Executive Certification in Leading with Strategic Thinking in Health and Social Care (United Kingdom)

# Integrated Care Systems Analysis

Accountability Framework – Related terms: Governance, Performance Metrics. A structured set of responsibilities, reporting lines and outcome indicators that ensures each organisation within an Integrated Care System (ICS) is answerable for its actions. Example: A local authority uses a dashboard to track community-based mental health referrals against agreed targets. Practical application involves linking funding to performance data, fostering transparency. Challenges include aligning diverse stakeholder priorities and avoiding metric fatigue.

Activity-Based Funding – Related terms: Resource Allocation, Cost-Weighting. A budgeting approach that allocates money based on the volume and type of health and social care activities delivered. Example: A district nursing service receives funds proportional to the number of home visits performed. It enables more precise budgeting but can create incentives to increase activity volume rather than improve outcomes.

Adaptive Governance – Related terms: Collaborative Leadership, System Resilience. A governance model that flexibly adjusts structures and processes in response to emerging challenges within an ICS. Example: During a flu outbreak, the steering committee temporarily reallocates decision-making authority to a rapid-response task force. It supports swift action but may blur accountability lines if not clearly documented.

Aggregated Data Sets – Related terms: Population Health Intelligence, Data Linkage. Combined datasets from multiple providers that enable a holistic view of patient journeys across health and social care. Example: Linking hospital discharge data with social care eligibility records to identify gaps in post-acute support. Useful for predictive analytics, yet data governance and privacy compliance remain significant hurdles.

Alignment of Incentives – Related terms: Payment Reform, Value-Based Care. The process of ensuring that financial and non-financial rewards encourage collaborative behaviour across organisations. Example: Introducing shared savings schemes where hospitals and community services split any cost reductions achieved through coordinated discharge planning. It can drive cooperation but may be resisted if perceived as threatening existing revenue streams.

Alternative Provider Contracting – Related terms: Commissioning, Market Competition. Engaging non-traditional or private providers to deliver services within an ICS. Example: contracting a third-party digital health platform to provide remote monitoring for chronic disease patients. It expands capacity but raises concerns about quality assurance and data integration.

Ambulatory Care Services – Related terms: Out-patient Care, Community Clinics. Services provided without admission to a hospital, often located in community settings. Example: A walk-in physiotherapy clinic that receives referrals from GP practices. Integration with primary care improves access, yet coordination of records can be fragmented.

Analytics Maturity Model – Related terms: Data Capability, Business Intelligence. A staged framework describing an organisation's progression from basic reporting to advanced predictive modelling. Example: A health board moves from descriptive dashboards to risk-adjusted forecasting of readmissions. The model guides investment but requires sustained leadership commitment.

Artificial Intelligence (AI) in Care – Related terms: Machine Learning, Decision Support. The application of algorithms to analyse clinical and social data, supporting diagnosis, triage or resource planning. Example: An AI tool predicts which elderly patients are at highest risk of hospitalisation, prompting proactive home visits. Benefits include efficiency gains; challenges involve bias, interpretability and regulatory compliance.

Asset Mapping – Related terms: Resource Inventory, Service Landscape. The systematic identification of physical, digital and human assets within an ICS. Example: Charting all community-based mental health facilities, transport links and volunteer groups in a borough. It informs strategic planning but must be regularly updated to remain accurate.

Behavioural Economics in Health – Related terms: Incentive Design, Patient Engagement. The study of how psychological factors influence health-related decisions, used to shape policies and interventions. Example: Offering small financial rewards to patients who attend scheduled physiotherapy sessions improves adherence. Designing nudges requires careful ethical consideration and robust evaluation.

Benchmarking Metrics – Related terms: Performance Indicators, Comparative Analysis. Standardised measures used to compare outcomes across organisations or regions. Example: Comparing average length of stay for heart failure patients between two neighboring trusts. Benchmarking drives improvement but must account for case-mix differences.

Benefit Realisation Plan – Related terms: Strategic Outcomes, Value Capture. A documented approach that outlines how expected benefits from an integration initiative will be achieved, measured and sustained. Example: A plan that specifies reductions in emergency department attendances as a result of enhanced community outreach. It clarifies expectations yet may be undermined by shifting priorities.

Bridging Funding Mechanisms – Related terms: Transition Finance, Joint Budgeting. Temporary financial arrangements that support organisations while new payment models are being implemented. Example: A pooled fund that covers both acute and community services during the rollout of a capitated contract. It smooths transitions but requires clear exit criteria.

