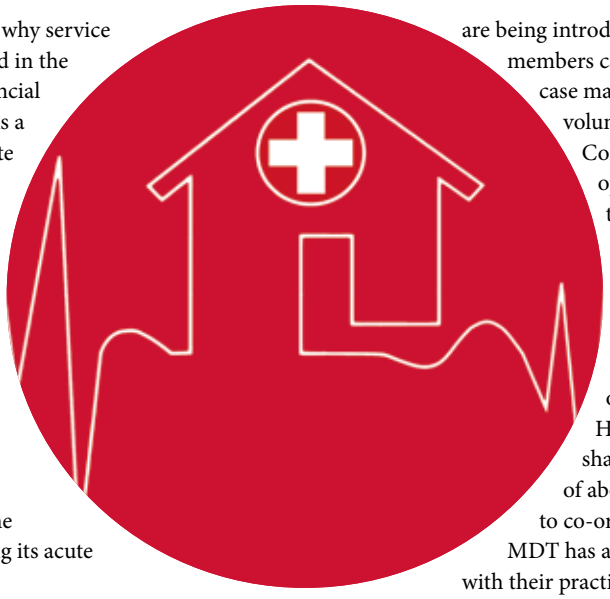
Holistic thinking

With vanguards getting into gear, Seamus Ward looks at how one in Dudley and another on the Isle of Wight are developing plans to integrate and transform care

It's almost become trite to list the reasons why service transformation and integration are needed in the NHS. But a few months into the new financial year and the vanguard programme there is a sense of movement. The primary and acute care systems (PACS) look to integrate services vertically, from the GP and district nurse to the consultant and hospital pharmacist. At the community level, multispecialty community providers (MCPs) have integration and transformation of community and primary care at their heart. However, as the case studies below demonstrate, the dividing lines between the types of vanguard are not always well defined. For example, the Dudley MCP looks across the patch, pulling all local providers, including its acute trust, into the partnership.



The Dudley model

The Dudley vanguard partners have designed their model around patients, focusing on delivering integrated care to those most at risk of emergency hospital admission. These patients are being identified using risk stratification tools. Consultations with patients have identified four key requirements for the MCP:

- Better communication with patients and between staff
- Improved access to consultation and diagnostics
- Continuity of care supporting the management of long-term conditions
- Effective co-ordination of care for the frail elderly and those with complex conditions.

As well as traditional health interventions, those on the Dudley team aim to reduce social isolation, improve patients' life skills and help them choose healthy lifestyles.

Multidisciplinary teams (MDTs) of about 10 professionals, led by GPs, are being introduced to implement the model. Team members can include a district nurse, assertive case manager, mental health worker and voluntary sector link worker. Dudley Clinical Commissioning Group chief finance and operating officer Matthew Hartland says this network will enable health, social care and voluntary sector staff to work together in 'teams without walls'.

The vanguard has organised the GP practices and their associated MDTs into five localities. To enable best use of resources and economies of scale, Mr Hartland says the teams in each locality share resources and cover over a population of about 60,000. Each locality has a lead GP to co-ordinate the model of care. In turn, each MDT has a lead GP and the teams are associated with their practices. GPs will continue to be patients' first point of contact, but it will now be for the GP, through the practice-based MDT, to ensure that a comprehensive package of care and support is agreed with, and delivered by, partner health, care and voluntary organisations.

'We are one of the CCGs to take on full delegation of primary care commissioning with NHS England – another significant strength given the integral nature of primary care to the development and sustainability of our MCP model,' Mr Hartland says. 'All participating providers have restructured their services so that all frontline staff work to the same registered population as the GP practices or, for more specialist services, linking them in to the MDTs.

'As a result of these changes we are seeing improvement in morale of our staff working across all agencies, because they are working better together. This is having consequential positive benefits on care to our patients. In addition, our work with the voluntary sector is helping people connect back into their own communities, which is having a genuinely transformative effect on their lives.'

