CHKS ADVISORY BOARD REPORT

How good quality community intelligence can improve health and social care

Foreword

The following report was put together at the start of 2020, prior to the outbreak of Covid-19 in the UK. When considering the views and recommendations contained in this report through the lens of the pandemic, however, the issues highlighted are perhaps now even more relevant than ever.

The rapid spread of the virus has demonstrated the importance of understanding and tracking local health needs. Community care data can help inform trusts about the vulnerable cohorts of their population, who are more at risk of developing a severe case of Covid-19, and enable them to direct resources to where they are needed most.

Many community care settings played an important role in making hospital beds available by providing space that facilitated patient discharge, and collecting data on capacity from community care providers has been integral to ensuring these facilities get the support they need to continue helping patients.

Community care data will also be important in the aftermath of the pandemic, providing an insight into service use during the peak of the crisis that will help to determine the likely impact on other parts of the health service in the coming months.

Data sharing across organisations has been integral to mitigating the impact of the virus. Whether this sharing will continue beyond the presence of Covid-19 is yet to be determined, but cross-boundary working was shown to be possible and extremely valuable to public health.

The pandemic has altered many aspects of our lives, with new ways of operating suddenly made possible, and it may have instigated the cultural shift needed to allow more seamless data flow across the NHS, from both a leadership and a data confidentiality perspective. As this report aims to demonstrate, community care data is an important issue to consider as the health service moves forward.

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About the CHKS Advisory Board

The CHKS Advisory Board was set up to help guide CHKS, part of Capita Healthcare Decisions, through the next decade of health and care. From time to time its views are sought on challenges facing the NHS. This report on the future of community intelligence and analysis is the result of such a discussion. This is the first in a series of reports and it will be followed by a second in the series taking into the account the views of local authority partners. We would like to thank the following for their input into this report:

Bob Alexander, Independent Chair at Sussex Health & Care Partnership

Amit Bhargava, GP Partner & Clinical Chief Officer, Crawley Clinical Commissioning Group

Maria Kane, Chief Executive, North Middlesex University Hospital NHS Trust

Jim Mackey, Chief Executive, Northumbria Healthcare NHS Trust

Martin Rennison, Director of Commercial Contracting, Spire

Andrew Ridley, Chief Executive, Central London Community Healthcare NHS Trust

Andrew Walton, Strategic Council Member at Independent Healthcare Partners Network

Charles Waddicor, Chair of F&I Committee and Chair of New Models of Care Committee, Barnet Enfield and Haringey Mental Health NHS Trust

Cathy Winfield, Advisor, NHS England

Executive summary

Community health services are present in virtually every healthcare journey and we will all inevitably encounter them at some point during our lives. The way community services are commissioned and designed is diverse and complex. In the past, these services have been overlooked by policy makers.

This is an urgent issue because we have an ageing population with more complex conditions and comorbidities. A prevalence of obesity, smoking, and drinking has had severe consequences for the health of the population. This means demand is set to continue rising, while resources are limited.

Change is coming as the power of these services to create healthier populations and reduce the burden on acute care is increasingly recognised. Closer alignment between community care and other parts of the health services was a focus of the NHS Long Term Plan and central to many of its larger ambitions.

Getting organisations to work more closely together will require a cultural shift that starts at the top. Leaders must be holistic in their view of healthcare and look at outcomes across organisational boundaries in order to understand population health needs and enable effective, targeted prevention and service design.

Cross-boundary data sharing will support targeted prevention by providing a full picture of resource use across patient cohorts and identify how resource-intensive patients can be better supported. Community data collection, however, is often not mandatory and pathways are complex, so quality varies widely. Where it does exist, data is rarely accessible across services.

Without standardised performance metrics in community care, benchmarking is not possible, but benchmarking is hugely important in deriving value from data and driving improvement. Common indicators need to be agreed and defined across the system to allow for quality data collection and benchmarking. Common indicators and data flow will also enable a clear view of the relationships between services – understanding not just the way individual services are used, but the impact this use has on other services.

More joined-up care could also be facilitated by giving patients greater ownership over their data and enabling them to share this with multiple providers across the care pathway, leading to more personalised care.