Care Coordination Hub – Related terms: Integrated Care Hub, Multi-Agency Centre. A centralised team that orchestrates patient pathways across health and social care providers. Example: A hub that arranges discharge plans, arranges equipment provision and schedules follow-up appointments for frail older adults. It improves continuity, yet staffing and data sharing can be complex.

Care Pathway Mapping – Related terms: Process Flow, Service Blueprint. Visual representation of the sequence of interventions a patient receives from entry to discharge. Example: Mapping the stroke pathway from emergency admission through rehabilitation and community support. It highlights bottlenecks and informs redesign, but requires cross-organizational collaboration.

Casemix Adjustment – Related terms: Risk Stratification, Funding Allocation. Statistical techniques that account for patient complexity when comparing performance or allocating resources. Example: Adjusting funding formulas for mental health services based on the prevalence of severe conditions in the catchment area. It promotes fairness but depends on high-quality data.

Clinical Governance – Related terms: Quality Assurance, Patient Safety. The systematic framework through which organisations are accountable for maintaining and improving clinical standards. Example: A joint clinical audit across hospital and community teams reviewing medication reconciliation at discharge. It enhances safety, but aligning governance structures across sectors can be demanding.

Community Health Partnerships – Related terms: Public Health Collaboration, Local Authority Alliances. Formal agreements between NHS organisations and local councils to address population health needs. Example: A partnership that co-designs a diabetes prevention programme targeting high-risk neighbourhoods. It leverages shared resources, yet differing organisational cultures may impede joint planning.

Complex Adaptive System (CAS) – Related terms: Systems Thinking, Emergent Behaviour. A conceptual model that views health and social care as dynamic networks where agents interact and adapt. Example: Understanding how changes in primary care appointment availability ripple through emergency department demand. CAS thinking aids strategic foresight but can be abstract for operational teams.

Contractual Alignment – Related terms: Service Level Agreements, Procurement Strategy. The process of synchronising contract terms across multiple providers to support integrated delivery. Example: Aligning performance targets for ambulance services and community nursing contracts to reduce delayed transfers of care. It reduces fragmentation, yet legal complexities may arise.

Cost-Effectiveness Analysis (CEA) – Related terms: Health Economics, Incremental Cost-Utility Ratio. An economic evaluation comparing the costs and health outcomes of alternative interventions. Example: Assessing whether a tele-rehabilitation programme provides better value than traditional face-to-face therapy. CEA informs resource allocation but requires robust outcome data.

Cross-Sector Workforce Planning – Related terms: Staffing Models, Talent Management. Coordinated planning of workforce needs across health and social care organisations. Example: Joint recruitment drives for care assistants who can work in both hospital wards and community settings. It improves flexibility but must respect differing employment contracts.

Data Governance Board – Related terms: Information Stewardship, Compliance Committee. A body that oversees data quality, security and ethical use across an ICS. Example: A board that approves data-sharing agreements between mental health trusts and housing services. It safeguards privacy, yet can slow data access if overly bureaucratic.

Data Interoperability Standards – Related terms: FHIR, HL7, SNOMED CT. Technical specifications that enable disparate information systems to exchange and interpret data consistently. Example: Implementing FHIR APIs to allow community health records to be viewed within hospital EHRs. Standards promote seamless

care but require substantial IT investment.

Digital Health Integration – Related terms: eHealth, Telemedicine, Health Apps. The incorporation of digital tools into routine clinical and social care workflows. Example: Deploying a mobile app that lets patients schedule home-care visits and receive medication reminders. Enhances patient engagement; however, digital exclusion must be addressed.

Discharge Planning Protocol – Related terms: Transition of Care, Care Coordination. A set of procedures that ensure patients leave hospital with appropriate follow-up and support. Example: A checklist that triggers community nursing referrals for patients with complex needs. Reduces readmissions, yet compliance can be inconsistent without strong leadership.

District Nursing Services – Related terms: Community Nursing, Home Care. Nursing provision delivered at patients' homes, often supporting complex clinical needs. Example: District nurses managing wound care for post-surgical patients. Integration with hospital discharge teams improves continuity, but funding uncertainties may limit capacity.

Donabedian Model – Related terms: Structure-Process-Outcome, Quality Framework. A classic health-care quality model that assesses care based on structural resources, processes, and outcomes. Example: Evaluating a new integrated care pathway by examining staffing levels (structure), adherence to care protocols (process) and patient satisfaction (outcome). It offers a clear assessment lens, yet may oversimplify system interdependencies.

