

A photograph of a woman and a man in a clinical setting, possibly a hospital or care home. The woman is on the left, wearing a white top with red polka dots, and is looking down at something in her hands. The man is on the right, wearing a white shirt and a patterned jacket, and is looking at the woman. They appear to be engaged in a conversation or a task. The background is slightly blurred, showing what looks like a desk or counter with some papers and a computer monitor.

**THE *FORWARD VIEW* INTO ACTION:**  
**New Care Models: update and initial support**

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## Making sense of the programme

- i. The New Care Models Programme began in March and this document 'New Care Models: update and initial support' comes from what vanguards have told us they want, including feedback during site visits to all systems and subsequent thematic reviews.
- ii. More than 260 health and social care organisations responded to an invitation in January this year to become vanguards to develop new care models that would act as blueprints for the NHS in England and an inspiration to others. In March, we announced the first vanguards leading on developing new models of care following a selection process involving patients, clinicians and peer review. The vanguards are working to enhance the care of more than five million people. These new models of care are being locally designed – by diverse communities and patients working in partnership with health and care organisations across England.
- iii. During April and May, the New Care Models team carried out two-day visits to each vanguard to understand their aims in more detail. Building on these visits, the team developed thematic reviews, which were then shared back with the vanguards. Following their support for these reviews, the key areas for transformation were summarised into eight enabling areas for support, forming the basis of the work programme over the next year.
- iv. The support package is built on the eight key enablers to maximise both the chances of successful local delivery of the care models and national spread. They come directly from the issues raised by the vanguards, the thematic reviews arising from the visits and the views of a wide range of stakeholders.



- v. Through the joint national/local work outlined in this document, we are making commitments about what will be developed and achieved during the remainder of 2015/16. At the same time, the programme will evolve and develop.
- vi. Each vanguard system is rooted in its local diverse community. The national New Care Models programme draws together these individual local threads into explicit patterns, in order to exploit common opportunities for radical care redesign and remove barriers to change. Through the support package, our focus is on creating simple standard approaches and products, based on best practice and co-produced with vanguards, which are designed from the outset for national spread.
- vii. This document covers support for the first three types of new care models:
  - multispecialty community providers (MCPs);
  - integrated primary and acute care systems (PACS); and
  - enhanced health in care homes.
- viii. All three of these care models will demonstrate the reinvention of out of hospital care, with PACS and MCPs organising this for the whole population, and enhanced care homes targeting their approach to a care home setting. It will shift the integration agenda much further, aided by the dissolution of existing funding, contractual and provider organisational silos.
- ix. Whilst the enhanced care home model will focus on the needs and preferences of a targeted and diverse population, MCPs will deliver an expanded version of core and enhanced general practice, based on larger, more resilient multi-disciplinary teams and bringing a broader range of specialist and generalist care closer to all patients and citizens in the diverse community. Similarly, the PACS model will also deliver an expanded version of core general practice, but will go much further by joining with acute hospitals to create a single provider system.
- x. Further vanguard systems and sites will be chosen, to accelerate the implementation of the Urgent and Emergency Care Review, and develop new models of acute care collaboration. Support for these two further vanguard types will be co-designed and published by November 2015. This will draw on and add to the activities described in this document. Rather than launching several additional types of vanguard, the New Care Models Board and national bodies will focus on delivering useful, practical support for these first five vanguard groups.

## The vanguard approach to change

- xi. Four core values underpin the New Care Models programme and the way we work. Our values are fundamental to the way that the programme has worked to date, the way the programme of support has been developed and the way we will work to deliver it.



- xii. Building on these core values, four design principles have emerged which frame the support package.

### **Design principle 1 – we solve problems through joint national and local leadership**

- xiii. Many of the local issues that the vanguards face stem from the adverse and often unintended consequences of the national rules, systems and behaviours within which the local NHS is forced to operate.
- xiv. The programme is being organised through the eight enabling areas of support. Ten joint workstreams will take these forward and will be jointly led by a vanguard leader and national subject matter expert. Together, the national and local leads will decide how the work should be taken forward, including the experts they want, and ensuring strong input from a range of different vanguards and other bodies, in line with the values of the programme and with the key objective of national replication. This document will serve as a signpost and starting point for their work.
- xv. Through their work, national bodies and vanguard sites will be jointly accountable for identifying and fixing specific problems, and taking advantage of common opportunities. In an inversion of the traditional hierarchy, the vanguards are commissioning the national bodies to support them. They will hold us to account for how well we deliver for them. The job of the national bodies is to help remove burdens, rather than add more through programme reporting that will not aid learning. In turn, the national

bodies expect the vanguards to engage fully with the programme; to collaborate with each other; to be open to doing things in common wherever that makes sense; and to deliver demonstrable value for any national investment across the triple aims of the programme: health and wellbeing, care and quality, and delivering financial efficiency.

### **Design principle 2 – we create simple replicable frameworks, built for spread**

- xvi. Right from the start of the programme, we have built in the principle of national replicability and spread to the design of what all vanguards deliver locally. The success of the programme and the value delivered for the taxpayer will not be defined by successful local delivery in the vanguard systems, but the extent to which they have made it easy to spread learning across the NHS and social care.
- xvii. This means the job of the joint leaders and supporting groups is to develop the simplest possible standard solutions wherever that makes sense – designed to meet the needs of multiple existing vanguards and future followers. For example, we are developing: model role definitions for new types of worker; common evaluation metrics; a single simple method for capitated pricing for a PACS and an MCP; a standard MCP contract perhaps with modular elements; new organisational forms; or “rights of return” for GP practices. The overall approach is for these simple solutions to be voluntary and vanguards will be able to tailor them to suit their own local circumstances.
- xviii. The NHS will own the intellectual capital for all the work of the vanguards. The programme will minimise duplication of wasted financial resource and avoid two or more local systems paying for what is in essence the same piece of work that can be developed once.
- xix. Together, the national bodies and vanguards, working with the Academic Health Science Networks (AHSNs), the Royal Colleges, NHS Confederation, NHS Providers, Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA), will be responsible for sharing learning across the NHS and social care.

