New care models

How to meet population health needs through workforce redesign

Joy and meaning in providing care

Our values:
clinical engagement, patient involvement,
local ownership, national support

August 2017

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Equality and health inequalities statement

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- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Foreword

In recent months the new care models (NCM) workforce redesign team has been focused on learning from vanguards, integration pioneers and primary care homes to better understand the key characteristics of integrated workforce models. We aimed to add to current thinking about integrated working and to understand how multi-disciplinary teams (MDTs) can contribute towards the delivery of the *Quadruple Aim*[1] – the Five Year Forward View's[2] (FYFV) *Triple Aim*[3] together with the fourth aim of finding joy and meaning in the experience of providing care.

This report seeks to describe the learning about workforce integration from vanguards, integration pioneers and primary care homes. We deliberately concentrated on what these entities identified as the success criteria to help others on their journey towards integration. We have shaped this report around the three key themes emerging from our investigations: *Designing a workforce around population health needs, leading change,* and *workforce redesign.*

The case studies and examples in this report show the strength and richness of the journey towards workforce integration. Strong system relationships exist and developing service models are beginning to align with local population health and wellbeing needs. There is some understanding of the vital importance of the interdependence of clinical service redesign, affordability and workforce development. We passionately believe that continued focus on the *Quadruple Aim,* rapid improvement methodologies, shared learning and robust delivery will lead to effective, replicable models of integration. The findings of this project suggest that, despite challenges, the journey towards integration is gathering momentum.

1. Introduction

The transformation agenda to support a long-term financially sustainable NHS through the implementation of the FYFV is challenging and extensive. It crosses multiple sectors and organisational boundaries in order to meet local population health needs. The new care model programme is a key element within the FYFV, with 50 vanguards focusing on redesigning the whole health and care system.

In the FYFV the focus is on the delivery of the *Triple Aim.* In the context of NCM workforce redesign, our focus was on capturing what vanguards, integration pioneers and primary care homes identified as the successful characteristics of integrated workforce models and on understanding how these supported accelerating the effective delivery of the *Quadruple Aim.*

Quadruple Aim:

1. Improving population health outcomes
2. Improving individual experience of care
3. Reducing the per capita cost of health care
4. Improving the experience of providing care
   [Sikk et al (2015) BMJ Quality and Safety]

Two factors have led us to frame this work around the *Quadruple Aim*: what vanguards set out to achieve and the values underpinning the NCM programme.

Vanguards produced value propositions[4] (VPs) defining the purpose, outputs and outcomes of their care models, which enable learning and identification of the return on investment. A review of the VPs of those vanguards with MDTs as a driver of proactive care identified how clear they were about their need for workforce change. The pressures of supply and demand on their workforce have been identified, and variable models of workforce integration have been chosen that match priority service needs. In addition, vanguards have routinely identified the critical importance of any workforce change and are working to ensure improved experience for their staff and the wider workforce.

The NCM programme has four key values which underpin the support it provides and drive the design of care models.

NCM programme values:

- Clinical engagement
- Patient involvement
- Local ownership
- National support

We believe these values reinforce the fact that engaging staff and the wider workforce in creating new models of care is critical to the delivery of the FYFV.

Integrated workforce models have been in existence in varying forms for many years[5]. From our literature search[6] it became evident that there are many definitions of integrated working and, following discussion at the integrated workforce models working group, the definition below was applied in this report:

> **Integrated workforce models:**
>
> *A workforce that includes healthcare professionals, social care, the voluntary and independent sectors and carers who are part of the team providing seamless care centred around the person.*

Additionally, discussions led to the following definition being applied with regard to population health:

> **A population health based approach:**
>
> *It involves segmenting the population into groups of people with similar characteristics to enable targeted interventions both for those population groups and for the individual citizens within.*

The literature search also demonstrated that whilst much is written about the features of integrated working, there is less information about addressing the practical challenges of implementation.

One practical guide to supporting workforce redesign is the Skills for Care seven principles of workforce redesign to support implementation of the Care Act 2014[7].

Our summarised literature research has enabled vanguards and partners to quickly sift through much material and adopt learning such as the Skills for Care guiding principles for workforce integration. The literature search also shaped our key lines of enquiry, which in turn supported identification of the key characteristics of success. The initial questions we aimed to address were:

- **Where** are the evidence and the stories to demonstrate progress towards achieving the Quadruple Aim objectives?
- **What** can we learn from vanguards about the effectiveness of approaches to workforce modelling against population health needs, new roles, developing people in existing roles and effective engagement and involvement of the workforce?
- **Who** are the organisations and partners that can offer support to create an effective integrated workforce?

This report explores some of the key characteristics of success we have identified from our review and work with vanguards, integration pioneers, primary care homes and other organisations. These can be summarised as:

Key characteristics of success:

- **Designing a workforce around population health needs**
  - **Modelling and planning the workforce** through a population health management approach – not letting organisational or professional boundaries block your way.
  - **Personalisation of care** by using people's needs as the key design principle to improve outcomes and resource efficiency – target the real need.
- **Leading change**
  - **Involve and engage** the workforce, people and carers in designing services across health, social care and the voluntary and independent sectors – recognise that your whole workforce is your greatest asset.
  - **Collaborative leadership** that builds trust and relationships and supports system-wide collaborative working – focus on common goals and a common purpose.
- **Workforce redesign**
  - **Design of team and design of roles** that deliver integrated working – recognising '*skill and competency'* rather than *'role and rank'.*
  - **Training and education networks** that support workforce development.
  - **Technologies** which drive and deliver improvements – embrace and learn from technology.

Input to this work has come from discussions and visits with vanguards, integration pioneers, primary care homes and other care providers, multiple webinar dialogues, analysis of achievements and metrics and collated case studies to identify characteristics of success and good practice. Additional input has also come from discussions with arm's length bodies, including through the integrated workforce models working group (see Appendix 1, p34).

We recognise from our discussions that the approach to workforce redesign is not necessarily linear – vanguards describe being at different stages and having the need to 'step into' the redesign journey at different points to meet local needs and timings. To support the workforce redesign journey we have produced a support guide with a collection of tools and examples, based on the learning from our review: 'New care models workforce redesign support guide'[8].

2. Key characteristics of success

2.1 Designing a workforce around population health needs

Integrated team working has been key to addressing the fragmentation of the health and social care system and the impact that fragmentation has on care and wellbeing needs of communities. The FYFV highlights the need for a focus on prevention and broader population health, including the wider social determinants of health. Where population health is the key driver of service and workforce design, creating the 'right' team, with the right size and composition to meet people's needs, should follow.

We found vanguards and localities engaged in activities to model different workforce scenarios and creating plans for workforce redesign. Modelling allows for clarity of population health needs and the workforce required to meet those needs; it does not detract from the fact that delivery of care is paramount. Modelling is a way of making sense of a complicated picture, helping to focus effort and resources where needed. There are approximately 1.6 million social care staff[9] and 1.4 million NHS staff[10] in England, and this workforce drives an estimated 70 per cent of the spend of an average health and social care provider[11]. It is therefore important that the workforce is modelled to ensure sufficient people with the right skills are available to deliver care within available resources.

2.1.1 Modelling and planning the workforce

We identified key characteristics of success for effective workforce modelling and planning including health and social care systems being able to recognise and own local system-wide challenges and solutions. This enables local agreement of priority areas and actions and forms a basis for moving towards integrated service provision based on population health needs.

Some key challenges were evident, including the increasing demands on the health and social care system coupled with an existing workforce needing to adapt to meet the demands of their local populations. We found stakeholders across all relevant sectors (including patients, staff, health, care, voluntary, local government) working together to be clear on and committed to the challenge to be addressed, in terms of both care model and the workforce required to meet those services. In Nottinghamshire STP, where four vanguards come together with partners, they have modelled the workforce across the whole footprint:

Case study summary: Nottinghamshire STP

Workforce modelling project covers the Nottingham and Nottinghamshire STP footprint and the following vanguards:

1. Principia Partners in Health (Southern Nottinghamshire)
2. Greater Nottingham Accountable Care System development
3. Mid Nottinghamshire Better Together
4. Nottingham City Clinical Commissioning Group enhanced health in care homes vanguard and primary care home pilot

Workforce issues: Working across organisational boundaries and thinking less in terms of where care is delivered and more on how it is delivered.

Approach: Delivery of an integrated strategy for the whole workforce to support the delivery of Nottinghamshire STP objectives, working through the local workforce action board to build networks to lead workforce change and piloting the use of systems dynamics to model skills and competencies required for the current model of urgent and proactive care and future desired model as described in the STP vision.

Population benefits: Aim to overcome barriers to deliver more joined up care.

Individual experience: Anticipate that experience of care will improve.

Reduced cost: The modelling approach connects population health needs, service transformation and strategic workforce planning to assess future workforce requirements, the potential routes to achieve this together and the cost of current and future workforce models.

Staff experience: The support of stakeholders has driven the modelling work and helped the system understand the importance of this work.

See Appendix 2, p35.

Primary care homes[12] (PCH) have been able to articulate clearly the link between the population health need, the care model, and the skills of the staff who deliver each care function. In Thanet Health CIC PCH they have created a task force of 16 different agencies to work together to address local population needs:

Case study summary: Thanet Health CIC PCH – Margate Task Force

Workforce issues: Pressures across frontline services working with a complex, transient and challenging demographic**.**

Approach: Bring together staff from 16 different agencies into a single 'street-level' team to address complex socio-economic issues (child protection, exploitation, safeguarding, gangs, crime, welfare dependency, health inequalities and poor outcomes, substance misuse, quality of life); target pooled resources, focusing on individuals/communities in greatest need; develop and enhance the skills and knowledge of front-line staff.

Population benefits: Preventative and proactive interventions to keep individuals and communities healthy and living at home; develop the capacity and capability of local communities to address own challenges.

Individual experience: People with complex needs receive an integrated and effective response from a range of appropriate professionals.

Reduced cost: Reduction in duplication and improved efficiencies as a result of targeted approach providing a holistic service; potential reduction in A&E attendances and admissions, particularly amongst hard to reach populations that are used to accessing services in this way rather than attending primary care services; early intervention before crisis point for some patient cohorts reduces the overall cost of care.

Staff experience: More positive working relationships across organisational boundaries.

See Appendix 3, p38.

Video: Thanet Primary Care Home: Bringing together health and social care

There are a variety of approaches that enable population segmentation and risk profiling. These approaches should be taken at the beginning of the workforce modelling process to inform design[13]. Some vanguards are demonstrating that taking a population health management approach, in which the population is segmented into groups of people sharing common characteristics, and then targeting interventions and the workforce design around these segments, can have a significant impact (e.g. on patients with 'complex care' needs). Some vanguards have concentrated on planning the workforce model so that there is an appropriate priority to augment the primary and community care workforce in order to reduce the impact on the acute care workforce.

Developing models rooted in local, linked data sets allows a whole population approach without risk of overlap or duplication. Leeds CCGs and Kent County Council (KCC) commissioned Whole Systems Partnership[14] (WSP) to support them in developing a whole population cohort model to inform the prevention agenda that is based on underlying trends in key health-related factors (smoking, hypertension etc.). This sets the long-term context for health promotion and prevention strategies in a dynamic modelling environment with the intention of re-invigorating prevention strategies and refocusing the integrated workforce to undertake many more 'upstream' interventions.

To plan and model 'for real' requires system leaders to have signed up to a large-scale workforce change in support of improvements to service provision. It is important that assumptions and their implications are understood across the system, exploring the feasibility of proposed changes in clinical, workforce and financial terms by utilising an agreed common language or currency. In Wakefield the development of a 'single team' led by a provider alliance has led to improvements:

Wakefield Connecting Care (multispecialty community provider (MCP) and enhanced health in care homes vanguard)

Workforce issues: Fragmentation between health, social care and the independent residential care sector; GP and other healthcare professional shortage.

Approach: Development of integrated 'single team' workforce spanning health, social care and community and voluntary sectors; led and modelled by a senior-level provider alliance working across all organisations.

Population benefits: Keeping people well, independent and in their own home or residential care and avoiding hospital admissions; providing a better range of integrated high-quality services in local communities.

Individual experience: Patients feel more in control of their health and wellbeing.

Reduced cost: Fewer hospital admissions, less demand for ambulances, reduction in hospital bed days; care provided earlier in the pathway and by the most appropriate professional.

Staff experience: Staff feel empowered and they are making a positive contribution to health and wellbeing.

See Appendix 4, p43.

Discussions with vanguards, integration pioneers and primary care homes identified a fairly consistent state of play in terms of articulating workforce planning assumptions. Most are actively engaged in rapid cycle learning/trials – the clinical service model has therefore been articulated in concept form and the concepts are being tested.

Stockport Together is using Health Education England's (HEE) workforce repository and planning tool (WRaPT) to baseline its entire health and social care workforce. Activity is being mapped system-wide to enable teams to model the impact on the workforce.

Stockport CCG:

"The CCG is committed to being an intelligence-led organisation. The WRaPT allows us to apply the same rigour we use in quality assurance and contracting to our workforce planning so that our new models of care are backed up by the right skills and capacity within our collective workforce across health and social care in Stockport."

Angela Dawber, Head of Strategic Development, NHS Stockport CCG

See Appendix 16, p84.

Stockport Together has also invested time into developing the infrastructure for a pooled fund between the CCG and council, as well as integrated commissioning arrangements for a wider set of services across health and care in Stockport. This has been facilitated by the creation of a health and care integrated commissioning board, with equal membership representing the Council and CCG.

In the seven counties in the HEE East Midlands area planning is focussing on using WSP's strategic workforce integrated planning and evaluation (SWiPe) framework and tool[15] to understand the shifts in types and levels of competencies required resulting from the key changes in the clinical service model. Work is advanced in both Nottinghamshire and Lincolnshire, and a picture is emerging of affordability, sustainability and cost which largely aligns with the STP financial requirements[16,17].

Wellbeing Erewash has used the SWiPe framework to plan the workforce around its frailty care pathway. Analysis of local population health need at different stages of the care pathway supported the alignment of the skills and competencies of the current workforce against the demand for health and social care services (see Appendix 14, p81).

Better Care Together (Morecambe Bay Health Community) has developed a clear set of change scenarios using WRaPT for a respiratory whole system pathway[18]. Nottinghamshire[19] has used the SWiPE framework to understand proactive and urgent care, publishing an annex to its STP providing details of the shift in workforce roles and skills required for delivery of pro-active care. Looking at skills across all professional groupings and at four levels (core, generic, advanced, specialist), it articulated the likely 'percentage changes' by level, in an effort to match the STP financial frameworks with a clear (workforce-based) transformational resource plan.

Healthy London[20] has modelled in some detail for all London CCGs and boroughs the implications of current planning assumptions on primary care, and is now applying the same methodology to social care. Tower Hamlets Together is testing the success of self-managed teams and the Burtzog[21] model against the *Triple Aim* related criteria to enable them to understand how to upscale from successful pilots.

Modelling and planning the workforce stems from identifying population health need and ensuring availability of staff with the right skills. In response to clinical service model changes there are essentially three stages in workforce planning:

Stage 1: Identify the population cohort and, if necessary, specific sub-cohorts which have a consistent way of working across the care or statutory system.

Stage 2: Identify the high level care functions this population cohort needs.

Stage 3: Identify the skills and competencies needed to provide these care functions, and who can do what across the system in the 'to be' service model.

Actions to support this can include a detailed examination of specific patient flows, analysis of care interventions to understand how 'things might be done differently' and a specific look at both appropriateness of intervention and how the use of technology can support improved service delivery.

Discussions with vanguards suggest that there is a skills gap relating to development of system-wide workforce change scenarios and therefore to the identification of the skills and competencies required to deliver integrated care. The issue is not about data processing and use of models, but rather more about building the new care model-type change scenarios and specifically the assumptions about population health-based workforce redesign. This requires a 'whole systems' understanding across health and social care and across commissioner and provider frameworks.

The following summarises 'top tips' for workforce modelling and planning:

***Top tips*: Modelling and planning the workforce**

- **Define the population:** Shape care around defined populations; focus on care function as well as organisational form
- **Identify your challenge and future state:** Understand and agree what needs to change, how you want to achieve it and the supporting integrated workforce model
- **Plan the workforce model:** Plan at all system levels and focus on the competency needed for care function

2.1.2 Personalisation of care

Involving service users in the design and development of care models is a core value of the NCM programme, and growing evidence suggests that it can also support better outcomes and utilise resources more efficiently[22]. In the FYFV, NHS England's aim is for *'a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health'*. The Care Act (2014)[23] also puts people at the centre of their care and support and maximises their involvement.

