

Developing new models of care in the PACS vanguards

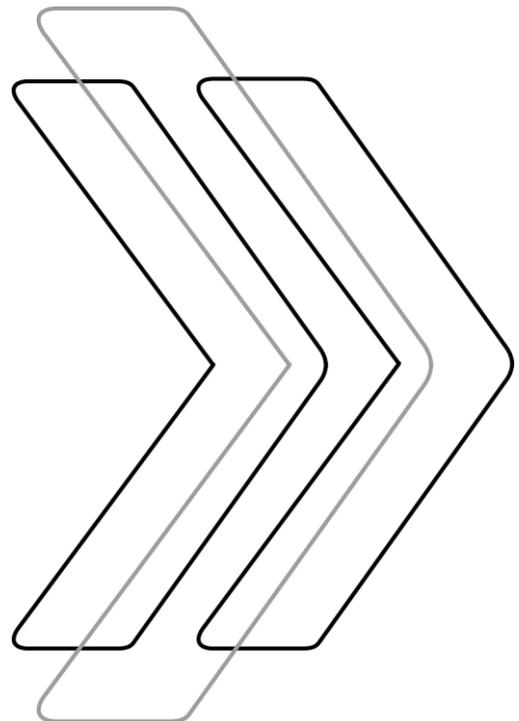
A new national approach to large-scale change?

Editors

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Key messages

- National bodies can support large-scale change in the health and care system by acting as catalysts of locally led innovation. The new care models programme provides a case study of a major national programme that has attempted to put this type of bottom-up, facilitative approach into practice, and shows the value of national bodies working in this way.
- In the PACS vanguard sites, relatively modest transformation funding has helped to catalyse significant amounts of innovation in terms of both frontline services and wider structures supporting system-wide collaboration. The most important enablers of change have included an infrastructure for sharing learning between sites, access to specific forms of technical expertise, and a supportive relationship with national bodies.
- Bringing about system-wide change at the local level requires strong relationships, trust and an ethos of mutual interest. Building this takes time, and in many vanguard sites efforts to develop system leadership and a shared local vision began several years before the new care models programme commenced.
- Relationships were strengthened in vanguard sites through regular communication, creating joint posts across organisations, co-locating teams, and fostering a culture of openness and transparency between partners. This kind of relationship-building needs to happen before making more formal changes to contractual arrangements or organisational structures.
- Further work is needed at the national level to remove legal, regulatory and financial barriers that inhibit integrated working across organisational boundaries, including issues around VAT, pensions, contractual terms and conditions, information governance, and procurement laws. Without this, progress locally will be frustrated and there is a risk of some of the momentum being lost. Changes to the legislation will be needed to ensure current developments are aligned with the statutory framework.
- Spreading and scaling-up innovations from the vanguards sites is the challenge to which system leaders are now turning. With funding for the new care models programme coming to an end, it is not clear where the support for this will come from. National leaders cannot rely on passive diffusion of good practice, and should develop a strategy to ensure that

insights from vanguard sites are actively applied in sustainability and transformation partnerships and integrated care systems. This is needed to avoid the risk of learning from the new care models programme being lost.

1 Introduction

The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS-- is increasingly a barrier to the personalised and coordinated health services patients need.

NHS five year forward view (NHS England et al 2014)

At the heart of the Forward View is the argument that the needs of an ageing population with rising rates of long-term conditions are not well served by the arrangements put in place when the NHS was founded. To overcome the boundaries and discontinuities between different parts of the system, the Forward View proposed a small number of 'new models of care' (see box below), to be trialled in selected vanguard sites across England. These new care models have been described by NHS England as providing 'a blueprint for the future of NHS and care services' (NHS England 2016b).

Primary and acute care systems

Perhaps the most ambitious of these new care models, in terms of potential scale and scope, is the primary and acute care system (PACS). The PACS model envisages a single entity or group of providers taking responsibility for delivering a full range of primary, community, mental health and hospital services for their local population. A framework published by NHS England in 2016 suggested this could range from relatively loose alliance arrangements (a 'virtual PACS') through to a fully integrated model in which a single body holds a contract to deliver the full spectrum of services including primary care (NHS England 2016a). This latter option would represent the most radical shift from the structures established in 1948, with GP practices becoming part of a shared organisational structure with hospitals and other local providers, rather than continuing to exist as independent small businesses.

The goals of the PACS model are to improve co-ordination of services, provide more proactive support for the health needs of populations and individuals, and move care out of hospital where appropriate. A central part of this has been the development of multidisciplinary teams of health and social care professionals working with clusters of GP practices, each typically covering a population of between 30,000 and 50,000. These teams aim to provide

integrated care for people with the most complex care needs, often including frail older people and people with multiple long-term conditions. Beyond this, the model can incorporate a diverse range of approaches and interventions. The summaries included in the appendix capture some of the main changes introduced to date in areas implementing the PACS model.

National support for implementation

In 2015, nine areas across England were selected to implement and test the PACS model (see appendix for a full list). These nine vanguard sites formed part of a wider programme led by NHS England to support the development of the new care models described in the Forward View.

NHS England has argued that the new care models programme represented an important departure from previous approaches to supporting large-scale change in the NHS. First, it was intended to be enabling rather than prescriptive. Although the basic principles of the PACS model and other new care models were sketched out in the Forward View and other documents, national guidance was permissive and much of the detail has been worked out bottom up (for example, the PACS framework published in 2016 was created in part by aggregating local developments and experience). The concept was that the work of the vanguard sites would help articulate the model with greater specificity, so that other areas could then apply it to their own systems – an idea described at the time as ‘an inversion of the traditional hierarchy’ (NHS England 2015).

To help put this facilitative approach into practice, the new care models programme team at NHS England was led by an experienced clinical leader recruited from the system, Samantha Jones, who had previously held a number of senior roles including as chief executive of two acute trusts. Vanguard sites were assigned account managers and also had named contacts in other national bodies such as the Care Quality Commission, whose role was to help resolve barriers to change created by the national policy framework.

The second way in which the new care models programme was intended to be different from previous national programmes related to the plans made for wider roll-out. NHS England has argued that the success of the programme ‘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’ (NHS England 2015). Vanguard sites were expected to

collaborate openly with each other, commission and participate in local and national evaluations, and commit resources to sharing learning with other parts of the country. The national programme team has emphasised the importance of identifying replicable components, frameworks and methods that are 'built for spread' and can be readily deployed elsewhere (NHS England 2015).

Since 2015, The King's Fund has supported the PACS vanguard areas to share learning by facilitating a community of practice, commissioned by NHS England. The community of practice has brought leaders from the nine areas together at regular intervals, helping them to work together to address common challenges, learn from the progress and experiences of others, and to access the most relevant expertise and research on the models they are developing. The community has also been a forum for the vanguards to engage in constructive dialogue with the national bodies regarding the challenges they have faced.

Collectively, the nine PACS vanguard sites received slightly more than £100 million of national transformation funding between 2015/16 and 2017/18 to help accelerate the changes being introduced. The national bodies offered to back local plans by permitting 'flexibilities in the current regulatory, funding and pricing regimes to assist local areas to transition to better care models' (NHS England *et al* 2014). Vanguard sites also received a package of expert support covering the following areas (NHS England 2016a):

- designing new care models
- evaluation and metrics
- integrated commissioning and provision
- governance, accountability and provider regulation
- empowering patients and communities
- harnessing technologies
- workforce redesign
- local leadership and delivery
- communications and engagement.

This support ended in March 2018, along with ring-fenced national funding for vanguards. Responsibility for ongoing implementation of the PACS model and

other new care models, in both the vanguard sites and more widely, now rests largely with sustainability and transformation partnerships, integrated care systems and other forms of local place-based leadership. Some of the core components of the PACS model are now being widely introduced across England (in particular, the development of multidisciplinary integrated care teams, something which is common to several of the new care models). However, most areas remain some distance from the most radical 'fully integrated' version of the model, in which the organisational barriers between primary and secondary care are dissolved entirely (Collins 2016).

About this report

The King's Fund has worked in close partnership with areas developing new models of care, including by facilitating the community of practice (described above). We have also conducted in-depth research examining emerging innovations in governance arrangements and organisational forms (Collins 2016).

As the national programme comes to a close, we invited those who have led the development of the PACS model, nationally and locally, to reflect on the process of being part of the programme, and of trying to bring about complex change in local systems. This report is not an evaluation of the PACS model or of the new care models programme (formal evaluation is being conducted separately by NHS England and an independent academic team). Instead, it offers a unique set of first-hand perspectives into the experience of those leading a major programme at the national level and those living it at the local level. The insights shared will be invaluable to those constructing future national support programmes intended to facilitate transformation in local health and care systems. The lessons learned will also be highly relevant to those involved in the ongoing implementation of PACS and similar models.

We have chosen to focus the report on the PACS vanguards because this builds on our experience of working with these sites through the community of practice referred to above. However, much of the commentary in section 2 will also apply to other new models of care, particularly the closely related multispecialty community provider (MCP) model.

New care models in the vanguard sites

- **Primary and acute care systems (PACS).** These involve a single entity or group of providers taking responsibility for delivering a full range of primary, community, mental health and hospital services for their local population, to improve co-ordination of services and move care out of hospital where appropriate. In its fundamentals the PACS model is similar to the MCP model but is wider in scope (potentially including a greater range of hospital services) and may also be bigger in scale as a result.
- **Multispecialty community providers (MCPs).** These involve GP practices forming 'neighbourhood' or 'locality' groups, with a multidisciplinary team in each neighbourhood allowing GPs to work together with other health and social care professionals to provide more integrated services outside of hospitals. This might include working with some specialists currently working in acute hospitals, as well as nurses, mental health professionals, community health services and social workers.
- **Urgent and emergency care (UEC) models.** These focus on improving the co-ordination of urgent and emergency care services and reducing pressure on A&E departments. Changes include the development of hospital networks, new partnership options for smaller hospitals and greater use of pharmacists and out-of-hours GP services.
- **Acute care collaboration (ACC) models.** These involve linking hospitals together to improve their clinical and financial viability, reducing variation in care and improving efficiency. Several of the ACC vanguards are focused on developing networked approaches towards a specific clinical area such as cancer, orthopaedics or neurology.
- **Enhanced health in care homes models.** These involve NHS services working in partnership with care home providers and local authority services to develop new forms of support for older people.

2 Perspectives on the programme

The King's Fund perspective: Chris Ham

Chris Ham is Chief Executive of The King's Fund.

In my work over the past two years I've encountered two versions of the NHS. Version one is an NHS under severe pressure from growing demand for care at a time of constrained resources. We've seen version one on our television screens many times during the recent winter as hospitals struggle to meet national standards and the quality of patient care is compromised, despite the best efforts of hard-pressed staff.