### **Design principle 3 – we encourage and support radical innovation**

- xx. Through the document, we want to encourage all vanguards to become more revolutionary in their thinking. It has not always been clear to local systems what is and is not “on the table”. Through the programme, we will allow and enable existing silos to be dissolved – for example through new approaches to commissioning, to contracting, to payment and provider forms.
- xxi. These are all necessary enablers of transformation but there is no point in pursuing these changes in isolation. Therefore, the support package will work to support the vanguards in transferring power to all patients and diverse communities; to re-design the health and care workforce; and to re-think how care is delivered by harnessing digital and other technology.

#### **Design principle 4 – we work and learn at pace, demonstrating that change is real**

- xxii. The NHS is looking to the New Care Models programme to create a better and more sustainable future. At the same time, the vanguards and the national bodies know that achieving transformational change is very difficult. The vanguards are telling us that their work has to improve the interaction between individual patients and care-givers. That is why, at this stage of the programme, we are focusing on the spread and depth of change within each of the vanguards, rather than wider spread into other systems.
- xxiii. The vanguards want to deliver improvements for patients as quickly as possible. Our collective task now is for the joint national and local leads to work at the pace of the fastest vanguards, and to develop quick wins along the way. Progress and impact will be measured and evaluated using common approaches as described in this document.
- xxiv. We know collectively that we need to work at pace. Unless we can start to see demonstrable, quantified change occurring in 2016/17, it will become harder to justify significant national investment.

## National Support Package

### 1. Designing new care models

- 1.1. Whilst vanguards have told us how they want to approach redesign locally, they also recognise that they need support to develop a more tightly defined overarching model of care, and crucially that they want to understand key components which add the greatest impact and value for patients. In this way, vanguards will help the national team to identify the active ingredients for each care model that can be replicated in other local health systems.
- 1.2. To share this with the wider NHS and social care, in collaboration with, and based on progress made by vanguards, the national team will develop and publish a common framework for each care model; PACS, MCPs and enhanced health in care homes.
- 1.3. Vanguards have identified the need for support at different phases of design and implementation, involving continuous evaluation, refinement and improvement. Alongside this, they want support to clearly convey components of the care model to their staff, patients and citizens, and engage them in helping to define local outcomes and determine factors for success.

### Learning from other countries and sectors

- 1.4. Leaders from each vanguard will have access to international experts who have successfully implemented new care models across Europe, Australasia and North America, through a seminar programme delivered in October 2015. They will hear first-hand how in each country the care model was transformed through changes in organisational form, accountability and digitalisation of care, and how the workforce has adapted around their care model. In addition, vanguards will be free to join the integration pioneers on a programme provided by the NHS Confederation to understand innovative models of care across the European Union (EU).
- 1.5. From December 2015, proposals will be developed for the vanguards to choose to learn about approaches to transformational change from successful public, private and third sector organisations outside the health sector.

### Supporting identification of the right care for the right groups of patients

- 1.6. The vanguards will be given preferential and funded early access to a version of NHS England's Rightcare programme. Rightcare is currently working with many Clinical Commissioning Groups (CCGs) to support their approach to integrated care. Initially there is an analytical approach to understanding unwarranted variation in outcomes and costs, then indicating where to prioritise action in the few services where the opportunity for improvement is greatest.



- 1.7. Vanguard are developing a model of care focused around their population as a whole, ensuring that across diverse communities all patients get access to the right care and treatment which is personalised to them. Vanguard want evidence-based analytical support to segment the local population and then match tailored interventions to suit each group of patients within the community.
- 1.8. In other countries, successful integrated health systems such as Geisinger have targeted their efforts on the relatively few patients who are most likely to incur greatest cost. This requires accurate predictive analytical tools which take account of the fact that the cohort of people at greatest risk of avoidable hospital admissions is dynamic. Vanguard will require access to outstanding commissioning support services, accredited under the lead provider framework.
- 1.9. Vanguard want to know how variations in the design of a core component of their model will influence outcomes and overall impact. The evidence base can be inconsistent and choosing the optimal design can be challenging. For example, some vanguards are choosing to risk stratify their population at the top 2%, others at 5%.
- 1.10. Therefore, from January 2016, vanguards implementing variations of the same component will be asked to participate in 'action research'. This will allow each component to be refined through continuous measurement of benefits and system-wide impact.

### **Accessing national clinical and programme expertise**

- 1.11. Vanguard will be able to draw on a range of clinical and technical experts in different pathways, disease and patient groups, for example focusing on: care planning for people with long-term conditions; the new five year strategy for mental health to be published later this year; delivering parity of esteem across care pathways; new models of elective care and diagnostics; improving cancer services in line with the recommendations of the Independent Cancer Taskforce; and care models for children and young people.
- 1.12. Alongside this, medical experts who already support over 30 CCGs nationally, will work with vanguards who are ready to take a "commissioning for outcomes" approach to their model. Vanguard will have an opportunity to understand implementation of this from others nationally who are part of the quality and outcomes working group.
- 1.13. 14 vanguards are already developing new approaches to extended access to primary care, through the Prime Minister's Challenge Fund. From August 2015, we will work with all vanguards to explore whether similar approaches could be taken in their local health systems. The Government has made seven day working a top priority for the NHS in this Parliament across all geographies, and the vanguards will have the opportunity to be at the forefront of this work.

## Building local capability for quality improvement

- 1.14. Evidence suggests that embedding good quality improvement methods at the outset of transformation leads to greater success<sup>1</sup>. It builds continuous improvement into implementation and avoids repetitive cycles of planning, and should feed into both local and national evaluation. Some vanguards have got to their state of readiness because locally they have good improvement methodologies in place and backing from system leaders to use them.
- 1.15. Stockport Together (MCP), for example, have adopted principles of improvement methodology by focusing on benefits realisation. Some themes that they make use of include: encouraging collaborative leadership at all levels, helping people to increase their knowledge and confidence in tools and techniques that create innovation and support change, encouraging people to make some decisions on intuition and focus everyone on the joint vision and outcomes whilst engaging large numbers of volunteers to help take ownership of change.
- 1.16. Many vanguards have asked for support to strengthen their approach and for advice on which methodologies are best practice. Vanguards will be supported to build “trial, learn and refine” into their local delivery approach, and the national team will encourage prototyping on the basis of strong evidence and clinical consensus.
- 1.17. Where vanguards need to develop local expertise, we will match them to experts in the improvement community who will signpost them to best practice tools and guidance.
- 1.18. From this output, the national team will facilitate a quality improvement network for vanguards, fast followers and pioneers so that methods can be shared and common problems can be solved collectively.