At a local level, being able to accurately and consistently measure improvement in patients' health outcomes would be beneficial, providing evidence of the effectiveness of interventions and services. Trusts need to look at their local population to determine what the priorities are and where resources are most needed. In small communities, access to health services would also be a useful metric and would help to address inequalities.

While creating the capacity to track and gather this data is important, it must also be transformed into intelligible insights in order to have any real impact. Trusts should draw on the experience and expertise of analysts to pinpoint trends and understand the factors influencing performance.

Quality community intelligence, and the effective sharing of this, will be vital for greater integration and prevention, enabling more personalised patient care across pathways and more effective resource allocation to better support patients. Providers of community services will need to work together to agree metrics and fostering cross-organisational data access will be critical. Trusts should ensure they make the most of existing data and that, where possible, this is turned into action.

1. Introduction

Community-based health services play a significant part in all our lives - whether we are seen by GPs, physiotherapists, community nurses, or other public health professionals, they are there to provide care at each point in our healthcare journey. The scope and scale of community health services mean that a wide range of organisations are involved including the NHS, local government, charities and private sector companies.

Each year there are 100 million contacts with community health services delivered by one fifth of the total NHS workforce and accounting for £10bn of the NHS budget – which was less than 10 per cent of the total NHS budget for 2018/19. However, community health services have previously been overlooked by policy makers. There are many reasons for this, including the fact that the range of services is so diverse and there are complex patterns of provision and commissioning.[1]

Both the *Five-Year Forward View* and the *NHS Long Term Plan* (LTP) have signalled community services must be more closely aligned – with a seamless flow of care from GPs to acute care and back into the community. Some parts of the country have been changing delivery models to improve co-ordination, but success and progress varies from one area to another.

This is, however, an urgent issue. The UK's ageing population has seen a huge increase in recent years, leading to more complex conditions and comorbidities. A prevalence of obesity, smoking, and drinking has had severe consequences for the health of the population and is placing pressure on an already overworked health service. Demand is set to continue rising, while resources – both financial and human – are limited. For this reason, prevention was high up on the agenda in the LTP, and the NHS aims to do more to support people to live healthy lifestyles.

This paper explores how quality community intelligence and sharing of data could become a catalyst for greater partnership working leading to improved health outcomes, whilst highlighting where leaders should focus attention to get the best results.

The precise range and configuration of community services varies between local areas, but services commonly include:

- adult community nursing
- falls services
- specialist long term condition nursing
- therapy services (such as physiotherapy, occupational therapy and speech and language)
- preventive services such as sexual health, smoking cessation clinics
- child health services including school nursing and health visiting
- intermediate care

(Kings Fund)

2. Current situation in health and community care

Successful integration between organisations, with joined-up provision of personalised care across multiple pathways, varies from area to area throughout the UK – in many places there is still work to be done.

Maria Kane, chief executive, North Middlesex University Hospitals NHS Trust believes that to get to a place where partnership working is truly successful, there needs to be change in both structure and governance, such as in budgets and payment mechanisms. There also needs to be a clear statement of what is expected in terms of outcomes.

She says: *"With integration, there was initially significant enthusiasm and engagement. However, this enthusiasm has waned, and this may have something to do with the length of time it takes to bring on board the large number of stakeholders needed for change."*

There are parts of the country making progress towards integrated systems and greater local partnership working, with innovative ways of working being adopted between health and community health services. For example, Connected Nottinghamshire is a health and care portal which allows different care providers across primary, secondary and community services to share information easily. In Southend, local partners have worked together to develop a joint paediatric clinic that allows children to be seen in a community setting.[2] West London CCG is also forward thinking, having set up an integrated care strategy for closer working.[3]

Martin Rennison, director of commercial contracting, Spire Healthcare, has been impressed by the way North Tyneside and East Yorkshire and Humber have managed to break down the historic barriers between health and community health services. He says: *"My elderly parents are users of these services and I can see how some of the barriers between health and social care are being broken down and there is cooperation between health service and local authority. They are willing to tackle things and be progressive, the dominance of the acute trust has been significant, and it has driven change."*

Flashback

Five Year Forward View called for a move to cohesive working through:

vanguards, sustainability and transformation partnerships (STPs) and multi-speciality community providers.

