# THE *FORWARD VIEW* INTO ACTION:

## Registering interest to join the new models of care programme

January 2015

# Forward View into Action

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1. This note informs applicants how to register their interest in becoming vanguard sites for some of the new care models, further to the December planning guidance *The Forward View into Action*.

2. Initially, we are inviting interest in four models:

    - multispecialty community providers (MCPs);
    - integrated primary and acute care systems (PACS);
    - additional approaches to creating smaller viable hospitals; and
    - models of enhanced health in care homes.

3. The December guidance said that successful applicants will already have in place:

    - an ambitious vision of what change local areas want to achieve to the model of care, in order to meet the needs and preferences of their local population;
    - a record of already having made tangible progress towards new ways of working;
    - a credible plan to make move at serious pace and make rapid change in 2015;
    - funded local investment in transformation that is already agreed;
    - effective managerial and clinical leadership, and the capacity and capability to succeed;
    - strong, diverse and active delivery partners, such as voluntary and community sector organisations;
    - positive local relationships, for example the support of local commissioners and communities;

and that they will also need to show:

    - appetite to engage intensively with other sites across the country, and with national bodies, in a co-designed and structured programme of support aimed at (a) identifying, prioritising and tackling national barriers experienced locally; (b) developing common rather than unique local solutions that can easily be replicated by subsequent sites; and (c) assessing progress, through a staged development process;
    - a commitment to co-design local and national metrics and to demonstrate progress against them, including real-time monitoring and evaluation of health and care quality outcomes, the costs of change, and the benefits that accrue.

4. The registration process is simple, to minimise bureaucratic burden. Interested sites are asked to complete a two page form, which is attached, and send it to the new care models team (england.fiveyearview@nhs.net) by **9 February 2015**.

5. The process thereafter will depend on the interest shown. We will consider this at the first meeting of the New Models of Care Programme Board, jointly chaired by NHS England and Monitor. We will use the registrations of interest, combined with other available information, to inform how we select a relatively small number of sites by early March. This is likely to involve discussing plans with a shortlist of applicants. We are seeking sites most likely to make the best progress during 2015/16.

6. From March onwards, we will work with partner sites to develop dedicated support. Our aim is to accelerate change in ways that can be replicated elsewhere. Support will blend peer learning with the provision of expertise in areas such as patient empowerment and engaging communities; clinical workforce redesign; using digital technology to rethink care delivery; the optimal use of infrastructure; creating joined-up information systems; devising new legal forms and new contractual models; integrated commissioning across CCGs, NHSE and LA and procurement; and capitated payment arrangements.

7. Each of the sites will benefit from a named account manager, dedicated to coordinating national help and support, including removing barriers to change.

***Characteristics of the new models of care***

8. All of the selected care model sites will have certain characteristics in common. Their shared purpose is to promote the health and wellbeing of their local populations, to increase the quality of care for their patients, and to improve efficiency for the taxpayer within the available resources. All are rethinking and redesigning the way care is delivered. The sites will show what the future NHS could look like: what integration can really mean in practice, for different communities, patient groups and staff; and across home and community based services, urgent and emergency care, elective care and specialised services. And we will be looking to all the vanguard sites to exemplify how much new care models can contribute to bridging the efficiency gap identified in the *Forward View.*

9. Each type of care model will also exhibit different specific characteristics. These distinguish one care model from another. Our aim in discussing these specific characteristics here is to provide shape and definition, in a way that helps rather than restricts. The new care models programme is looking to create a limited number of tangible and clearly identifiable prototypes that can be replicated elsewhere in subsequent phases of the programme.

10. The characteristics described below are not set in stone. They are intended as an early guide. Some of these care models, such as multispecialty community providers and primary and acute care systems, do not yet exist in England, although a number of areas are well on the way.