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<sup>1</sup> The Health Foundation – *Safer patients initiative: lessons from the first major improvement programme addressing patient safety in the UK*, Feb 2011

## **2. Evaluation and metrics**

- 2.1. The New Care Models programme is complex in its breadth and depth. It also combines experimental discovery with standardisation. This calls for a sophisticated and multi-faceted approach to measurement and evaluation. Working closely with the vanguards, we will identify the impacts they are having on patients, staff and the wider population. We need to understand how and why these impacts are arising so that the learning about what works and what does not work can be shared rapidly amongst vanguards and spread throughout the NHS.
- 2.2. At its heart, this is about identifying the active ingredients for each care model to establish nationally visible patterns that will support replication across different local health systems. These will include the interventions themselves, the local context, and the process by which change occurred.

### **Development of logic models as a foundation for evaluation**

- 2.3. Logic models originate from the field of programme evaluation, and are simply diagrams or flow charts that convey relationships between: the resources being put into a programme; the interventions, activities and processes planned; the outputs from these; and the short-term, intermediate and longer-term outcomes. Logic models provide a visual means of showing complex chains of reasoning.
- 2.4. Experience from other large-scale programmes suggests that having a clear logic model is one of the active ingredients for successful change. Logic models can also be used as a planning tool, helping to clarify thinking and reduce the scope for programme failure owing to poor design and untested assumptions.
- 2.5. Drawing on the diagnostic visits and thematic analyses, we are co-developing draft logic models for every vanguard as a basis for further discussion and refinement. We have aggregated each logic model so that we can understand the totality of the PACS, MCP and care home models nationally.
- 2.6. From September 2015, all vanguards will receive intensive one-to-one support to develop and refine their logic models. By March 2016, the learning from these sessions will have been shared not just across cohorts but across the NHS.

### **Evidence-based interventions**

- 2.7. The diagnostic visits and thematic analyses highlighted variation in both the type and application of planned interventions.
- 2.8. The national team and vanguard leads are working with key partners to co-produce evidence summaries for the interventions being implemented across each care model. National partners include, amongst others, the Health Services Research Network (HSRN), AHSNs, Collaborations for Leadership in Applied Research (CLAHRCs), NHS Confederation, NHS Providers, the

Nuffield Trust, Health Foundation and the King's Fund. By December 2015, this evidence will be made available to the rest of the NHS.

## **The vanguard approach to evaluating new care models**

- 2.9. During our discussions with vanguards on evaluation and measurement, we were asked to set out details of our approach to evaluation, including national and local roles, the common metrics to be used across care models, and how progress will be reported for the vanguards and the rest of the NHS.
- 2.10. Using a set of high level metrics, co-produced with the vanguards, the national evaluation will monitor the progress being made to address the gaps in: health and wellbeing; care and quality; and efficiency.
- 2.11. The local evaluations will identify the active ingredients of each care model. These will include: the local health system context; specific intervention and how change has been implemented. Through the local evaluation, vanguards will track progress and performance in real-time which, in turn, will support the ongoing design and delivery of the new care model.
- 2.12. For example, Salford Together (PACS) vanguard has developed a detailed approach to evaluation. The Comprehensive Longitudinal Assessment of Salford Integrated Care is an evaluation framework designed to provide a rigorous test of the ability of their care model to deliver through measuring: improved user/carer experience; improved wellbeing and quality of life and reduced costs of care and improvements in cost effectiveness.
- 2.13. This will focus on areas which pose common challenges, or areas where there is benefit from standardisation. These will include measuring patient-centred care. For example, Northumberland Accountable Care Organisation (PACS) is building on the strong patient-centred narrative co-developed with the health and care system by National Voices. They capture feedback from more than 50,000 people every year and measure what matters most to patients in a variety of ways and at different points of care. There is a mechanism of real time measurement feedback to clinical teams within 24 hours.
- 2.14. By October 2015, we will publish an evaluation strategy, co-produced with vanguards and subject-matter experts from the research community. This will continue to evolve over the life of the programme as we try things out and adapt on the way.

## **Core metrics across all care models**

- 2.15. By October 2015, we will publish the initial suite of core metrics for each of the three care models. For the PACS and MCPs, these metrics will include emergency admissions per person, bed days per person and quality of life for people with long- term conditions. Metrics for care homes will include emergency admissions for residents. The core metrics will also include measures of progress against key national enablers set out in this document, such as shared care records, personalisation, and capitated budgets. The King's Fund is developing a new scorecard for measuring CCG performance,

and the new care models evaluation programme will provide input on the transformation domain.

- 2.16. Alongside these, we will describe and monitor a set of supplementary metrics, aimed at providing additional information about what is driving change in the core indicators e.g. emergency admissions for particular age groups.
- 2.17. From October 2015, we will produce a standard dashboard for each vanguard showing its trajectory compared to a baseline and compared to other vanguards, for each of the metrics. This is owned by the vanguards and as part of this, we will help them measure the difference that their new care model is making by comparison with what would have happened if no changes had been made.

### **3. Integrated commissioning and provision**

- 3.1. Vanguard told us they need support to break down the artificial divisions within local health systems which prevent properly integrated commissioning and provision designed around the whole needs of patients.
- 3.2. The New Care Models programme is creating new ways to dissolve these traditional boundaries. The vanguards have asked the national bodies to help them make much faster progress. This section of the document considers these key technical enablers: capitated payment; bundled contracts, integrated commissioning and fair procurement; and new provider forms.