Version two is an NHS finding ways to innovate despite the pressure it faces. I've seen version two in the work The King's Fund has done with the new care models programme over the past three years. The nine areas identified in the programme as primary and acute care systems (PACS) have been at the forefront of efforts to integrate care and improve population health and they have put in place a wide range of innovations in care.

Many of these innovations focus on services in the community. Examples include improving patients' access to general practices, establishing integrated teams to meet the needs of high-risk patients, and supporting patients living in care homes in order to avoid hospital admissions. The Isle of Wight has established an integrated care hub that brings together all parts of the emergency and unscheduled care system and other areas have enabled GPs to seek advice and guidance from specialists more easily.

The reach of some PACS has extended beyond mainstream health and care services. In Morecambe Bay, for example, a local GP has worked with schools to introduce the Daily Mile. Originating in Scotland, the Daily Mile encourages pupils and staff to recognise the importance of regular exercise by building time into the curriculum for exercise, and the Daily Mile is now in use in several schools in the area.

Morecambe Bay has also worked in Millom, an isolated community of 8,500 people in south Cumbria, to create a population health and wellbeing system.

This means using all the assets in the community to support healthy living. The energies of local residents, once directed at saving the community hospital, are now channelled into strengthening local services in partnership with NHS organisations. An advanced community paramedic plays a key role in the system and a community-led recruitment campaign has helped fill GP vacancies.

In North East Hampshire and Farnham, safe havens offer a drop-in service for people with mental health needs in town centre locations in the evening and weekends as an alternative to A&E. People with experience of mental illness support the staff delivering the service and have been instrumental in identifying small changes in how care is offered to make services more responsive to mental health users. An example is providing wrist bands to people in crisis to wear to signal their needs to staff, recognising that these people may not always find it easy to articulate what these needs are.

The most ambitious PACS are working to become integrated care systems for the populations they serve. Northumberland and Salford are examples with the NHS foundation trusts in both areas now providing hospital and community health services and working closely with local authorities to align these services with adult social care. GPs are increasingly involved in this work and in a similar initiative in south Somerset. The aim in these areas is to break down the organisational and other silos that create barriers to care being joined up around the needs of patients.

A number of ingredients have enabled these and other innovations to make an impact. The additional funding received by the PACS has been important in releasing staff from other roles to lead the development of new care models and to pay for associated costs. Clinical and managerial leadership have been central to the work that has been done and patients and communities have played an important part in some areas. The involvement of local authorities has been notable in a few places and has facilitated the focus on population health as well as on integrated care.

Visible support from organisational leaders, where it has been evident, has helped accelerate progress. Not surprisingly, changes among these leaders has been disruptive. Not all of the PACS have been able to demonstrate progress.

The national team leading the work in NHS England adopted a facilitative approach that encouraged the testing of different models in different areas

and offered advice to the PACS when they needed it. The team also requested regular progress reports from each of the PACS, and challenged the staff involved to demonstrate the impact of their work on service use. Regular meetings of PACS leaders to share experiences with each other contributed to the development of a community of practice focused on learning and development.

Data collected by NHS England indicates that the new care models, including the PACS, appear to be moderating demand for hospital care more effectively than other areas. This is not because they have discovered a major breakthrough in how to deliver services but rather that they are seeing the benefits of making many small changes in care. Cumulatively, these changes are beginning to have a measurable impact, illustrating that the 'aggregation of marginal gains' applies in health care as well as sport.

Three years into the new care models programme, there is sufficient evidence to suggest that version two of the NHS holds part of the solution to version one. Of course, there is a compelling case for the NHS to be allocated extra funding and to address growing staff shortages, but on their own more funding and additional staff will not provide a sustainable solution. Doing things differently by putting in place new care models is also essential, and the examples I've seen in the PACS and other new care models show that this is now happening.

The focus on operational pressures will surely continue but this must not be at the expense of a commitment to transform care at scale through sustainability and transformation partnerships and integrated care systems. This is best done by building on the work of the new care models and moving from innovative projects to large-scale change across whole systems. The progress made by the best of the PACS offers hope of a better future in which this is the reality in a growing number of areas.

Let's call it version three.

A national policy lead perspective: Jacob West

Jacob West is the Executive Director of Healthcare Innovation at the British Heart Foundation. Before taking up this post, he was a national lead for the NHS new care models programme. As deputy director of the Prime Minister's Strategy Unit, he advised two Prime Ministers on health, education and criminal justice policy. From 2010 to 2014, he was Director of Strategy at King's College Hospital.

From the Isle of Wight to Northumberland, it's been my privilege to spend much of the past three years on Britain's (surprisingly reliable) railways, working with health and care systems to put in place a different way of caring for patients.

Forget the labels – and there's a lot of them MCP, PACS, ACO, ICS, PCH, STP, etc. I hear a remarkable degree of consensus around the country about how the NHS needs to change. People want more collaboration between the different pieces of the NHS and its partners. They want the patient, the place and the population to be the focus rather than the interests of individual organisations. They want services to anticipate people's needs, not just respond to them. And they want the 'system' to make it easier to do all of this.

If the new care models programme has done nothing else than help build the consensus around population-based care of this kind, then I think it can rightly claim to have made a lasting difference.

But what's encouraging is that we now have some hard evidence that supports this – emergency activity is noticeably slowing down in vanguard geographies compared to the rest of the country. Sir Andrew Morris, Chief Executive at Frimley Health, says that this is the first time he has seen this in nearly 30 years at the helm. When *The Economist* travels to Morecambe Bay to see how the NHS is 'changing at its core' then perhaps we are getting something right.

So, what have we learnt over the past three years?

The vanguards have been doing something different to traditional service redesign. It's been about whole-system redesign – both of the care model (all the things that affect patients) and of the business model (the IT, funding, decision-making and so on). We have helped codify the specific interventions

the vanguards have been implementing – from health coaching and extensivist services to multidisciplinary teams and predictive analytical tools. But none of these features of the new care models are themselves revolutionary. The innovation is in implementing them in a co-ordinated way, at scale and for the long term.

At its best, the national programme has afforded local systems the time and space to innovate in this way. I think all the vanguards would be doing this work, whether they had been selected or not. But the programme has helped accelerate their efforts. 'We're a couple of years ahead of where we would have been' is a common refrain. But this also means having a tolerance for some things not working – to fail well. I don't think we've always done this during the programme as well as we might have, particularly as our focus has narrowed in on specific activity measures.

The sites that have made most progress have done this by investing in relationships. Implementing the kind of system-wide change that the vanguards have been engaged in is a technical and human endeavour. But mainly a human one. We forget this at our cost. Sites that prioritised detailed discussions of new contractual approaches over relationship building or a shared understanding of priorities for patients have, I think, made slower progress.

At a national level, we have played a small part in stimulating these relationships through communities of practice and other networks. These provide a space for people to draw inspiration and motivation from each other, even when things aren't going well back at home base. In the NHS, it appears, this kind of peer learning is sometimes best undertaken with those who are not your near neighbours.

So, where next for new care models?

That the vanguards should succeed in their own terms was only ever one of the objectives for the new care models programme. The bigger prize was to encourage widespread adoption of the most promising models.

The imperative for the NHS to work in local systems (through sustainability and transformation partnerships and now integrated care systems) provides a framework for new care models to scale up.

In a few places we can see a clear model for how this will work. The Frimley system, for instance, is leaning heavily on the work of the North East Hampshire and Farnham vanguard as it develops its integrated care system.

But adoption won't happen by edict alone. Not least, because these bigger geographies bring with them a more complicated set of relationships.

So we will need multiple approaches – what Don Berwick calls 'flooding the zone'. Some of this will be about the national bodies working quite differently with local areas, even while the legislative framework makes this difficult. In particular, they will need to behave in a way that gives 'primacy' to the local system rather than individual providers or commissioners. We'll also need to find agile ways of connecting the reformers across the country so that they accelerate their learning with each other.

In the past we've tended to launch pilots only to ask them to land again. To set up demonstrator sites but ignore the implications. We need to do much more than this to encourage wider adoption of new care models across England. Scaling the new care models in this way truly would be a breakthrough – and one that the vanguards should rightly feel proud to have played a role in.

A local vanguard lead perspective: Nicola Longson

Nicola Longson was appointed the Programme Director for My Life a Full Life (the Isle of Wight PACS vanguard) in 2016. Before this, she was Assistant Chief Transformation Officer for North Derbyshire Clinical Commissioning Group, with responsibility for service integration and commissioning of community and voluntary sector services.

The new care models programme has felt like a genuinely different national approach to transformation. When we first applied to be a vanguard site, we were not convinced that any of the models described in the *NHS five year forward view* really fitted with what we needed to do on the Isle of Wight. But thankfully the programme recognised early on that one size does not fit all.

The approach taken by the national team has not been a 'Big Brother' approach but rather a supportive one in which we have been encouraged to push the boundaries and develop our own model of care, within the loose framework provided by the PACS model. The model recommends a set of components that experience has shown provide a good model of care, but it

also recognises that local systems can and will implement these components in different ways based on their existing provision and population needs.

Perhaps the most significant benefit from being part of the programme has been the opportunity to learn from others and share experiences – including insights into what has not worked well and how people might have approached things differently in retrospect. The national team organised some very useful learning events where vanguard sites came together to discuss our experiences and to share progress and ideas.

Being a vanguard site also gave us an opportunity to increase our local capacity and capabilities so that we could transform our services at greater pace. It enabled us to benefit from specific expertise, with support from specialists in evaluation, logic modelling, information governance and other issues.

There have, of course, also been challenges. Vanguard sites have been required to undertake a substantial amount of reporting. Efforts were made throughout the programme to make reporting requirements as simple as possible, but this was still a large commitment. We also felt the goal posts seemed to move between year zero and year three, with priorities, funding and expectations changing.

Although the programme was designed to drive integration across health and social care, some of the national communication and requirements had the unintended effect of disengaging non-health partners. For example, the national indicator sets used to measure success were very health-focused (eg, non-elective admissions or hospital bed days). This sometimes made it harder to engage with our local stakeholders beyond the NHS.

In terms of lessons from our experience, the first piece of advice I would offer to other local leaders embarking on this kind of journey is to ensure you focus on key priorities. Keep it simple – avoid taking on too much or having too broad a scope. It is better to pick off a couple of areas, deliver on them, learn and celebrate, and then move on to the next areas. And as part of this process, it should be remembered that it is okay to not get it right first time. The important thing is to fail fast – to implement, evaluate and adapt where necessary.

My second piece of advice for leaders in other areas is never to underestimate the importance of relationships. Ensure you have the right people involved in

each part of the programme, and that there is regular communication with all involved on plans and progress. Keeping the momentum up means maintaining trust and being open and transparent with partners at all times.