Long Term Plan highlights five major changes to the NHS service model, to be brought about over five years

1. Boost out of hospital care – dissolve the historic divide between primary and community health services
2. NHS will redesign and reduce pressure on emergency hospital services
3. People will get more control over their health and more personalised care when they need it
4. Digitally enabled primary and outpatient care will go mainstream across the NHS
5. Local NHS organisations will increasingly focus on population health and local partnerships with local authority funded services through new integrated care systems everywhere

3. Culture change and leadership

The LTP outlined the strategic direction of the NHS to be more joined up in its delivery of care, setting a goal for all of England to be covered by an Integrated Care System by April 2021. More recently, NHS England has joined forces with staff, patients and NHS groups to ask the government to put forward an NHS integrated care bill containing legislative changes that would help deliver on the ambitions of the LTP, particularly around more integrated services. If passed, this bill could give healthcare leaders support in driving effective, sustainable change.

Building successful integrated care systems requires a change in culture to overcome the complex relationship between the NHS, local government and other community organisations.

Neil Griffiths, Head of The Network Group and Health Sector Strategic Adviser to Capita says: *"The difficulty is that it's really hard to get different organisations to work together. It's sometimes hard enough to do it just within the NHS as people tend to be naturally loyal to their own organisation."*

"However, to avoid health in the community being overlooked, organisations have to become better at communicating across boundaries – for example, with healthcare providers recognising the important role and contribution local government has to offer."

Several leaders in the independent health sector feel that this cultural change in leadership needs to look beyond immediate objectives and focus on delivering services across organisational boundaries – as a key to effective integration.

Andrew Walton is founder and executive chair of Connect Health, providing musculoskeletal services (MSK) services on behalf of the NHS. He says: *"We are seeing increasing optimism around integration and some cultural change at senior level. The pressure for agencies and organisations to work in partnership is building and there is an increase in the level of interest from primary care networks in working with us to integrate services."*

Successful integration is where Martin Rennison believes leadership can make the difference: *"When you have multiple providers with multiple interests sometimes it is difficult for people to step back, look across boundaries and say what is the best value and most effective for patient outcomes because there's simply not enough information crossing those boundaries. It inevitably comes down to individual vision and leadership."*

One challenge faced by senior leaders is that they don't always have the bandwidth to focus on the future whilst ensuring the delivery of today's services. A culture change needed is for leaders to give responsibility for what is happening now to their managers so they can look beyond today's issues and concentrate on implementing the vision for the future.

"To avoid health in the community being overlooked, organisations have to become better at communicating across boundaries."

4. Improving health and community care through better data

Bringing organisations together is an important first step in having a population-wide understanding of where health and care needs are greatest. It is also useful when it comes to prevention and providing effective multi-disciplinary care for those with chronic and complex conditions using multiple pathways. Prevention is the watchword for the LTP and is key to improving the health of communities which, in turn, takes the pressure off acute and primary care services. Professor Martin Marshall, chair-elect, Royal College of GPs, is optimistic about the future and believes *"the kind of things that can be done at a community population health improvement level, the kind of efficiencies that can be made through working more closely together are really exciting."* [4]

i) Data sharing and common indicators

Data sharing supports the prevention agenda by helping organisations to identify cohorts of the population that use the largest share of resources and then direct their funding to proactive care. However, it is often hard to identify these cohorts because the data is either not required to be collected in the first place or, where it is recorded, it isn't accessible across health and community care systems. The quality of data that is recorded also has an impact, with gaps and inconsistencies potentially limiting its meaningful use.

Maria Kane says: *"We need to be able to use the intelligence in an effective way. For example, to help a resource-intensive family. This could mean bringing together data that is collected in different parts of the system, perhaps from safeguarding, social care and health. We need to understand the resources being used and the impact of intervention. Knowing this will help us design a different service care model."*

As well as greater accessibility, Maria highlights the need for common indicators that everyone within the system agrees can be used as measures for benchmarking services and improvement. *"We need a common way of working across the system to understand the art of the possible and to be able to test ourselves to make sure we are getting better at what we do,"* she says.

Sharing good quality intelligence between organisations is critical to success, but more work is needed to find ways of consistently sharing common data, particularly in bigger cities. This will help provider organisations determine whether they are meeting national outcomes.