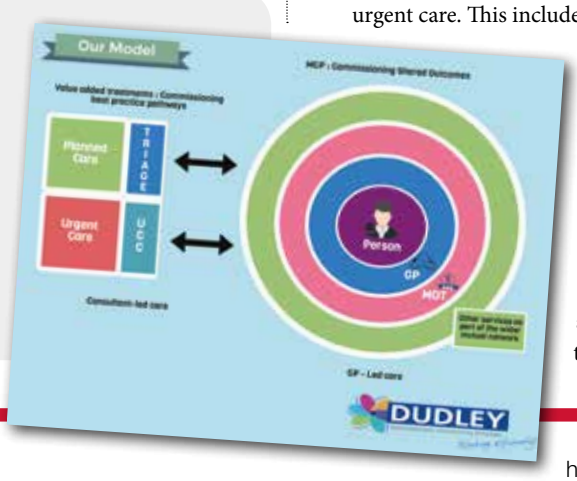
The second phase of the MCP development will see the care network expand to include specialist community services and some aspects of urgent care. This includes the establishment of a community-based rapid response service. In a crisis this will intervene in the patient's home. This should reduce the risk of A&E attendance and linking the patient back into their local network of care.

The recently opened primary care urgent care centre is another element of the second phase. Co-located with Russells Hall Hospital A&E, it acts as a triage point for patients coming to the emergency department. Where

Dudley partners

The CCG's bid for vanguard status brought together:

- Dudley Council
- Black Country Partnership NHS Foundation Trust
- Dudley Group NHS Foundation Trust
- Dudley and Walsall Mental Health Partnership NHS Trust
- Dudley Council for Voluntary Services
- Local GP provider company Future Proof Health



appropriate, patients are diverted into primary care services, relieving pressure on the hospital A&E department, which is one of the top-performing units in the country.

The third phase focuses on bringing consultant-led services into the community. This 'community retrieval' will include consultants working alongside GPs to manage long-term conditions such as diabetes. Similarly, with consultant support, the practice-based MDTs will be responsible for the whole care pathway for frail, elderly patients – from community, into hospital and back into the community.

'There are no longer any transfers of care. Patients will be retrieved back into the community rather than transferred from one team, or one organisation, to another – ensuring better co-ordinated care,' Mr Hartland says.

The CCG is acting as a lead commissioner, though there is significant input from partners and core elements are co-commissioned with the council under the better care fund.

As lead organisation, the CCG has an overview of what services are needed now and in the future, Mr Hartland says. 'This overview is also useful in working on the enablers of change – including a borough-wide estates review, roll-out of a single IT system and an overarching workforce plan, which transcends the organisational boundaries of the different agencies and professions in the system.

'Ultimately we are creating a fully integrated, population-based organisation that is delivering better person-centred care and which is better connected into our local communities.'

He adds that there are a number of financial aspects to the initiative. 'We are in the process of undertaking financial modelling of the MCP, and how it will contribute to the financial sustainability of the health and social care economy. We are working with partners to map services to each phase of the model and will construct projected activity and financial flows for the next five years for primary care, our main acute and community providers and social care.

'All of the financial modelling is being done with openness and transparency, involving all parties. The early hypothesis that such analysis is testing is that while the new model will not necessarily deliver a reduction in current cost, it will be a mechanism to stem growth and make our whole health and social care economy more sustainable.'

With its acute provider, the CCG is also examining entire pathways in eight specialties, but is in active dialogue with acute consultants initially in ENT, musculoskeletal, ophthalmology and urology, with the aim of identifying and reducing variation. Looking at 18 months of

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data, they are analysing each healthcare resource group to identify the number of patient interventions on the pathway, such as the number of appointments before or after a procedure. It may be some consultants have an outpatient appointment with a patient, then a follow-up before a procedure. Others may go straight to the procedure without the follow-up appointment.