There are also some important lessons for those designing future national programmes. There has been, and continues to be, frustration in relation to the legal and technical barriers to introducing new care models – for example around VAT, pensions, contractual terms and conditions, information governance and procurement laws. More consideration and support need to be given to these issues, so that they are tackled once at a national level rather than each area having to work things through independently and finding local fixes or workarounds, which are often less than ideal. Related to this, national partners need to identify where real practical support can be procured at scale, for example, specialist support in organisational development that could be offered to local areas or legal advice to support national contract changes.

In recent years there have been a large number of national programmes intended to support local transformation, and it would be helpful if there was greater alignment between these. The impact of the new care models programme could have been strengthened if there was more explicit and more practical tie-in to NHS RightCare, Getting It Right First Time, the Carter review on hospital productivity, and the Model Hospital programme. The goal of national leaders should be to secure alignment between these and other programmes, in order to maximise the benefit for local systems and minimise the effort.

It would also be helpful if there was a clearer national focus on prevention. Keeping people healthy and reducing avoidable NHS activity are critical parts of all new care models. Local efforts to do this need to be backed up by more investment at the national level and a firmer national approach towards prevention.

The Island now has an agreed transformation plan – the Local Care Plan – that sets the vision for the next two years across the health and care system. This single plan for our system has been informed by the PACS framework and builds on the work we have done through the new care models programme. We will continue to work with local partners on and off the Island to implement this shared vision.

A CCG perspective: Andrew Bennett and Sophy Stewart

Andrew Bennett is Chief Officer of Morecambe Bay Clinical Commissioning Group. He has been the Senior Responsible Officer for the Better Care Together programme across Morecambe Bay since 2013 and currently chairs the Bay Health and Care Partners Board.

Sophy Stewart is Head of Engagement and Communications for Better Care Together. She has worked on a number of projects concerning engagement, communications, empowering people and communities and social movement projects across Morecambe Bay since 2004.

It is fair to say that our development as a local health and care system had begun well before we joined the new care models programme and its cohort of primary and acute care systems.

Eighteen months earlier, colleagues had come together from across the system to develop a strategy to address the well-publicised challenges of care quality, health outcomes and finance that were facing Morecambe Bay. We called this strategy (and our vanguard) Better Care Together in recognition of the fact that we faced these challenges together and could only truly fix them by working together. From this strategy, a system partnership of general practice, community, mental health and acute providers, local authorities and clinical commissioning groups (CCGs) was established to implement our new care models for out-of-hospital care, planned care and women's and children's services.

Becoming a vanguard system essentially meant that we were able to go further and faster with the implementation of our strategy to improve the health of people living in Morecambe Bay. Given the national consensus around service integration and system collaboration that had formed around the *NHS five year forward view* in 2014/15, it was vital for us to establish our programme with credibility and momentum. At the same time, we used the status of the programme to demonstrate to our staff, patients and the public that Morecambe Bay had begun an improvement journey and there had been an investment in our collective success.

Bringing people together to agree shared goals and a vision for improving health and care has not been difficult. Clinical leadership has been vital at all levels of our programme – our clinicians have the day-to-day contact with patients, public and communities and they have led the changes in our care

models supported by managers and system leaders. We have also benefited from a positive working relationship with the new care models team, frequently using our review meetings to identify other communities facing similar challenges or that could be approached to understand their learning.

Inevitably, however, given the fragmented arrangements of the NHS, we have had to work through the challenges posed by our differing organisational priorities, by mixed signals from the regulators and by the variation in our clinical cultures. We have learnt that system leadership sometimes requires us to 'push the chairs back', creating a space for us to listen to differing perspectives across the system. Often, this has led us to reset our priorities and our focus.

A key learning point from our vanguard experience is about the time and persistence that is required to change operating cultures across a large system. After five years of effort in Morecambe Bay, perhaps we are about halfway there! Though we can demonstrate a wide range of strong and developing relationships between health and care professionals from all sectors, we recognise that it takes time for people to know they have the freedom and permission to work as a team, to co-design for the whole health system and population, rather than simply focusing on what works for their own organisation.

We are proud of the work that has taken place as part of the vanguard programme. We have reduced A&E attendances, cut emergency admissions rates, provided alternative referral routes for patients, reduced patient journeys, improved clinical communication and delivered a wide range of other benefits, driven by the tireless energy of colleagues across the system. But there have been other great discoveries too. Particular ones that stand out include new methods of patient and public engagement and communications, and the power of social movements to engage our communities in a fresh approach to population health.

Post-vanguard, our ambition is to see the further development of a culture of continuous improvement across the whole system – of our staff knowing they don't need 'explicit permission' to implement ideas that improve health and health care; for professionals to know that NHS leaders trust in their expertise and ideas for innovation. I would like to see our new care models embed further, particularly where this strengthens the integration of hospital/out-of-hospital, mental/physical health and health/social care services.

We now talk about ourselves as the Bay Health and Care Partners, an integrated care partnership which remains committed to the further development of Better Care Together in Morecambe Bay. We are also working as part of a wider integrated care system in Lancashire and South Cumbria and recognise this wider partnership has the potential to set an ambitious agenda of wider public sector reform in which Morecambe Bay should play a leading role. In so doing, we will remain focused on the needs of the communities we are here to serve.

A GP commissioner perspective: Andy Whitfield

Dr Andy Whitfield is the Chair and Clinical Lead of North East Hampshire and Farnham CCG. He led the formation of the CCG from 2012 and then developed the local PACS vanguard from 2015 onward. He has been involved in commissioning since the early 2000s and has been a GP since 1990.

My involvement with the PACS concept started long before the term was discussed. In 2012, as CCGs were forming, we had a system transformation board of the acute and community providers together with fledgling local CCGs. The atmosphere was one of blame, competition, success and failure, but not trusted collaboration. One of the local authorities sponsored a system leaders programme over six months where we learnt about each other's drivers and challenges and using the example of older people's care we began to plan together with shared purpose. This led to the rapid realisation that the local health and care system would be financially unsustainable within five years unless we collaborated.

Then came our clinically led CCG five-year strategy, looking remarkably similar to the *NHS five year forward view* which followed some months later. Our plans included transforming general practice and developing services based in our local community to prevent people going into hospital unnecessarily. With what had become excellent relationships between GP commissioners, providers and local authority leaders, we set out on our transformation journey.

A very early success was the Safe Haven for mental health crisis – designed by service users, delivered by the third sector, local authority and NHS combined. Following delivery of successful outcomes, appreciated by patients, GPs, the police and local A&E, it has been replicated in other places. Patient co-design set the scene for future transformation.

Our clinical leaders agreed that what we were planning fitted perfectly with the outline of PACS and our application for Happy Healthy at Home was successful. Notable at our initial NHS England visit was the presence of five local chief executives, demonstrating the shared belief of senior leaders in our joined-up work.

Local people became Community Ambassadors and joined Collaborative Trios with clinicians and managers to co-design the transformation. Colleagues from our local authorities were central to our work from the start, and with early recognition of the power of good relationships, multidisciplinary development programmes combining people from partner organisations were started.

Many practices seized the opportunity to innovate, though some were not convinced at first. Concerns included threats to the 'traditional partnership' model, loss of autonomy, and a lack of spare capacity to 'transform'. In spite of these concerns, five localities were created, new GP leaders emerged, GP federations formed, and now practices are merging, and competition has largely gone. The need to transform had become urgent with primary care vacancies, funding shortfalls and rising patient needs. We now share a paramedic visiting service, practice physiotherapists and clinical pharmacists. Our clinical IT systems are linked and we are starting to share the daily patient demand. Patients are referred to locality integrated care teams co-ordinated by the GP federations, there are social prescribing options delivered by the third sector, and family members now have the support of a carers' hub in each town. The GP leaders have done a fantastic job in bringing all the practices together. Now the localities are well established with all practices included, and GPs are seeing the benefits for both their patients and themselves.

Our larger providers are changing too. The out-of-hours GP service dovetails with 111 and is co-located next to A&E, enabling patients to be seen by the most appropriate service. A&E and out-of-hours GPs can now access GP patient records. Frimley Park Hospital has collaborated with the county council and community services to provide the Enhanced Recovery at Home service to enable safe early hospital discharge and reduced readmissions. Our GPs have become part of the inpatient frailty unit assisting the hospital teams from A&E until discharge home. We have community one-stop respiratory clinics, GPs have access to on-call consultant phone advice to reduce inappropriate emergency admissions and plans are in place to regain the everyday close working between GPs and consultants that was once the norm.

We started to explore what it might look like if we created an integrated care system board with both commissioning and federation GP leaders along with leaders of providers and the local authorities. Our population is too small for full implementation of this concept, but we wanted to understand the benefits and challenges of sharing financial and service delivery decisions across health and care organisations. The arrival of sustainability and transformation partnerships brought other CCGs and providers into our 'system', and now Frimley Health and Care is one of the accelerated national integrated care systems taking on a financial system control total from April 2018. Many of the system transformational plans are modelled on our vanguard developments.

As CCG Clinical Chair I was confident that our new care model was right, but we also had concerns about whether it would deliver value for money and improved outcomes within the timeframe expected by NHS England. Thankfully these concerns were not borne out – we have seen a reduction in activity and improved wellbeing, to the extent that the new services are now self-funding and sustainable into the future. Patients are reporting improved outcomes, A&E attendances are no longer rising, and emergency admissions, time spent in hospital and routine GP referrals were all lower in 2017 than the previous year. The largest reductions came for ambulatory care-sensitive conditions (which are most influenced by integrated care and enhanced primary care) – emergency admissions for these conditions fell by almost 10 per cent.

My GP colleagues are reporting that they can now deal with the daily demands better, some are now moving to 15-minute appointments, and the spirit of locality working is lifting morale. This, I hope, will improve recruitment and retention in the future.

What have we learnt?

Everything revolves around good relationships first and foremost. This enables a shared purpose of system success with better care for local people being more important than individual organisational performance. Someone recently asked me which formal contract we had used to commission our new care model. There has been no overarching written agreement, just strong relationships and a belief in collaboration.

Clinical leadership and local people have been involved at every level and this is what has marked out this transformation when compared with others in the

past. We have understood that spending time and effort recognising and developing all the talented people within our teams delivers great benefit to the population. This has included providing bespoke development programmes for integrated care team members, commissioners and community ambassadors.

Being a vanguard site accelerated our transformation plans by giving us permission given to experiment without (much) fear of criticism, by helping us to learn and develop together as a system, and by supporting us to share ideas with others across the country. As a local GP I can now see a way forward for general practice that will be attractive to new recruits and will provide improved joined-up care for local people.