Economic Evaluation Framework – Related terms: Cost-Benefit Analysis, Budget Impact. A structured approach to assess the financial implications of health interventions. Example: Using a framework to compare the long-term savings of a preventative falls programme versus the upfront investment. Guides decision-making, but data limitations can impair accuracy.

Electronic Health Record (EHR) Integration – Related terms: Clinical Information System, Interoperability. The technical linking of EHR platforms across organisations to allow shared patient information. Example: A shared EHR that enables GPs to view hospital lab results instantly. Improves clinical efficiency, yet legacy systems may hinder seamless connectivity.

Empowerment Model of Care – Related terms: Patient-Centred Care, Self-Management. An approach that places decision-making authority with patients, supported by collaborative teams. Example: A care plan co-created with a patient with chronic obstructive pulmonary disease, outlining home-based exercises and monitoring. Enhances adherence but requires robust education resources.

Enabling Legislation – Related terms: Health and Social Care Act, NHS Reforms. Statutory provisions that create the legal basis for integrated care structures. Example: The 2012 Health and Social Care Act that introduced Clinical Commissioning Groups (CCGs). Provides authority, yet frequent legislative changes can create uncertainty.

Equity Impact Assessment – Related terms: Health Inequalities, Social Determinants. An analytical tool that evaluates how policies affect different population groups. Example: Assessing whether a new tele-health

service disproportionately benefits urban versus rural patients. Supports fairer planning, but data granularity may be insufficient.

Evaluation Framework – Related terms: Logic Model, Outcome Measurement. A systematic plan for assessing the effectiveness of integration initiatives. Example: Using a logic model to track inputs, activities, outputs and outcomes of a joint mental health crisis team. Provides clarity, yet requires dedicated evaluation expertise.

Experience-Based Co-Design (EBCD) – Related terms: Patient Involvement, Service Improvement. A participatory method that uses patient and staff narratives to redesign services. Example: Conducting joint workshops with older adults and care staff to redesign discharge processes. Generates user-focused solutions but can be time-intensive.

Fast-Track Referral Pathways – Related terms: Urgent Care, Streamlined Access. Direct routes that allow patients to bypass routine waiting lists for timely specialist input. Example: A fast-track pathway for suspected stroke patients from ambulance services to a neuro-imaging centre. Improves outcomes, yet requires capacity planning to avoid bottlenecks.

Financial Sustainability Model – Related terms: Budget Forecasting, Cost-Recovery. A projection that outlines how an integrated care system will maintain fiscal health over time. Example: Modelling the long-term savings from reduced hospital admissions against the upfront cost of community staffing increases. Supports strategic planning, but assumptions must be regularly validated.

Fit-for-Purpose Data – Related terms: Data Quality, Information Needs. Data that is appropriate, accurate and timely for a specific decision-making context. Example: Using real-time occupancy data to allocate community rehabilitation beds. Enhances responsiveness, yet data collection processes may need redesign.

Framework for Joint Accountability – Related terms: Shared Governance, Mutual Responsibility. A set of principles that define how multiple organisations hold each other accountable for collective outcomes. Example: A joint accountability charter that outlines shared targets for reducing delayed transfers of care. Clarifies expectations, but requires robust monitoring mechanisms.

Health Asset Mapping – Related terms: Community Resources, Asset-Based Approach. Identifying existing health-promoting assets within a population, such as gyms, support groups and healthy food outlets. Example: Mapping local walk-groups to support a physical activity promotion programme. Leverages community strengths, yet data collection can be labour-intensive.

Health Inequalities Dashboard – Related terms: Equity Metrics, Population Health Monitoring. Visual tool that displays disparities in health outcomes across socioeconomic groups. Example: A dashboard showing higher emergency department attendance rates among deprived neighbourhoods. Guides targeted interventions, but must be updated regularly to remain relevant.

Health Promotion Intervention – Related terms: Preventative Care, Behaviour Change. Programs designed to improve health behaviours and reduce risk factors. Example: A smoking cessation service delivered through community pharmacies. Supports population health, yet sustained funding can be challenging.

Health Technology Assessment (HTA) – Related terms: Clinical Effectiveness, Cost-Effectiveness. Systematic evaluation of medical technologies to inform adoption decisions. Example: An HTA of a remote monitoring device for heart failure patients. Provides evidence-based guidance, but timelines may delay implementation.