The Social Care Institute for Excellence[24] describes personalisation to mean putting people at the centre of their care, enabling individuals to plan their care with those who work together to understand them and their carer(s), giving individuals control, and bringing together services to achieve the outcomes important to individuals. This personalisation, which is precise and specific to the individual, should focus on both *supporting health and wellbeing* and on *managing illness*, tailoring support to individual needs. This requires an integrated workforce that thinks about what is best for the individual, shifting primary focus from either the employing organisation or professional body.

The People and Communities Board, one of seven governance boards to support the delivery of the FYFV, is chaired by National Voices and includes patients, the voluntary sector, and the wider health and care system. It has set out six principles[25] to support the empowerment of patients and communities in new care models. We found vanguards enabling this type of shift of focus adopted different approaches to patient activation.

Patient activation is important as it ensures the individual is engaged with discussions and decisions about their health; evidence suggests that improved patient activation can lead to improved outcomes[26]. Vanguards are actively engaging with family and informal carers and finding this a valuable input to service and workforce redesign. Fylde Coast Local Health Economy is using a tool to facilitate patient activation as well as support MDTs to work together in a person-centred way:

Case study summary: Fylde Coast Local Health Economy (extensive care service)

Workforce issues: Staff working in a different way as part of the wider MDT, incorporating health and wellbeing; recruitment to new roles prior to the new care model being operational.

Approach: Extensive care service to give proactive support for people aged 60 and over, who have two or more long-term conditions.

Population benefits: Patients have a greater sense of empowerment to manage their conditions and stay healthy; they avoid unnecessary hospital admissions or contact within primary care.

Individual experience: A team of health and care professionals working together to give support to individuals, to prevent unnecessary admission to hospital; the team introduced the patient activation measure as a tool to support patients to increase their knowledge, skill and confidence in managing their health and wellbeing.

Reduced cost: November 2016 data shows a 14% reduction in A&E attendances, 25% reduction in non-elective hospital admissions, 21% reduction in elective admissions and 6% reduction in outpatient activity; there has also been a reduction in unnecessary patient contacts with their GP, practice nurse or practice pharmacist.

Staff experience: Staff feel most effective when they work with colleagues with different skill sets to achieve the best outcome for the patient.

See Appendix 5, p47.

Many have chosen to use social prescribing[27], or voluntary sector care navigation and support, to create a missing ‘societal infrastructure’ maintaining or increasing the individual’s independence. For example, My Life a Full Life (Isle of Wight) has worked with Age UK to implement primary care navigators who assist people to lead independent and healthy lives by connecting with health, social care and voluntary sector organisations (see Appendix 9, p64). The nature of voluntary sector development varies in different communities[28]. The solution is to engage with, utilise

and develop those voluntary sector services as they can provide a valuable workforce resource to the wider health and social care agenda.

Integrated working contributes to patients feeling their needs as a person are understood and that they are supported to understand their choices and to set and achieve their goals. Utilising a personalisation of care approach supports workforce modelling in ensuring staff availability with the right skills and competencies. Population health modelling and personalisation of care are intrinsically linked – they are two sides of the same coin, one needing the other to succeed.

Below are 'top tips' for personalisation of care:

***Top tips*: Personalisation of care**

- **Focus on the person:** Design services around their needs and focus on services to *support health* and not just *manage illness*
- **Personalisation of care drives workforce redesign:** Design the workforce to meet people's needs, focus on the right people being in the right place
- **Carers and family are important:** They are part of the wider workforce

2.2 Leading change

The Point of Care Foundation report '*Staff care: How to engage staff in the NHS and why it matters' (2010)*[29] argues that caring about the people who work in healthcare is the key to developing a caring and compassionate health service. It puts the case that supporting staff should be a central driver in efforts to improve patient care, productivity and financial performance. The report, which reviewed evidence from a wide range of sources, highlights that patient satisfaction is consistently higher in trusts with better rates of staff health and wellbeing and that there is a link between higher staff satisfaction and lower rates of mortality and hospital-acquired infection.

> *"There is evidence that the way staff feel – about their jobs, their colleagues and the organisations they work in – has demonstrable impact on the quality of patient care and on efficiency and financial performance*."
>
> **The Point of Care Foundation (2014)**

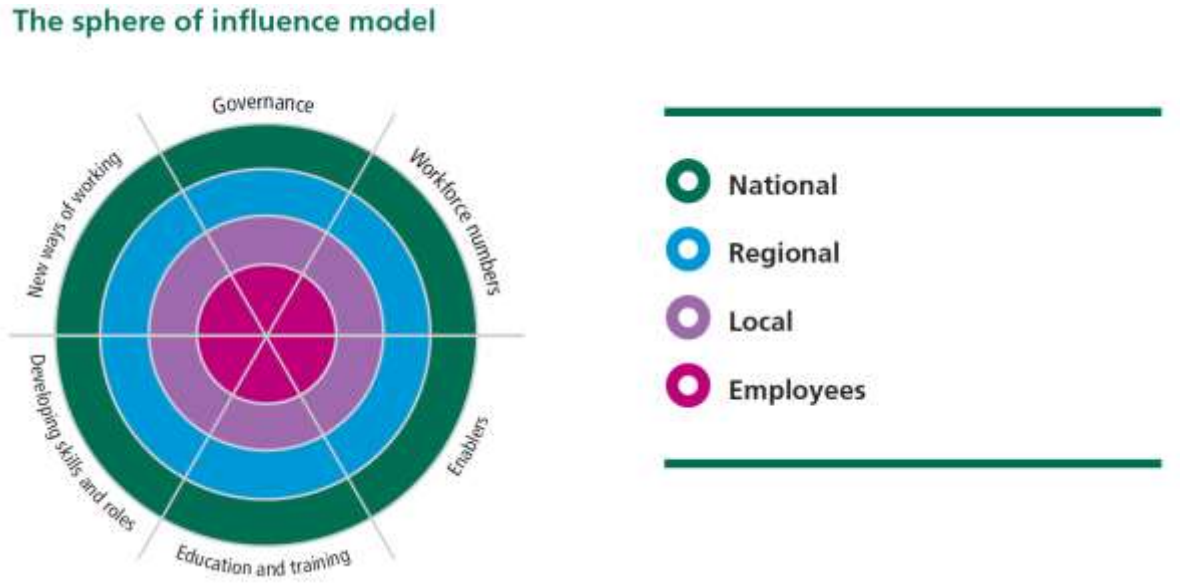
Leading staff, teams and organisations and being a leader as part of a system for health and wellbeing require compassion and a collaborative approach to making change happen.

2.2.1 Involve and engage

We defined integrated working as involving healthcare professionals, social care, the voluntary and independent sectors and carers supporting the care needs of groups of people who share common characteristics as well as the individuals within the group.

In order to successfully design and deliver services based around the health needs of the population, it is key that those people who are involved in care are involved in shaping its design, including the service user. Input from specific professions or people will be dependent on the local shared challenge and the issues to be addressed. Tools and frameworks can help. The London workforce strategic

framework[30] was published in March 2016 and it was used to establish a coherent voice around the most pressing workforce priorities in London. A workforce *spheres of influence* model was developed, which provides a consistent approach to determine the workforce implications of future models of care. All Together Better Sunderland utilised the *sphere of influence* model to support its discussions about its service and workforce redesign; it helped them to engage and involve a wide range of people in considering their workforce challenges:



Staff engagement is not simply *informing staff* about changes to care provision and any related workforce changes, more it is about *supporting* them to be involved in the design of future integrated care models as well as *supporting* staff through change.

> *"Sutton would agree that staff are the best asset of any organisation and as workers in the current process they are best placed to comment on what could be improved and can often come up with the best ideas to innovate and improve care."*
>
> **Sutton Homes of Care**

The NCM workforce redesign team involved Do OD (expert resource supporting organisational development for the NHS, delivered by NHS Employers in partnership with the NHS Leadership Academy) to explore how staff are being involved and engaged in developing new care models and the impact this may have on staff's sense of inclusion and well-being, as well as the impact on people's care[31]. It illustrates the experiences of workforce and OD practitioners in new care models, recognising there are pockets of great practise, that the work is complex and that organisations and regional footprints are ready for a more sophisticated model of staff engagement and involvement.

Barking and Dagenham, Havering and Redbridge (BHR) A&E delivery board put patient and staff engagement at the heart of what it wanted to achieve. It identified that there was confusion amongst patients over the appropriate service or location to use for their care (40 per cent of A&E attendances were not an emergency) whilst

staff were frustrated that they were unable to implement the changes they recognised would help. By bringing together both patient and staff voices they have been able to implement improvements (see Appendix 17, p88).

All Together Better Sunderland recognised the importance of staff involvement and experience when designing multi-disciplinary locality teams and established a consistent meaning of 'care coordination'. Their recent staff survey of their integrated teams illustrates the link between the joy and experience of providing care and the quality of the service provided:

- 80 per cent of the 216 respondents believed that they had seen a positive change in the way they work collaboratively with other colleagues
- 72 per cent agreed there was trust and openness across all team members
- 80 per cent agreed that they would recommend the service they provide to their family members.

Case study summary: All Together Better Sunderland

Workforce issues: Establishing locality teams; different meanings and understanding of the meaning of 'care coordination' within teams.

Approach: Planning an approach to multidisciplinary working that results in a model where staff feel supported and part of a long-term plan for organisational development.

Population benefits: Improved and more responsive patient support network.

Individual experience: More patients with care plans who appreciate the 'personal' touch.

Reduced cost: Reduction in unplanned admissions.

Staff experience: Positive impact on sense of learning and development; multidisciplinary meetings have helped to clarify, coordinate and speed up responses to patients' needs.

See Appendix 6, p53.

In Dudley Multispecialty Community Provider the focus was on improving organisational development rather than looking to restructure or change employers or hosting arrangements in order to develop a 'without walls' culture. A strong programme of staff engagement to introduce changes helped to break down barriers between professionals employed by different organisations who were working in the same team (see Appendix 7, p57).

Staff can feel more empowered as a result of proactive involvement and engagement,

"Staff engagement can help ensure the right issues are identified and the most realistic solution is progressed. Staff engagement is also a way of making change and change management less challenging by asking and involving staff rather than informing/telling."

Working Together Partnership (South Yorkshire, Mid Yorkshire, North Derbyshire)

which in turn can lead to a greater sense of job satisfaction; the link between staff experience and positive patient care suggests that increasing joy and meaning for staff can improve patient care[32].

Key 'top tips' from our report are below:

***Top tips*: Involve and engage**

- **Staff ownership:** Supporting their role in redesign enhances their versatility
- **Appreciate the impact:** Support staff to embrace change – understand concerns about impact on roles
- **Break down barriers:** Work across organisations and sectors by developing a 'without walls' culture – work on the task in hand and not within the parameters of a culture or organisation

2.2.2 Collaborative leadership

To successfully deliver population health-based services and outcomes, there is a need to develop a leadership culture that supports collaborative working. The right leadership creates the right environment to nurture and develop integrated teams focused on the delivery of patient-centred care[33].

> *"Great leadership has four facets: exhibiting empathy or being willing and able to see things from others' perspectives; building a common purpose, and developing teams and teamwork accordingly; encouraging 'followship' or empowering others to rise to opportunities and challenges and to share in the leadership; but above all, the best leaders in class show humility and courage. When all these facets coalesce, improvement will be secured and sustained."*
>
> **Mark Rogers, Chief Executive and STP Lead, Birmingham City Council and Birmingham & Solihull STP**

As care provision spans multiple organisations, leaders need to develop skills to work effectively and collaboratively across the whole system with key colleagues and partners. This means leaders thinking about their role within the broader system – connecting across health and social care, local authority and the voluntary sector and beyond[34].

> *"The Art of Change-Makers are not described in terms of charismatic heroes or divas, but as thoughtful, calm personalities who are as confident working in the background, supporting and enabling others, as they are in the limelight, leading from the front."*
>
> ***'Art of Change Leadership for exceptional times',* Virtual Staff College, 2013**

Vanguards that have most successfully implemented integrated workforce models talk about a 'without walls' approach to designing care and are able to collaborate across system networks to improve outcomes.

Dudley Multispecialty Community Provider has successfully introduced MDTs focusing on improving organisational development, as outlined in the case study summary below, where leadership for improved outcomes across the system is seen as 'the day job' not as an adjunct to it. Compassionate and inclusive leadership allows staff to feel engaged with and empowered by the change process, allowing them to explore ideas to make improvements.

Case study summary: Dudley Multispecialty Community Provider – Multidisciplinary team work

Workforce issues: People learning to work across organisational boundaries

Approach: Improving organisational development rather than looking to restructure or change employers or hosting arrangements; strong programme of staff engagement to introduce changes helped to break down barriers between professionals employed by different organisations who were working in the same team.

Population benefits: Reduction in primary care appointments, home visits and phone consultations.

Individual experience: Improved quality of care.

Reduced cost: Analysis of 50 patients showed saving of approximately £300,000 deriving from a reduction in GP appointments and patient reliance on health care.

Staff experience: Highly motivated through greater patient involvement.

See Appendix 7, p57.

Video: **Working differently to improve patient care and staff morale in Dudley**

The leadership and involvement of clinicians at all levels, and from all disciplines, in the design of new ways of delivering care is a success factor. For example, in the development of the extensivist model in Fylde Coast Local Health Economy, consultant geriatricians worked with GPs to establish an extensive care model to complement enhanced primary care services (see Appendix 5, p47). Clinicians were also closely involved in designing and implementing the care facilitator role and subsequent new ways of working in Gnosall, part of Rugeley Practices PCH. Gnosall Surgery introduced the care facilitator role to coordinate care in primary care to support older patients showing early signs of dementia:

Case study summary: Gnosall, Rugeley Practices PCH – Memory clinic and care facilitator

Workforce issues: Creation of a new care facilitator role, associated training and safe practice guidelines; GPs and primary care adopting new ways of working; working closely with consultant psychiatrist.

Approach: Care facilitator acts as a single point of contact for patients and carers whilst the GP is now the lead clinician; surgery-based psychiatrist reviews undertaken and therapy follows NICE guidelines.

Population benefits: More proactive and preventative care addressing both physical and mental health needs, delivered closer to home.

Individual experience: Improved patient experience and reduced patient concerns about attending a psychiatric clinic.

Reduced cost: Reduced reliance and spend on hospital services, delays in treatment minimised and almost 100% clinic attendance rates.

Staff experience: The holistic approach to patient care, providing the best possible support, has resulted in staff having an improved sense of job satisfaction.

See Appendix 8, p60.

Organisational integration appears to be neither necessary nor sufficient to deliver integrated care[35]. Clinical and service integration is much more likely to deliver the required change; such change requires effective leadership throughout co-design, co-production and commissioning phases. Leadership styles and behaviours have an impact on and drive team, organisation and system culture and can influence the effectiveness of any change programme.

The 'top tips' for collaborative leadership are detailed below:

***Top tips*: Collaborative leadership**

- **Everyone is a leader:** Encourage leadership at different levels and by different disciplines to build an effective model of care – value peer support
- **Vibrant clinical leadership:** Involve to design and deliver change – clinicians win hearts and minds of other clinicians
- **Collaborative leadership:** Shapes the culture of the team – team, organisation or system culture can drive change

2.3 Workforce redesign

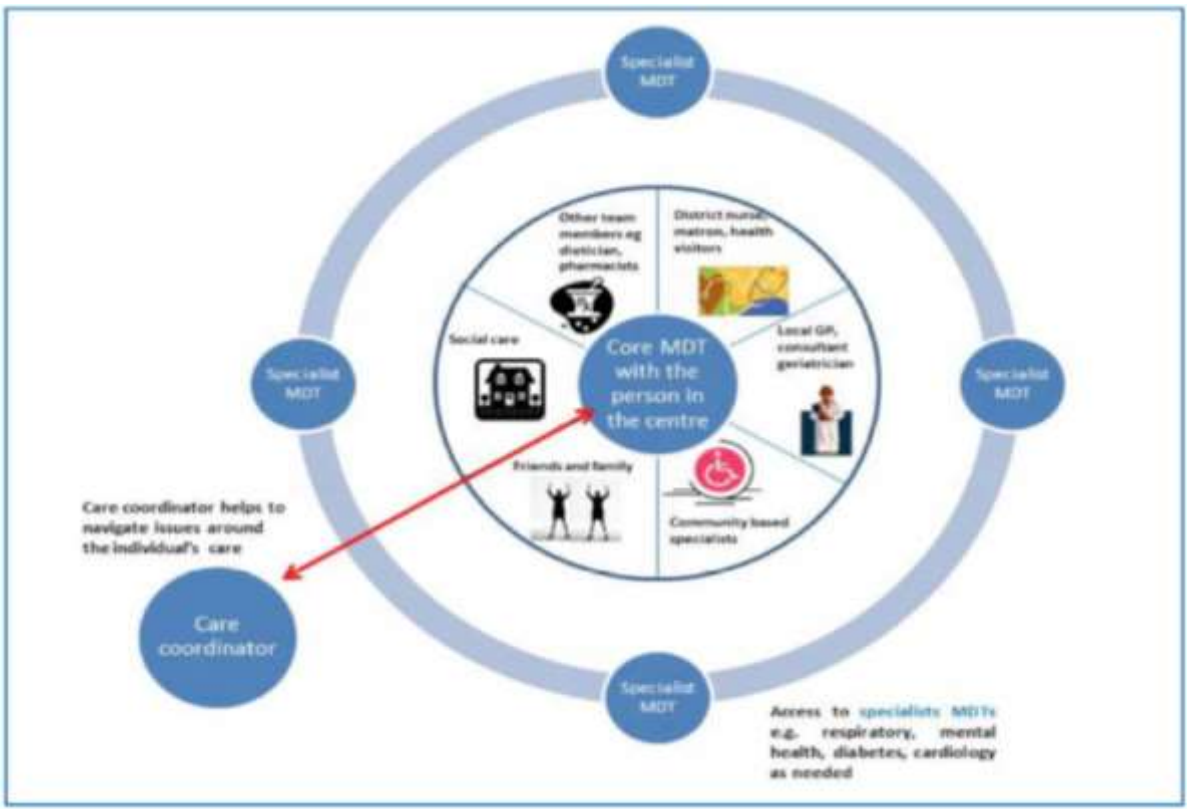
We found workforce redesign should be driven by an understanding of population health needs and the services to be provided to meet those needs. Making the best use of the existing workforce through approaches to team and role design, upskilling where needed, using retention strategies and maximising the student population will all support supply challenges. This was reinforced by The Health Foundation's '*Fit for purpose? Workforce policy in the English NHS'* (March 2016), which counsels a policy shift from organisational and financial incentives to working with the grain of the professional and personal motivation of staff to deliver faster, more sustainable change.