A local authority perspective: Daljit Lally

Daljit Lally is the Chief Executive for Northumberland County Council and is employed in a formal joint role between the County Council and Northumbria NHS Foundation Trust, where Daljit is the Executive Director of Delivery. Daljit has worked in formal joint roles in Northumberland since 2007.

Health and social care in Northumberland have been intertwined for more than 20 years. When I came to work here ten years ago, that was what attracted me. In my own career, I had started as a nurse, and moved first into joint teams (I was a nurse inspector in a joint inspection unit in Northumberland in the 1990s) and then into social care management. The post I took in 2007 was as statutory director of adult social services – but I was also responsible for managing the county’s community health services. There weren’t many opportunities like that.

At the time, these services were in a primary care trust (PCT)-based ‘care trust’, an ambitious model for integration, which also brought together the commissioning of health services and adult social care, but this was already being overtaken by events. NHS commissioning was being centralised into a new NHS organisation based on a ‘cluster’ of PCTs commissioning on behalf of the care trust and the two other PCTs North of the Tyne. I was in charge of a joint management structure for social care and community health which had an independent governance structure to maintain its arm’s length relationship to NHS commissioners. In 2011, when national policy made this odd arrangement unsustainable, the council transferred the operational adult social care functions to the local acute trust, Northumbria Healthcare, which also took over community health services. Social care commissioning moved

back to the county council – and from 2013 health commissioning also became coterminous again, with the CCG based at County Hall.

This was the context for our vanguard bid in 2015. The new care models described in the *NHS five year forward view* seemed to offer an opportunity to strip away some of the remaining organisational obstacles to making changes which we all agreed were necessary: redesigning services for people with long-term health and care needs, shifting from a model centred on episodic hospital treatment to an approach based on planned long-term individual support. Our initial intention was to move to an accountable care organisation (ACO) model, with a single organisation (Northumbria Healthcare) taking on contractual responsibility for the health and care of the local population. It remains to be seen whether this is the approach we will take in practice.

Being part of the national vanguard programme has brought a number of advantages. It gave us ready access to the unit at NHS England that was working on the technical complications of introducing new care models that were very unlike the arrangements envisaged by the drafters of the Health and Social Care Act 2012. It brought us into regular contact with other areas who were also trying to move away from the 2012 model – though no two areas were trying to solve quite the same problems or proposing quite the same solutions. And, of course, it brought in some additional funding, which supported a number of interesting pilot schemes, though no pilot could really test the effects of a proposed change that was based on reshaping the overall organisational relationships and incentives in the local system.

Being part of the new care models programme also meant that we attracted national attention, though the nuances of what we were doing weren't always nationally understood. The 2015 Spending Review listed Northumberland's proposed ACO as one of three models for health and social care integration which the government commended as examples. But our proposal wasn't, directly, about integrating health and social care – though it was closely related. The direct objective was to move away from a funding model that, in Northumberland as elsewhere, was increasingly in tension with our wider aims. The Payment by Results system for acute health care makes episodic crisis treatment the first call on NHS funding. In Northumberland the effect of this has been to lock the local system into a pattern where the CCG is in financial deficit and struggles to invest in community services, while the acute trust has to maintain hospital activity to achieve its control total. We saw the ACO model as a way of breaking out of this trap, making possible long-term

planning based on the real costs and benefits for local services and service users.

Some vanguard areas proposed to include social care in their contracts. We didn't. Our existing partnership arrangements are simpler and more flexible. But a further shift from hospital-based crisis treatment to individualised community support will of course mean changes in how we work together. Our proposal also included the integration of officer support for strategic commissioning of health and social care, though the CCG would remain a separate statutory body, with a strategic rather than transactional role.

ACOs, like other new NHS structures before them, have turned out to be more complicated than we'd hoped. Our proposal was quite simple. Northumbria was to hold the contract, on behalf of a partnership of the key NHS foundation trusts and a GP federation. It avoided complex financial mechanisms: effectively all NHS financial risks were to transfer to Northumbria Healthcare, along with all related funding (and all social care financial risks were to remain with the council, at least for now). But agreeing the details – including, in particular, a financial plan that meets the organisational needs of all parties at a time of extreme pressures on the NHS, has turned out to be very difficult.

As I write this, it is still uncertain whether and when the ACO will come into existence. That is frustrating, but the ACO was only ever a means of dealing with some structural and financial obstacles to a broader plan. What matters most in the end is how services work together and whether managers support or obstruct that. About that, I am optimistic. The council and its NHS partners continue to understand the importance of working as a single system. I am now both Chief Executive of the council and the Executive Director responsible for delivery in Northumbria Healthcare. Vanessa Bainbridge, the council's statutory Director of Adult Social Services, is also now the Accountable Officer for the CCG. At all levels below them, managers and professionals work flexibly across the health and social care system. In the end, that is more important than organisational structures, and I hope will continue whatever happens to those.

An acute trust perspective: Andrew Morris

Sir Andrew has more than 40 years' experience in NHS management and has held a range of senior NHS appointments. He was appointed General Manager of Frimley Park Hospital in 1989 and became Chief Executive in 1991. He was knighted in January 2015 for services to public health.

For the past four years, local leaders in the system have grappled with the genuine question about how we can continue to deliver sustainable, high-quality health care in an increasingly challenging financial climate. The purchaser/provider split and internal market has, over time, fragmented the delivery of care and worked against the goal of integrating services for patients. Demand for health and social care continues to increase and the past decade has seen a big rise in the number of older people, many of whom have complex health needs and lifestyle factors that have put added pressures on an overstretched system. In spite of all this, life expectancy and health outcomes are at an all-time high in North East Hampshire and Farnham. Even so, four years ago it dawned on the leadership of the system that all organisations would have to work very differently to meet the growing demand for services with little real growth in resources. We quickly worked out that failure in our collective resolve to work differently would result in one, several or more likely all organisations breaching their financial duty.

Frimley Health NHS Foundation Trust serves 750,000 people in North East Hampshire, West Surrey and East Berkshire. In the catchment area there are three other providers, five local authorities and five CCGs. Frimley Health, with three hospitals (Frimley Park, Wexham Park and Heatherwood Hospitals), spends more than £670 million, and what has been clear for some time is that delivering services with hospital-centric models of care and a flawed national tariff has a limited future. Unfortunately, costs continue to rise faster than resources and while, historically, the finances of the trust had been strong, the outlook was increasingly challenging with ever-rising cost improvement plans and unaffordable increases in activity levels, particularly emergency admissions.

Our local system has benefited from stable leadership with provider chief executives, the CCG accountable officer and clinical leaders all working together over a 10-year period. As a result, there is a high level of trust and strong relationships within the local NHS and social care leadership. The application for vanguard status offered an opportunity to rethink how we should work together with GPs, primary care, acute, mental health and

community providers, local authorities and voluntary sector bodies to provide better integrated care using new models crafted by clinicians and local people.

Working collaboratively is not new but local leaders started to put to one side their organisational allegiances and wanted to redesign services with the aim of improving integration, outcomes and patient experience. The vanguard programme presented the opportunity, before sustainability and transformation partnerships and integrated care systems, to collectively develop a shared vision for people living in the CCG area. Historically, financial performance had been strong but early on in the vanguard programme we recognised that we were hitting a new tipping point as the acute sector was consuming a disproportionate level of resources and there was no financial headroom to create new models of care. As the acute provider chief executive, I was aware that some risks had to be taken to find new ways of providing care as it was not possible to continue to meet the cost of increasing levels of hospital activity.

The plans for the vanguard programme included transforming services to prevent people from going into hospital unnecessarily. From an acute provider perspective this was counter-intuitive, but the marginal tariff rate for increases in emergency admissions meant that the trust was doing extra work for little or no financial benefit. It also had the disadvantage of creating significant operational pressures in meeting the four-hour and 18-week waiting time targets and there was a constant drive to further expand bed capacity. Emergency pressures were and still are an all-consuming preoccupation for the executive team, which often leaves limited capacity to properly address all the other leadership functions. In the light of these circumstances there was a compelling set of reasons to explore alternative models of care not only in North East Hampshire and Farnham but also with the other CCGs in the catchment area, who at the same time were adopting similar approaches to collaborative working.

Bringing together clinical leads, managers and local people to co-design services has become the new norm and the clinicians have felt very energised by the opportunity to improve services and create new pathways of care, particularly for long-term conditions. It has also helped to better integrate patient care between organisations.

The initiatives introduced as part of the vanguard programme have taken a while to establish and bed in, but for 2017/18 there has been no growth in emergency attendances and the number of emergency admissions has flat-

lined, which is a first in 29 years at Frimley. Based on previous experience, we would have expected emergency admissions to grow by 3,000 in 2017/18, but thankfully the various initiatives are having a really positive impact. Clinicians in the hospital have welcomed no increase in emergencies as until now they have been overwhelmed by inexorable year-on-year rises in workload and the operational pressures that extra work generates, and although these pressures still exist, it feels more manageable.

GP referrals for elective care are also on plan for 2017/18 which is also a first and the joint approach with the Right Care programme has resulted in reductions in inappropriate referrals to hospital, a better dialogue on managing complex conditions along with the development of triggers for surgical intervention.

All of the above has been achieved as a consequence of modest investment in out-of-hospital services and all of the initiatives have resulted in better patient experience, which is a good outcome for the local system. Even though it has resulted in less income for the trust, increases in activity would have generated relatively little financial benefit because of the way the local risk-share arrangements are structured along with the use of high-cost agency staff often required to undertake additional work.

Progress could not have been achieved without good relationships and trust among the senior leaders, with a shared purpose of system success being more important than individual organisational success. This way of working has been the forerunner in establishing an integrated care system (ICS) which now covers most of the Frimley Health footprint and is one of the 'accelerated' national systems. The Frimley ICS will be using the vanguard models of care along with the best of many other initiatives to redesign health and social care to better meet the growing needs of local communities while working to a financial control total. Indeed, there is the ambition to build on much of the work undertaken by the Canterbury system in New Zealand to better integrate care, improve patient experience and achieve enhanced clinical outcomes for the people we serve.

A mental health trust perspective: Sarah Gill

Sarah Gill works for Tees Esk and Wear Valleys NHS Foundation Trust as a Locality Manager for Older People's Mental Health Services. Since May 2017, she has been instrumental in offering additional operational management support to the Harrogate Vanguard Programme, working across the six partners involved in the programme. Sarah started her career in 1998 as an occupational therapist within adult mental health services before moving into operational management in 2006.

Our journey within Harrogate's new care model programme has been an exciting, challenging, at times frustrating, yet rewarding experience. The key piece of learning along the way has been that the role of mental health professionals in the new care model has been much greater than we initially anticipated.

Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) is one of the largest specialist mental health and learning disabilities trusts in the England, with Harrogate and Rural District being one of the geographical areas we cover. From the outset, TEWV has felt a valued and important partner of the vanguard programme in Harrogate, playing a small but critical role in a model whose measures of success were largely attached to the performance of the acute hospital. Regardless, we willingly participated in those early developments given the focus was on the older, frail population, which my staff have a vested interest in. Our experience of managing and treating co-morbid conditions and the impact of not being able to provide holistic support for people and their families in a timely way due to organisational silos was a big frustration. We recognise the importance of treating a person's mental and physical health together and how this can impact a person's recovery. The opportunity to develop new and closer ways of delivering person-centred care, breaking down barriers between health, social care and the voluntary services was exciting, and the opportunity to do some innovative clinical work supporting our colleagues was something we couldn't afford to miss.

It became apparent early in the programme that we were in the minority being a mental health trust within a PACS site. Therefore, our initial contribution was tentative and reflective of what we thought would be a minor role within a larger solution. What we found over the three years was quite the opposite. As an organisation, we discovered we could offer far more than we first thought, and not just through delivering clinical interventions, education and supervision of others. Part of the way through our collective

journey, as a system we recognised we needed to change the way we tested our new care model and carry out a focused piece of work. We took the learning acquired so far and designed and tested what a 'perfect' fully integrated multi-agency team would look and feel like. TEWV supported the programme by sharing and using its own quality improvement methodology to create a purposeful and productive community service. Through using our own internal approach to transforming community services and coaching our partners in the methodology, we applied some basic core principles to test a fully integrated multi-agency service that is co-located, and has a defined, standard approach to managing day-to-day clinical delivery including having one set of documentation held in one electronic patient record. The goal was to understand how an integrated service works in practice and to use the learning to inform what the future model of service delivery should look like across the Harrogate health and social care system.

The latter part of the new care models programme also gave TEWV the opportunity to become core members of a multi-agency team as opposed to being on the periphery. So rather than working Monday to Friday 9am–5pm while our colleagues were doing shift work across a seven-day week, our clinicians changed their hours to the same seven-day shift rotation. The impact of this surprised us all as we discovered the demand for mental health assessment and intervention was higher than expected. The proportion of people requiring low-level mental health interventions who had complex physical needs and were at risk of admission into an acute hospital bed turned out to be approximately 64 per cent of all referrals. Working alongside people with complex physical needs also meant we could undertake tasks and interventions that were not directly mental health related. This has included assessing patients and issuing equipment if needed, wound dressing and checking pressure sores. By doing this, we helped eliminate the need for a further visit from another professional and ensure that the person receiving help didn't have to wait any longer than necessary.

As mental health clinicians, we were able to train and supervise other health and social care colleagues in low-level mental health interventions. This gave other staff members more understanding about mental health and the confidence to know what to do. For example, until the new care models programme, one voluntary sector service had felt unable to see anyone referred with a mental health problem due to insufficient skills and knowledge. By supporting staff and offering education and training, they now see people with mental health issues as they feel we have 'demystified' mental health for them. The impact for service users has been significant and

for some, life changing, as they no longer need the same level of input from multiple services they once received.

As a mental health trust, the programme has helped us to think differently when considering early interventions in mental health, specifically for people who are older and have more complex needs as a result of frailty. We've found some of the more traditional ways of offering primary care mental health to be not always appropriate because either the person cannot physically access the services or does not meet the criteria. Working alongside the GP and our physical health and social care colleagues offers a more timely and integrated approach to managing the wellbeing of our local population. It has demonstrated the potential to pre-empt and intervene early for people with low-level mental health needs, and to work collaboratively to prevent people reaching crisis point and becoming part of the secondary care mental health system.

Based on my experience as a senior leader, the value of involving mental health in the development of new care models should not be underestimated. For us it has helped the system as a whole to view mental health and wellbeing as everyone's business, not just that of specialist clinicians. For staff on the front line, it has started to break down taboos and helped practitioners understand the complex relationship between physical and mental health. For us in Harrogate it is just the start of our transformation journey. However, I am confident that in five or ten years' time, how mental health is configured and delivered will look very different to how it is now, and the learning from the new care model programme will have contributed to that.

A GP perspective: Robin Hudson

Dr Robin Hudson has been a GP in Northumberland for 20 years and has a background in postgraduate medical education. For the past three years he has been GP Clinical Director for the Northumberland PACS vanguard and Primary Care Quality Lead for Northumberland CCG.

When Northumberland was awarded vanguard status in early 2015 this reflected the reality that our system was already quite far along on its journey toward integration. As described in Daljit Lally's essay, Northumbria Healthcare NHS Trust has delivered adult social care through its partnership with the county council since 2011, while the county council and clinical commissioning group (CCG) are co-located, which has fostered constructive working relationships.

Having vanguard status has helped us to put a name to this journey and given us some funding to innovate in new ways. The effect I have observed is that different providers now want to work in a way that is mutually beneficial to the population and the health care system as a whole.

General practice has benefited in that the programme provided the impetus to elect new leaders to represent practices with a provider perspective at a system-transformation board level. Developing a 'voice' for general practice came from the work of a primary care leadership group, which functioned as a testing group for the vanguard programme and the initiatives which we were developing. Our plans to ultimately create a county-wide GP federation will remain in abeyance until our health care system allows easier movement of resources to the areas of greatest need in the community.

When we asked our population about their views on general practice this revealed a shift occurring in their expectations. Balancing the needs of patients who increasingly want same-day access with those who need long-term continuity with a specific clinician is putting our traditional general practice model to the test. In Northumberland, we successfully undertook an activity-and-demand analysis across 100 per cent of practices, primarily to help practices understand how they match patient demand with their individual and varied appointment systems. The non-recurrent vanguard funding helped practices to modify or radically change their access model. For instance, the majority of practices have increased the number of telephone appointments being offered to patients to speed up access to appropriate medical advice. Results from our access initiative are showing that the number of patients being helped each week had increased by slightly more than 3,000, which equates to an extra 170,000 patient contacts per year. This did not have a significant effect on attendances in our emergency departments or urgent care centres which highlights the multifarious issues at play in the system as a whole.

Interestingly, this learning about how to balance same-day demand against the numbers of pre-booked appointments mirrors directly the work which is being undertaken within secondary care concerning how they manage attendance in their outpatient departments. Our shared learning has been strengthened by ongoing quarterly system-wide clinical strategy meetings. I believe these meetings will allow hospital teams to better support GPs and their patients in the community by building the capacity needed for the future.

Patients should only have to tell their story once and steady progress is being made towards a truly integrated IT clinical record system. The benefits to patients' safety and care were clear from the start with the implementation of a 'medical interoperability gateway' giving emergency departments sight of the GP medical summary. Furthermore, more than 80 per cent of the population now have practices on the same IT system which is already integrated with community nursing, diabetes and palliative care teams. Huge payoffs are anticipated if the same IT system is adopted by more providers across the health and social care sector as an integrated IT system will hold the patient's story in one place, ensure safety and promoting communication at a population-wide level.

More than 10 years ago, Northumbria Healthcare NHS Foundation Trust embarked on planning for a new hospital that opened in 2015. It is England's first purpose-built specialist emergency care hospital in Cramlington. The three district general hospitals were reconfigured in terms of their function and GPs now work alongside nurse practitioners in urgent care centres that also provide minor injuries care. Introducing this has not been without its challenges, but results show a reduction in the length of stay for the over-75s and a possible reduction in the attendance of patients with primary care problems. This innovation has created the momentum needed to reform other parts of the health and social care system by disrupting the status quo which had existed before.

We have had a growing sense of interdependence particularly between general practice and secondary care. The challenges being faced in terms of workforce recruitment and retention are similar across the system. Northumbria Healthcare NHS Trust employed 16 new pharmacists to work across primary and secondary care, to build capacity in the community as well as to improve the quality of prescribing in nursing homes and general practices. Clinical pharmacists have skills that can be used to further release time for GPs. The foundation trust has also implemented accelerated nurse training with Northumbria University, shortening the training from three years to 18 months for certain staff groups. Three GP federations made a successful bid for the creation of a community provider education network, which is enabling more health care students to gain experience in the community and, it is hoped, choose to remain there for their careers.

Despite the vanguard programme coming to an end in April 2018 the commitment to integrate and re-align our system is as strong as ever. An honest appraisal to date will conclude many positives have occurred in terms

of building trust and understanding that we are in a mutually dependent system. It has also highlighted that we have a long way to go and the challenges remain formidable in terms of sustaining our workforce and supporting more out of hospital care. While Northumberland develops its strategy and vision for the future we therefore need continued national support to give us the permissions required and changes to legislation necessary to realise our ambition to move towards a more integrated care system.

A patient representative perspective: Steve How

Steve How has a background in health care-related industries, and his interest in patient and public engagement dates back to being elected a public governor for South Staffordshire and Shropshire Foundation Trust in 2007, where he chaired the strategy group. On moving to Nottingham, he was elected as a governor of Nottinghamshire Healthcare NHS Foundation Trust. Steve volunteered to be the trust's representative on the Better Together Mid-Nottinghamshire Alliance Citizens Advisory Board and was elected as Vice-Chair in 2017.

The development of new models of care raises some profoundly important questions about how patients and the public are involved in efforts to transform local services. How do the structures supporting participation need to change in the context of a model of care that involves multiple organisations working together in new ways? And is meaningful engagement compatible with national pressure to deliver change rapidly? We have had to confront these questions as part of the Mid-Nottinghamshire Better Together PACS vanguard. And I believe we are now arriving at an effective solution to some of the challenges encountered.

The work being done in mid-Nottinghamshire is based on an alliance model with member organisations involving the local CCGs, acute trusts, community and mental health trust, ambulance services, social services, and out-of-hours provider. When it was set up patient engagement was integrated into the governance processes via a local Citizens Advisory Board and Healthwatch, the leads of both sitting on the Better Together Leadership Board. It was felt important that the Citizens Advisory Board was public rather than patient-focused, reflecting social care, carers and prevention programmes as well as patient care.

The Citizens Advisory Board was originally made up from member organisation patient representatives and other interested parties, eg, Cancer UK, Diabetes UK. Many of the members represented the patient and public view of a number of services engaged in care within the locality. However, this structure was a little unwieldy and was redefined as patient and public representatives from each of the member organisations plus a local Healthwatch representative. The citizens board took a while to begin to work out its function within the organisational structure but developed terms of reference based on proactive confirmation and challenge of the transformation approaches being developed by the alliance, as well as bringing an understanding of the impact and benefits of the alliance to the public. There was particular focus on engagement activities supporting the development of key public communication messages as well as developing citizen-focused experience measures. Essentially, the citizens board is a group of 'critical friends' concerning the impacts of system changes on service-user experience.