Holistic Needs Assessment – Related terms: Social Determinants, Patient Assessment. Comprehensive evaluation of a patient's medical, psychological, social and environmental needs. Example: Conducting a holistic assessment for a newly diagnosed cancer patient to identify transport, housing and support requirements. Enables tailored care plans, yet requires multidisciplinary coordination.

Human-Centred Design (HCD) – Related terms: User Experience, Service Innovation. Design methodology that prioritises the experiences and needs of end-users. Example: Co-designing a patient portal with input from older adults to ensure ease of navigation. Improves adoption, but may need multiple iterative cycles.

Integrated Care Board (ICB) – Related terms: Strategic Oversight, NHS England. The statutory body that leads commissioning and strategic planning for health services within a defined geography. Example: An ICB developing a joint acute-community care model to reduce bed occupancy. Central to system governance; however, balancing local autonomy with national priorities can be contentious.

Integrated Care Pathway (ICP) – Related terms: Clinical Protocol, Multidisciplinary Care. A structured multidisciplinary plan that outlines the sequence and timing of interventions for a specific condition. Example: An ICP for chronic kidney disease that coordinates nephrology, dietetics and community dialysis services. Standardises care, yet requires regular review to stay current with evidence.

Integrated Care System (ICS) – Related terms: Collaboration, Population Health Management. A legally recognised partnership of NHS organisations, local authorities and other stakeholders that plan and deliver health and care services collectively. Example: An ICS that creates a pooled budget to fund joint mental health initiatives. Provides strategic alignment, but cultural differences among partners may hinder seamless integration.

Integration Readiness Assessment – Related terms: Organisational Culture, Change Capacity. A diagnostic tool that evaluates an organisation's preparedness for collaborative working. Example: Surveying staff attitudes towards shared decision-making before launching a joint commissioning project. Identifies gaps early, yet may uncover resistance that needs targeted interventions.

Interoperability Maturity Model – Related terms: Data Exchange, Capability Framework. A staged model that measures an organisation's progress towards seamless data sharing. Example: Moving from basic data exchange (Level 1) to fully automated, real-time patient record sharing (Level 4). Guides investment priorities, but requires clear governance.

Joint Strategic Needs Assessment (JSNA) – Related terms: Population Health, Local Authority Planning. A collaborative analysis of health and social care needs within a defined area, used to inform commissioning. Example: A JSNA identifying rising demand for dementia services, prompting joint investment in community memory clinics. Aligns resources with need, yet data integration can be complex.

Key Performance Indicator (KPI) – Related terms: Metrics, Benchmarking. A quantifiable measure used to evaluate the success of an organisation or programme. Example: Tracking the percentage of patients discharged within 24 hours of being medically fit. Enables performance monitoring, but over-reliance on single KPIs may obscure broader outcomes.

Learning Health System (LHS) – Related terms: Continuous Improvement, Data-Driven Care. An ecosystem where data from routine practice continuously informs research and quality improvement. Example: Using real-time outcome data from a falls prevention programme to refine intervention protocols. Accelerates innovation, yet requires robust data governance.

Local Health Economy (LHE) – Related terms: Regional Planning, Service Ecosystem. The aggregate of health-care providers, resources and activities within a defined geographic area. Example: Mapping all acute, primary and community services in a city to identify service duplication. Supports strategic alignment, but boundaries may not align with patient flows.

Macro-Level Policy Alignment – Related terms: National Strategy, Regional Implementation. Ensuring that local integration initiatives are consistent with overarching health policies. Example: Aligning an ICS's mental health strategy with the national suicide prevention plan. Provides coherence, yet policy shifts can disrupt local plans.

Medical Home Model – Related terms: Primary Care, Patient-Centred Medical Home. A model where a primary-care practice leads coordinated, comprehensive care for a defined population. Example: A GP practice that manages chronic disease registries, arranges community services and monitors outcomes. Enhances continuity, yet funding mechanisms may not fully support expanded roles.

Mixed-Methods Evaluation – Related terms: Quantitative, Qualitative Research. An approach that combines statistical analysis with narrative insights to assess programme impact. Example: Using hospital readmission rates alongside patient interviews to evaluate a community transition service. Provides depth, but requires expertise in both methods.

