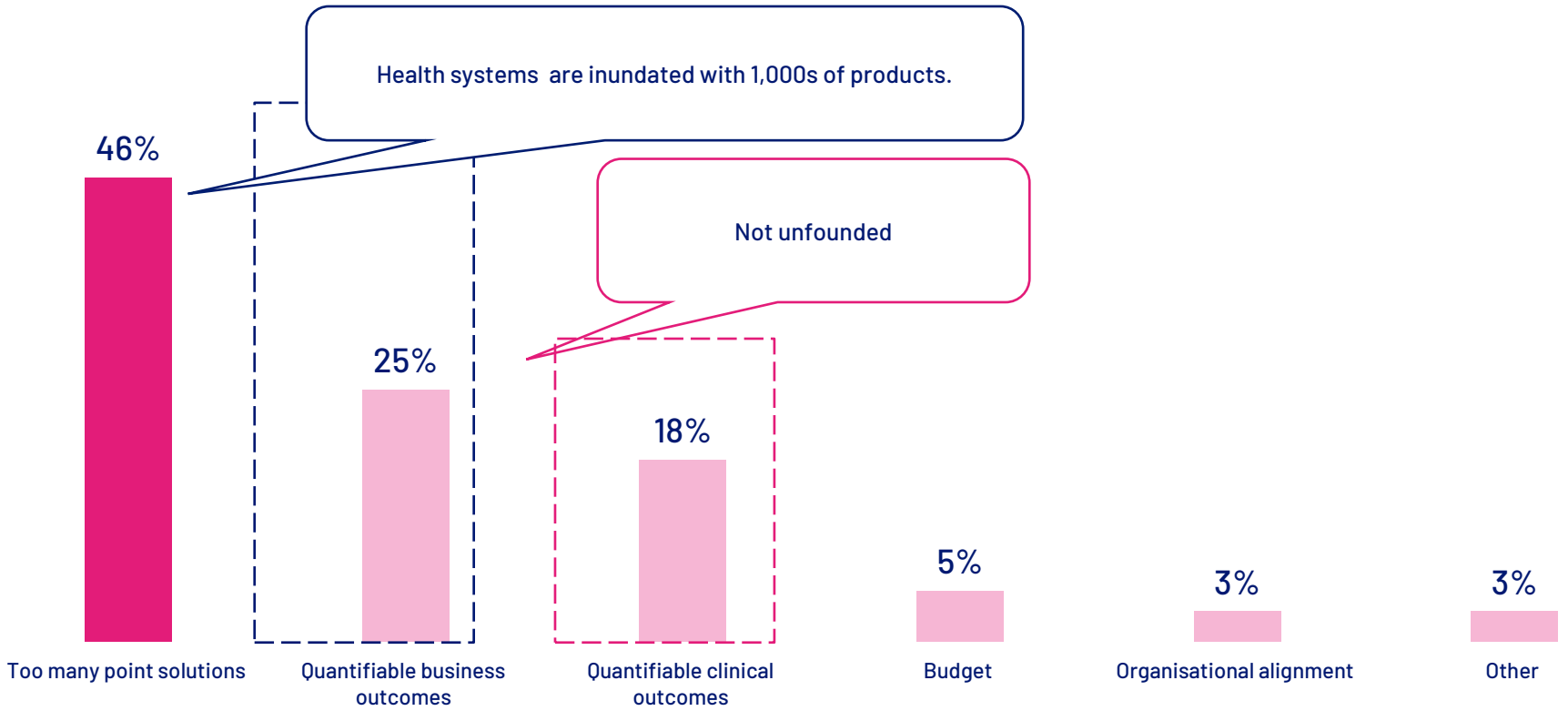
@Orcha

# Each assessment framework considers the differing risk and applies a “proportionate” analysis



# There are Barriers to utlising Digital health

Despite the opportunities in digital health, persistent challenges and concerns about data privacy, clinical evidence, interoperability and compliance with regulations exist as a main barrier to healthcare systems

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# Keynote Presentation

**Dr Malti Varshney**
Director of Strategic Change and Population Health
NHS Kent and Medway Integrated Care Board


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# Panel Discussion

**Belinda Yeldon**
Head of Integration
NHS North East London ICB

**Mariela Borisova**
Income & Cost Recovery Facilitator
King's College Hospital NHS Foundation Trust

**Amy Dolben**
Assistant Director of Partnership & Integration
Aneurin Bevan University Health Board


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# Food, Drinks & Networking