Technology can deliver services in a more seamless way – focused around the individual and making it easier for staff to work across organisations.

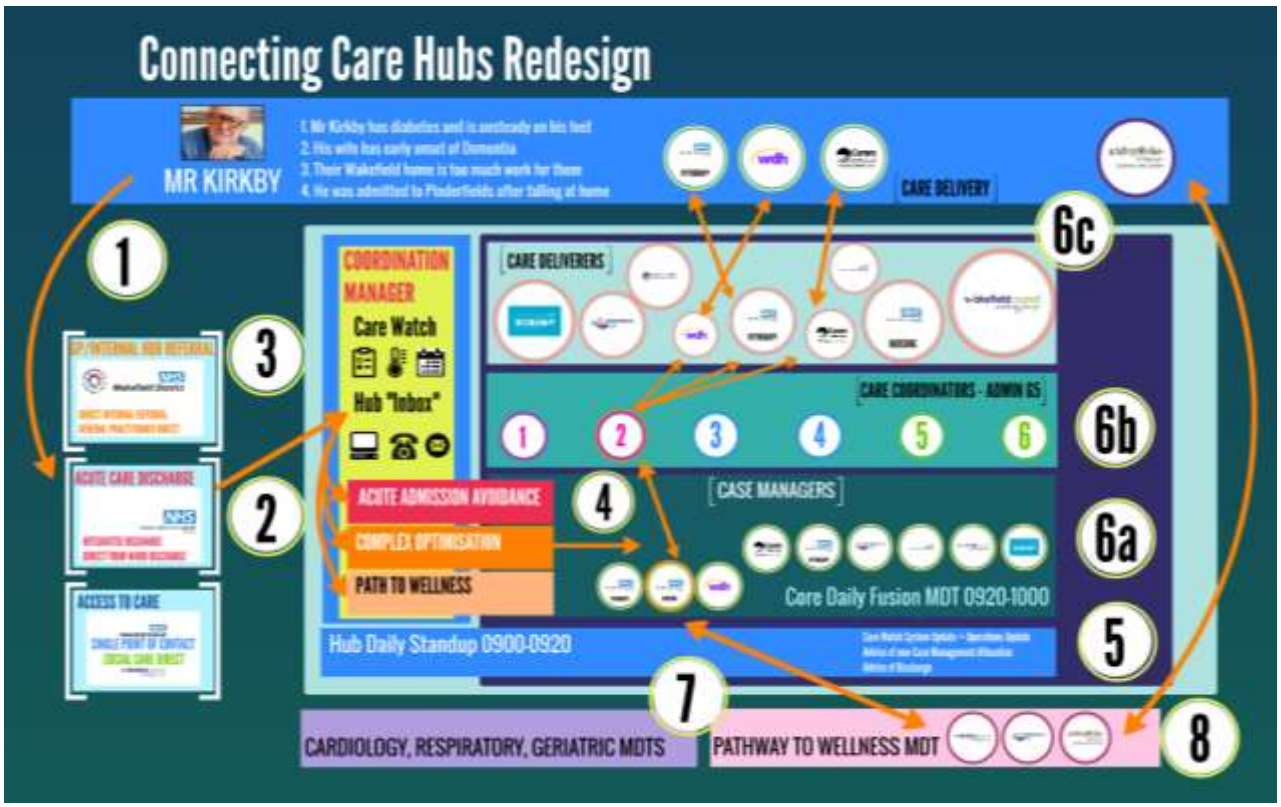
2.3.1 Design of team and design of roles

Population size and health needs will influence the size and shape of the team. A consensus on skills mix for new care models is yet to emerge. In the main we found most locality MDTs have representatives of primary, community, social care and mental health professionals – the inclusion of the voluntary sector, representatives of the private sector (such as a care homes association), public health and other agencies varies depending on both relationships and need.

Vanguards such as Dudley Multispecialty Community Provider and All Together Better Sunderland have developed guides to multi-disciplinary working to support the development of the team's culture[36, 37] to deliver agreed service improvements. These documents describe a core team, what it does and how it works and assumes that clusters of practices have an MDT which then decides care plans and allocates resources of wider integrated teams. Sunderland's guide supports the working arrangements and culture across their multi-disciplinary teams, helping people to understand each other's roles and how they link together to provide joined up, coordinated care which is patient focused. The structure of Dudley's integrated community MDT is shown below. It is a core component of each hub or locality within a MCP.



Similarly, in Wakefield, the vanguard has designed an operating model with standard operating procedures for integrated patient care at the Waterton Connecting Care hub. The eight-stage system-agreed 'fusion pathway' for the provision of integrated patient-centred care is shown below. This supports the delivery of a system-endorsed, intelligence-driven integrated care model for health and adult social care. It will help identify the skills and competencies required to deliver health and care.



Other areas have started (like Wellbeing Erewash) by defining the complex needs of a cohort of patients and the skills needed. They have modelled the 'proactive workforce' rather than a specific MDT structure. A core MDT would be the integrated leadership of that wider group. In Erewash's case, their frailty workforce model has led to very similar MDTs in both of their localities.

Another set of vanguards – North East Hampshire and Farnham, and Better Care Together (Morecambe Bay Health Community) being two examples – have enabled their individual localities to explore different models of MDT and indeed different scopes for integrated working before undertaking an informal SWOT (strengths, weaknesses, opportunities and threats) analysis across their different emerging models to define a more standardised model. These two vanguards are now actively working on standardisation.

In understanding how vanguards are adjusting to different settings of care, it became evident how critical geography and societal infrastructure are as drivers for workforce redesign. Rural geographies have to adapt to distance from health facilities; for example, the telemedicine links between the Millom integrated care community and University Hospitals of Morecambe Bay NHS Foundation Trust enable GPs to share information with consultants and avoid urgent and emergency care costs (see Appendix 13, p77). Inner-city communities provide patients with a choice of hospitals and other urgent care facilities. Both of these will impact on service provision and workforce redesign.

The geography of the Isle of Wight has been a key driver in partners engaging to identify solutions to service and therefore workforce challenges. Care navigation was seen as an opportunity to try a different way of working, utilising the voluntary sector to build capacity (see Appendix 9, p64). **'**Speed of trust'[38] partnership training was completed across the Isle of Wight to support the integrated working model. This cultural intervention is based on the philosophy that:

> *"Trust is like the air we breathe. When it's present, nobody notices, but when it's absent, everybody notices."*
>
> **My Life a Full Life (Isle of Wight)**

This training seeks to help people at all levels learn and apply behaviours that increase trust, and enables organisations to institutionalise trust as the key competence.

Case study summary: My Life a Full Life (Isle of Wight) (care navigator)

Workforce issues: Understanding the voluntary sector workforce capability and approach; improving team building by offering longer term employment prospects beyond annual contract review.

Approach: Building trust and relationships between voluntary sector and GPs to help them to understand and engage with the care navigator role.

Population benefits: Supporting independent living and self-management; providing community-based solutions.

Individual experience: Greater confidence and ability to self-care; feeling more supported at home and with finding services in their local community.

Reduced cost: Estimated cost saving of £553k (ROI 53%); easing pressure on primary and secondary care by avoiding admissions through crisis response and preventative approach.

Staff experience: GPs to see care navigators as the single 'go to' point of access to support patients with non-clinical needs; basing care navigators within Age UK means stronger connections with other voluntary sector support projects; care navigators have a network of support from colleagues supporting the same communities.

See Appendix 9, p64.

During our review, shortages in key workforce groups and the need to develop new staff and new roles were highlighted. While these approaches will support workforce redesign, the most effective way of transforming the workforce is to enhance the versatility of existing people by fully utilising existing skills. From our review, we found where there was most versatility, identifying 'skills and competencies' rather than 'roles' led to the most progress in developing integrated working. Retaining and, where necessary, upskilling the existing workforce is more cost-effective than recruiting from new. We found many vanguards had created job descriptions for roles such as care navigators to support upskilling approaches[39]. Understanding local student attrition and outturn utilisation rates and maximising retention of this education outturn are critical in helping to meet new supply and skill demands. Some vanguards have worked with local HEE colleagues on this approach.

The Nuffield Trust report '*Reshaping the workforce to deliver the care patients need*' (2016)[40] finds that equipping the existing non-medical workforce – NHS nursing, community and support staff – with additional skills is the best way to develop the capacity of the health service workforce. Upskilling and new ways of working are essential to transforming services. They should enable new approaches and allow people to access services in a joined-up way. The introduction of new roles requiring national recognition or accreditation takes time; identifying skills needed will help identify ways these can be met other than through the creation of new roles. Nottingham City CCG has established a multidisciplinary dementia outreach team to provide care home staff with skills to better support residents with dementia:

Case study: Nottingham City Clinical Commissioning Group – Dementia outreach team

Workforce issues: Development and provision of staff training to improve dementia patient support in care homes.

Approach: The dementia outreach team draws on expertise from a range of disciplines including mental health nurses, physiotherapists, occupational therapists and community support workers; the vanguard developed a programme of training provided by the multidisciplinary dementia outreach team to improve standards of dementia care in care homes.

Population benefits: The aim is for care home residents to have improved health and better quality of life and to be treated with dignity and respect.

Reduced cost: Inpatient mental health referral avoidance provides a better patient experience and avoids unnecessary costs.

Staff experience: Care home staff can access skilled, specialist advice on a case by case basis and receive training to build their confidence in caring for people with dementia. This helps to increase their knowledge and ensure patients receive care that is tailored to their needs.

See Appendix 10, p68.

The Kings Fund[41] '*Supporting integration through new roles and working across boundaries*' report (2016) focussed on roles facilitating coordination and the management of care, seeking a workforce to support boundary-spanning activity. Encompass (Whitstable, Faversham and Canterbury) has adopted an integrated case management approach to support some of the practical challenges of multi-disciplinary working. Coordination and routine communication with system partners are key.

Case study summary: Encompass (Whitstable, Faversham and Canterbury) – integrated case management trial

Workforce issues: Pressure across the system contributed to by a fragmented workforce working in isolation; capacity for regular attendance at multidisciplinary team meetings.

Approach: Trialling integrated case management by a multidisciplinary team for patients at risk of long-term conditions and hospital admission; aiming to introduce video conferencing to reduce travel times to team meetings.

Population benefits: Proactive care keeping patients healthy and living at home; model being rolled out wider to different patient groups.

Individual experience: Patients feel more in control of their health and wellbeing.

Reduced cost: Reduced chance of hospital admission.

Staff experience: Opportunities for staff training and development; more positive working relationships across organisational boundaries and commitment to spreading the model.

See Appendix 11, p70.

Relationships matter if the full creativity of integrated working is to be realised. We know from extensive research into effective teams how important the conditions (such as team purpose and autonomy) are for teams to be effective, and how factors such as diversity of the team and how conflict is handled will also determine how effective the team will be[42]. Six vanguards[43] have been working with the Dartmouth Institute[44] on developing models and tools which facilitate the design of effective teams in holding each other to account towards their goals.

Vanguards have focussed on the use of measures of teamwork at the frontlines and through the system to achieve integration and other aims. A key tool for measuring team work was the 'RATE' suite of tools, measuring at the frontlines how teams work together from the perspective of the patient and meet the needs of the patient.

A number of the place-based care networks were keen to adopt these tools, and Better Local Care (South Hampshire) has begun to implement this and is piloting it in local practices – this is contributing to a culture shift in approach from paternalism towards shared decision-making with patients. Other tools have enabled teams beyond the clinical lens to hold stakeholders within the wider system to be mutually accountable to each other.

The implementation of new care models, together with devolution and STPs, mean that different employment models are being considered to support staff working across organisational and professional boundaries, including staff being aligned, assigned, seconded, embedded or transferred to different organisational forms.

Discussions have shown that integrated working can broadly be achieved through two forms of employment models:

- **Actual integration:** Where an integrated team is established within a single employing organisation, or a new organisation is created for the purpose of delivering the integrated services.
- **Virtual integration:** Where staff remain employed in their current organisations, but work together in integrated teams.

In the main we found that in effective integrated teams, staff are able to work 'where needed' rather than be constrained by employment arrangements. Whilst it is recognised that this can bring certain challenges, some vanguards have adopted practical arrangements to support integrated working. For example, Northumberland Accountable Care Organisation allows pharmacists and pharmacy technicians to be based over multiple sites to support integrated primary and secondary care (see Appendix 15, p82).

Below are the 'top tips' for design of team and design of roles:

***Top tips*: Design of team and design of roles:**

- **Change your thinking:** Think '*skill and competency'* not '*role and rank'* – focus on what staff can do and not how many you have at what grade
- **Maximise current skills:** Share skills and encourage everyone to work at the top of their licence
- **Use everyone's contribution:** Public health, other agencies, community assets or informal care can all help achieve change

2.3.2 Education and training networks

Education and training enable the workforce to develop new skills and knowledge and support staff to work and learn together, providing the glue to hold the new workforce together in the day-to-day delivery of new care models. Vanguards have been considering how to develop education and training solutions and whilst individual approaches vary, an education network is proving to be an effective way of identifying and delivering education and training needs. Networks can operate at different levels but all provide systems and processes to support integrated teams to continue to share education and training, offering shared supervision and supporting work-based learning and portfolio development:

Education and training networks can take various forms and there are a range of models across the country. The starting point is often clinicians coming together to redesign patient care, based on the needs of patients, and aimed at delivering the highest quality of care for the local population. As networks are maturing, some common functions are beginning to emerge:

- **Workforce planning** – developing robust local planning data to inform decisions about how education and training funding should best be invested.
- **Education quality** – supporting improvements in the quality of education programmes delivered in primary and community care e.g. through peer review.
- **Faculty development** – developing local educational capacity and capability e.g. accommodating greater numbers of nursing placements or development of multi-professional educators in community settings.
- **Responding to local workforce needs –** collaborating to meet local workforce requirements, such as specific skills shortages and the development of new programmes to meet specific local needs.
- **Workforce development** – developing, commissioning and delivering continuing professional development for all staff groups.
- **Education programme coordination** – coordinating programmes locally to improve economy of scale, reduce administration costs and improve educational governance.

At the Royal Free in London, the Royal Free Academy brings together all areas of teaching and learning from across the organisation into a central learning platform. This will allow investment in centrally produced content and is aligned to the improvement faculty delivering the Royal Free Bohmer programme, which supports the embedding of improvement tools and techniques. The Bohmer programme is running its fourth cohort, which includes primary care staff.

In the West Midlands, as part of its recovery workstream, MERIT is rolling out a mental health first aid train the trainer programme which aims to help people identify the signs of mental illness earlier, so that support can be accessed.