The citizens board was supported by the CCG engagement lead and developed feedback reports for Better Together Leadership Board via the Citizens Advisory Board leads. However, it was noted by the citizens board and Better Together Leadership Board that these reports, though highlighting local issues, were often disconnected from the Better Together activity. More disconcertingly, key pathways were being developed without patient engagement.

In light of these challenges, the public engagement model was identified as having a number of operational issues related to structures, capacity and capability. These issues meant that public engagement activities were initially not always well aligned with the Better Together programme.

Structurally, many Better Together members had their own engagement teams, and there was no central engagement strategy. Further, each of the member organisations had their own governance structures and processes which led to gaps in assurance across pathways delivered by multiple providers. Transformation teams did not have a map of where they could identify relevant engagement processes.

Capacity was another issue. Lay members representing each of the organisations had limited time and were often required to attend their own organisation's member meetings as well as those of Better Together. This coupled with the wide number of reports across all organisations can limit

depth of understanding. The pressing financial and transformation agenda often led to a scale and pace in pathway development that could not accommodate lay engagement in time for delivery.

This capacity issue also has an impact on the capability to deliver relevant engagement as it tends to give the citizens board a membership that does not represent its public in diversity. Though citizens board members are by definition highly networked, there were gaps in representation in specific areas such as obstetrics and gynaecology services. Understanding of assurance and patient experience measures also varied between members, from foundation trust governors with extensive mandatory training, through experienced committee members to newly interested members.

We are in the process of developing a new model of engagement that should overcome most of these issues. It is proposed that the citizens board operates as second-tier assurance by holding the Better Together Board to account for public engagement and experience. The citizens will be represented at the Better Together Leadership Board by an employed chair (either Better Together Leadership Board Chair or Healthwatch) as in the foundation trust model, where the chair is held to account by a lay lead governor.

It is proposed that the engagement activity is an executive responsibility and should be set up as a transformation enabler (similar to IT or estates). This experience enabler function would be responsible for an integrated engagement plan, across all member organisations. It would develop processes to ensure public engagement is a critical part of transformation and pathway development, with the relevant leadership and cultural training and engagement. It would be responsible for supporting the development of relevant patient experience outcomes measures.

This structure ensures we have effective engagement as an executive responsibility, where the citizens board can act as second-tier assurance, supporting legislative Healthwatch functions, assuring that signed-off pathways and programmes have had patient engagement, as well as triangulating local experience of services against those plans.

One last point has been the recent active engagement with the sustainability and transformation partnership to ensure we are aligned across the region. This has also led to increased resource such as our local Healthwatch mapped engagement network, a database of groups representing multiple

communities, and engagement research often illuminating underrepresented health and social care issues.

As a result of these changes, for the first time as a lay representative I now feel we are beginning to make a difference. As with many functions of an alliance organisation, the key is integration, with public engagement and experience as a core transformation activity running through all services and assured by (and by default) a part-time group of local citizens.

An international perspective: Don Berwick

Don Berwick is a leading authority on health care quality and improvement. He was the founding chief executive of the Institute for Healthcare Improvement for 19 years. In 2015 he became an international visiting fellow at The King's Fund and contributes to the Fund's work to improve health and care in the NHS.

When it comes to effective leadership, I put more stock in 'curiosity and invitation' than in 'command and control'. Among the lessons I have learned in three decades in pursuit of improvement, none is stronger than this: the workforce is wise. W Edwards Deming, the great teacher of improvement of the last century, put it more contentiously; he asserted that: 'We have to bring back the individual. Management has smothered the individual.' And, elsewhere, that 'Management does not know what a system is' (Deming 1986).

That's a bit harsh, perhaps, but there is a kernel of truth in it. If we really want to improve health care by changing health care, the people who actually do the work day to day will almost always have the best ideas about what is amiss, where the waste is, and what new approaches are worth trying. When they do try out changes, they can learn fastest because they are closest to the action. Leaders who know this will ask the workforce for help and will give them time, space, and permission to innovate. Leaders who try to provide only answers, rather than questions, may squander the biggest resource for improvement that they have: the minds of the people at work.

That is the brilliance of NHS England's vanguard programme – also known as new care models: inviting the workforce to help. Like any large health care system, the NHS in England has serious problems, such as patient safety hazards, unwanted delays, failures of co-ordination across the continuum of care, unsustainable workloads, and severe budget constraints. Its ambition

was clearly articulated in Simon Stevens's *NHS five year forward view*, one of the most cogent and patient-centred national health improvement plans of our time. But, manifestly, no 'top-down' directives, no design specification from above, could ever bring that good plan into reality. Only the people who do the work could ever make that happen. And they can do that only if they have the latitude to invent and learn.

The vanguard programme was no mere 'management by objectives' approach (as in, 'Get me these results, I don't care how.'). It was a far more sophisticated invitation for ambitious local systems to think boldly and to get the headroom to innovate and learn for the nation as a whole. It included a potent national infrastructure for shared learning among vanguard sites, for enlisting the help of subject-matter experts, and for celebration of the journey. It seemed to me, properly, far more about release of energy than about central control. And it was big: arguably the largest project on national health care delivery redesign in history, with the possible exception of the Center for Medicare and Medicaid Innovation established with a \$10 billion fund in the United States in 2010.

I had the privilege of visiting and talking with many vanguard sites during the three-year programme, and what I saw often thrilled me. In the midst of an NHS period deeply troubled by budget austerity and professional demoralisation, I saw in these vanguards a sense of abundance, empowerment of staff at all levels, authentic involvement of communities, patients, and carers, pride in the learning process, and – in some ways best of all – the emergence of local leaders who often lacked formal authority, but who made up for that in enthusiasm, inclusiveness, and resilience.

The vanguard experiment has important lessons for any large-scale innovation investment, especially in health care.

- **With proper invitation, local leaders will emerge and thrive.** Some will be already branded with formal titles and assignments, but more will be good-hearted, creative, courageous, and energetic informal leaders, many of whom will have long nurtured in their minds a powerful new idea that, at last, they will have time, permission, and resources to run with. The harvest can be large.
- **Even small amount of slack can release a large amount of energy.** Most vanguard sites did get some extra budget resources compared with the non-vanguards. Everyone said that the headroom helped, but, in

retrospect, these extrinsic sums were remarkably small. The energy supply seemed more to be intrinsic motivation, which multiplied the effect of the marginal slack the programme provided.

- **Local executive behaviours matter a lot.** The most successful vanguards seemed to me to benefit from a virtuous cycle of mutual encouragement, between local executives and boards, who welcomed the exploration and risk-taking of pioneering clinicians and staff, and those risk-takers, who trusted their executives to trust them. The sense of celebration was palpable. As I said earlier, successes came, not from command and control, but from curiosity and invitation.
- **Bold goals can be fuel for change.** In a stressed system, the tendency to lower sights is common. The vanguards evinced a very different psychological dynamic, seeking, without apparent trepidation, breakthroughs and unprecedented results. The confidence of local change-agents, especially the emerging, informal leaders, seemed in part to explain this comfort with ambition, as did the permission from formal leaders to try and sometimes fail in order to learn.
- **Measurement can be a friend.** The toxicity of the NHS 'target' culture is frequently lamented among the NHS workforce and local leaders. The successful vanguards embraced metrics – but as resources for learning, not tools for judgment. And the relevant, helpful metrics were used locally in short 'plan-do-study-act' cycles of growth and development.
- **Spread is difficult – not at all automatic.** Perhaps the most informative unfavourable result of the vanguard effort is the general lack of spread throughout the NHS of even the best emerging new models of care. Indeed, even among vanguards working on nearly identical challenges – such as specialty–primary care relationships, home-based care, digital health, and reducing unnecessary hospital days – exchanges of models were viscous and inconsistent. This is a matter worth working on now – hard. I doubt that any form of directive or command from above will produce speedier spread. But I am confident that some new system of support can help.

As the vanguard programme transitions to other forms, including, importantly, integrated care systems, I hope and trust that the lessons of the vanguards will not be lost, either lessons about their now-proven health care delivery redesigns or lessons about the activities, behaviours, and mental models among leaders that best help those innovations emerge from a workforce that, in the final analysis, wants very much to help, and can.

3 Conclusion

At the heart of the new care models programme is a good news story – that despite the pressures the health and care system is under, innovation is still possible when the enthusiasm of local leaders is fully harnessed. In the PACS vanguard sites, as in many other areas, there has been a determination to improve care and redesign the ‘traditional boundaries’ referred to in the Forward View (NHS England *et al* 2014). This sense of ambition is clear to see in many of the essays in section 2 of this report.

The findings of the formal evaluation, when available, will tell us more about the impact these innovations have had on patient outcomes and resource use. Contributions to this report suggest that for many of those involved, the most significant steps forward have not been about specific service changes (important though these have been), so much as ‘reshaping the overall organisational relationships and incentives in the local system’ (to quote Daljit Lally’s essay). Much of this reshaping remains incomplete and involves moving away from a system predicated on competition between autonomous organisations paid on the basis of activity levels, to one in which place-based collaboration and pooled funding play a much greater role. An important question that remains is how far this movement can go in the absence of legislative change to ensure the statutory framework keeps pace with developments in the system.

A new national approach to large-scale change?

Previous research has shown the limitations of approaches to improvement which rely on external stimuli (such as targets, regulation, competition and choice), and suggested that a new emphasis on ‘reform from within’ is needed in the NHS (Ham 2014). This kind of approach invites national bodies to reframe their roles as being facilitators of locally led change, and leads to a focus on strengthening local system leadership, clinical engagement and improvement capabilities.

The design of the new care models programme represented an attempt to put this kind of facilitative philosophy into practice, and there appears to have been some success in doing so. Don Berwick observes that in his experience, the programme has been ‘far more about release of energy than about central control’. For local vanguard lead Nicola Longson, the programme ‘has felt like

a genuinely different national approach to transformation' which recognised that 'one size does not fit all'. Several contributors remarked that the most helpful things about being part of the programme have been the opportunities provided for vanguard sites to connect with and learn from each other, and to benefit from external expertise on specific issues, brokered by the national programme team.

Some of our contributors reflected that being part of the programme still involved substantial amounts of data reporting to NHS England and that the requirement to show progress against nationally determined metrics sometimes influenced local conversations in ways which were not always helpful. For national bodies this illustrates the tension between acting as a catalyst and playing a performance management role. Learning to strike the right balance between these two distinct roles remains a key challenge for the system.