Bob Alexander is independent chair at Sussex and East Surrey STP. He says: *"[In areas like London] You will find many health providers plus a wide range of community services providing care to six or seven boroughs, so you have to ask what the impact of this is on the integration with social care?"*

"Fundamentally you want to be able to track outcomes at patient level but, at the same time, also be able to aggregate up to clinical and resource management level. You need to be able to aggregate at each relevant stage in the pathway to support effective decision-making."

ii) Identifying preventable hospital admissions

The ability to analyse data from multiple providers from the acute and community services makes it possible to identify people who would benefit from services designed for patients with specific conditions, or to prevent unnecessary hospital admissions. For example, services which help individuals overcome crises and to continue to live independently in their own home, enabling them to maintain and manage their daily life, as well as services which provide support following hospital discharge.

Bob Alexander says: *"Meaningful population health management means carrying out analysis to understand which cohorts of patients are at the highest risk of preventable hospital admission. Tackling these health challenges will have implications for funding, commissioning and budgeting."*

One example of carrying out population health management in this way is Berkshire West CCG's 22-week accelerated programme, investigating how health services are used at a macro system level to find inappropriate patterns of usage. Clinical leads from each primary care network are now working alongside analysts to highlight and address issues.

Cathy Winfield, chief executive of Berkshire West CCG, says: *"When we looked at the diabetic population in south Reading, we found the most at-risk cohort was older generation Nepali with issues around language and literacy, so we had to develop a different way of working with this group within the community."*

Amit Bhargava, GP and formerly chief clinical officer at Crawley CCG, believes that good community intelligence helps to create personalised, connected care for patients on multiple care pathways and that this is crucial to help ease the pressure on services: *"If we can gather and share good community patient data, increase productivity and provide connected care with a wellness agenda then patients use our services 30 per cent less and hospital services 30 per cent less. Prevention work includes approaching people in September who we know are likely to become depressed in the winter period."*

Preventative care will be further enabled by machine learning techniques and artificial intelligence (AI) technology capable of processing, and deriving insights from, huge amounts of data. Machine learning and AI are increasingly in use across the healthcare sector, but large-scale implementation will be needed in order for population health management to become mainstream in care delivery.

iii) Engaging patients through technology

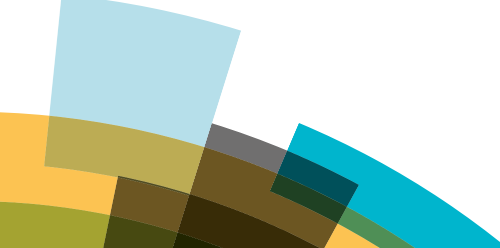
Technological advances have brought diagnostic testing and health monitoring into the home via smartphones and Bluetooth-connected wearable devices. These devices collect data which can be used to gain an insight into the risks faced by people with long term health problems, such as diabetes, to improve preventative care.

Being able to self-monitor their care, update their own data and access their own records, using devices such as smartphones, is beneficial for patients. For example, SMS text prompts when a check-up is due or encouraging the use of apps to show people a wellness score as evidence that their health is improving. A study by the Health Foundation revealed that patients who are better able to manage their conditions had 38 per cent fewer emergency admissions than the patients who were least able to, had 32 per cent fewer attendances at Accident and Emergency and 18 per cent fewer general practice appointments.[5]

Giving patients secure access and ownership of their health data so they can share with different providers can encourage greater integration between providers. Sir Jim Mackey is chief executive of Northumbria Healthcare NHS Foundation Trust. He says: *"From a patient perspective, when it comes to integrating care, we need to get to the point where a patient's data is held by the patient and then health services are given access to it. This will help a patient receive timely and appropriate care and we can aggregate the data at a macro level to tell us what we need to know from a population health point of view so we can direct resources to the right place."*

For healthcare providers, having access to such data helps to close the loop from diagnosis, admission and treatment to prevention. The data helps clinicians track and review progress, offering intervention methods should they see a change in the trend.

The Kings Fund's Professor Sir Chris Ham describes how a GP practice in Manchester has engaged its patients through apps that provide access to electronic patient records, running alongside the surgery website.[6] This enables patients to take more control of their care by flagging any errors or omissions and tracking trends. They were also able to share their records when coming into contacts with other services.



iv) Greater interoperability between systems

One of the responsibilities of NHSX, a new joint unit launched in February 2019, is to ensure interoperability between systems is realised and new technologies can be incorporated 'without breaking the technical plumbing underneath'.[7] Speaking about NHSX aims, chief executive Matthew Gould says: *"The most important thing that we will do is set rules so that our systems can talk to each other."*[8]

He has set five missions for the organisation which include ensuring patient data moves seamlessly around the health system. This is in recognition that for change to be effective, good quality information and intelligence must be made available across the system.