***Multispecialty community providers and primary and acute care systems***

11. A fully formed multispecialty community provider (MCP) will eventually:

- be an integrated provider of out-of-hospital care;
- have a clear and robust governance structure, with its own organisational capability. Its leadership is invested with the power and ability to reshape care delivery. It is more than a loose cluster or network of like-minded partners;
- extend beyond being primary care at scale. It combines core primary medical care services with wider community-based NHS services and, potentially, social care. For example, district nursing and health visiting, pharmacy, dentistry, step-down beds, re-ablement and domiciliary care services. It may well provide mental health and preventative services;
- as an essential building block, incorporate the list(s) of registered patients for the population it intends to cover. It will serve a minimum population size of at least 30,000-50,000 registered patients but could be larger;
- have a joined-up electronic health record for its registered population;
- use risk stratification and patient population segmentation to identify patients who will benefit most from intensive support;
- design dedicated services for different groups of patients, making full use of digital technology;
- run expanded multi-disciplinary community-based teams, including for example pharmacists, social workers and nurse leaders;
- incorporate, through employment or partnership, some acute specialists e.g. consultant geriatricians, psychiatrists and paediatricians, to provide integrated specialist services in the community. It may well develop new clinical roles such as 'generalist' consultants (sometimes called hospitalists) to coordinate care for people with long-term conditions;
- excel at both empowering patients and involving local communities, with strong voluntary sector input. It guarantees NHS constitution rights and supports the development of personal budgets;
- lead the way in reducing avoidable mortality, for example through better early diagnosis of diseases such as cancer;
- provide redesigned and more accessible urgent care services in the community, in line with the urgent and emergency care review;
- take on responsibility for managing a new type of capitated contract for population health and care that encompasses the wider range of services it directly provides for its registered patients. (The MCP programme is likely to co-design a limited suite of such model contracts and payment currencies with sites);
- potentially provide in-reach services to other settings of care: for example into care homes or services within local community hospitals, or providing some services within, or conceivably even running sections of district general hospitals. It could involve GPs with admitting rights within hospitals.

12. The primary and acute care systems (PACS) model is similar in many ways to the MCP model. Like MCPs, the PACS model is a new provider-based approach to population health management. Both models are about breaking down silos between existing services and settings, to free up the redesign of care around the different needs of different patient groups. Given what MCPs and PACs have in common, elements of the support programmes for each will be run together.

13. The main difference is that PACS are a significantly extended form of an MCP. It is an approach to full 'vertical' integration: unlike the MCP, PACS also incorporate all core hospital services. This means the model is likely to operate at a larger geographical scale than an MCP, involves more complex regulatory issues, and is taking on greater risk.

14. There is no right answer nationally as to whether an MCP will be a better solution than a PACs, or indeed some other model. A local health economy might contain a combination of different models. What works best for a local community will depend on its particular local conditions, capabilities and preferences.

15. A primary and acute care system:

- goes beyond MCPs and integrates the provision of hospital and mental health services - as well as primary community and potentially social care services;
- has clear and robust governance, capability and leadership - whatever the organisational form, e.g. formal agreement such as a joint venture. Without clear leadership, with rights to make decisions about reshaping care, it is unlikely to succeed and be able to manage risk;
- incorporates the list of registered patients for the population it intends to cover, as well as wider community and hospital services for those patients. Positive engagement, behaviours and partnership working between the NHS Trust or Foundation Trust, other community providers, and participating GP practices, is essential;
- may typically cover a population size of at least a small District General Hospital, e.g. 200-250,000 patients. The size of the PACS is the size of its registered list. It may become much larger. We also recognised in the *Forward View* the need to expand the supply of primary care in deprived, under-doctored and poorly served communities. We are not ruling out PACS (or indeed MCP) models that offer the provision of new GP-based services;
- demonstrates a consistent cultural and strategic focus on developing preventative, primary care and community-based services. This focus is likely to be at least as strong as its focus on improving acute and tertiary medicine. PACS may well integrate mental health services with physical health services;
- uses risk stratification and patient population segmentation to identify patients who will benefit most from intensive support. PACS would design dedicated services for different groups of patients, using remote and digital technology;
- redesigns and manages complete patient pathways, running multi-disciplinary teams with redefined workforce roles. PACS might for example blend the role of a general physician with that of a general practitioner;
- excels at both empowering patients and involving local communities, with strong voluntary sector input. PACS will be required to offer its registered population choices in line with NHS constitution rights, and offer personal health budgets, rather than assume it is the guaranteed provider of services;
- leads the way in reducing avoidable mortality, for example through better early diagnosis of diseases such as cancer as well as better treatment and support;
- provides redesigned emergency care, and well as urgent care services in the

community, in line with the urgent and emergency care review;

- brings the acute partner's balance sheet and infrastructure to bear in helping develop upstream services, It makes optimal use of community assets across the combined estate;
- takes on from commissioners (NHSE, CCGs and potentially local government acting together) a single full capitated budget for its registered population, on a long-term basis.