#### **Capitated payment**

- 3.3. The joint local and national workstream on payment design and pricing will co-produce a limited number of simple and standard new payment and incentive models that can be implemented and tested locally. For the care homes vanguard, capitation may not be the preferred payment model and we will also explore how best to improve incentives.
- 3.4. The MCP and PACS vanguards are clear they want to move towards capitated payment for a whole population. To support that, the joint workstream will provide budgetary flexibility for merging separate provider funding streams into a single MCP or PACS pot.

#### **Capitation for PACS providers**

- 3.5. The idea behind a PACS is that there is a single local system of provision. The implication of that is for a PACS to take on a single capitated budget for all health care (and potentially social care) for their registered population.
- 3.6. Every PACS vanguard will be supported by expertise from the NHS England pricing team with additional support available from the New Care Models finance team and supplemented with expertise from Monitor. The joint workstream on payment design and pricing will also help sites to access support from commissioning support services where appropriate.
- 3.7. The joint local and national workstream will co-produce direct support for sites to help implement a new capitation payment approach as soon as practicable. The feedback we have received suggests that some sites may be able to begin using capitated payments in 2016/17. More will be ready to shadow capitation during 2016/17.
- 3.8. From August 2015, the joint workstream will begin to co-produce support to allow payments to other providers outside the PACS, enabling patient choice.

#### **Capitation for MCPs**

- 3.9. Many of the same principles apply to developing new funding models for MCPs and will require similar support.

- 3.10. The joint workstream on payment design and pricing will work closely with MCPs and their commissioners to build their new payment structure. The MCP model is based on a GP registered list. The structure will build in additional community and mental health services and social care as appropriate, converting these into an amount per patient that can be combined with core general practice funding.
- 3.11. For those sites that want to go live in April 2016, the joint workstream will work directly with them to reshape their existing cost and payment structures into a capitation type payment with appropriate incentives and risk sharing. Over the longer term, we will work with vanguards to refine the payment method using bottom-up patient costing using linked data, and work with them to address data constraints.
- 3.12. As with PACS, we envisage that the use of these simple standard payment methods will be voluntary. One of the most complex issues for the programme to deal with – both for MCPs and PACS - will be developing simple and attractive options for existing GP practices to migrate from their current funding and contractual arrangements, including ways to enable “rights of return”.

### **Quality payments**

- 3.13. Existing quality payments such as Commissioning for Quality and Innovation (CQUIN), Quality and Outcomes Framework (QOF) and the Quality Premium, will need to be reimagined and simplified, in order to create aligned, whole-system incentives that support new care models.
- 3.14. From September 2015, the joint workstream on payment design and pricing will take learning from these existing schemes and academic research to start developing new pay for performance schemes. For example, East and North Hertfordshire Clinical Commissioning Group (enhanced health in care homes) have introduced a complex care premium payment to reward care homes signed up to provide enhanced care for complex conditions in care homes.
- 3.15. A short menu of standard options will be co-designed with the vanguards. The work will also examine how the current system of sanctions might operate in a PACS or MCP contract.

### **Bundled contracts**

- 3.16. By December 2015, working with CCGs and providers in the vanguard systems, we will co-produce the first draft of a new standard MCP contract and a new standard PACS contract, for use between commissioners and providers in vanguard areas.

### **Model provider-to-provider sub-contract**

- 3.17. Many vanguards are moving towards more integrated forms of provision. Others are developing lead provider arrangements. In any event, lead providers are likely to need to sub-contract the provision of some services.

- 3.18. Through our joint local and national approach over the next few months, vanguards will tell us whether an updated model form of sub-contract will help them to deliver their care model. The new model sub-contract, co-produced with the vanguards, would be available for use by early 2016.
- 3.19. As a potential alternative, we have begun working with vanguards to co-produce a non-mandatory model alliance agreement which can be adapted for local use where appropriate. If vanguards decide that they want it, the model alliance agreement will be available later this year.
- 3.20. Alliancing principles are already being explored and adopted by some NHS commissioners and providers. To prevent vanguards from seeking and paying for legal advice multiple times, vanguards will have access to the legal advice provided for existing projects, as a starting point for local discussions.

### **Integrated commissioning**

- 3.21. Developing a bundled contract, based on a bigger capitated sum, requires pooling of different commissioner budgets. Working closely with providers and local commissioners in vanguard systems, the joint workstream leads will co-produce practical support for vanguards to plan for and manage the changes needed to bring about integrated commissioning.
- 3.22. For enhanced health in care homes vanguards this will mean creating commissioning and contracting arrangements across health and social care to enable shared accountability for care home residents.

### **Options for new integrated organisational forms**

- 3.23. Vanguards have asked for help to work through the different options for new integrated organisational forms. Different provider forms, such as partnerships, social enterprises, staff-owned mutuals and limited companies, each have benefits and limitations and we cannot take a “one size fits all” approach.
- 3.24. For example, South Somerset Symphony Programme (PACS) have set up a newly-established joint venture board with their local GP federation to hold a single capitated budget and allocate resources to where they are required in order to make the most difference to their patients’ care. The hospital trust and GP practices will be working together to develop the appropriate contractual arrangements. Under the new model, a patient with multiple long-term conditions will see improvements in the way different professionals will work together to meet their needs. Initial guidance will be co-produced with vanguards and published by December 2015.
- 3.25. Where appropriate, we will co-commission legal advice centrally to address common issues, ensure that advice is available nationally for the rest of the NHS, and avoid individual vanguards paying separately. Support will include helping the vanguards understand their options for different provider forms and the associated risks and benefits.



- 3.26. One of the most significant barriers to creating person-centred networks of care is the rules around information governance. A particular issue is the removal in the 2012 Health and Social Care Act of the normal ability of commissioners to share information where it is not for the purposes of the direct provision of care.
- 3.27. Following a national information governance summit in March 2015, the integration pioneer programme, as part of the new care model programme, commissioned the national bodies to lead intensive work to understand and resolve these issues insofar as this is practical within the existing legislative framework. These solutions will be tested back with pioneers and vanguards to see if they meet their needs and will also be used to support the range of programmes, including the Integrated Personal Commissioning and the Better Care Fund programmes.