While education networks will develop to suit the local system and population health need, some common design principles have emerged:

- **Purpose** – a clearly defined and shared sense of purpose. Developing measurable education and learning targets is more likely to lead to a viable network in the longer term.
- **Participants** – knowing who the members of the network are going to be. Although education networks are essentially 'open' in character, there is value in defining boundaries, particularly in terms of focus and coherence.
- **Structure** – can be a 'moderated' network with a coordinating hub, or a 'radial' network diffusing information from the centre, or a 'member-to-member' wheel model.
- **Roles** – identify the key roles, particularly those of coordinator and facilitator, as networking may not happen without some assistance.
- **Type of learning** – clarify the nature of learning or education likely to be involved. Learning may range from the simple acquisition of factual data, through adaptive learning (e.g. learning to do things a little better), to challenging assumptions and reframing problems at a higher level. Different types of learning have implications for the design and operation of the network.
- **Content of learning** – clarify what needs to be learned. Education content has implications for the mechanism used for delivery and diffusion.
- **Stages of learning** – how the different stages of the learning cycle could be addressed. What combination of experience-sharing, structured reflection, introduction of new concepts and shared experimentation will be used? How will these be mobilised in a programme of activities?

Community education provider networks (CEPNs) or training hubs bring together the workforce required to improve population health and therefore provide the structure for the whole integrated team to learn together. These education networks provide the opportunity for clinicians to share ideas, learning, skills and experience across professions and settings, giving them the full range of perspectives needed to effectively deliver integrated care to the local population.

The concept of an integrated learning and development organisation forms part of the Isle of Wight (A Centre of Excellence for Health and Social Care Development) vanguard values proposition and is central to the delivery of their new care model. Many of the primary care home (PCH) rapid test sites explicitly name education networks as part of their delivery models and include plans to reinvest any savings made though the model into education and training provision. For example, Beacon Medical PCH is an active member of its local CEPN and has made education and training a central feature of its service redesign.

It has developed a career pathway for nursing staff and has an in-house nurse trainer. Beacon is the largest GP trainer in the area and trains undergraduate medical students, nurses, PAs and paramedics. It is planning to start training pre-

registration pharmacists shortly. It has also started working with local pharmacies to integrate services and has funded a number of pharmacists to undertake prescribing while being supervised by GPs, which has led to improved working relationships. Since implementing these new systems staff survey results have improved, in particular with regard to access to training.

Rugeley Practices PCH is also an active member of its local CEPN and has used education and training opportunities created by the network to build a community-based geriatric care workforce. The urgent care practitioner role is an example of how Rugeley Practices PCH has done this. The PCH identified a gap and created a new role called the urgent care practitioner (UCP) including a skills matrix and career framework known as the 'UCP ladder'. The recruitment and training of the UCPs is run on a hub and spoke model with the local out of hours cooperative, ShropDoc, acting as the hub. ShropDoc has a training contract with local practices and places the learners with them. ShropDoc has a corporate indemnity policy which covers the learners while they are in practice and has trained a supervisor based in the hub as part of its governance requirements for the insurers. This model developed for the UCP role can now be used for any other learners being trained by the PCH. For the first time primary care providers are working with local universities and colleges to tell them what they want for their workforce.

Both of the PCHs and the Isle of Wight vanguard have started to think about or actually develop education and training infrastructures as part of their service models, and there is early evidence that it is having a positive effect on their service offer as well as on their staff morale and engagement.

Community education networks can deliver the aspirations for patient-centred care, in part because they are rooted in local knowledge and local communities, with the values of supporting improved population health. They can help make primary and community care an intellectually vibrant learning setting for GPs, general practice nurses, physicians, associates and community pharmacists alike.

Education networks can develop the support workforce to deliver more effective and efficient services to patients through the development of new roles such as primary care navigators and medical assistants.

Education networks as part of the new model of care can enable:

- Workforce planning and development specifically to support the new care models being designed
- Partnership working between all health and care providers
- Preparing the current and future workforce to fit the new models of care provision and
- Ultimately being accountable for the cost and quality of education and training

***Top tips*: Education and training networks**

- **Define the purpose and participants:** A clearly defined and shared sense of purpose with a focused and measurable learning target for a specified group of participants is likely to lead to a more viable, cohesive and coherent network.
- **Identify the structure and roles:** Dependent upon the type of learning involved, choose the right structure to enable effective sharing and coordination of learning and identify the key roles, particularly those of coordinator and facilitator. Networking as a process may not happen without some assistance.
- **Clarify the type and content of the learning**: Clarify the nature of the learning likely to be involved and how it will be diffused/shared. Consider how the different stages of the learning cycle will be addressed.

2.3.3 Technology

NCM sites have been exploring and embracing the opportunities technology can provide in provision of health and care services – linked communication and information sharing, timely access to the right clinician leading to more prompt diagnosis and decision making, delivering care closer to home and providing training to staff.

Technology can help drive and deliver improvements to the way services are provided[45]; data can support investment discussions and demonstrate ROI. Digital technologies can play an important role in enabling people to access information and services, strengthen their social networks and reduce isolation. The National Information Board's '*Personalised health and care 2020 – framework for action*' recognises staff will require training and support to adopt technology-enabled new ways of working to be able to maximise its benefits.

In Better Care Together (Morecambe Bay Health Community) vanguard the team has begun piloting linking a GP surgery with the emergency department in Furness General Hospital, 25 miles away. Emergency department staff can see the patient via a camera and monitor and, together with the GP, can make a decision on the best course of action for the patient without initially needing to travel (see Appendix 13, p77).

In Stockport Together, new advice and guidance (A&G) technology has been introduced, spearheaded by the CCG's primary care development team. It supports care closer to home by breaking down the barriers in communication between GPs and consultants. In the first six months of using the A&G technology, 1,029 calls were answered and of these 51 per cent of call outcomes were 'referral avoided'; 33 per cent were 'referral made'; nine per cent were 'diagnostics requested'; four per cent were 'admission avoided', and three per cent resulted in admission (see Appendix 16, p84).

It is important to help practitioners to understand the relevance of digital technologies to their role, providing access to the necessary technical support and advice. Senior leaders and decision-makers play an important role in creating the right environment and culture for embracing the benefits of using technology to support integrated

working. An appreciation that new digital platforms may require new ways of working and that these will require time to embed is also needed.

In Airedale & Partners, the same telehealth technology is being used to both connect colleagues to advice for the care of patients and to virtually train staff, increasing skills and confidence:

Case study summary: Airedale & Partners – Telehealth technology and virtual learning

Workforce issues: Ensuring care home staff were confident using new technology; introducing and embedding new ways of working at care homes; variable senior level 'buy-in' from all partners including budget sharing.

Approach: A video link and other monitoring equipment allow clinicians to connect with the care home instantly and give advice on patient care and treatment; staff have received virtual training on everything from falls prevention to pressure ulcer care, increasing their skillset and boosting their confidence.

Population benefits: Care closer to home; minimising unnecessary attendances.

Individual experience: 40 per cent of patients treated in their home, offering timely and convenient service.

Reduced cost: Estimated savings of £3m in 2016/17.

Staff experience: Care home staff more confident.

See Appendix 12, p74.

A system-wide digital strategy will help support integrated working focused around population need. Wirral Partners vanguard has implemented the Wirral care record (WCR), a new confidential single digital care record for a person, which contains information from multiple health and social care organisations. This cross organisational information sharing enables an integrated workforce to more effectively care for patients through improved decision making, communication and identification of those at risk.

Below are 'top tips' for using technology to improve care:

***Top tips*: Technology**

- **Secure clinician buy-in:** Engage clinicians to adopt and adapt to new technologies.
- **Provide support:** Provide support and guidance for introducing and using new technologies.

3. Conclusion

Understanding local population health needs and personalisation of care will shape the way patient needs are met and the workforce skills that are required. Having a single agreed vision of local population health needs assists workforce modelling and planning; understanding the impact on the wider system of MDTs is important, linking STPs explicitly with 'bottom up' workforce plans. Supportive decision-making to encourage integration requires closer collaboration on system governance.

Involving and engaging people and a collaborative, inclusive leadership approach are important. Technology can help systems to meet people's needs, removing barriers to seamless care. How technology is identified and introduced will influence its success as staff and patients need time to understand its benefits. There can be a positive impact on people's experience of care when staff feel valued and find joy in the work they undertake.

Innovation and sustainability are linked – developing a culture where people are free to design and implement change means that changes are more likely to become part of normal organisational practice. Sustainability should be an integral element of an organisation's culture. Where staff believe their input will make a difference and the organisation's culture is such that sustainability is important, they are more likely to think about how to ensure changes become embedded[46]. The 'cost' of a lack of sustainability of service improvements is not only represented in financial terms – people can become disillusioned, resulting in long-term implications for an organisation or system.

Building time into the change programme for staff to learn together is vital for success. Systems and processes which support integrated teams to continue to learn and share such learning in a constructive way are important. Close working between health, social care and the voluntary sector will help address workforce skills and training gaps to deliver integrated care.

It is too early in the development of new care models to analyse whether all whole system workforce models in rural areas are similar, or whether vanguards are choosing to use and support the voluntary sector and informal carers in similar ways. However, when seeking to understand the most effective out of hospital workforce models, geography and societal infrastructure are clearly emerging as two of the main drivers in workforce redesign. Further exploration of the impact of, and solutions to, these factors in 2017/18 would potentially increase the pace of integration.

Resources and references identified throughout this report can be found in *Section 4: Appendices, Section 5: Resources* and *Section 6: References*.

Please email sharon.dixon21@nhs.net if you require further information.

4. Appendices

Appendix 1: Integrated workforce models working group

Membership: Representatives from the following organisations:

- New care models programme
- All Together Better Sunderland vanguard
- Health Education England
- Public Health England
- NHS England
- Local Government Association
- Skills for Care
- Department of Health

The purpose of the working group was to shape and deliver the NCM workforce redesign integrated workforce models work programme.

The working group was accountable for demonstrating that the integrated workforce models based on defined populations support the effective delivery of the Quadruple Aim.

The working group advised on the design and development of the programme and agreed actions for effective and timely delivery. It ensured the engagement of key partners to support delivery and supported the identification of vanguard and non-vanguard sites to work with alongside identifying and utilising available resources. The group represented the programme at a national level and used member networks and contacts to spread learning and engage with individuals and organisations.

Appendix 2: Case Study – Nottingham and Nottinghamshire STP workforce modelling project

The workforce modelling project covers the Nottingham and Nottinghamshire STP Footprint and the following vanguards:

1. Principia Partners in Health (Southern Nottinghamshire)
2. Greater Nottingham Accountable Care System development
3. Mid Nottinghamshire Better Together
4. Nottingham City Clinical Commissioning Group enhanced health in care homes vanguard and primary care home pilot

- Population served: 1 million

Background

Nottinghamshire is unique in having a number of vanguards that, together with the partnership working of the two acute service providers in the patch, provide the opportunity to pilot new ways of working and collaboration.

The Nottinghamshire Sustainability and Transformation Partnership (STP) identifies the need to make some quite fundamental changes to be able to deliver care in a more joined up way, working across organisational boundaries and thinking less in terms of where care is delivered and more on how it is delivered. The success of this depends on having the right people with the right capacity and capability to deliver transformation.

The aim is to deliver an integrated strategy for the whole workforce to support the delivery of the Nottinghamshire STP, working through the new local workforce action board to build networks to lead workforce change. The strategy will take account of the development needs of the whole workforce including enhancing the skills of patients, families, carers and communities for self-care and prevention, of volunteers and the third sector, and of staff employed by organisations commissioned to deliver health and care services in the private and public sector.

To inform the strategy the group is piloting and developing a population/place-based approach to workforce re-design using a system dynamics modelling tool with supporting tools as required, working in partnership with Health Education England (HEE). This is enabling them to explore and test a range of options for feasibility and affordability to maximise the opportunity for successful resolution of the workforce challenges and planning to deliver optimum skill mix.

The group is piloting the use of systems dynamics to model the skills and competencies required for the current model of urgent and proactive care and the future desired model as described in the STP vision. They are also applying a similar model to other areas of the system including general practice with a project initially in mid-Notts but with further rollout planned across the STP footprint.

The current workforce baseline in health and social care has been collated and the group is working to improve the quality of data available on the general practice workforce and the voluntary sector.

The modelling approach connects population health needs, service transformation and strategic workforce planning to assess future workforce requirements and the potential routes to achieving this together with the ability to cost current and future workforce models.

Using a modelling approach enables the project to take an 'organisationally agnostic' view of the numbers, skills and behaviours that will be required across the whole system to deliver new models of care and to test the impact of a range of options over different delivery timescales.

The challenges

The initial phase of the work sought to summarise the 'whole Notts' workforce by working with HEE to access Electronic Staff Record (ESR) data, alongside other sources of workforce intelligence, in order to identify the current workforce. This work also applied high level assumptions derived from the local STP returns to arrive at a high level 'workforce futures' picture.

Bringing together this data from across the STP partners proved challenging as some organisations had to provide data manually. The project team also had to provide assurances of how the data would be utilised and interpreted. This was overcome with support from the HR collaborative and workforce transformation delivery group, who also tested the initial assumptions.

For the general practice modelling consent has been sought from practices to extract data from clinical systems and the project team is in the process of developing clinical leadership to help support this as they further roll out the model.

Impact on staff and patients

The modelling tools being used keep population need at the centre; the approach considers the functions and skills required to meet the current and future needs of a population cohort e.g. those who require proactive care. For patients, this is about providing the right care in the right place at the right time.

For staff – the model does not focus on job titles but recognises skills and expertise. The outputs are not prescriptive, but a number of routes to delivering the future workforce are identified – e.g. upskilling and developing staff to undertake working differently and taking on different roles which may be currently outside of their roles – based on local workforce demographics.

Reducing healthcare spend

It is important to understand the current capacity in primary care. Workforce headcount is an element of this but it is not the full picture. By using modelling tools the project team will understand the current capacity in primary care and the future demand, which is driven by population changes and also service transformation. The purpose of this project is to review modelling solutions and make recommendations for a solution to be adopted across the system and then deploy the solution across

the whole county. This will enable scenario-based workforce planning in general practice to test out workforce solutions that are achievable in the different localities.

Mid-Nottinghamshire is leading on a general practice workforce modelling pilot. Phase one is complete and the baseline position has been presented. This demonstrates a level of unused capacity, unmet demand and clinical variation and offers the opportunity to shape a range of solutions to better match capacity to demand. Phase two of the project will model various scenarios, and solutions that will be presented to practices via locality meetings, protected learning time (PLT) and practice manager forums to identify practices willing to pilot new roles and new ways of working.

Learning and advice

The project team recognised early that the system needed to have a robust plan for workforce to ensure a supply of staff with the right skills, capacity and confidence to deliver the new models of care. The team mobilised the workforce modelling early to support the baseline submission for the STP.

Early launch of the project has meant that the second phase – 'scenario modelling' – has been paused whilst the system describes care delivery.

Workforce and organisational development is an enabling theme of the STP. The team has been quick to respond to the ambitions described in the STP with the development of a supporting governance structure, made up of existing, new and repurposed groups of key stakeholders.

Having the support of the stakeholders has driven the modelling work and help the system understand the importance of this work.

Appendix 3: Case study – Thanet Health CIC (primary care home)

One of 15 national rapid test sites for the primary care home

Margate Task Force (MTF) – Delivering effective integrated services

- Focused on two deprived council wards in Margate, Kent

Workforce issues

- Significant pressures across frontline services working with a complex, transient and challenging demographic
- A fragmented workforce working in isolation across statutory and voluntary/community sectors – serving a population cohort requiring integrated multi-disciplinary support
- Potential for waste and duplication in service provision
- Learning and development needs

Approach

- Bring together staff from 16 different agencies into a single 'street-level' team to address complex socio-economic issues such as child protection, exploitation, safeguarding, gangs, crime, welfare dependency, health inequalities and poor outcomes, substance misuse and quality of life
- Improve information-sharing and collaboration between agencies to identify those most at risk
- Pool and target resources to focus on individuals and communities with the greatest need for support
- Develop and enhance the skills and knowledge of front-line staff
- Develop and increase the capacity and capability of local communities to address their own challenges

Challenges

- Bridging historical divides between local health practitioners and providers – in particular mental health – and other agencies working with deprived communities
- Data and information sharing barriers
- Reduced budgets and resources

Healthier communities

- Addressing entrenched socio-economic problems that could not be tackled by single agencies working in isolation
- Preventative and proactive interventions to keep individuals and communities healthy and living at home
- Empowering communities to tackle their own issues

Happier patients

- Local people with complex needs receive an integrated and effective response from a range of appropriate professionals

Reduced healthcare spend

- Earlier interventions to mitigate the higher costs of health crises, hospital admission and long-term illness – particularly with mental health need
- Reduced waste and duplication across agencies

Motivated workforce

- Opportunities for staff training and development
- More positive working relationships across organisational boundaries

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Background

Thanet is one of 15 national primary care home rapid test sites – aimed at bringing together the full range of NHS and social care services into defined localities of around 50,000 people.