As well as being accessible throughout the system, data also has to be presented in a way that can be easily understood by a range of healthcare professionals and managers. Its report Untapped potential: Investing in health and care data analytics, the Health Foundation highlights one study which looked at how boards work on improving the quality of care.[9] The study ranked organisations in terms of the maturity of their approach to quality improvement.

The findings were not surprising: organisations with high levels of improvement maturity received reports in which the data were clear and readable. Reports to boards with low levels of quality improvement maturity, on the other hand, were characterised by a large volume of data, which was often not clearly presented, reviewed in silos and not linked to improvement actions.

Sir Jim Mackey believes that some electronic patient record (EPR) systems can be an obstacle to data sharing and that more work needs to be done for a joined-up view of healthcare, with one version of a patient record. *"We always try to use common systems where possible, but I'm against one single system for the EPR as this restricts the way data can be shared. We should have a situation where it doesn't matter which system you have bought because the systems should be able to talk to one another so everyone can get the information they need out of it. As for the wider NHS, improvements are needed in interoperability. We need to be able to stand back and see patterns emerging without getting lost in trends that are not statistically significant."*

It's difficult to show the impact that individual services are having on overall activity within the system because data is collected separately. For example, Andrew Walton says that while Connect Health has detailed data on the MSK services it provides, getting the data that shows the impact on the acute sector is a different matter.

Andrew Ridley, Central London Community Healthcare NHS Trust Chief Executive, agrees that a wider perspective is important. "We're overwhelmed with opportunity to improve population health management in terms of interoperability. Rather than focusing on the patient who arrives in the clinic or hospital, we need to change our way of thinking about the sector, working in a smarter way to make use of the potential for interoperability between all those organisations that touch on population health."

5. How to measure success

“If we adopted outcome measures, and there was greater standardisation in these measures, it would help us to see the impact of different levels of funding – we need to start reflecting where investment priorities should be.”

i) Using benchmarking and data to underpin service design

Benchmarking is valuable for making comparisons between organisations and to help identify local priorities and allocate resources. Geraldine Strathdee, chair of the National Mental Health Intelligence Network believes that, without benchmarking data, NHS resources are allocated on the basis of historical patterns, guesswork or the loudest voice.[9]

One criticism levelled at the current system is that it encourages activity within the acute sector through tariffs under payment by results (PbR). Patient experience is not recognised or subject to rewards in the same way, and yet, the patient should be at the centre of care delivery and their experience a key driver for improvement. One way to do this would be to link financial rewards to improvement in patient experience.

Bob Alexander says: *“One Secretary of State asked me how you could build the patient experience into the payment model. There was some discussion about whether you could have a system where a provider would receive just 90 per cent of the tariff and 10 per cent would be withheld pending the positive experience or outcome for the patient. But how could you operationalise something like that in a healthcare environment without increasing the cost of providing care?”*

Leaders need good quality information for community healthcare, such as outcomes and benchmarking data, to make informed decisions about how services are designed. It is not enough to simply have good data - to draw value from it, it needs to be benchmarked. However, without robust, standardised data in the first place, it's not possible to benchmark community healthcare and makes it much harder to achieve better outcomes.

Charles Waddicor is chair of Herefordshire and Worcestershire Sustainability and Transformation Partnership. He explains: “Whilst we're looking at issues of quality and efficacy we should consider the efficiency of the community services and workforce themselves, but these are particularly complex areas in terms of measuring success.”

Performance metrics in community healthcare aren't as straightforward as in acute care (such as length of stay, referral to treatment and readmission), making effective benchmarking between providers more problematic. Community services are likely to have a wide range of metrics, further complicated by complex pathways, which is why reaching agreement on common KPIs or metrics is more difficult.