### **Procurement and patient choice**

- 3.28. The vanguards have asked for practical support on commissioning, contracting and procurement. Working with the joint local and national workstream, Monitor will lead on procurement support and NHS England will lead on co-producing new contracts. Vanguard systems were selected on the basis of the strength of their local partnerships, and the job of the joint workstream and the national bodies is to help those partnerships work as quickly as possible.
- 3.29. The Five Year Forward View made a commitment that the NHS would make good on its longstanding commitment to offer patients choice and the planning guidance for 2015/16 made a clear commitment to a major expansion in personal health budgets. The promise and subsequent delivery of personalisation is a core part of the programme. We also expect commissioners to insist on creating additional local choices where the quality of services is not as good as patients have the right to expect.

## 4. Empowering patients and communities

- 4.1. New care models and the priorities of the NHS Five Year Forward View are achievable only by fundamentally changing the relationship that the NHS and social care have with patients, people and communities. Vanguard teams want to deliver care that is personalised, coordinated, tackles inequalities and effectively provides for the whole population. They want to work in partnership with patients, local people and their community, empowering them and enabling choice through the use of personalised budgets, care planning and peer support.
- 4.2. Fully harnessing the energy of patients, local people and diverse communities requires a new model of partnership. In order to support this new relationship, the Five Year Forward View People and Communities Board, working with patients, the voluntary sector and vanguard teams, has set out six principles for new care models:
  - Care and support is person-centred: personalised, coordinating and empowering
  - Services are created in partnership with patients and diverse communities
  - There is a focus on reducing health inequalities
  - Carers are supported
  - Voluntary, community and social enterprise sectors are key enablers
  - Volunteering and social action are key enablers
- 4.3. The way in which vanguard teams implement these will vary. Working with vanguard teams, the new care models team will co-produce and oversee this support.
- 4.4. Working with the vanguard teams, we will recruit a team of expert advisors to support the vanguard teams to undertake a baseline review of the way they are currently meeting the six principles, identifying strengths and weaknesses. The advisors will also support the vanguard teams to deliver the six principles, building on their existing expertise and the work they have done to date. This includes supporting them to share their learning across the NHS and social care, and to unlock the expertise within the third sector.
- 4.5. From September 2015, the vanguard teams will have preferential access to all tools and resources being developed by NHS England and its partners to empower, support and engage patients, including: Realising the Value, personal health budgets, integrated personal commissioning, building health partnerships, carers programme and a collaborative programme to support volunteering, social movements and social action.
- 4.6. In November 2015, we will publish a comprehensive directory of national and local services available to the vanguard teams.
- 4.7. Vanguard teams will be able to access support from expert advisors at the Institute for Health Equity as they develop their care model. They will be provided with

evidenced-based approaches to tackle health inequalities, provide outreach services for targeted groups and improve digital literacy.

## **5. Harnessing technology**

- 5.1. Vanguard's have asked for our support to rethink how care is delivered given the huge potential of digital technology to offer care in radically different ways. Vanguard's will be provided with dedicated expert resource to put them at the forefront of digital delivery. We will align with upcoming test bed sites which, together with the work of the National Information Board, will accelerate adoption and spread of digital health care. They will be supported to develop a local digital strategy identifying how they can transform access and delivery of care through technology solutions. This will include: extended GP access and seven day NHS services; prevention and self-care; and enabling personalised care.

### **Connected digital solutions and information systems**

- 5.2. Full interoperability ensures that all local information systems can 'speak with each other' and information can flow between them seamlessly. Across the NHS, many sites are struggling because key information systems do not allow them to share essential patient information throughout the health and care system.
- 5.3. A good example has been established in West Yorkshire, where Airedale and Partners (enhanced health in care homes) vanguard currently provides 24 hours a day, seven days a week telemedicine (clinical consultation via secure encrypted video links) to 133 care homes in Airedale, Wharfedale, Craven, Bradford and East Lancashire. This provides homes with access to an established clinical team in the telehealth hub based at Airedale Hospital. Wireless connectivity across the home allows video consultations from residents' rooms and the team has access to the full patient record.
- 5.4. From November 2015, building on the National Information Board (NIB) commitment that all patient and care records will be digital, real-time and interoperable by 2020, we will start to provide dedicated technical and strategic support for vanguard's to produce their roadmap to interoperability.
- 5.5. By December 2015, we will publish examples of digital successes so other vanguard's and the wider NHS can see what good looks like. Vanguard's will also be expected to share their digital strategies, learning and any technical solutions or designs within cohorts and with the rest of the NHS through the Code for Health initiative.

### **Information governance**

- 5.6. Vanguard's have asked for support to clarify information governance requirements, focusing on what is possible and how to unblock barriers across the whole care pathway.
- 5.7. Some vanguard's are already well on their way to resolving this locally. For example, North East Hampshire and Farnham Clinical Commissioning Group (PACS) has provided staff with access to an integrated digital care record. The

Hampshire Health Record (HHR) combines patient data from a range of health and care settings, and is now being used to support more targeted provision of care. Mid-Nottinghamshire Better Together (PACS), through their links to the multi-agency 'Better Together' programme, is close to implementing an agreed data sharing and consent model, defining how they will handle different types of information safely.

- 5.8. This will build on the suite of resources being developed by the pioneers throughout 2015/16 which will include guidance on real-life clinical scenarios and the information governance approaches taken, and nationally agreed standard templates that can be adopted by the wider system.
- 5.9. From November 2015, vanguards will have access to practical support to develop information sharing agreements and guidance on how to manage risks for different purposes including direct care, case finding, profiling, and stratification.

## **Digital strategy**

- 5.10. The NIB framework published in November 2014 sets out the vision and approach to accelerating the use of data and technology across the NHS. The support for vanguards will build on this by providing vanguards with dedicated expert and technical resource.

## **Managing system vendors**

- 5.11. To deliver better outcomes and value for taxpayers, vanguards have told us that they need support to navigate a rich and dynamic technology supplier market, which includes both national and international suppliers. From October 2015, vanguards will receive support, co-produced with national bodies, to collate technology requirements, create shared frameworks and enable collective market engagement and procurement at scale.
- 5.12. We will co-produce and publish a toolkit setting out the key stages of effective procurement and contracting.