'We can see the most commonly used pathway, the variation that currently exists and decide what we will accept as a commissioner and where we need to understand the differences at a consultant or provider level. From that, we can gauge the most appropriate "best practice tariff" we are willing to pay and hopefully set that tariff for all providers,' Mr Hartland says. 'We are working with Monitor to identify how this could be implemented, but clinical agreement to the pathway is paramount.' Providers will also benefit from the joint work to identify the best pathways, he insists, as the aim is also to reduce costs for providers.

The vanguard work underpins the development of standardised best practice pathways for services outside the MCP. These will be commissioned to incentivise optimum outcomes for the patient, maximise efficiency and enable effective communication with the GP. This could include outcomes-based contracts, where outcomes (and the associated remuneration) will be the same for all providers in the model, be they primary or secondary care providers.

'Those requiring care outside the remit of the MCP will benefit from the consistency, agreed outcomes and whole pathway focus that will characterise the way that care is commissioned, no matter who they choose as to provide it.'

Dudley is clearly thinking holistically, using its MCP not only to improve care for a specific group of patients, but also expanding it to provide better services for all its patients.

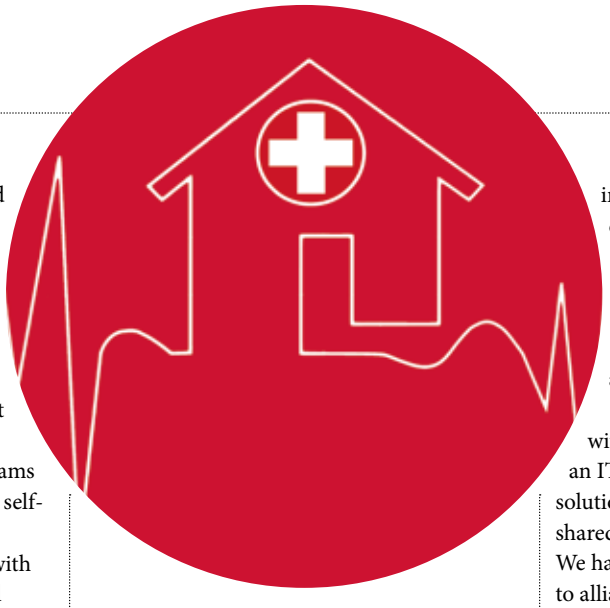
For further details, see www.dudleyccg.nhs.uk/dudley-to-lead-nhs-into-newera-of-patient-care

Island journey

In many ways the Isle of Wight is ideally set up for integrated care. Physically separate from the rest of England, it has a unitary authority, a CCG and a single healthcare trust that provides community, acute, ambulance and mental health services. Recently, the 17 GP practices have formed a federation. This is complemented by a vibrant and strong voluntary sector.

The island faces familiar problems: increasing demand, tight finances and an ageing population. The latter is particularly acute – the Isle of Wight has a higher percentage of older people than the rest of the country, with 26% aged over 65 and 12% aged over 85, compared with averages of 17% and 8% for England as a whole. To address this, in 2013 the Isle of Wight council, Isle of Wight NHS Trust, Isle of Wight CCG and the island's voluntary sector founded *My life a full life*, underpinned by a shared strategic vision of person centred, co-ordinated health and care. Earlier this year it was named a primary and acute care systems (PACS) vanguard site, which the partners hope will accelerate the integration of services across the island.

'For a long time people have been telling us that if integration doesn't work on the Isle of Wight, it won't work anywhere, and this very much encouraged us to apply for the vanguard initiative,' says Loretta Outhwaite chief finance officer at NHS Isle of Wight Clinical



Commissioning Group. 'Being a vanguard will help us take our plans further, faster through *My life a full life – powered by vanguard*. It also provides us with the mechanism to share successes and learning with other health and social care organisations."

The GP federation and the independent sector have now joined the programme. The vanguard builds on existing workstreams – crisis response, integrated localities and self-care and self-management.