Maria Kane agrees: *“At the moment we have various contact points within the system, but because these aren't connected, no one knows whether if we invest, say, an extra ten per cent in one area, we will see an improvement elsewhere.”* She believes a move is needed towards population-based contracts and levels of care delivery at every tier of the system.
“If we adopted outcome measures, and there was greater standardisation in these measures, it would help us to see the impact of different levels of funding – we need to start reflecting where investment priorities should be. Most importantly, we should be taking into account all determinants of health - physical and mental - such as poor housing, employment status, opportunities for education, impact of crime and community safety.”

The bottom line is being able to measure how patients' lives and health outcomes are improving, and finding a way to accurately and consistently evidence this through measurement. One example of how this could work in practice is to find measurements that show how patients with complex health issues are able to lead more independent lives, improving their quality of life while reducing reliance on services.

Jim Mackey says his trust is currently defining what success looks like and is focussing on the main health issues affecting people in the local population. He says: *"For example, we are an outlier on lung disease because traditionally a higher proportion of the population are smokers than elsewhere in the country. So, there is clearly a need for each trust to look at individual local needs to determine what the priorities are and then move resources to improve outcomes in those high priority areas."*

"We are showing that you can make improvements in a system with multiple providers. There is more to do and even now there is a big gap between health services and social care but once we have cracked this, we will really be on the way to more integrated services."

Cathy Winfield says Berkshire West CCG is looking at demand patterns with a view to reducing demand on Accident and Emergency time and encouraging more appropriate use of services. She says: *"If I was looking for a composite measure, I would want to know: are we reducing an individual patient's risk score? To have most impact we have decided that the top 5 per cent of users of our services aren't where our focus should be, it's the people in the next layer down. We can do this by looking at clinical outcomes, (e.g. cholesterol levels), but what we would want to see is a change in the pattern of demand."*

An additional performance metric could be to look at the overall health of the local population, perhaps particularly where inequalities in access to healthcare are being addressed. Neil Griffiths says: *"Being able to see and understand the health of the local population is very important. In relatively small or specific-need communities we also need to measure the ability to access health services. If we can show improvement in this, that's an important building block."*

"We should be able to examine what is having an impact on the health of the population so we can address areas needing improvement. For example, some primary care networks are focusing on homelessness to identify and address inequalities in healthcare provision that affect some of the most vulnerable people in society more generally."

ii) Harness the expertise of data analysts and analysis effectively

Good quality data is only useful if it can be analysed, understood and reported on to provide crucial intelligence for senior leadership to act on. A study of NHS providers suggested that one of the key elements in achieving successful provider information is making use of the insights available from data analysis to enable a fact-based understanding of problems, informed decision making and to facilitate performance tracking.[9]

In North Middlesex intelligence and data are gathered to support outcomes, but they rely on patient input to make sure these outcomes are significant. As Maria Kane explains: "We can then work backwards *to work out what information we should focus on to make expected progress. Data itself is not intelligence and its effectiveness in helping to prioritise resources depends on the questions you are asking of it."*

There is often a rich resource of expert analysts within health organisations, and it is vital that they work together using their experience and knowledge to highlight ways forward. Cathy Winfield says that during a review of the analytics function of the NHS and the local authority they discovered a small army of analysts, an as-yet relatively untapped resource -which the CCG is looking at making the most of.

Neil Griffiths works increasingly closely with local government in his role and suggests bringing together analysts in different organisations, so they have the opportunity to discuss and share their findings. He says: *"We have this fantastic wealth of talented analysts, but they're often asked simply for operational performance figures. We need to pool this expertise and ask them to come up with an answer to the big questions, such as how to measure and tackle health inequality in this community. From my own experience of talking with analysts from across health and local government, they would really welcome being involved."*

6. Case study

North East London Commissioning Support Unit (CSU) provides expert advisory services to the NHS and other organisations to help deliver improved health services to local populations.

For the last six years it has been using iCompare from CHKS as general benchmarking to support a large number of CCGs across London, providing them with a better understanding of how they compare with peers.

In one instance the unit was able to carry out a whole-system analysis using iCompare for commissioners to identify areas where more patients were being sent to acute care. Anne-Marie Morgan is acting associate director – specialist BI. She says: *"The CCGs wanted to understand whether they were getting value for money in secondary care and wanted us to look at datasets from different settings of care so they could take action."*

"iCompare for commissioners is very quick and easy to use, quite intuitive and we can navigate around the data. Implementation has worked very well – if we had tried to carry out the same level of analysis ourselves across multiple datasets it would have meant setting up multiple systems and would have been more difficult to use."