***Additional models for viable smaller hospitals***

16. Both the PACS, and on a smaller scale the MCP model, may offer options for a viable future for smaller district general or community hospitals. The first wave of PACS will almost certainly include some small district general hospitals, as well as larger institutions.

17. However, small hospitals may also wish to explore how to integrate acute and community services to deliver new ways of working. Demand for these services could increasingly come from MCPs seeking to work in partnership rather than develop these capabilities in house. This could be combined with new ways of delivering acute services including the following options:

    - Focusing on delivering elective services, in areas of excellence, across different geographical sites. Several examples both in England and internationally have pursued this option working together with other like-minded acute providers in orthopaedic, ophthalmic and other services. To improve efficiency, these groups of providers may also share back office and clinical support functions (e.g. pathology);
    - Focusing on delivering specialist tertiary services across multiple sites—for example, cancer services—using an NHS franchise model;
    - Creating multi-service chains, or "foundation groups". This option could be of interest to a group of small, like-minded district general hospitals conceivably in different geographies. It could equally appeal to medium or large teaching institutions;

18. We encourage interest from organisations that have a strong immediate interest in pursuing these options. The focus of this cohort is likely to be on unlocking faster and more effective change including addressing any regulatory barriers; and on codifying and standardising outstanding care delivery across increasing numbers of sites, in order to unlock the quality and efficiency benefits of scale and concentration. This cohort will also be exploring the organisational models in the Dalton Review to facilitate change.

***Enhanced integration with care homes and social care***

19. We outlined in the *Forward View* the need to develop a care model to deliver enhanced health in care homes. This model could also be included as a major element in MCPs or PACS. However, we recognise that there may be a distinct option for areas seeking to integrate with social care services, and with a specific focus on connecting care homes into healthcare, to provide a dedicated offer for older people.

20. Although we will work with leading areas to develop this option further, we expect it to include:

- strong and inventive partnerships with local community and voluntary sector services to augment NHS and social care services;
- a focus on residents' capabilities, not their dependencies – and a demonstrable commitment to prolonging independent living;
- in-reach services provided in partnership by the NHS, local authority social services departments and other partners for people in care homes, as well as services for helping older people to stay in or return to their own homes. These may be aligned to other new care models;
- use of new technologies and telemedicine to provide fast and effective access to clinical and specialist input;
- innovative approaches to local assets, including intermediate and respite care beds, to support people to return to independent living with appropriate support from community services;
- multiagency and multidisciplinary teams to identify people whose health is at risk of deterioration, to provide regular medication reviews and to help coordinate health, mental health and social care services in a more holistic way;
- flexible workforce models enabling clinicians and to care for patients in care homes, primary care and care home settings;
- redesigned hospital discharge processes that support patients to return to care homes as early as possible, seven days a week;
- training and support for staff and families for patients to die in a place of their choice.

***Transformation funding***

21. We are seeking bids from individual sites as part of the application process. We will also work with vanguard sites to develop support packages and, where required, business cases for transformation funding where to cover non-recurrent costs. For example, this transformation funding could be used to cover the double-running costs, capital projects or to fund dedicated implementation teams, potentially over several years. Local areas will be expected to make a contribution to transition costs.

22. Transformation investments will be made on a conditional basis, focused on the successful implementation of new care models. An agreement between local and national bodies will be concluded for each vanguard site specifying roles and responsibilities on each side. Investment will be contingent on progress. We will also expect each participating area to participate in an operational research and evaluation programme that will measure progress against process and outcome measures. These measures will be developed at the outset of the programme, in discussion with sites. We recognise that it will take time for new care models to achieve their full potential.