Through its developing integrated accountable care organisation, NHS Thanet CCG is working with partners to develop four primary care homes – in Margate, Ramsgate, Broadstairs and Quex. They are focussed on providing care for local people through a single integrated team made up of GPs, pharmacists, nurses, social care professionals, hospital clinicians and the community and voluntary sector.

By working together in this way, there is an increased focus on preventing illness, supporting people to stay healthy and keeping people out of hospital wherever possible – while making best use of resources and staff. People in Thanet will receive joined-up care that puts their needs at the centre – minimising delays, gaps and overlaps in care and improving communication between all parties.

The Thanet primary care home is regarded as a leading example – winning 'provider of the year' at the National Association of Primary Care awards in 2016.

The place

Margate is a coastal town in Thanet, Kent, and contains two of the most deprived wards in the South East of England. Two particular wards, Margate Central and Cliftonville West, experience a highly transient and diverse population with an annual residential turnover of close to 30 per cent. As a result, people living in these areas can face multiple layers of risk, vulnerability and disadvantage including unemployment and poor-quality accommodation.

Emergency departments at local hospitals have high admission rates, with the majority of ambulance responses caused by assault and overdoses. There are significant health inequalities, with men dying 15 years younger than the average for the general population.

The approach

The Margate Task Force (MTF) is a keystone in the primary care home response to tackling health inequality. It involves an effective partnership and integration with health and other statutory and voluntary organisations working with vulnerable communities. It acknowledges that good health and wellbeing cannot be achieved by NHS organisations alone, and that other factors including deprivation, crime, lifestyles, housing, education and employment play a crucial role.

The task force was created in 2010 to better share information and collaborate to deliver more effective and timely responses for the community and address serious challenges such as child protection, exploitation, safeguarding, gangs, crime, welfare dependency, health inequality and poor outcomes and substance misuse.

The team comprises 40 members of staff from 16 different agencies including health, criminal justice, social services, education, housing, environmental health, trading standards and the community and voluntary organisations. Co-located at Thanet district council, the task force identifies the most complex social issues and delivers joint 'street level' services and interventions to better respond to the needs of communities. The partnership ensures more integrated services and enables the deployment of joint resources in a cost-efficient and effective way.

Together, these agencies allocate resources to tackle health inequalities, reduce the number of vulnerable people who are at risk, provide greater access to education, work and skills and improve the physical environment of Margate. This is not achieved through a pooled budget; instead each agency allocates people, either on a full-time or part-time basis.

A key driver behind the success of the scheme is the ability of each agency to share and tap into relevant data sources so that they can identify the needs of the local population. Geo-mapping has enabled them to identify geographical hot spots which frequently require the attention of public services.

The challenges

Key challenges related to the support provided by the task force included:

- Bridging historical gaps between task force agencies
- Ensuring geographical risk factors, such as known locations of vulnerable people, gang activity and drug or alcohol provision, are taken into account by agencies placing young people and ex-offenders into the area
- Reducing the levels of missing young people, including those who are missing from the area as well as those who are found in the area from a home outside of Margate or Kent and who are often linked to urban gangs and county lines drug activity
- Quantifying the impact of the task force model (early intervention, streamlined referrals, joint working etc.) on wider public sector budgets

Impact on staff and communities

The task force has delivered a range of street level services and interventions focussed on prevention and early intervention, targeting pooled resources where they are needed most.

It runs street weeks, during which staff conduct a survey to collect information about residents and their concerns. During the street weeks, the task force is able to act on residents' short-term goals and can refer to other agencies for more complex, long-term needs. This work has helped to identify a number of people with mental health problems who were not receiving any support.

Crucially, the task force is working alongside local residents to build capacity and capability of the community to address its own challenges. Resident-led partnerships encourage residents to take responsibility for their own environment. There is also a neighbourhood responsibility panel, which includes all agencies on the task force as well as people from the local community.

Of particular note are the family support panels, which involve skilled staff from across multiple agencies meeting in a group with the parents and siblings of a gang affected/exploited young person. With the permission of participants, the support panel session is recorded and lasts about 50 minutes using a basic cognitive-behavioural approach that explores emotions and causal factors. Participants have often referred to it as the 'power of the semi-circle', as it has proved highly cathartic and beneficial to all involved.

A housing intervention project focuses on updating existing properties and a selective licensing scheme allows the team to regulate the private rental sector. This means they can provide good quality and sustainable housing, which helps residents' mental health and wellbeing.

The task force has been responsible for a reduction in multiple referrals to different services for the same person, preventing duplication and waste. It has strengthened the relationship between residents and agencies through case findings and a joint problem-solving approach, reduced the impact of crime and victimisation in the area, improved housing and brought about regeneration of the area.

- The task force model was identified as an example of overcoming "historical divides between organisations", resulting in better services for the individual. (HM Treasury and Department for Communities and Local Government, '*Total place: a whole area approach to public services*', March 2010)
- The team won the prestigious partnership and innovation award at the Kent community safety awards 2013, and the collaboration award at the inaugural national Fighting Fraud awards held in London in December 2012.

Learning and advice

Training and education for front-line staff has emerged as a key role for the team. For example, 'gangs – need to know' sessions have been delivered across the patch to raise awareness of issues, improve safeguarding and make joint assessments more effective. This has strengthened integrated responses to young people affected by gangs and means opportunities to intervene with support are acted on earlier.

What do the professionals say?

Dr Tony Martin, Chair of NHS Thanet CCG: *"The primary care home is about delivering health services in local communities, based on the needs of local people and provided in partnership. As part of this, the Margate task force is a particularly*

successful model that proves effective place-based integration can be achieved, and deliver positive outcomes."

Inspector Mark Pearson, Kent Police: *"These transformative approaches have generated positive outcomes; offering better, more timely joint responses to the complex needs of our most vulnerable young people and their families. This integrated focus on key areas of safeguarding threat, risk and harm, supported by enhanced information sharing, has the potential to offer more sustainable positive outcomes for young people treading the path towards entrenched reoffending and increased levels of violence, trauma and substance misuse."*

Servicer user case study

Alex was previously in care but is now living with his mother in Margate. His mother is an alcoholic with drug issues and he has younger siblings who are in care. Alex has a history of petty crime and cannabis dealing, and is currently out of work. On the health front, he has a history of long-term poor diet, poor sleeping habits and asthma. He smokes cigarettes and is a cannabis user. When he came to notice at Margate task force, Alex's family was already known to many support agencies, but there was limited activity currently and Alex was very reluctant to engage. Following initial discussions, the team looked into opportunities for training and support for him. A key part of this was the 1:1 support from officers in the team.

During this time Alex became a father for the first time. His partner was herself known to local services. At birth, the baby was placed under a child protection order; a life-changing experience for any parent and a tipping point for some. The story could have gone a number of ways at this point.

Due to his work with the task force, Alex has developed trust in three key professionals, possibly for the first time in his life. These professionals have become role models. They have led him to engage with services and his family has moved from the child protection order, to 'child in need' and now, four months later, onto 'team around the family' support. This is a significant step for them all. Alex is looking for work and developing his skills so that he can provide for his family. He has also self-referred for a mental health assessment. This is only the start of the process but is a good example of how lives can be changed through perseverance and through support from the right people.

Appendix 4: Case study – Wakefield Connecting Care (multispecialty community provider and enhanced health in care homes)

Workforce issues

- Historical silo working and lack of integration – meaning challenges in provision of joined up care
- Pressure on acute and primary care due to lack of joined-up community services
- Shortage of GPs and other healthcare professionals
- Fragmentation between health, social care and the independent residential care sector.

Approach

- An integrated 'single team' workforce developed, spanning health, social care and community and voluntary sectors, working out of three central connecting care hubs
- Dedicated community MDT for care homes established
- Led and modelled by a senior-level provider alliance working across all organisations.

Challenges

- Governance obstacles, regulatory frameworks, insurance, risk etc.
- Access to data

Healthier communities

- Keeping people well, independent and in their own home or residential care and avoiding hospital admissions
- Providing a better range of integrated high-quality services in local communities

Happier patients

- Patients feel more in control of their health and wellbeing

Reduced healthcare spend

- Fewer hospital admissions, less demand for ambulances, reduction in hospital bed days
- Care provided earlier in the pathway and by the most appropriate professional

Motivated workforce

- Investment in training and development
- Staff feel empowered and that they are making a positive contribution to health and wellbeing

Background

In 2015, Wakefield was chosen as the only district nationally to take forward two vanguard programmes to join up health and social care and develop new models of delivery across the area.

The Enhanced Health in Care Homes Vanguard – Connecting Care – is improving the health and experience of people living in care homes. The 27 care homes and six supported living facilities currently involved are being linked to a dedicated GP practice which works with multidisciplinary teams including community nurses, therapists, voluntary carers and other professionals to provide a flexible, efficient and responsive service that reacts to the needs of residents.

The Wakefield MCP vanguard initially operated in the west of the district between 2015 and March 2017 as a collaboration of 18 practices, covering around 160,000 patients. The vanguard has focused on providing a larger, more diverse primary care team that delivers services 'on the ground', and has so far introduced specialist care into GP practices, including physiotherapists, pharmacists and specialist clinics.

The approach

The connecting care team is helping avoid ill health among residents by taking action before people become unwell – reducing the need for reactive care and unplanned hospital admissions. They do this by proactively monitoring residents to make sure care for potential health problems is offered as early as possible and by building the skills and confidence of care home staff through training and education.

GPs, health professionals and specialist voluntary workers are involved in making sure residents have their health and social care needs met and are helped to make use of activities in their local community. Within connecting care is a multi-disciplinary team made up of healthcare professionals from different specialisms. They meet weekly to agree and plan the care that will be offered to residents.

One of Wakefield's aims is to improve the way people access services and support through an enhanced 'care navigation' system. It is helping to direct people more efficiently, to get the right care at the right time, and has made it easier and quicker for patients to get the help they need.

A key milestone has been the integration of health and social care 'hubs' covering the whole district. Created in 2014, the hubs offer a wider health and social care service and focus on crisis intervention, to prevent avoidable hospital admission and support services to enable people to be discharged from hospital earlier. This model is designed to support citizens to achieve better health outcomes, closer to home, and at the same time generate the capacity required to enable acute hospital reconfiguration to be delivered.

As well as co-locating therapists, community matrons and social workers, they have established new roles for the voluntary and community sector organisations who are working directly in the hubs, with new health roles such as community-based pharmacists working as integral members of the team.

Developing the workforce

Effectively bringing together multiple professionals across the health and care spectrum has been crucial to the success of both Wakefield vanguards.

To achieve this, the partners developed an integrated health and social care workforce transformation framework that seeks to:

- Design and develop new models of care, clinical leadership and ways of working that span organisational and service boundaries
- Move towards a competency-based approach to training, recruitment and roles
- Break down historical organisational obstacles and silo working
- Model an environment which promotes collaborative, less authoritarian system leadership.

A provider alliance (PA) was formed, bringing together CEOs and senior leaders of all organisations in the district that play a part in health and wellbeing including NHS bodies, local authorities, fire and rescue, housing and the community and voluntary sector.

Importantly, each CEO has taken on a system leadership role – many in areas they may not consider themselves to be experts. By stepping out of their comfort zone they are modelling this behaviour for frontline staff who may also be required to work in a different way – e.g. community matrons doing a basic occupational therapy assessment.

The PA comprises two groups:

1. Workforce steering group – providing governance and workforce-related system leadership thinking to support clinical redesign.
2. Reference group – HR and OD professionals and key partners. This group has devised and oversees a workforce framework and delivery plan.

The challenges

While there has been clear energy, vision and will for change, the vanguards had to overcome challenges in respect of governance, regulatory frameworks, insurance and risk.

Effective leadership has been an important enabler. The approach has been to trust and empower staff to make their own decisions based on what's best for patients and service users. Direct lines of communication were opened up – enabling frontline staff to talk directly to CEOs and senior leaders as they adapt to new ways of working.

Being part of a place-based care network through the Dartmouth Institute has helped – including supporting an approach to shared decision-making with patients. It provided practical tools such as the value compass, which helps people to determine what's important to them.

Impact on staff and patients

- More than 2,400 hours of GP time have been saved at local GP practices in West Wakefield thanks to pharmacists being introduced into general practice. Over 7,300 medication reviews/repeat prescriptions have been reviewed and just 4.7 per cent of over 19,500 interventions so far have needed to be referred back to a GP.

- GP practices have successfully tried and tested a new care navigation model of care that, since April 2016, has helped to signpost more than 9,500 patients to other health, care and community professionals, aside from the GP, to receive the right care more quickly. It has also saved over 1,145 hours of GP time that has gone back into caring for more patients with complex, long-term conditions.
- A new physiotherapy triage service within GP practices in West Wakefield has saved over 178 GP hours. PhysioFirst is a new model of care where patients can choose to see a physio for an initial assessment rather than wait to see a GP. Since April 2016, local practices have offered over 2,200 assessments. As a result, 82 per cent of patients have been given advice on self-care, 29 per cent have been referred onto community physio and just seven per cent needed to be referred on to see their GP.
- Care homes within the vanguard have reduced their ambulance call out by six per cent compared to a nine per cent increase in call outs to care homes that are not in vanguards. There have been significant reductions in relation to A&E attendance and admission, and a 26 per cent reduction in bed days. This means more people are getting the right care in the right place at the right time.
- There has been a change in staff behaviours and morale – professionals feel more valued and empowered and that their contribution is having a positive impact on people's health.

Learning and advice

The vanguards have benefitted from a permissive leadership culture that encourages change and innovation and supports colleagues to trial new ways of working. This has helped develop a culture where professionals feel safe and able to have the 'big conversations' about change.

Having a director of the provider alliance who is completely impartial – not attached or associated to any particular organisation – proved helpful. It helps people and organisations to start thinking about whole-system ways of working and overcome perceptions of organisational loyalty. There is also an impartial programme coordinator overseeing delivery of the workforce programme.

Meaningful patient engagement and co-design has been essential to help ensure services are right for local citizens. Use of the voluntary sector and focus groups has proved effective.

Appendix 5: Case study – Fylde Coast Local Health Economy (multispecialty community provider)

Introducing an extensive care service to support older people with long-term conditions

Population served: 320,000, living across a mix of coastal towns and rural villages

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Background

Health and care organisations on the Fylde Coast are working together to implement new models of care within their local system. This work began as early as 2013/14 when partners started to look at new ways of organising and delivering care, including evidence from successful international models. Following this, Fylde Coast developed its own new models of care tailored to meet the needs of its local population and also ensure the sustainability of services going forward.

In developing these new care models, the Fylde Coast team looked in depth at the current usage of local services. Using all the data available to them from the local hospital, GP practices and other services they were able to see exactly which types of patients were using which services and, most importantly, which patients could benefit from better support to help them stay well. To put this into context, the work showed that on the Fylde Coast around 55 per cent of the local healthcare budget was being spent on supporting and treating just three per cent of the local population. This three per cent of the population was mainly elderly patients with multiple conditions.

With this in mind, plus other factors such as a growing elderly population (by 2020 the number of over 70s living on the Fylde Coast is expected to rise by 28 per cent) and an increasing number of people living with long-term conditions, they knew that they needed to think and act differently.

The extensive care service aims to greatly improve care for people who need it the most by providing one comprehensive service for all of their needs in order to reduce their risk of hospitalisation. This means all the doctors, nurses, care coordinators and other professionals supporting an individual are in the same place, working together, to provide the right care to keep them well for longer in the community.

Complementing the extensive care service are locally based neighbourhood care teams who work alongside local GPs and existing community services within ten natural geographic areas on the Fylde Coast to deliver an enhanced primary care model. They offer clinical and social support for people who have been identified by their GP as needing some extra help to stay well and to avoid their health from deteriorating. This could be because they have a long-term condition or because of other factors such as their carer not coping well.

The approach

The extensive care service was introduced to give proactive support for people aged 60 and over, who have two or more long-term conditions. Patients benefit from a team of health and care professionals working together to give the support they need to keep them out of hospital. This includes helping people to understand and

manage their health conditions but also includes other aspects of their life which might impact upon their general wellbeing.

Patients remain registered with their GP but their care is managed and delivered by the extensive care team. The aim is to stabilise patients' conditions and lifestyle to a point that they no longer need the input of the service and are then discharged back to the care of their GP with the knowledge, skills and confidence gained during their time with the service.

The team consists of senior medics with a consultant physician or GP background working as 'extensivists'. They are supported by advanced practitioners, pharmacists, clinical care coordinators, pharmacy technicians, wellbeing support workers, primary care assistants, admin staff and managers. The team works in a person centred, joined up way to support patients through a holistic approach to care, which focuses on health and wellbeing.