## **6. Workforce redesign**

- 6.1. A modern flexible workforce is needed to enable networks of care organised around patients and local populations – reflecting the diversity of the communities served. Multi-disciplinary team working will be at the centre of this.
- 6.2. From August 2015, the joint workstream for workforce redesign will co-produce practical support for vanguards, working closely with Health Education England (HEE), the Royal Colleges, regulatory bodies, NHS Employers and trade unions. This will include work with Public Health England to help vanguards build a workforce based on population health needs, focusing on prevention and early intervention.
- 6.3. This section explains how the joint workstream leads will co-produce support for vanguards to help them: develop an effective local workforce strategy; introduce new and extended roles; enhance the skills of existing staff; and build an engaged, satisfied and healthy workforce.

### **Local workforce strategy**

- 6.4. A number of vanguards told us that they want support to map and profile their existing workforce across the local health and care system. By January 2016, vanguards will be supported to develop local workforce strategies that identify the training needs of existing staff, the new roles they need to create and the number of staff needed with different skills to deliver the new care model. Vanguards will be supported to engage closely with local education and training boards (LETBs) through the annual planning process to ensure that local and national investment reflects the shape of the future workforce.
- 6.5. Over the next three months, vanguards will be provided with a self-assessment tool to assess their capacity and capability for workforce redesign, helping to identify gaps in local expertise. This tool, which has been co-produced with Health Education Yorkshire and the Humber, has already been successfully piloted in Wakefield. Building on this, vanguards will have access to further analytical support and input from workforce experts to help profile the workforce.

### **New and extended roles, skills and training**

- 6.6. Vanguards told us that they want practical support to develop new and extended roles. Some local health systems have already piloted new roles, including physician assistants, care navigators, pharmacists in GP practices and mental health leads in CCGs. The regulators and HEE have an explicit responsibility to ensure that new roles, and the training and development programmes that underpin them, are based on a clear understanding of relevant skills and associated scope of practice.
- 6.7. Sutton Clinical Commissioning Group (enhanced health in care homes) is enhancing the skills and expertise of care home staff and managers. A targeted development programme has been developed for care home managers so that

they can deliver care to their residents proactively and work together as a key member of the local multi-disciplinary team.

- 6.8. Northumberland Accountable Care Organisation (PACS) is developing a new type of band 4 community care practitioner role and is testing this out on behalf of other vanguards and the rest of the NHS. The learning will be used to develop a model job description as quickly as possible.
- 6.9. From September 2015, the joint workstream will start to co-produce common skill descriptors and job descriptions for new and extended roles so that all local health and care systems can start training and recruiting the people they need. To take this forward, workstream leads will work closely with HEE and the regulators, as well as the Royal Colleges, Skills for Care, Skills for Health, NHS Confederation and other professional groups.

### **New ways of working**

- 6.10. Too often, our current system has incentivised different parts of the health and care system to work separately from each other. That can mean that vulnerable patients with more than one health or care need, such as older people with dementia, are not always getting the high quality care they deserve.
- 6.11. Changing the workforce culture to a more collaborative approach between different sets of clinicians, health and social care professionals and across all frontline staff, will be crucial. For instance, building on the Mental Health Taskforce recommendations, lead vanguards will take forward new ways of delivering mental health crisis care and ensuring there is parity of esteem between physical and mental health.
- 6.12. From December 2015, all vanguards will be offered facilitated simulation exercises to understand better the challenges of multi-professional working and the culture change required. These build on the work we have done with the pioneers and will be tailored to the specific contexts and professional skill mix of each of the first three care models.
- 6.13. Age UK in London has developed a primary care navigator role to support patients who are over 75 to access community support services which helps them to stay well and at home for longer. Through the programme, work is underway with National Voices and a consortium of leading patient and care charities to enhance these roles across the country. This consortium will also be offering the opportunity for the vanguards to work with them to ensure true local integration including with voluntary sector services.

## **7. Local leadership and delivery**

### **System leadership**

- 7.1. A number of vanguards have asked for targeted support for leaders to partner across their local health and care system.
- 7.2. System leaders from MCP vanguards are taking part in a targeted leadership programme, or 'community of practice', and a similar programme for PACS vanguards will begin in September. Through expert national and international facilitation, executive level participants will explore factors which support effective system leadership for each care model, reflecting their local context and experiences. Participants will be able to have open and honest conversations and debate with peers about challenging the status quo in their health and care economy.
- 7.3. In December 2015, vanguards will also have the opportunity to learn from international partners to gain insight and knowledge from leaders elsewhere. This has been a successful scheme for the pioneers, and vanguards will be invited to take part in a series of study tours to the EU. The first of these will take place in Spain to learn from the Alzira care model. Alongside this, vanguards will be invited to join an international seminar programme where leaders from across the world will discuss their innovative models of care.

### **Integrated and flexible leadership**

- 7.4. To deliver full integration, frontline clinical and professional leaders need to be willing and able to work together across different care settings, sharing their expertise across organisational boundaries. This has not been achieved at scale before.
- 7.5. Enhanced health in care home vanguards have told us that to deliver their care model, clinical, care home and social care leaders will need to develop side-by-side. Some have already begun to do this, but others have asked for additional support.
- 7.6. We are working with care home vanguards and the NHS Staff College to co-design a leadership programme, which will begin in October 2015. The programme will support clinical and non-clinical leaders to enable multi-disciplinary and multi-agency working across health, social care, housing, independent and third sectors.
- 7.7. PACS and MCP vanguards know that clinical and social care leaders will need to support generalists and specialists to work together, and decide how responsibility and accountability will be shared across multi-disciplinary teams. We will support clinical and social care leaders to work out the best way of working together, breaking out of traditional hierarchies, while maintaining clear lines of delegation.