An important role for national bodies is to identify systemic barriers that need to be 'fixed once'. Some of our contributors alluded to the complex legal and technical issues that still need to be addressed if new models of care are to become more widespread, including issues around VAT, pensions, contractual terms and conditions, information governance, and procurement laws. There also needs to be further work on new approaches to regulation and payment that support the move to whole-system collaborative working. Without national solutions to some of these issues, there is a risk of some of the momentum for change in local systems being lost.

Relationships before structure

The centrality of relationships and trust is a notable theme in several essays. Echoing findings from elsewhere (Addicott 2014), a key message from our contributors is that relationship-building needs to take place before new ways of working are formalised through organisational or contractual changes. From his role in the national programme team, Jacob West argues that 'sites that prioritised detailed discussions of new contractual approaches over relationship-building or a shared understanding of priorities for patients have, I think, made slower progress'. Similarly, Daljit Lally observes that one of the most significant achievements in the Northumberland system has been the improved ability of local leaders to work flexibly across the health and care system, with key leadership posts spanning both the NHS and local authorities. This flexibility and continuity may be more important than the precise organisational structures that underpin it.

In many vanguard sites efforts to develop system leadership and a shared local vision began several years before the new care models programme commenced. Relationships were further strengthened through regular communication, creating joint posts across organisations, co-locating teams, and fostering a culture of openness and transparency between partners.

Importantly, these collaborative relationships need to be truly system wide, so that the full range of local partners can shape the model of care and contribute their expertise. For example, Sarah Gill's essay highlights the benefits of including mental health expertise in new models of care, many of which were not anticipated at the outset. System-wide collaboration also needs to involve going beyond mainstream health and care services, working in partnership with other sectors, and harnessing the energies of local residents. Local authorities have played an important role in some vanguard sites, but this has not been consistent across the programme and could be strengthened in future change programmes. Similarly, Steve How's essay demonstrates the challenges faced in involving patients and the public in complex system changes that involve multiple organisations working together – but also shows that with the right structures in place, it is possible to give local people a meaningful role in system redesign.

Spreading and scaling-up change

From the outset, the ambition for the new care models programme was that the innovations tested in vanguard sites should be scalable and replicable elsewhere – albeit with local adaptation where necessary. Vanguard sites were expected to protect time for dissemination and for helping other areas to benefit from their learning. It was envisaged that by 2020/21 at least half the population of England would be served by areas adopting the PACS or multispecialty community provider (MCP) models.

There are a few examples in vanguard sites which illustrate how scaling-up of innovation can occur, mostly to neighbouring geographical areas or to larger areas that subsume the original vanguard site. For example, the approaches developed in the North East Hampshire and Farnham vanguard now form the basis of the wider Frimley Health integrated care system (see NHS Providers *et al* 2018 for other examples of spread from other vanguard sites).

However, spreading and scaling-up change remains one of the most difficult aspects of any innovation programme, and is the challenge to which system leaders are now turning. Research on large-scale change suggests that it will

not be sufficient to publish case studies of good practice from the vanguard sites and expect other areas to follow suit (McCannon *et al* 2007). A major programme of work on diffusion of innovation led by the Center for Medicare and Medicaid Innovation in the United States found several factors associated with successful spread, including:

- active dissemination strategies rather than reliance on natural diffusion of good practice
- adaptable models of care rather than rigid adherence to original designs
- a focus on peer learning and exchange rather than top-down instruction from national bodies
- empowerment of local leaders responsible for implementing change, including through building local capacity and capabilities (McCannon 2017).

Spreading innovation from the vanguard sites will require paying attention not just to what has worked well, but also to how and why it has worked, and in what contexts (Perla *et al* 2015). It may also need to involve providing expert support to areas now adopting new care models, similar to that received by vanguards themselves (Albury *et al* 2018).

National leaders will need to draw on this evidence in developing a strategy for spreading new models of care through sustainability and transformation partnerships and integrated care systems. As Jacob West concludes in his essay, 'Scaling the new care models in this way across the NHS truly would be a breakthrough.'

Appendix: PACS site profiles

Better Care Together (Morecambe Bay Health Community)

Population characteristics

- Population size: 365,000.
- Geographically dispersed population.
- Significant deprivation and health inequality.

Partner organisations

- One acute hospital trust, two mental health/community service trusts, two local authorities, one CCG, two GP federations and one ambulance trust.

Main changes introduced

- Creation of 12 integrated care communities, each consisting of a multidisciplinary team of nurses, GPs, physiotherapists, occupational therapists and social workers, to deliver co-ordinated care to people with the highest level of care needs and reduce avoidable hospital stays.
- A major focus on community activation and self-care, involving individuals and communities in managing their own health and wellbeing. Specific interventions have included:
 - Identifying volunteer Community Health Champions to act as focal points for health-related activities in their communities
 - training staff in shared decision-making and motivational interviewing
 - 'wellness days' to avoid social isolation and promote independence
 - free diet, nutrition and exercise classes, a community choir and volunteer-led mindfulness groups
 - a run-a-mile-a-day programme in schools.

- Introduction of new technologies such as access to online consultations, high-definition video links between GP surgeries and the A&E department in Furness General Hospital, and an 'advice and guidance' system allowing GPs to seek advice from a specialist without making a referral. There has been a particular focus on using these technologies in geographically isolated areas with low population density.
- A range of initiatives to deliver care and treatment in community settings rather than hospital (for example, for ophthalmology and musculoskeletal appointments), including through development of new facilities to allow co-location of services in one building.

New contractual arrangements

- No formal contractual changes but in 2016 a Memorandum of Understanding was agreed, describing how local organisations would work together more closely as Bay Health and Care Partners.

Further information

- Website: www.bettercaretogether.co.uk
- Twitter: @BCTMorecambeBay

Harrogate and Rural District Clinical Commissioning Group

Population characteristics

- Population size: 160,000.
- Geographically dispersed population.
- Population older than the national average.
- Affluent area with pockets of deprivation.

Partner organisations

- One acute/community trust, one mental health trust, two local authorities, one CCG, a network representing the 17 general practices in the district and a charity that supports and brings together local voluntary and community sector organisations.

Main changes introduced

- The initial model involved piloting four community interdisciplinary hubs bringing together GPs, community nurses, adult social care, occupational therapists, physiotherapists, mental health professionals and the voluntary sector.
- In the second iteration of the new care model, these were replaced with a single integrated response service working with three GP practices. This offered a seven-day-a-week rapid response intervention from an interdisciplinary team and, wherever possible, avoidance of hospital admission.
- Electronic Palliative Care Co-ordination System (EPaCCS) template used by GP practices to support the sharing of information and co-ordination of care between providers for people at the end of life.
- Worked with the local voluntary and community sector and other partners to develop a community directory of local services and resources.
- 'Open space' public engagement event held at the start of the programme to shape the new care model and to hear from local people about 'what matters to us'.
- Events held with staff from all local providers to collate lessons learned from the programme for future use in transforming services.

New contractual arrangements

- Currently operating on the basis of relationships and trust, but with the aspiration of contractual changes being made in 2019/20.

Further information

- Website: www.harrogateandruraldistrictccg.nhs.uk
- Twitter: @WMTU_Harrogate

Mid-Nottinghamshire Better Together

Population characteristics

- Population size: 310,000.
- Geographically dispersed population.
- Significant deprivation and health inequality.

Partner organisations

- Three acute hospital trusts, one mental health/community service trust, one local authority, two CCGs, a consortium of local third sector organisations, an independent NHS treatment centre and one ambulance trust.

Main changes introduced

- Creation of local integrated care teams, each consisting of a multidisciplinary team of GPs, specialist nurses, social workers and a voluntary sector worker, to deliver co-ordinated care – led by an assigned key worker – to people at the highest risk of hospital admission.
- An Intensive Home Support service – a specialist intermediate care team consisting of therapy, nursing and social care staff who can support earlier discharge from hospital or step up care to avoid admission.
- Introduction of Call for Care – a care navigation service for health and social care professionals that can offers clinical triage and can arrange a response from community clinicians within two hours.
- Introducing enhanced clinical support for care homes.
- Working with general practice to organise 41 practices into four locality primary care hubs, which has resulted in the introduction of primary care led schemes such as a new acute home visiting service.
- A range of initiatives to enhance self-care, including self-care advisers working within the local integrated care team and a self-care hub offering signposting and support.
- Improving A&E streaming by creating a 'single front door' for co-located A&E and primary care services.

New contractual arrangements

- Forming a contractual alliance between the CCGs, local authority and key providers to formally embed the partnership-working and creating an Alliance Leadership Board and Alliance Operational Oversight Group.

Further information

- Website: www.bettertogethermidnotts.org.uk
- Twitter: @bettermidnotts

My Life a Full Life (Isle of Wight)

Population characteristics

- Population size: 140,000.
- A higher proportion of older people than the population average.

Partner organisations

- One CCG, one integrated NHS trust (provides acute, ambulance, community, hospital, learning disability and mental health services), one local authority, one GP federation, and other public, voluntary and independent sector partners.

Main changes introduced

- Integrated locality teams supporting frail older people and people with long-term conditions.
- Integration of a wide range of expertise into the emergency control room to reduce avoidable hospital admissions. The integrated care hub includes a new crisis response team, district nurses, social workers, mental health workers, pharmacists, occupational therapists and others working alongside emergency call operators and NHS 111.
- Introduction of new 'local area co-ordinator' roles. Co-ordinators are recruited from their local community and work with people at risk of loneliness and isolation. They help people to identify their strengths and skills and make use of these in their local community, reinstate their social

networks and build new relationships, and explore what a 'good life' would look like for them.

- Technology Enhanced Care Service – digital health systems installed in care homes to allow staff to monitor a range of biometric indicators including blood glucose levels, blood pressure, urine analysis and oxygen saturation. This information can then be shared with GPs, out-of-hours services, the integrated care hub and others as necessary.

New contractual arrangements

- Currently developing an alliance framework to enable the system to commission in a different way from 2018/19 onwards. This alliance approach will in the first instance be focused on a selection of community services provided across various partner organisations and will develop over time.

Further information

- Website: www.mylifeafulllife.com
- Twitter: @mylifeafulllife

North East Hampshire and Farnham

Population characteristics

- Population size: 225,000.
- A relatively affluent population with some small areas of deprivation.
- Key issues include the ageing population and high prevalence of long-term conditions in the area.

Partner organisations

- One acute hospital trust, one community/mental health services trust, one mental health trust, two local authorities and one CCG, an out-of-hours service and one ambulance trust.

Main changes introduced

- Creation of five integrated care teams to support individuals with complex care needs in their own homes, preventing emergency hospital admission

where possible and facilitating faster discharge from hospital. These consist of a multidisciplinary team of community nurses, occupational therapists, physiotherapists, social workers, paramedics, pharmacists, mental health practitioners, geriatricians, GPs and voluntary sector workers.