The clinical care coordinator role is a generic role which is undertaken by nursing and allied professional staff. They use their traditional professional skill set alongside newly developed skills to provide holistic care coordination to patients. The staff work collectively together as part of the team. Group clinical supervision was set up where staff with a therapy background and staff with a nursing background can support one another to learn new skills and knowledge. Group clinical supervision is also provided for the wellbeing support worker role, which allows them space to share knowledge of local services, develop their skills in supporting behaviour change and increase their confidence in working with complex patients within an MDT environment.

The team introduced the patient activation measure as a tool to support patients to increase their knowledge, skill and confidence in managing their health and wellbeing. Using this tool helps every member of the team tailor their approach to patient care and support communication within the team by allowing people to think differently about how they can work together for the benefit of the patient. Rather than: "You do your bit, and I'll do my bit", the conversation becomes: "How are we going to help this patient feel more confident?".

The challenges

Getting staff to work in a different way as part of a wider multidisciplinary team to integrate health and wellbeing elements for patients has been challenging. It is a different approach for healthcare professionals who traditionally focus on only the health element of a patient's life.

Recruitment to a new model of care with new job roles continues to present difficulties for the Fylde Coast team. Part of this relates to national issues around recruitment and retention, and part relates to the lack of information that could be provided to prospective candidates about the roles and services. The service was not operational when recruitment began and so some people were unsure of what they were applying for. This lack of knowledge has been resolved over time as Fylde Coast now has experience and learning from a service which has been running for nearly two years.

The higher grade professional roles – medics, advanced practitioners and pharmacists – have been more difficult to recruit to and there is an acceptance that this is an issue across the Fylde Coast. The team is looking at how it can develop

existing staff to undertake these roles in the future. It is also considering what other roles could be introduced to support the delivery of the service going forward. These include nurse and therapy consultants, nurse practitioners and physician associates.

The concept of an extensive care service has been difficult for some people to understand as it is a hybrid between primary care and acute/community services. This has led to recruitment problems and being able to tap into a workforce that can work across all these areas.

Training and development for wellbeing support workers has been another challenging area as there is no nationally recognised qualification for them to complete. Internally, all these staff have had a four to eight week induction programme. This started with classroom-based learning and continued to working in the service and shadowing other staff. Wellbeing support worker skills can be taught in a classroom to a good level, but only mastered in practice. There is need for reflection and MDT discussion to support their ongoing development, including group clinical supervision, capturing patient stories and using the patient activation measure in caseload review meetings.

Impact on staff and patients

Staff have said they feel most effective and excited by what they do when they work together with colleagues who have a different skill set to achieve the best outcome for the patient.

They also found joint working helpful as they better understand the needs of the patient and are able to support them in more realistic settings. Clinical care coordinators and wellbeing support workers are able to plan their visit and approach together before seeing the patient.

For patients there is a greater sense of feeling empowered to better manage their conditions and stay healthy. Their experience is better as a result of coordinated, streamlined care through a single point of access and agreed shared electronic care records.

Reducing healthcare spend

The service is helping to relieve pressure on the health system through better coordination and fewer unnecessary hospital admissions. Results of an audit show that the number of contacts patients have with their GP, practice nurse or practice pharmacist via face-to-face appointments, telephone appointment and home visits has reduced significantly.

Data from November 2016 from 849 patients supported by the extensive care service shows:

- 14 per cent reduction in A&E attendances
- 25 per cent reduction in non-elective admissions
- 21 per cent reduction in elective admissions
- Six per cent reduction in outpatient activity.

All wellbeing support workers within the service are also now using the patient activation measure (PAM)[47] tool as of October 2016. Latest figures show:

- 78 per cent of patients increased in their PAM score (knowledge, skills and confidence to manage health and wellbeing) after second assessment (based on 110 patients)
- 52 per cent of patients increased in their PAM level (knowledge, skills and confidence to manage health and wellbeing) after second assessment (based on 110 patients)

Learning and advice

The Fylde Coast team feel that having a shared vision from the outset is crucial for delivering any new care model.

A blueprint to guide the development of the service was created to give them a starting point, although this process in itself highlighted that some of the ideas were great on paper but difficult to implement on the ground and so there was a need to be flexible and adapt.

Involving staff in the development of the service and seeking regular feedback is a must for anyone looking to introduce a new care model. Proactively talking to staff, being honest about starting from scratch and adapting and changing the model based on learning is an ongoing cycle for the project team. Staff were heavily engaged with this work in the first 12 months, but the team recognise they have more to do to maintain the focus on staff engagement.

What do health and care professionals say?

A video about the extensive care service, which includes interviews with a range of staff members providing their personal perspectives, is available here.

What do patients say?

Holistic care helps John turn his life around

John, 67, from Blackpool, has diabetes and a heart condition. His health had been declining and in early 2015, after a fall and hip replacement John was struggling to get around, so his GP referred him to the extensive care service.

John said: *"I was in a poor state of health after my fall. I was also feeling very lonely because I had no company. Everything was getting me down and impacting upon my health."*

John worked with the team to set achievable goals that would make a difference for him, including learning to better manage his finances and joining local groups to take part in regular activities.

John added: *"If it wasn't for the extensive care service then I don't know where I would be. The team have increased my confidence to tackle issues that I wouldn't have done on my own.*

"They take the time to listen to me. I feel a lot happier and healthier now. Through their care they've given me the confidence to regain my independence. I look forward to seeing them."

John’s improved health and confidence should help reduce his need for urgent care services.

Tailored support through extensive care makes a ‘massive difference’

Retired firefighter Stuart, 64, struggles with multiple health complaints including heart problems, diabetes, kidney failure, severe arthritis and gout.

Wellbeing support worker Lee Jones regularly meets Stuart and his partner and helped him devise a set of goals that he’d like to work towards.

Stuart said: *“The goals are just simple things like doing more DIY, cooking and more exercise, but things that have become incredibly difficult in recent years.*

“I wanted to paint the hallway so Lee got me a perching stool and I have been able to make a start. The stool has also helped me do some cooking.

“I also wanted to start swimming but I can’t manage the ladders into and out of the pool, so Lee found me a pool with a walk-in area. These are little things to many people but they make a massive difference to me.

“And the speed of the service is incredible. If anything goes wrong I can ring a number, 24/7, and someone will help me.”

Lee added: *“Through developing a relationship with Stuart I have been able to look at more preventative measures so, in the main, he is able to look after his conditions himself and avoid the need for emergency treatment.”*

Supporting the needs of carers

When Lily Greenwood's husband, Peter, left hospital after suffering from a stroke, they were referred to the extensive care service.

“The doctor sent us here. We didn't want to come, but it's been the best thing ever.”

Although Lily wasn't the patient, the team's approach of looking at every aspect of the patient's wellbeing meant that attention turned to 80-year-old Lily too, as Peter's sole carer. The team helped her to take control.

“It took its toll on me at the beginning, but now, I just feel that with coming here, we can cope with it.”

The team filled in all the forms that Lily had been baffled by, they helped her to apply for the extra benefits she was entitled to and, most importantly, they helped her to manage her husband's condition.

They even introduced her to local support groups for carers so that she no longer feels alone or overwhelmed.

“The nurses to me are friends. They have time for you. We're a lot happier now. I feel I can cope with Peter now.”

Feedback gathered via the Friends and Family Test from patients who have experienced the extensive care service

"Would certainly recommend to other people like me. I feel more confident in myself. I'm living life like I used to."

"It's like you're knocking down brick walls I couldn't get through."

"You have been really helpful, thank you for everything you have done for me. I really appreciate the support and the confidence you have given me."

"The support and help given has been a credit to the NHS."

"I think it's wonderful. Makes me feel safe. It makes me feel so cared for."

"My health and wellbeing have improved massively. I can only thank everyone for their help and support."

"Thanks for your help for me and my husband. Marvellous."

Appendix 6: Case study – All Together Better Sunderland (multispecialty community provider)

Developing a sustainable approach to multidisciplinary working

Population served: 275,500 across 48 GP practices

Workforce issues

- Planning an approach to multidisciplinary working that results in a model where staff feel supported and part of a long-term plan for organisational development

Challenges

- Establishing locality teams
- Different meanings and understanding of what 'care coordination' meant within teams
- Operational issues, such as equipment ownership and supplies

Healthier communities

- Improved and more responsive support network for patients

Happier patients

- More patients with care plans who appreciate the 'personal' touch

Reduced healthcare spend

- Reduction in unplanned admissions

Motivated workforce

- Positive impact on sense of learning and development
- Multidisciplinary meetings have helped to clarify, coordinate and speed up responses to patients' needs

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Background

All Together Better Sunderland brings together health, social care and voluntary sector teams to provide better care for patients at home.

Five multidisciplinary community integrated teams focus on supporting vulnerable patients with complex conditions who are frequently admitted to hospital. In Sunderland the life expectancy for men and women is two years lower than the England average. The three per cent of the population with the most complex needs drive 50 per cent of the costs in the system.

The teams are based at five locations across Sunderland and include GPs, nurses, social care experts and living well link workers.

Working in closer proximity to each other prevents duplication, which often proves costly to the NHS and frustrates patients who have to repeat their history to different healthcare professionals.

The community integrated teams create tailored care plans that reflect patients' medical, social and emotional needs – helping improve their quality of life and avoid unnecessary hospital admissions.

The vanguard commissioned the University of Sunderland to undertake an action research project to support workforce development. This included interviews with patients, clinicians and managers.

The research looked at gaps in skills including system leadership, patient and carer engagement, use of technology, team building and training for carers. The findings are informing a workforce plan to help develop the new care model to ensure it is sustainable.

The recommendations from the research included:

- Carrying out a baseline workforce self-assessment and ensuring recruitment and retention, training and staff engagement are part of the workforce plan
- Developing local system workforce data
- Carrying out a generic training needs analysis for everyone working in integrated teams
- Developing an OD strategy – including a plan for individual and team leadership development. This has included an OD lead meeting with integrated teams and offering support and coaching using tools like Myers Briggs profiles to build a team and model what works now and in the future
- Running workforce modelling workshops with community integrated teams
- Developed a local definition of care coordination as the term had different meanings to different organisations and professionals
- Ensuring self-care skills, co-production skills and holistic care skills (including emotional and psychological wellbeing) are built into workforce profiling

The challenges

Challenges included agreeing co-locations and basic operational issues, such as equipment ownership, supplies and repairs. These were largely 'bedding-in' issues and staff now report that being co-located has improved communication with different disciplines.

Some staff struggled to attend multidisciplinary team meetings in the early days of implementing the model as they felt they simply didn't have time. This was resolved once people saw how the meetings resulted in a faster and more effective way of managing patient care, allowing actions to be taken quickly by the appropriate professional.

Impact on staff and patients

Staff have reported improved communication, with co-workers being able to address issues over their desks in a matter of minutes instead of days. As well as seeing improvements in patient care, staff also feel there has been a positive impact on their own learning and development as a result of working in an integrated team.

Multidisciplinary meetings have helped to clarify, coordinate and speed up responses to patients' needs. There is a dedicated team coordinator who supports the planning and monitoring of multidisciplinary team meetings.

There have been a number of positive outcomes from this new way of working: the number of patients with care plans is now 1.82 per cent of the population (reported February 2017) and continues to climb steadily. The number of unplanned admissions in the three per cent stratified population from April to December 2016 reduced from 1,893 to 1,645 (13.1 per cent); permanent admissions to residential and care homes reduced from 360 to 298 for the same period (17.2 per cent). Each locality monitors emergency and A&E admissions for complex patients pre and post MDT and there has been an average 13.1 per cent reduction in admissions and an 8.7 per cent reduction in A&E attendance in the period since implementation of the MDT meetings to the date of reporting (December 2016).

Patients appreciate the 'personal' approach where they know a single dedicated team is looking out for them.

Learning and advice

The action research project provided an independent, insightful and honest view of workforce development and planning challenges. It has informed the way the Sunderland team approaches workforce planning for the future and complemented their organisational development work, which addresses the separate cultures in each of their five localities.

What do health and care professionals say?

"I just have to turn around from my desk and I can talk to a social worker and organise a patient's care in minutes instead of days."

Sue Hughes, a district nurse, works as part of the North of Sunderland CIT. She said: *"My role involves caring for patients in the community, primarily at home – whether that is their own home, at a family member's or a residential care home. I also deliver care from a GP practice treatment room to those who can get to the surgery.*

"Since we have been working as part of All Together Better, I have seen a lot of changes.

"Referrals from a GP for district nursing are quicker and we are sharing more relevant information so there is less duplication. Patients are at the centre of care and we discuss a person's needs holistically, getting the right care to people when they need it most.

"I think we often approach cases with a much better starting-level of knowledge about the person's history, circumstances and needs since MDTs came into place.

“A doctor might talk about a person in an MDT meeting and discuss the case with a social worker, and weeks later, they might need medical care. We can recall their history and it means that the person doesn’t need to keep repeating themselves. We go there knowing what has happened in the past and able to put together an effective care package.”

What do patients say?

The community integrated teams are making a real difference for one patient whose health problems meant she was in constant pain and visiting A&E up to twice a day.

Linda, 48, suffers from a range of complex health issues. She said: *“I would feel that I was taking up a bed in hospital, and an ambulance that somebody really poorly might need, but at the same time, I had no other option. The pain would get so bad that I couldn’t cope and there was nobody willing to help me.*

“Now, with the care plan put together by my GP and the other services involved, I am managing with the care of my husband John, and we are fully supported by a team should we need their help.

“The whole thing is set up around me – to support me and to support John. I can’t explain how much of a difference it has made to my life.”

Appendix 7: Case study – Dudley Multispecialty Community Provider

Multidisciplinary team work in Dudley

- Population: 315,000
- Multidisciplinary teams in 46 practices

Workforce issues

- People learning to work across organisational boundaries

Challenges

- Multidisciplinary teams including GPs and other health and care professionals.
- Public concern about information sharing across organisations

Healthier communities

- Reduction in primary care appointments, home visits and phone consultations

Happier patients

- Improved quality of care

Reduced healthcare spend

- Analysis of 50 patients showed savings of approximately £300,000 deriving from a reduction in GP appointments and patient reliance on healthcare

Motivated workforce

- Highly motivated through greater patient involvement

A 'team without walls' approach reduces pressure on general practice and improves the quality of patient care

Multidisciplinary teams (MDTs) are operating in all of the clinical commissioning group's 46 member GP practices. They provide focused support to Dudley's most vulnerable patients identified as the most at risk from long-term health conditions or frailty, representing two per cent of the population.

The team is made up of a GP, community nurse, social worker, mental health nurse, voluntary link worker, practice pharmacist and other health and care professionals.

The MDT works as a 'team without walls' and focuses on reducing the number of unplanned hospital admissions and supporting people to live independently in their community. By setting up MDTs, Dudley MCP also wanted to improve staff morale and the effectiveness of individuals by working in a team.

Each MDT is responsible for their respective GP surgery's register of patients, which can range from 2,000 to 25,000.

Patients are selected via a risk stratification tool and other professionals (such as Macmillan nurses) drafted in as and when they are needed.

The GP is the patient's main advocate and has the lead role in bringing together other professionals to close the 'care gap' for patients at high risk of admission to hospital.

The challenges

There were initially some difficulties in how often the MDTs met with GPs because of time constraints. This was resolved once practices saw the benefits the MDTs could bring to their work and to the quality of patient care.

Impact on staff and patients

Staff can address and solve problems quickly and with greater ease as part of an MDT and can make a far more effective and personal contribution to patient care. This has resulted in more motivated staff and a boost in morale.

The ability to work comfortably across organisational boundaries is a great advantage for both staff and patients and has developed strong working relationships and improved communication.

An in-depth analysis of 50 of the 2,000 clients seen to date by the MDTs shows financial savings of £300,000, as well as significant improvements in health and quality of life.

A 30 per cent reduction in primary care appointments, 21 per cent reduction in primary care home visits and a 30 per cent reduction in phone consultations have also been recorded since MDTs were introduced in Dudley.

Emergency admissions continue to rise in line with the rest of the UK, however Dudley is beginning to see a reduction in length of stay since the inception of the MDTs.

Learning and advice

Successfully introducing MDTs across Dudley was heavily reliant on improving organisational development rather than looking to restructure or change employers or hosting arrangements. Each team member is accountable to their own employing organisation, so there was no need to use TUPE arrangements. A strong programme of staff engagement to introduce changes helped to break down barriers between professionals employed by different organisations but working in the same team.