- 7.8. Given the significance of primary care across the care model cohorts, from October 2015 National Association of Primary Care (NAPC) and NHS Alliance will develop a learning community for primary care and community professionals, where participants can share insights and concerns with peers.
- 7.9. In conjunction with key partners, for example NHS Confederation (encompassing the breadth of their membership base including NAPC and NHS Providers), the LGA and the Royal Colleges, we will offer multi-disciplinary learning sets for clinical and professional leaders from October 2015. These will include facilitated discussions on: improving patient safety; improving access to voluntary sector services; and harnessing skills and experience of Allied Health Professionals. The work here will tie in closely with plans to commission NHS Confederation to support the spread of innovation to non-vanguard sites, including work led by the Chief Allied Health Professional Officer.

## **Leadership at all levels**

- 7.10. Leadership development should not be limited to system leaders and experienced clinical and professional leaders. Dudley Clinical Commissioning Group (MCP), for example, has placed a strong emphasis on the leadership and cultural change process needed to support their Multi-Disciplinary Team (MDT) model. This will encompass frontline leaders, whilst also identifying emerging leaders for their talent management programme.
- 7.11. Similarly, Better Local Care (Southern Hampshire) (MCP) leaders are creating an environment that supports collaboration and enthusiasm for change. This includes development of the next generation of leaders, by creating clinical fellowships that could support backfilling and give emerging leaders a range of experiences.
- 7.12. The national NHS bodies will take into account the leadership challenges and responses identified above when considering the future priorities of the Leadership Academy.

## **Supporting local delivery**

- 7.13. Many vanguards already have strong programme delivery arrangements in place with local teams working across organisations to design and drive change in a coordinated way. For instance, Better Health and Care for Sunderland's (MCP) programme management has been integral in bringing their partners together and helping to build momentum in driving the programme forward.
- 7.14. Vanguards told us they want to be able to self-assess their ability to deliver the new care model. To support the wish for local delivery and additional capacity, vanguards will be supported by a dedicated account manager from November 2015. Account managers will provide help in problem-solving and facilitate access to the relevant expertise when required.

## **Use of local health and care assets**

- 7.15. Implementing new care models across vanguards will in many cases require a different approach to the use of NHS assets and other estates. For example, moving care out of hospitals needs modern and suitable local primary and community care facilities. Vanguards have asked for support to take a view across the local health system about how to manage, develop and rationalise estates and assets.
- 7.16. This is not straightforward, the land and buildings used to provide health and care for diverse communities are owned by different organisations and individuals including NHS foundation trusts, NHS Property Services, GP partners and other professionals, voluntary and community providers and local authorities.
- 7.17. From October 2015, a joint workstream for estates and use of assets will co-design the support that vanguards need for the delivery of new care models. Vanguards will also receive advice and legal support to deal with the financial legacy of private finance initiative (PFI) deals and local improvement finance trust (LIFT) schemes.

## **Transformation funding**

- 7.18. The vanguards have access to the bulk of the £200 million Transformation Fund. Each vanguard has been given the opportunity to submit value propositions demonstrating delivery against the triple aims of the programme. Efficiency requirements are core to this, and vanguards are demonstrating through these propositions how they will deliver the requirements of additional efficiencies by the end of 2017/18.
- 7.19. Following consideration by NHS England's Finance and Investment Committee, approval has been given in principle to the initial £60m requests for funding, subject to some clarification, including of savings. Vanguards that chose not to submit a value proposition will be able to submit in September 2015.

## **8. Communications and engagement**

- 8.1. To be successful, the new care models will be designed and delivered by a strong collaboration of partners where staff, patients, local people and other stakeholders are engaged and committed to the vanguard's vision.
- 8.2. Evidence shows that effective communications play a key role in improving the performance of NHS organisations. Many vanguards are leading the way in some elements of communications and engagement – for outstanding involvement of patients, public or staff. For instance, Northumberland Accountable Care Organisation (PACS) has received significant praise from their local Healthwatch about the way they have involved patients and local people in the development of their new emergency care hospital.
- 8.3. The support explained in this section is designed to enable all vanguards and pioneers to be exemplars, demonstrating best practice in the way they communicate and engage with local diverse communities.

### **Local communications and engagement strategy**

- 8.4. As discussed in the empowering patients and communities' chapter, co-designing the models hand-in-hand with local people and staff will mean that the needs of all involved, including those who are vulnerable or from hard-to-reach groups in the community, will be the focus of the new care model. This will involve comprehensive targeted strategies for a wide external audience including patients, carers, politicians, local charities and support groups, and the media. To harness the renewable energy of local diverse communities, vanguards will act as a catalyst for social movements.
- 8.5. Successfully breaking down traditional boundaries of health and social care will involve well-planned clear strategies. Many of the vanguards have multiple partners and sites. For example, the Mid Nottinghamshire Better Together (PACS) has 14 partners and, the Better Care Together (Morecambe) (PACS) vanguard comprises 11 organisations.
- 8.6. All vanguard sites will, from September 2015, receive support from independent experts to develop, review and provide feedback on their communication and engagement strategies. There will also be opportunities for peer review, whether across all of the vanguards or within their care model type.
- 8.7. By September 2015, a new evaluation tool – developed in partnership with leaders in the field – will enable vanguards to assess the impact of their strategy and compare results with their peers. It will also allow them to undertake an assessment of their communications and engagement to date, providing a baseline for comparison as they move forward.

### **Sharing best practice and methods**

- 8.8. In the NHS we have not always sufficiently shared and learnt from each other. From September 2015, working in partnership with NHS Confederation, NHS

Providers, the LGA, NHS Clinical Commissioners and others, vanguards will be offered a range of tools to share the learning from the programme as part of a detailed collaboration plan, including conferences, events, visits, publications and ambassadors' programme. The ambassadors' programme will harness the energy of staff to individually and collectively champion their own emerging models and the difference it is making to patients.