- A variety of schemes designed to prevent ill health and support self-care, including support for carers, training for pharmacists and other professionals in giving self-care and wellbeing advice, and a social prescribing scheme to connect people to local resources and voluntary sector services.
- Improved access to primary care through extended opening hours and an online tool (E-Consult) that allows patients to have a consultation with a GP without having to visit the surgery.
- Introduction of a wider variety of health care professionals in primary care, with direct access to physiotherapists and clinical pharmacists, as well as broadening the roles of paramedic practitioners and nurse practitioners to help with urgent on-the-day care.
- A range of initiatives to improve the connections between hospital and out-of-hospital services – for example, GPs are working in A&E and on hospital wards to facilitate earlier discharge and IT systems have been introduced to allow hospital staff to view GP records.
- Closer working between the acute trust and social care, including more support to reduce delayed transfers of care.
- Expansion of the Recovery College offering educational courses and workshops to improve the health and wellbeing of people living with, or recovering from, chronic mental or physical health conditions.
- Better mental health crisis support through the introduction of Safe Havens for adults (and a separate service for young people) to improve quality of care and reduce attendances in A&E, and to respond to service user feedback about preferring being seen outside of clinical settings.
- A paramedic rapid home visiting service in every locality to better support GPs, provide a more timely service to patients and to divert appropriate activity away from hospital.

Further information

- Website: www.northeasthampshireandfarnhamccg.nhs.uk
- Twitter: @NEHFCCG

Northumberland PACS vanguard

Population characteristics

- Population size: more than 320,000.
- A very large and highly rural geography.
- Higher than average older population.
- Areas of affluence and deprivation.

Partner organisations

- One acute trust, one CCG, one county council and one ambulance trust, working together with local GPs and others. The work also links closely with a neighbouring CCG, acute trust and the main local provider of mental and community health services.

Main changes introduced

- Integrated care hubs in each locality, including a multidisciplinary enhanced care team to care for people with the most complex needs in a more proactive, co-ordinated way, and to avoid unnecessary hospital admissions.
- A trial of an acute home visiting service to support GPs in managing home visit requests, drawing on a multidisciplinary team of community nurses, pharmacists, and social workers.
- Clinical pharmacists now work with community nurses, GPs and others to ensure people living in care homes are taking the most effective combinations of medication and that they stop taking medicines they no longer need or want.
- A new workforce strategy for Northumberland focusing on creating more community-based specialists and developing staff with flexible skills.

- Building of a specialist emergency care hospital to centralise delivery of emergency care 24/7. This includes the use of 24-hour urgent care centres in Hexham, Wansbeck and North Tyneside.
- Establishing a GP federation across practices to ensure that primary care is represented as a single voice.
- The introduction of a single point of access for patients with health and social care needs.
- Capacity and demand exercise undertaken across primary care to support the need to extend access to patients and reduce demand into secondary care.

Further information

- Website: www.northumberland.nhs.uk
- Twitter: @N_LandNHS

Salford Together

Population characteristics

- Population size: 230,000.
- An urban area with a growing population.
- Significant inequality across the city, with high levels of deprivation in some areas.

Partner organisations

- One acute/community trust, one mental health trust, one local authority, one CCG and a GP provider body.

Main changes introduced

- Creating five multidisciplinary local neighbourhood teams consisting of GPs, community nurses, social workers and mental health professionals. They can deliver proactive, co-ordinated care to people with long term conditions, and enhanced care for people requiring intensive support.

- Bringing in a new multidisciplinary crisis response team to offer urgent, community-based support to people experiencing a physical, mental or social care crisis within two hours.
- Developing an integrated care record that will eventually bring together information held by primary care, hospitals, community services, mental health services and social care.
- Introducing health coaches, care navigation and social prescribing to support people to make positive changes to their health behaviours.
- Working collaboratively with the community, voluntary and social enterprise sector through a memorandum of understanding.
- Engaging the local community in shaping changes to the delivery of health and care services through community events involving more than 4,000 people.

New contractual arrangements

- Creating an integrated care organisation that brings together hospital, community, mental health and social care services. Salford Royal acts as the prime provider responsible for delivering all Salford's core hospital, community health and adult social care services, and acts as the prime contractor responsible for commissioning non-specialist adult mental health services and procuring a range of residential, domiciliary and social care support. The aim is to ensure that all these services work together as an integrated system.
- Establishing a joint commissioning board to oversee a pooled budget of £236 million for all adult health and care services (excluding specialised and GP services).
- Establishing Salford Primary Care Together, bringing together the 46 separate general practices into a single grouping, providing a basis for GPs to engage with the integrated care organisation.

Further information

- Website: www.salfordtogether.com
Twitter: @SalfordTogether

South Somerset Symphony Programme

Population characteristics

- Population size: 135,000.
- Rural area, mostly small towns and villages, often with poor public transport connections.
- Proportion of population aged over 65 higher than the national average and rising.

Partner organisations

- One acute trust, one community and mental health trust, one GP federation, one CCG and one county council.

Main changes introduced

- A new enhanced primary care model offering proactive and holistic care for people with long-term conditions, delivered by an expanded primary care team including health coaches, pharmacists, physiotherapists and mental health workers. The teams meet for regular 'huddles' to discuss the patients they are most concerned about. The model includes stratification of the practice population and proactive outreach for groups at highest risk of hospital admission.
- New health coach role introduced as part of the enhanced primary care model. Health coaches help patients with long-term conditions to manage their health and wellbeing, and are responsible for proactively reaching out to patients, monitoring and co-ordinating their care.
- Closer working between GP practices and Yeovil Hospital to reduce the need for referrals, for example, through virtual diabetes clinics allowing hospital consultants to discuss complex cases with the practice team, practice-based musculoskeletal practitioners, and respiratory clinics allowing practices to obtain an urgent opinion without making an outpatient appointment.
- Three new complex care hubs providing intensive support to people with three or more long-term conditions. These are staffed by multidisciplinary teams including care co-ordinators and a new expert generalist or 'extensivist' role (GPs or general physicians specialising in caring for people with multiple conditions and the highest level of care needs).

- Creation of an integrated dataset bringing together data from primary, secondary and social care. Analysis of this has supported new insights into how different patient groups use resources across the health and care system.

New contractual arrangements

- Original aim was to have a lead provider (potentially a joint venture between the acute trust, GPs and others) able to take on a 5- to 10-year capitated, outcomes-based contract covering most hospital, community and social care services, but this is not part of the current project.
- Symphony Healthcare Services – a subsidiary of the acute trust – holds GP contracts for seven practices.

Further information

- Website: www.symphonyintegratedhealthcare.com
- Twitter: @SymphonyProj

Wirral Partners

Population characteristics

- Population size: 330,000.
- Very high levels of deprivation in some areas, but other areas more affluent.
- Mixture of urban and rural areas.

Partner organisations

- One CCG, one local authority, one acute trust, one community services trust, one mental health/community services trust, local professional committees, and voluntary and independent sector partners.

Main changes introduced

- A major focus on strengthening the digital infrastructure to support better population health management, based on the Wirral Care Record (an electronic patient record bringing together data from primary care, the

acute trust, community services, mental health and social care into a read-only record that can be accessed by all providers).

- Development of clinical registries outlining evidence-based, locally agreed packages of care for selected long-term conditions, which can then be compared against current practice using data from the Wirral Care Record.
- Four integrated care co-ordination hubs across Wirral, bringing together community nursing, social care, physiotherapy, occupational therapy and mental health services.
- Improved links between hospital and community care, with an initial focus on diabetes and respiratory pathways. This includes an integrated community respiratory service, and new community diabetes clinics offering access to hospital diabetes consultants.
- Enhanced support to care homes, for example, through a specialist diabetes nurse going into nursing homes to educate and support staff
- Expansion of social prescribing options to help people remain well and socially active.

Further information

- Website: www.wirralccg.nhs.uk/healthy-wirral/
- Twitter: @healthy_wirral

References

- Addicott R (2014). *Commissioning and contracting for integrated care*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/commissioning-contracting-integrated-care (accessed on 22 March 2018).
- Albury D, Beresford T, Dew S, Horton T, Illingworth J, Langford K (2018). *Against the odds: successfully scaling innovation in the NHS* [online]. Innovation Unit website. Available at: www.innovationunit.org/projects/against-the-odds/ (accessed on 22 March 2018)
- Collins B (2016). *New care models: emerging innovations in governance and organisational forms*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/new-care-models (accessed on 20 March 2018).
- Deming WE (1986). *Out of the crisis*. Cambridge, Massachusetts, US: Massachusetts Institute of Technology, Center for Advanced Engineering Study.
- Ham C (2014). *Reforming the NHS from within: beyond hierarchy, inspection and markets*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/reforming-nhs-within (accessed on 22 March 2018).
- McCannon J (2017). 'How can we accelerate the focus on spread and scale in population health?' Presentation at The King's Fund Annual Conference, 29 November 2017. Available at: www.kingsfund.org.uk/audio-video/joe-mccannon-accelerate-spread-scale-population-health (accessed on 22 March 2018).
- McCannon J, Berwick D, Massoud M (2007). 'The science of large-scale change in global health'. *JAMA*, vol 298, no 16, pp 1937–9.
- NHS England (2016a). *Integrated primary and acute care systems (PACS) – describing the care model and the business model*. NHS England website.

Available at: www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/primary-acute-sites/ (accessed on 20 March 2018).

NHS England (2016b). *New care models: vanguards – developing a blueprint for the future of NHS and care services* [online]. NHS England website.

Available at: www.england.nhs.uk/ourwork/new-caremodels/vanguards/care-models/ (accessed on 20 March 2018).

NHS England (2015). *The forward view into action: new care models: update and initial support* [online]. NHS England website. Available at:

www.england.nhs.uk/wp-content/uploads/2015/07/ncm-support-package.pdf (accessed on 20 March 2018).

NHS England, Care Quality Commission, Health Education England, Monitor, NHS Trust Development Authority, Public Health England (2014). *NHS five year forward view* [online]. NHS England website. Available at:

www.england.nhs.uk/publication/nhs-five-year-forward-view/ (accessed on 20 March 2018).

NHS Providers, NHS Confederation, NHS Clinical Commissioners, Local Government Association (2018). 'Learning from the vanguards: spreading and scaling up change'. NHS Providers website. Available at: nhsproviders.org/learning-from-the-vanguards (accessed on 22 March 2018).

Perla R, Reid A, Cohen S, Parry G (2015). 'Health care reform and the trap of the "iron law"'. Blog. Health Affairs website. Available at:

www.healthaffairs.org/doi/10.1377/hblog20150422.047092/full/ (accessed on 22 March 2018).

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