Staff engagement was as important as the avoidance of the word 'pilot' – which suggested a temporary arrangement. The following steps will help others looking at setting up a similar model:

- Agree your vision with all partners and providers in the system
- Assign an OD expert to oversee the implementation of a new way of working
- Engage the public early in the journey of implementation
- Work with staff in each provider to explain the model and get their suggestions on how a new way of working can best be implemented

- Provide OD through team development to support each practice in establishing an MDT
- Continuously review the model and its implementation
- Be open to difference – accept that each practice is different and must be allowed to develop the MDT differently within the scope of the model
- Ensure each team is fully operational before you remove OD support
- Celebrate success
- Remove barriers as they arise

The next step in Dudley is to integrate social workers into MDTs, as well as links to every other element of the health system, such as physiotherapy and occupational therapy, as well as to other organisations such as the fire brigade and ambulance service.

What do health and care professionals say?

Ghulam Shabar, Manager of Lye Community Project, Dudley Metropolitan Borough Council: *"Having that access to professionals and not having some of those boundaries, that helps us to deal with things much more efficiently."*

Terry Gee, Voluntary Sector Locality Link Development Officer for Integrated Plus: *"A really exciting part of my job is attending the multidisciplinary team meetings. The best bit about it is that we talk about patients who are at high risk of admittance or recently discharged, or just generally people bring patients forward who they're a bit worried about and they don't know what else they can do for them.*

"That's our opportunity to pull people straight into the mix and say – this person needs this, let's make it happen."

Dr Ruth Tapparo, GP at Three Villages Medical Practice and board member for Dudley CCG: *"It's a new way of working, therefore there's going to be highs and lows to the process. It's taking a while to get it streamlined to be the best model, but it's certainly getting there and it's very exciting times for Dudley to see how the new change will benefit the whole system – not just the patients, the GPs, the community and us working as a whole."*

What do patients say?

"I'm really pleased with all the link officer has done for me. Thanks to their support I have lost weight and can visit my dad more often."*

"They are someone to turn to when you feel you have no-one and I can't thank the voluntary sector link worker enough."

*Link workers are now part of the teams, helping patients take the first steps toward accessing the services and support available to them. A good example is Pat, who was feeling lonely and isolated until her GP arranged for a link worker to visit. They chatted about her situation and the link worker made several suggestions, including putting Pat in touch with an exercise group and local social group at the church. She went on to volunteer for Age Concern two days a week, helping her and other people in the process.

Appendix 8: Case study – Gnosall Primary Care Memory Clinic (Rugeley practices primary care home)

- Population: 8,100 (including 1,150 aged 65 and over)
- Part of NHS Stafford and Surrounds CCG

Workforce issues

- Creating a new care coordinator role and developing the associated training and safe practice guidelines
- Primary care staff adapting to work with newly created care coordinator

Challenges

- Capacity building and training
- GPs and the primary care team have had to adapt to new ways of working
- Supporting role of care facilitator

Healthier communities

- More proactive and preventative care that is closer to home and addresses physical and mental health needs

Happier patients

- High satisfaction levels from patients/carers/families

Reduced healthcare spend

- Reduced reliance on hospital and mental health services
- Delays in treatment minimised and nearly 100 per cent clinic attendance rates

Motivated workforce

- Patient information kept in primary care and available to whole team helping improve shared decision-making among the team. Staff have an improved sense of job satisfaction as they feel the holistic approach is providing patients with the best support possible.

Background

Gnosall Surgery has offered a primary care based memory service for people showing early signs of dementia since 2006. This includes assessment, early diagnosis and support in the community.

Patients are cared for by the GP and a consultant psychiatrist who is based at the surgery 3.5 hours a month, and receive ongoing support via telephone.

Patients with initial memory problems are subject to a GP review and preliminary investigation, before being referred to the monthly memory clinic.

Clinical assessment depends on the individual's current mental state and more sophisticated neuro-psychological testing can be requested, as can brain scans.

The clinic is coordinated by a care facilitator who is employed by the GP practice. They play a key role in supporting each patient in the following ways:

- The care facilitator meets the patient after initial referral to carry out a structured assessment in their home.
- If their initial assessment shows noticeable memory loss, the patient is given a memory clinic appointment to see the care facilitator and psychiatrist.
- The surgery-based psychiatrist reviews the patient history and earlier assessments and then meets with the patient and their carers to discuss diagnosis and a treatment plan.
- The psychiatrist follows NICE guidelines and supervises any therapy, although principle responsibility for patient care rests with their GP.
- The care facilitator acts as a link between the patient, carer(s) and other agencies once diagnosis is confirmed and a treatment plan is in place. The care facilitator has in-depth knowledge of support and services available locally.

The challenges

GPs and the primary care team have had to adapt to new ways of working, where the majority of patients are managed within primary care. GPs have become the clinician with lead responsibility for a person's care – working closely with the consultant psychiatrist and the care facilitator. This means that patients will contact the practice whenever they have queries or concerns – so there are practical implications that need to be considered before replicating this model.

Patients and carers have also had to get to grips with a locally delivered service which includes home visits and the role of the care facilitator.

In turn, the creation of the care facilitator post required work on developing training and defining responsibilities and boundaries of safe practice.

Impact on staff and patients

The care facilitator acts as a single point of contact for patients and their carers, minimising delays and encouraging them to regularly attend the clinic. They are valued by GPs who can talk to them directly about queries raised by patients and their families.

The care facilitator is linked with social care and voluntary groups to offer a more holistic approach to care and this is reflected by the whole team, who feel they are giving patients the best support they can.

Additional benefits of introducing the care facilitator role include:

- The care facilitator closely monitors a patient's condition and can quickly address any physical/mental health deterioration
- It is easier to identify and treat patients' co-morbidities
- The role has improved patient experience and reduced fear/stigma of attending psychiatric clinic

- Gnosall and local GPs offer a visiting service to minimise hospital admissions
- Delays in treatment are minimised and the clinic has nearly 100 per cent attendance rates
- The reliance on hospital and mental health services is less, meaning the spend on hospital-based care health for patients aged over 65 has substantially dropped
- It supports continuity of care so patients have a seamless experience

Learning and advice

Gnosall Surgery found it was important to maintain a good working relationship with the local mental health trust and ensure changes to dementia assessment and diagnosis did not undermine their approach.

The surgery team also feel they have been able to achieve genuine integration of health and social care services with care planning supporting and meeting an individual's needs.

There needs to be early consideration of data entry processes to avoid duplication of records between primary care and the mental health trust.

The first steps towards implementing a model like this should include looking at the local area's current commissioning model to see what is feasible and identify resources and capacity. A comprehensive programme of engagement with appropriate stakeholders is then necessary to get their opinion on proposals, and then to refine them based on their feedback.

The selection and training of people with the attributes and skills required to become a care facilitator will also determine whether extension of the model is successful elsewhere.

Any new service requires changes to GP responsibility, especially around prescriptions. A 'bedding-in' period and a robust evaluation and review process need to be agreed at the start so that the model works in the long term.

What do health and care professionals say?

Care facilitator 1: *"Eric and Paula are both very grateful for the support they have received so far. The best part for me was seeing Eric smile for the first time."*

(Note: the care facilitator carried out a home assessment of Eric and arranged for a same day emergency GP visit along with an appointment at the memory clinic).

Care facilitator 2: *"If this lady hadn't been referred to me who knows what situation she would have found herself in. Her son is now able to concentrate on his own wellbeing knowing that his mother is getting the professional help she needs."*

(Note: care facilitator conducted home visit and assessment of Mrs Brown including subsequent liaison with GP and social services, which led to care home placement).

What do patients and carers say?

“Our care facilitator has been a great help to me and my mother. She helped me realise how much help there was for people like my mother.”

“She talks to us and I feel that she cares about us.”

“From the time my mum was diagnosed she has been a source of strength. She is always there with practical advice, help and a sympathetic ear.”

“Very helpful indeed, willing to offer advice…. patient and understanding. I am thankful to have her phone number to hand.”

“Counselling and constant assessment of her condition have helped a great deal. She has followed up the treatment plan suggested by the doctor.”

“I don’t feel so worried and alone now, knowing that there are so many people in my situation and the amount of people out there that can help.”

“It is very helpful to discuss any problems regarding memory loss and to know that helpful advice is always available…. a relaxed friendly approach puts one at ease.”

Appendix 9: Case study – Isle of Wight – My Life A Full Life (integrated primary and acute care system)

Age UK primary care navigators

- Population: 140,000

Workforce issues

- Understanding the voluntary sector workforce capability and approach
- Improving team building by offering longer term employment prospects beyond annual contract review

Challenges

- Building trust and relationships between the voluntary sector and GPs to help them to understand and engage with the care navigator role

Healthier communities

- Supporting independent living and self-management
- Providing community-based solutions

Happier patients

- Greater confidence and ability to self care
- Feeling more supported at home and with finding services in their local community

Reduced healthcare spend

- Estimated cost avoidance of £553k (ROI 53 per cent)
- Easing pressure on primary and secondary care by avoiding admissions through crisis response and preventative approach

Motivated workforce

- GPs to see care navigators as the single 'go to' point of access to support patients with non-clinical needs
- Basing care navigators within Age UK means stronger connections with other voluntary sector support projects. Care navigators have a network of support from colleagues supporting the same communities.

Background

My Life A Full Life is a partnership between the Isle of Wight NHS Trust, Isle of Wight Clinical Commissioning Group, Isle of Wight Council and the GP collaborative One Wight Health.

They worked with Age UK to launch an initiative to prevent ill health by supporting self-care and empowered communities by developing the role of primary care navigators.

Care navigators play a crucial role in helping people to get the right support to manage a wide range of health and care needs. This can include providing information about health, social services and voluntary sector organisations, support with managing long-term conditions, help with managing money and guidance on self-care – all of which can enhance a person's health and wellbeing, help them to live independently and help avoid unplanned hospital admission.

Nine care navigators offer up to six visits where they help patients to agree a set of goals that address their three most urgent priorities. The patient will then be introduced to the relevant support organisations who can help them achieve these defined goals. Care navigator notes and progress reports are then fed back to patients' GPs so they have a better understanding of the range of issues affecting each person and the progress they are making to address them.

Each care navigator works alongside the individual and their family, encouraging a proactive, 'can-do' approach to managing their condition(s).

A good example is mental health, where care navigators help prevent a deterioration in a patient's condition through provision of a good support network and early intervention.

The challenges

One of the biggest challenges to introducing the role of care navigators was empowering patient confidence to self-manage and move away from being overly dependent on health services.

Developing a clear system to assess the way care navigators work and ensure there is evidence to support the positive difference they are making has also been difficult. To overcome data sharing and information governance barriers, care navigators input information onto the patient database so GPs can see where a patient has been referred to. The team hopes to use this as part of their evaluation of the care navigator role.

The Isle of Wight team also found there were a number of communication-based issues to resolve, so that GPs could clearly understand the role of care navigators and feel confident in making referrals to them. As the role becomes more embedded, there has been a shift in perception amongst GPs to see care navigators as the single 'go to' point of access to support patients with non-clinical needs.

The uncertainty posed by annual funding reviews presented some concerns around the ability to create a team environment.

Impact on staff and patients

Care navigators have seen more than 3,500 people in the past two years (2.5 per cent of the population of the Isle of Wight). Feedback gathered from wellbeing scores given at the start and end of support show patients feel more confident in their ability to look after themselves and maintain independence. Patients building up to or experiencing a mental health crisis are given support early, preventing a deterioration in their health and potential hospital admission.

Basing care navigators within Age UK gives them stronger connections to a network of support from colleagues working on other voluntary sector projects with the same communities.

The Isle of Wight team also offered short-term placements for social work students to work alongside care navigators. This has proved invaluable for broadening the view of the benefits of holistic care.

Impact on reducing healthcare spend

The cost of the service with nine full time employed care navigators, plus an administrator, is £360,000 per year.

Currently the Isle of Wight team estimates costs of £553,000 (ROI 53 per cent) per year have been avoided through a reduction in service use. An integrated evaluation is under development to explore this further.

Learning and advice

The Age UK team started out by getting to know each of the practices the care navigator would work with. Working proactively with GPs from the start has been crucial in building trust and supporting referrals.

Being a voluntary sector organisation means that there is freedom to be flexible in recruitment and to build a team from different but complementary backgrounds. The foundations must be laid to build trust with the statutory sector – particularly at senior level. Helping them to recognise the professionalism of the voluntary sector, see it as an equal partner and understand its potential to deliver high quality services is vital to progression.

When developing the project, Age UK also visited care navigators in Kensington and Chelsea to learn about their model and find out what they would do differently. Sharing this learning has been crucial to anticipating issues that may arise and acting on them to create a model that works.

For others wanting to implement a similar model, the advice from Isle of Wight is: ‘don't reinvent the wheel’. There are many examples of this type of holistic work and people are very happy to share their experiences, but do remember you know your client group best, so don't be afraid to adapt and then evolve to meet their needs.

What do health and care professionals say?

Dr Michele Legg, GP at Tower House surgery: *“Care navigators are providing a vital form of support in our local communities, helping to ensure that people access the right kind of support, in the right place at the right time. In many instances, the solution to their needs has been met by voluntary and community services, which has also helped alleviate some of the pressures on statutory services, in particular primary care, and ensure, for example, that GP appointments are there for those that really need them.*

“At the same time, it has helped people to understand the wealth of support available in their local area, which has increased their interaction with that community, reduced isolation and helped build their resilience.”

The following quotes were taken from interviews with care navigators:

"I think there is something in the continued support from us; they know we are going to be there for a set period of time, so we don't just give them a leaflet for a walking group and then we are off, we say, the walking group is here, if you want to, I can come with you and help you and support you to become active in that group before we withdraw. Others are happy to go along to the groups once they know about it but they know you will be calling or visiting them in a couple of weeks' time to find out how they're getting on. There's that extra incentive for them to go because they know somebody is going to be following it up."

"We are doing a lot of falls prevention assessments with people so if anybody is wobbly on their feet or if they have had a few falls, we would automatically do a falls prevention assessment with them. We may put in grab rails, find a bath support or raise their toilet, which can prevent them from falling and other admissions that go with that. We also ask about medications; it does happen that we find someone with a whole cupboard full of out-of-date medication; it's been prescribed and they are not using it so we will report that back to the GPs."

What do patients say?

One gentleman, near end of life but being cared for at home, wanted his last care call later in the day as he was going to bed at 7pm and staring at the ceiling for 12 hours. He didn't know he could ask for a change.

One lady who had called the local out of hours service 28 times in four weeks reporting side effects of her medicines was supported to be less socially isolated and to rebuild the relationship with her son, which had been damaged by the stress of caring for her. A medicines review with the pharmacist also reduced the side effects she felt she was experiencing. In the following four weeks, she only called the out of hours service four times, all of which were appropriate.

Appendix 10: Case study – Nottingham City CCG (enhanced health in care homes)

Dementia outreach for care home staff

- Population served: 314,000

Background

Improving care for people with dementia in care homes in Nottingham is part of a wider dementia strategy developed by NHS Nottingham City and Nottingham City Council.

In Nottingham City there are about 1,500 GP-registered care home (for older people) residents in non-specialist care homes. With an ageing population this number is expected to increase in the future. Care home residents have complex medical needs and the average resident has six diagnoses and takes eight medications. Currently, care homes residents are 0.5 per cent of the city's population but account for five per cent of all admissions to hospital. Many older people are cared for in hospital but best practice evidence indicates that care is most effective when provided at home or in the community.

The vision for this vanguard is to enable residents living in a care home to be healthier, have a better quality of life and to be treated with dignity and respect, focusing on residents' capabilities rather than their dependencies.

The approach

As part of this strategy, Nottingham City CCG vanguard developed a programme of training from the dementia outreach team. They provide a dedicated service for care homes and aim to increase standards of dementia care in care homes, increasing independence and choice for the person with dementia, providing skilled, specialist staff to support people with dementia, and offering training to care home staff to build their confidence in caring for people with dementia.

The dementia outreach team supports around 50 care homes and up to 450 residents at any one time, with a staff outlay of £630,000 per year.

Impact on staff and patients

One specific case involved a resident with particularly challenging behaviour. Through the support of the dementia outreach team, care home staff learned to understand behaviour triggers and how to mitigate them. Staff were also better able to manage their own anxiety when caring for this resident, seeing her as a whole person with a range of care needs. As a result, the resident was able to continue being cared for at the home.

Reducing healthcare spend

Avoiding a referral to inpatient mental health care gives the individual a better experience of care and avoids unnecessary costs. There are also savings expected by avoiding the cost of injuries to residents and staff caused by potential escalation in any individual resident's behaviour.

In the case of the resident referenced above, the outreach training and support from members of the multidisciplinary team cost £789 – a negligible amount compared to the savings from inpatient care.

What do health and care professionals say?