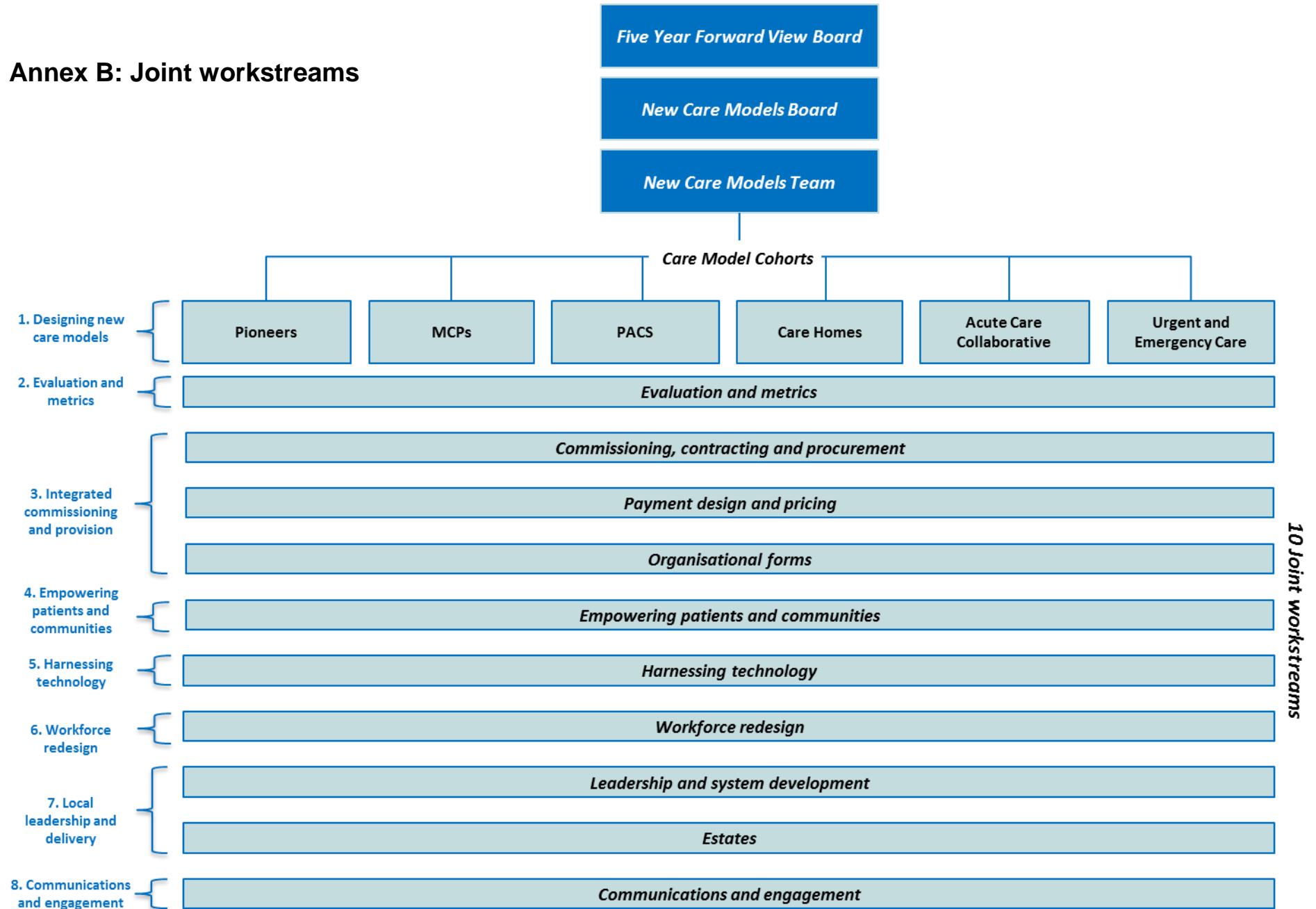
- 8.9. From November 2015, an online tool available to all of the NHS and social care will enable the rapid dissemination of learning and information across the vanguards as well as real-time conversations between peers to help solve problems.

## Annexes

### Annex A: Vanguard sites

Cohort	Names	Location/County
Integrated Primary and Acute Care Systems	Wirral Partners	Wirral/Merseyside
	Mid Nottinghamshire Better Together	Nottinghamshire
	South Somerset Symphony Programme	Somerset
	Northumberland Accountable Care Organisation	Northumberland
	Salford Together	Salford/Greater Manchester
	Better Care Together (North Lancashire and South Cumbria)	North Lancashire and South Cumbria
	North East Hampshire and Farnham Clinical Commissioning Group	Hampshire
	Harrogate and Rural District Clinical Commissioning Group	North Yorkshire
	My Life a Full Life (Isle of Wight)	Isle of Wight
Multispecialty Community Providers	Calderdale Health and Social Care Economy	Calderdale/West Yorkshire
	Derbyshire Community Health Services NHS Foundation Trust	Derbyshire
	Fylde Coast Local Health Economy	Fylde/Lancashire
	Vitality (Birmingham and Sandwell)	Birmingham and Sandwell, West Midlands
	West Wakefield Health and Wellbeing Ltd	Wakefield/West Yorkshire
	Better Health and Care for Sunderland	Sunderland
	Dudley Clinical Commissioning Group	Dudley, West Midlands
	Whitstable Medical Practice	Whitstable/Kent
	Stockport Together	Stockport/Greater Manchester
	Tower Hamlets Integrated Provider Partnership	Tower Hamlets/East London
	Better Local Care (Southern Hampshire)	Southern Hampshire
	Primary Care Cheshire	Cheshire
	Lakeside Surgeries (Northamptonshire)	Northamptonshire
	Principia Partners in Health (Southern Nottinghamshire)	Southern Nottinghamshire
	NHS Wakefield Clinical Commissioning Group	Wakefield/West Yorkshire
Enhanced Health in Care Homes	Gateshead Care Home Project	Gateshead
	East and North Hertfordshire Clinical Commissioning Group	Hertfordshire
	Nottingham City Clinical Commissioning Group	Nottinghamshire
	Sutton Clinical Commissioning Group	Sutton
	Airedale & Partners	West Yorkshire

## Annex B: Joint workstreams





The NHS Five Year Forward View has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Care Quality Commission, Health Education England, Monitor, The National Institute for Health and Care Excellence, NHS Trust Development Authority and Public Health England.