**REGISTRATION OF INTEREST**

| **Q1. Who is making the application?**<br>(What is the entity or partnership that is applying? Interested areas may want to list wider partnerships in place, e.g. with the voluntary sector. Please include the name and contact details of a single senior person best able to field queries about the application.) |
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| **Q2. What are you trying to do?**<br>(Please outline your main objectives, and the principal changes you are planning to make to change the delivery of care. What will it look like for your local community and for your staff?) |
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| **Q3. Which model(s) are you pursuing?** (of the four described) |
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| **Q4. Where have you got to?**<br>(Please summarise the main concrete steps or achievements you have already made towards developing the new care model locally, e.g. progress made in 2014.) |
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| **Q5. Where do you think you could get to by April 2016?**<br>(Please describe the changes, realistically, that could be achieved by then.) |
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| **Q6. What do you want from a structured national programme?**<br>(Aside from potential investment and recognition: i.e. what other specific support is sought?) |
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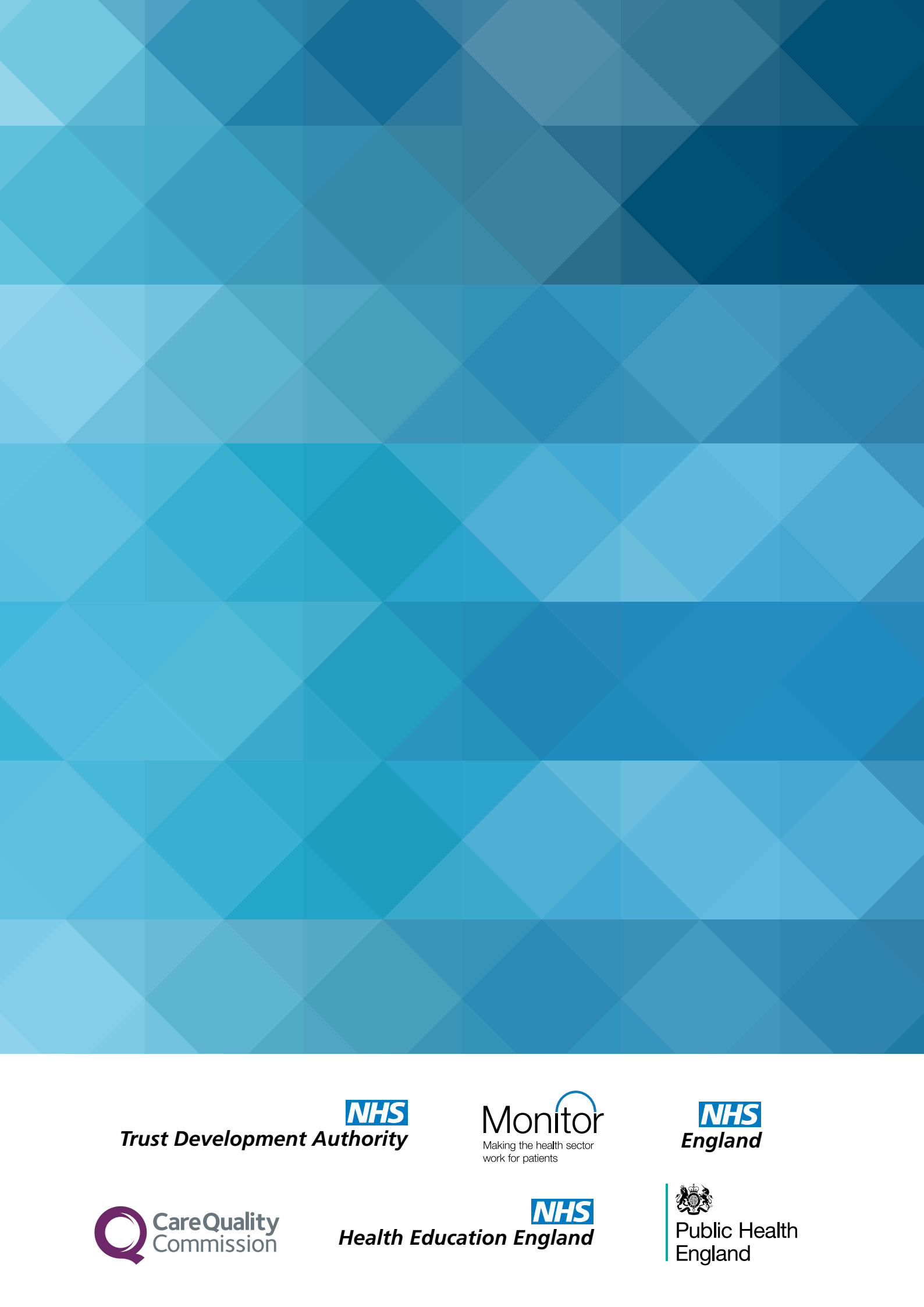
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