Multidisciplinary Team (MDT) Governance – Related terms: Team Leadership, Clinical Accountability. Structures that define roles, decision-making authority and reporting for teams comprising diverse professionals. Example: An MDT overseeing complex wound care that includes surgeons, nurses, physiotherapists and social workers. Improves collaborative care, yet clear governance is essential to avoid role ambiguity.

National Institute for Health and Care Excellence (NICE) Guidelines – Related terms: Clinical Standards, Evidence-Based Practice. Authoritative recommendations that inform best practice across health and social care. Example: NICE guidance on managing chronic obstructive pulmonary disease influencing care pathways within an ICS. Standardises care, but local adaptation may be needed.

Needs-Based Funding Allocation – Related terms: Population Health, Resource Distribution. Distributing financial resources according to identified health and social care needs. Example: Allocating additional community nursing funds to areas with higher rates of multimorbidity. Promotes equity, yet accurate need

assessment is critical.

Network Analysis – Related terms: Systems Mapping, Relationship Mapping. A methodological approach to examine the connections and flow of information between organisations. Example: Mapping referral patterns between hospitals, community mental health teams and voluntary organisations. Identifies central nodes, yet data collection can be intensive.

Neighbourhood Health Hubs – Related terms: Community Centres, Integrated Services. Physical locations that co-locate health, social care and voluntary services for local residents. Example: A hub offering GP appointments, social prescribing and adult education classes under one roof. Improves accessibility, but governance of shared spaces can be complex.

Negotiated Service Agreements – Related terms: Contractual Arrangements, Partnership Contracts. Formal agreements that outline service specifications, performance expectations and financial terms between partners. Example: A negotiated agreement between a hospital trust and a community care provider to jointly manage post-acute rehabilitation. Encourages collaboration, yet requires robust monitoring.

Outcome-Based Contracting – Related terms: Performance-Linked Payments, Value-Based Procurement. Contracts that tie remuneration to achievement of predefined health outcomes. Example: Paying a community mental health provider based on reductions in inpatient admissions. Drives focus on results, but measurement of outcomes must be reliable.

Patient-Reported Outcome Measures (PROMs) – Related terms: Patient Experience, Quality Metrics. Standardised tools that capture patients' perspectives on health status and quality of life. Example: Collecting PROMs for hip replacement patients to assess pain reduction and functional improvement. Informs service improvement, yet response rates can be low.

Patient-Reported Experience Measures (PREMs) – Related terms: Service Satisfaction, Feedback. Instruments that gauge patients' experiences of care processes. Example: Surveying patients on the clarity of discharge instructions received from a joint hospital-community team. Highlights areas for improvement, but data collection must be timely.

Population Health Management (PHM) – Related terms: Risk Stratification, Preventative Care. The systematic approach to improving health outcomes of a defined population through coordinated interventions. Example: Using risk scores to identify high-risk diabetic patients and assigning them to intensive community support. Enhances efficiency, yet requires robust analytics.

Policy Levers – Related terms: Regulatory Instruments, Incentive Mechanisms. Tools that governments use to influence behaviour and shape health system performance. Example: Introducing a policy leaver that rewards organisations for meeting integrated care targets. Can accelerate change, but may create unintended incentives.

Practice-Based Learning (PBL) – Related terms: Continuing Professional Development, Reflective Practice. Learning activities embedded within routine clinical work to develop skills and knowledge. Example: Multidisciplinary case reviews that focus on integrating social care considerations. Supports workforce

development, yet time constraints can limit participation.

Programme Theory – Related terms: Logic Model, Theory of Change. A narrative that explains how and why a programme is expected to achieve its outcomes. Example: Describing how coordinated discharge planning leads to reduced readmissions through improved patient self-management. Guides evaluation, but must be explicit and evidence-based.

Quality Improvement Collaborative (QIC) – Related terms: Learning Community, Best Practice Sharing. A structured group of organisations that work together to improve specific aspects of care. Example: A QIC focused on reducing medication errors across acute and community settings. Facilitates shared learning, yet sustained engagement can be challenging.

Real-World Evidence (RWE) – Related terms: Observational Data, Pragmatic Studies. Data collected from routine clinical practice that informs decision-making. Example: Using electronic health records to assess the effectiveness of a new community physiotherapy model. Complements trial data, but data quality must be assured.

Risk-Adjusted Capitation – Related terms: Funding Model, Population-Based Payments. A payment system where a fixed amount per patient is adjusted for health risk factors. Example: Providing higher capitation rates for practices serving older adults with multiple chronic conditions. Aligns incentives with need, yet risk adjustment algorithms must be transparent.