The crisis response service is working with the voluntary sector and health and social care teams, which include district nurses, occupational therapists and physiotherapists and social workers, to provide a rapid response to a person or carer in crisis.

'If someone is in crisis and needs care but does not need a hospital admission, the team can give them up to 72 hours of support,' says Gill Kennett, integrated locality workstream lead for *My life a full life*.

'The team also looks forward beyond those 72 hours to see if the person might need a care and/or support package while they get back on their feet. It's been really successful. It started as a pilot in June 2014 and has now been commissioned as a service from 1 April 2015.

'Of the people seen at home, only 10% have been subsequently admitted to hospital,' adds Ms Kennett. 'At the time of assessment, there's also an opportunity to promote self-care and self-management and prevention, where, for example, an occupational therapist can make adjustments to the home to make sure people remain safe.'

The service has helped older people in the main, where a crisis can occur if they have fallen or their main carer becomes ill. But Ms Outhwaite stresses that the programme is not solely about caring for older people. 'Because the majority of health and social care demand is from an older population, it started out with that focus, as we recognised we needed to do something to manage the increased activity with no increased level of resources. But this is now about the whole population – for example, it's as much about children's or mental health services as it is about older people.'

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The second strand of the work has focused on developing integrated locality teams to facilitate joined-up working in day-to-day community and primary care services. Local GPs had already divided themselves into three localities, so the partner organisations have aligned their frontline staff with those localities.

Ms Kennett explains: 'It prevents duplication and ensures we can react quickly when patients need our help in the community. It gives patients the tools to build their resilience and enable them to live at home where possible.'

The third workstream has concentrated on self-care and self-management, with the statutory organisations working heavily in partnership with the voluntary sector to provide information and advice.

Building on the successes of *My life a full life*, as part of the vanguard the organisations are developing integrated commissioning, integrated service provision and strengthening these arrangements through the integration of corporate services.

Five key enablers have been identified:

- One technology-enabled care system
- One island pound
- One leadership
- One information
- One empowered people and workforce.

Located in an area of poor employment and career opportunities, the vanguard is exploring staff development and looking at how to develop and recruit more local young people to health and social care roles.

Ms Outhwaite says: 'We are also actively looking at ways in which we can develop the skills of our workforce and redefine roles to maximise people's strengths. This is especially important in areas where recruitment is challenging. For example, where we have difficulties with GP recruitment we have been supporting practices to come up with other solutions – utilising the skills and experience of nurse practitioners and pharmacists.'

Better IT will play an important role, with health and social care bodies sharing an IT strategy and investing in the same IT solutions so that records can be appropriately shared. 'Contracting is one of the key strands. We have an ambition to move, over 12 months, to alliance-type, outcome-based contract arrangements, though we have not yet worked through the details.'

Currently, the CCG has cost per case contracts for acute services and block contracts for the majority of the remaining services. Ms Outhwaite says: 'Our view is that commissioning will change over the next 12 months, with other organisations taking on the role of commissioner – such as lead service providers and individuals through their personal health budgets. This will change the landscape.'

The vanguard programme means the partnership can bid for additional investment, she adds, but points out the CCG would be implementing this vision even if it was not a vanguard – albeit at a much slower pace.

'The bidding process will show we are already investing local resources in delivering *My life a full life* – staff time as well as money,' says Ms Outhwaite. 'We have significant ambitions but will need further investment, particularly around IT, and to backfill staff to release people to work on the vanguard to take it further, faster. The island wants some quick wins in the first 12 months, followed by longer term success in the second and perhaps third year of the project.'

While the focus is clearly on improving services, will savings flow from the work? 'The island needs to focus on containment, as there is rising demand and an increasing level of allocation is not going to happen,' Ms Outhwaite replies. 'Therefore, where there are savings, where possible, they will be reinvested within the system to create capacity where it is needed and better health and social care services for people.'

- *For further details about the programme, see www.mylifeafulllife.com*