North East London CSU is one of the first health organisations to use the system which gives it access to national Hospital Episode Statistics (HES) data, saving time when it comes to in depth analysis of the data across CCGs. Anne-Marie says: *"We save resource and time that other CSUs might have to use to analyse HES data. It's quick and easy and we can deploy it to a lot of users."*

"[iCompare is] quick and easy and we can deploy it to a lot of users."

7. Recommendations

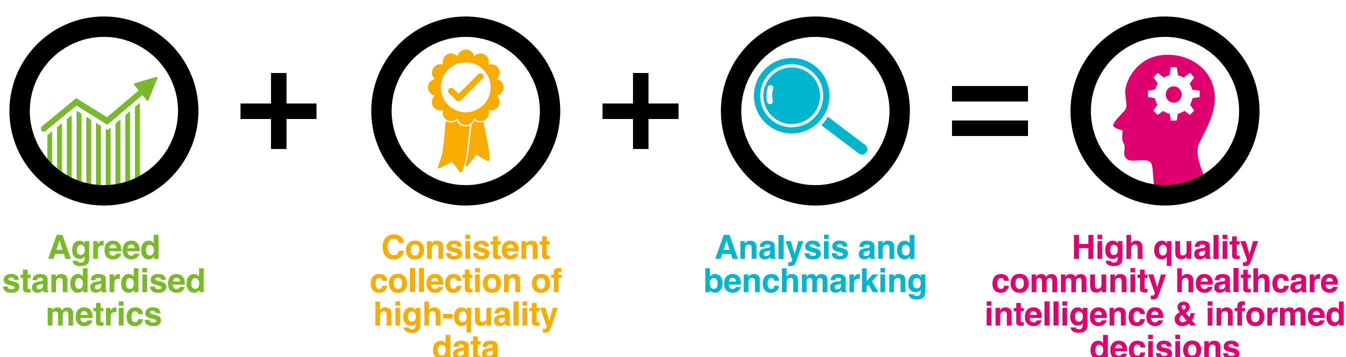
To ensure effective integrated care, good community intelligence is critical for directing resources where they're needed most. From developing personalised care for patients with complex conditions using multiple pathways, to identifying at-risk patients likely to use resources in the future, the NHS, local government and other providers of community services will need to work closely together to reach an agreement on metrics and how to share data.

In particular, finding solutions that overcome organisational boundary and data confidentiality challenges, and allow organisations to share and interpret data together, will be key.

Better integration of services is certainly an organisation-wide goal for the NHS, but the complex nature of commissioning means that many of the changes needed to make this a reality will be driven at trust-level. For this reason, integration must be a central theme in trusts' 2022 strategic plans. Some trusts are leading the way by making integration a central theme of their strategic plans. The Royal Wolverhampton NHS Trust's Vertical Integration efforts are an example of this.[10]

There can be no one-size-fits-all solution – each area of the country has different challenges and priorities that will affect how indicators are decided. Ensuring joined-up care means agencies overcoming boundaries as they consider patient cohorts in different ways, identifying different communities of care. To do this, data needs to be shared through systems that are interoperable so that everyone can see one story and one vision of the patient care.

Agreeing standardised metrics will be crucial to success, as will bringing skilled analysts on board to interpret and draw value from available data – this analysis will highlight where change is needed and whether services are providing value for money.



8. Conclusion

Progress is being made across the UK to provide joined-up patient care through integrated care pathways. However, significant barriers still exist and there is much to be achieved through a change in culture to encourage greater integration.

The patient perspective should be uppermost with a view to supporting the co-production of care in line with personalised care and support plans. This will help to transform patient care and experience.

Good quality data collection and sharing are fundamental to achieving both – the NHS and local government are rich in data, but this needs to be shared and understood to create a picture of how health and community services are performing. For many patients, particularly those with complex conditions, good care is dependent on seamless joined-up delivery, where all professionals have access to the same information. Future healthcare can no longer be reliant on treatment and aftercare, prevention and proactive care are where the future of effective, sustainable health services lies - this is where data will be the powerful catalyst for improvement.

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