Service Integration Blueprint – Related terms: Strategic Plan, Implementation Roadmap. A detailed document that outlines the steps, timelines and responsibilities for integrating services. Example: A blueprint that maps the phased rollout of a joint mental health crisis response across emergency departments and community teams. Provides clarity, but must be adaptable to emerging challenges.

Shared Care Record (SCR) – Related terms: Data Sharing, Unified Patient Profile. A single electronic record that aggregates clinical information from multiple providers. Example: An SCR that combines hospital discharge summaries, community nursing notes and social work assessments for a patient with complex needs. Improves continuity, yet data security and consent management are critical.

Shared Savings Model – Related terms: Cost Reduction, Incentive Alignment. An arrangement where participating organisations share a proportion of any cost savings achieved through collaborative initiatives. Example: Hospitals and community providers split savings realised from reduced bed days after implementing a rapid discharge pathway. Encourages efficiency, but must have robust measurement to prevent gaming.

Social Determinants of Health (SDOH) – Related terms: Health Inequalities, Community Factors. Non-clinical factors such as housing, education and employment that influence health outcomes. Example: Addressing food insecurity through a partnership with local charities to improve nutrition among diabetic patients. Central to holistic care, yet often falls outside traditional health budgets.

Stakeholder Engagement Framework – Related terms: Consultation, Co-Design. A structured approach to involve patients, carers, clinicians and community groups in planning and decision-making. Example: Using

a framework to conduct focus groups with ethnic minority communities when designing a new vaccination outreach programme. Enhances relevance, but requires time and resources.

Strategic Partnership Agreement (SPA) – Related terms: Collaboration Contract, Joint Working. Formal document that sets out the vision, objectives and governance arrangements for a partnership. Example: An SPA between a NHS trust and a local authority outlining shared responsibility for adult social care transformation. Provides legal clarity, yet must be regularly reviewed.

System Dynamics Modelling – Related terms: Simulation, Feedback Loops. Computational modelling technique that captures complex interactions and time delays within health systems. Example: Modelling how changes in community nursing capacity affect hospital admission rates over a five-year horizon. Supports strategic forecasting, but model validation is essential.

Targeted Case Finding – Related terms: Screening, Early Intervention. Systematic identification of individuals at high risk for a condition who may benefit from early treatment. Example: Using electronic risk scores to identify patients likely to develop chronic kidney disease and enrolling them in a preventive programme. Improves outcomes, yet requires careful risk communication.

Telehealth Service Integration – Related terms: Remote Consultation, Digital Pathways. The incorporation of virtual care modalities into existing service pathways. Example: Adding video follow-up appointments for post-operative patients to reduce travel burden. Increases accessibility, but digital literacy and connectivity issues must be addressed.

Transition of Care Protocol – Related terms: Continuity, Discharge Planning. Standardised procedures that ensure safe and coordinated movement of patients between care settings. Example: A protocol that triggers a community mental health referral when a patient is discharged after psychiatric inpatient stay. Reduces gaps, yet adherence monitoring is needed.

Triple Aim Framework – Related terms: Population Health, Experience, Cost. A model that simultaneously pursues improved health outcomes, better patient experience and lower per-capita costs. Example: An ICS measures progress against the Triple Aim by tracking population health metrics, satisfaction scores and expenditure trends. Provides balanced focus, but measuring all three dimensions can be demanding.

Value-Based Procurement – Related terms: Outcome-Focused Purchasing, Cost-Effectiveness. Procurement approach that selects suppliers based on the value they deliver rather than price alone. Example: Purchasing a home-care technology platform that demonstrates reductions in emergency admissions, justifying a higher upfront cost. Aligns spending with outcomes, yet contract management can become complex.

Virtual Ward Model – Related terms: Remote Monitoring, Acute Care Substitution. A service that provides hospital-level monitoring and support to patients in their homes. Example: A virtual ward for heart failure patients that uses daily telemonitoring to adjust diuretics, preventing readmission. Demonstrates innovative care, but requires robust IT infrastructure and skilled staff.

Workforce Capability Framework – Related terms: Skills Matrix, Competency Development. A structured description of the knowledge, skills and behaviours required across roles within an integrated system.

Example: Defining competency levels for community nurses to manage complex medication regimens. Guides training, yet maintaining up-to-date standards demands ongoing effort.