"Sharing the experience of care home managers at the care home managers forum is invaluable and has helped to raise the standard of dementia care."

"The carers have been buzzing about the training. They loved it!"

What do patients/carers say?

"The nurse from the dementia outreach team has given me invaluable advice and support over a lengthy period during which there have been serious issues and concerns relating to my mother's health … she is very accessible and willing to assist in support in every way possible, liaising with other health professionals when appropriate and promoting education and training from management and care staff within the home. What a wonderful service".

"The support I received was excellent. The dementia outreach worker was extremely knowledgeable and understanding and helped me through every difficulty. I felt reassured by her care. She has supported me and I am truly grateful. She is a lovely lady."

"My dementia outreach worker has been extremely helpful and very supportive. As my mum has been a very complex case with very challenging behaviour I have at times needed help and advice and I couldn't have received any better service/support."

"Over the 10 years of my mother's dementia, I have felt very alone and isolated as I struggled to obtain the best care for her. When I met the dementia outreach nurse this all changed. She has supported my mum and also me in every possible way. She has tried everything to ease her suffering, from dietetics to medication; everything was done in a very professional manner but with a kind and caring approach that I have very much appreciated.

"In fact, without her, I really don't know what I would have done. Whoever is lucky enough to have this dementia outreach nurse to help them will soon realise her worth and I thank her from the bottom of my heart."

"The carers said they felt [the training] gave them a real insight into Mum as a person, 'the softer side' as they put it. They all picked up on her being bullied and totally understood how her reaction now relates to that experience.

"It sounds like it was a real success, with some great sharing of ideas. Thanks so much for thinking of doing it. I already think the carers feel like it has helped them, and that can only be good for Mum."

Appendix 11: Case study – Encompass multispecialty community provider

Integrated case management trial

- 13 GP practices across Ash, Canterbury, Faversham, Sandwich and Whitstable
- Population served: 170,405

Workforce issues

- Pressure across the system contributed to by a fragmented workforce working in isolation
- Capacity for regular attendance at multidisciplinary team meetings

Approach

- Trialling integrated case management by a multidisciplinary team for patients at risk of long-term conditions and hospital admission
- Aiming to introduce video conferencing to reduce travel times to team meetings

Challenges

- Communications and engagement – between multidisciplinary team members and wider system partners, and making patients aware of the new way of working
- Recruitment from a range of disciplines
- Separate IT systems

Healthier communities

- Proactive care keeping patients healthy and living at home
- Model being rolled out wider to different patient groups

Happier patients

- Patients feel more in control of their health and wellbeing

Reduced healthcare spend

- Reduced chance of hospital admission

Motivated workforce

- Opportunities for staff training and development
- More positive working relationships across organisational boundaries and commitment to spreading the model

Background

A growing and ageing population with multiple complex conditions is putting pressure on health and social care services across East Kent. Historically, different organisations involved in planning and delivering care have worked in isolation. This has created a fragmented workforce and is confusing for patients who have multiple agencies involved in their care. Bringing together a team of professionals with a broad skill mix to meet all of a patient's health and social care needs has presented a range of practical challenges for the workforce – such as travel time and capacity to attend meetings.

Encompass is a group of 13 GP practices is Whitstable, Canterbury, Sandwich and Ash which works together as a multispecialty community provider (MCP). Their aim is to make sure health and social care is integrated and based around local needs so that patients can receive more of their treatment close to home, rather than having to travel to hospital.

The approach

Encompass led a trial into fully integrated case management. This involves bringing together a team of professionals from different disciplines – mental health, social care, community nursing, voluntary sector – to create single care plans, designed around the individual needs and goals of each patient.

GPs identify patients who are at risk of developing long-term conditions that could limit their ability to live independently and, if they are not addressed, lead to hospital admission.

The integrated care management process puts health and wellbeing professionals around a table to create one plan that meets the physical, mental and social needs of the individual.

The approach is improving relationships across organisational boundaries, helping staff to feel more supported in their roles and providing more coordinated care.

People receive tailored support and care professionals don't have to interpret each other's care plans in isolation. This is truly integrated care planning with the patient at the centre – reducing the likelihood of trips to hospital and the GP.

The challenges

Finding time to bring together all the professionals needed for this joined-up approach has been a significant hurdle for Encompass to overcome. Regular attendance from *all* key members of the multidisciplinary team is crucial for making the right decisions about patient care. Encompass wants to introduce videoconferencing to reduce travel times for professionals, meaning better meeting attendance and improved patient outcomes.

The Encompass team also feels there is room to improve the way in which the purpose and benefits of working in this way are shared with a range of staff to help the model grow and spread.

Recruiting staff from a range of disciplines is also problematic, which has implications for the sustainability of the model.

Separate IT systems for each organisation make it difficult to share data that could help to improve care. Work continues to address this issue.

Impact on staff and patients

Over 100 patients have been supported through integrated case management so far. Encompass is now focused on rolling the model out on a larger scale and is starting to work with different groups of patients with similar needs.

Encompass reports a noticeable difference in positive working relationships and the motivation and momentum to continue to grow this approach. The local community care provider has seen the value of this way of working and is now working under alliance contract principles.

Opportunities to improve staff training were identified and will be a focus for 2017/18 to strengthen joined-up working.

Patients also notice a difference in their experience of care. They tell staff they feel more in control of their own health and wellbeing and know who to contact for help.

Learning and advice

Strong communication at an early stage is vital. Every member of the integrated team, including the patient at the centre, needs the same information to understand and feel part of the new way of working.

Encompass also found that developing a new assessment tool to identify patients was not necessary. Instead, they used GP data and found that trusting the experts in the room was far more productive. When tackling data sharing challenges, Encompass found that getting information governance and sharing agreements in place across all organisations is vital from the start.

One of the most significant benefits to the system has been the building of relationships across organisational boundaries. This has helped to make sure all professionals feel equally important and involved.

What do health and care professionals say?

Dr John Ribchester, GP and Clinical Lead for Encompass: *"Rather than any one agency intervene when a particular problem starts to disrupt a patient's life, we are able to look at all aspects of their day to day routines and work together to create interventions that keep them healthy and living in their own home."*

Shirley Rashid, Clinical Lead Occupational Therapist: *"Being part of the integrated team allows you to say: 'I can do this part but I need some support from another element of the system'. That could be the voluntary sector helping someone deal with loneliness. I might've recognised it but before working in this way, I haven't been in a position to provide the support that is needed."*

Tamsin Parry, Adult Community Team, Canterbury City Council: *"We have better access to our health colleagues and they have faces to put to names. And social services aren't some kind of shapeless entity in the background – it becomes a real thing."*

What do patients say?

Valerie, 92, is a full-time carer for her husband, who has dementia. After a fall at home and trips to hospital, she stopped doing normal day to day tasks and was scared of falling again.

She was confused by all the different agencies visiting her – social workers, GPs and other health professionals.

Valerie was part of the integrated case management trial. A number of simple interventions have improved her life significantly:

- She now receives one daily visit from a carer who is part of the integrated team and has a relationship with all those involved in her care.
- A falls wrist band gives her confidence that, should she fall over at home, the right individual will be notified immediately and any response will be coordinated with her other care providers.
- The simple addition of a Zimmer frame trolley made her more confident in moving around the house on her own. She is now coping far better, reducing deterioration in her mental health.

"It's the first time in years I feel confident enough to go outside and hang my washing out to dry!"

Appendix 12: Case study – Airedale and Partners (enhanced health in care homes)

Telehealth technology and virtual learning

- Population: 7,687 residents living in nursing homes across Lancashire and Yorkshire

Workforce issues

- Ensuring care home staff were confident using new technology
- Introducing and embedding new ways of working at care homes
- Initial limited senior level 'buy-in' from all partners including budget sharing

Healthier communities

- Care closer to home
- Minimising attendances

Happier patients

- 40 per cent of patients treated in their home offering timely and convenient service

Reduced healthcare spend

- Potential savings of £3m in 2016/17 (circa 220 care homes; 7,500 residents)

Motivated workforce

- Care home staff more confident using new technology, which supports them to perform better in their caring roles

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Background

In Airedale, the introduction of telehealth technology is improving the quality of life and end of life care for more than 7,000 nursing and care home residents across Yorkshire and Lancashire.

This initiative combines two ways of integrated working:

- 24-hour clinical support to care home patients via a video link to the Airedale digital care hub, and other monitoring equipment.
- Virtual training of care home staff to implement a telehealth or telemedicine programme.

The challenges

Care home staff were consulted as to which training modules should be delivered virtually or remotely. These covered:

- Balance classes
- Falls prevention
- Pressure ulcer care
- End of life
- Inhaler technique

There were some initial reservations about this arm's-length training, but 63 staff members have now successfully completed the training and can see the benefits of quick, easy access to advice for both themselves and patients.

Face-to-face training with an assistant practitioner was also provided to some homes to support them in competency assessment and documentation as well as hands-on clinical training on phlebotomy, cannulation and ECG recording.

Impact on staff and patients

Telehealth support has produced a sustained reduction in care home referrals to GPs by 40 per cent and ambulance calls by almost 30 per cent over a 12-month period in those homes that use the system. To date, more than 7,500 patients in 220 care homes have benefited from the scheme with a potential roll-out to a population of 14,000 in up to 475 care homes across the local health economy.

40 per cent of existing patients are effectively assessed and treated in their place of residence, avoiding unnecessary journeys for themselves and clinical staff.

Potential savings for 2016/17, which will be confirmed through the evaluation measurement process of the vanguard programme, are approximately £3 million. This includes £332,800 in GP visits, £1m through fewer ambulance callouts, £1.5m through reduced non-elective admissions and £200,000 through reduced A&E attendances.

Learning and advice

The virtual training delivered in care homes highlighted some simple but important learning for anyone thinking of taking a similar approach:

- Ensure you have buy-in from all the relevant organisations and they are clear about what telehealth is and the benefits it can deliver, both directly and indirectly. Don't make assumptions about what you think people do and do not know.
- Start 'small' by introducing telehealth in a handful of care/residential homes before expanding, although be aware that this approach will initially only result in 'small' outcomes.
- Engage with and foster a good relationship with care home staff so they feel part of a collective team.

- Agree to pool training budgets and resources as virtual training and learning ultimately benefits everyone, freeing up time and resources.
- Ensure contractual levers are used by local authorities and CCGs to support the changes, ensuring staff make full use of the system and are comfortable using the relevant IT and video link equipment.
- Equipment must be fit for purpose as a number of homes initially complained about connectivity problems as the reason for not taking part in training.

What do health and care professionals say?

Staff at one care home made an urgent video call to the digital care hub based at Airedale General Hospital after an 86-year-old resident suddenly collapsed and developed left sided weakness, a facial droop and slurred speech.

Rachel Ford, the nurse on duty at the hospital, said: *"I could see immediately from his symptoms it was highly probable the patient had suffered a stroke."*

Rachel called 999 for an ambulance and continued to monitor the patient and give support and advice to the care home staff via the video link until the paramedics arrived.

Hospital staff confirmed the patient had suffered an ischemic stroke but, thanks to the early diagnosis of his symptoms, he was a suitable candidate for thrombolysis treatment. This is known to greatly improve recovery after a stroke, but is only effective if administered within four and a half hours of the onset of stroke symptoms.

The patient made a full recovery.

Rachel added: *"The prompt action of the care home staff meant the patient was given an early diagnosis and subsequent treatment, which prevented a lifelong severe disability."*

Appendix 13: Case study – Better Care Together (Morecambe Bay Health Community) (integrated primary and acute care system)

Increasing use of telemedicine in Morecambe Bay

- Population served: 365,000
- An area that is rural and financially challenged with pockets of deprivation and health inequality.

Background

The Better Care Together vanguard comprises 11 health and social care organisations working across north Lancashire and south Cumbria. The issues facing the vanguard are an ageing population, enduring health inequalities, and increased pressure on hospital attendances.

Combine those with the rurality of the region and staff shortages in some specialities, and the key priorities for the vanguard are clear – increasing out of hospital care, delivering care closer to home and helping multidisciplinary teams to work better together.

One of the ways those priorities are being addressed is through an innovative approach to telemedicine. This is a project with an ambitious target. Within two to three years, the Better Care Together vanguard wants telemedicine to account for 20 per cent of outpatient activity.

Just two months after the first live pilot the project is already delivering tangible results for patients and clinicians alike.

The approach

With a population spread over 1,000 square miles, it's no surprise that telemedicine was first considered in 2014 as part of the Better Care Together information management and technology strategy. It's taken a small dedicated team and changes in technology to turn that vision into reality.

Paul Charnley, CIO at University Hospitals Morecambe Bay, knows that projects championed by the IT department alone can often fall flat for want of clinician and patient buy-in. This was resolved by involving the chief clinical information officer in the original proof of concept and engaging patients from the outset.

Three 'remote clinician' pilots in gastroenterology, rheumatology and mental health drove a lot of interest and got health professionals talking about telemedicine. Just eight months on from project go-live, there are now 20 telemedicine units installed and making a difference in a number of remote community and acute settings.

The vision of the telemedicine project is to deliver the same level of care to a patient as an in-person appointment, but in a much more convenient location, as the examples below demonstrate.

GP surgery link to Furness General Hospital ED

Waterloo House Surgery in Millom is video-linked to the emergency department at Furness General Hospital 25 miles away. A GP who is unsure whether a patient presenting needs to attend ED is able to video conference at the touch of a button. ED staff can see the patient and, together with the GP, decide on the best course of action.

Maternity units at University Hospitals of Morecambe Bay

Telemedicine units are on site at each of the three maternity hospitals, providing supervision, mentoring and support to staff. Proving the value of telemedicine, one ward was able to remain open recently when a senior midwife called in sick. Staff were able to run the service safely thanks to video advice and guidance from staff at the other two units.

People often think of telemedicine in relation to patients connecting from home using their own device. A key feature of the Better Care Together programme is that telemedicine takes place within existing clinical settings, where the technology is controlled and staff are on hand.

The challenges

Aside from time to plan with clinical teams, the main challenges to delivering this telemedicine project for Morecambe Bay have been the information governance and commissioning models. The team underestimated how much time this would take when they started the project.

Negotiating connection to each other's networks and the ability to use equipment owned by another organisation also took more time initially than anticipated, but has since become less problematic.

The thorniest challenge still to resolve is the way in which contractual arrangements deal with telemedicine activity in commissioning models. "We're trying to find the right internal market in which this can fit," says Paul Charnley, "as otherwise there's a very perverse incentive to drag people to an outpatient appointment just because we get paid for seeing them face-to-face, and might not if we see them on camera."

There are many blocks to the successful adoption of telemedicine, not least concerns about patient confidentiality and clinical efficacy. Engagement with clinicians and patients was seen as key to the success of the project.

Each organisation sent questionnaires to its members, supplemented by live surveys in outpatient departments. The process culminated in patient focus groups comprising people both for and against the project.

"The focus groups were a chance to get under the skin of the project and explain to people why we think telemedicine is so important," says programme manager Keith Bentham. "Those involved quickly saw the benefits for themselves and it was gratifying to witness people who had entered the room firmly against telemedicine leaving the session firmly in favour of it."

Two patients from the focus group will soon be working with the team to trial a new virtual waiting room project, which will eventually allow video consultations with healthcare professionals to take place from the patient's home.

The project team acknowledges that it is still in the early stages of technology acceptance and adoption by clinical colleagues. The change model so far has been to work with natural early adopters. Following the three 'remote clinician' pilots, clinicians are now coming forward with their own suggestions for telemedicine. These include care for prisoners without the need for transport and accompaniment, and remote children's clinics that reduce the need for young children to attend hospital outpatient appointments.

Impact on staff and patients

In a context where the system is facing difficulties in recruiting staff, resources are utilised more effectively and the patient gets faster, more timely access to the relevant clinician.

Longer term, patients have better outcomes because of timelier access to specialists who can apply the highest standards of care associated with their clinical discipline when evaluating the patient.

The patient saves time travelling to hospital sites, improving their outpatient experience and daily lifestyle. The same applies to clinicians, who save time travelling to see patients, increasing their productivity and sense of job satisfaction. A study of 26 video consultations showed that they saved 1,281.6 miles of travel and 2,232 minutes of travel time.

Reducing healthcare spend

The team has concentrated its ROI thinking on wider socio-economic benefits and workforce utilisation, rather than looking at the tariff and "just moving money around the system".

For instance, there are 22,900 journeys a year between Millom and Furness General Hospital alone. Reducing those journeys is a clear KPI for telemedicine, and a dashboard now shows mileage saved per patient based on outpatient appointments.

Looking beyond the NHS to a whole system view, the team sees the potential for telemedicine to realise significant efficiencies. For instance, a prisoner taken out of prison to a hospital appointment incurs a high cost of transport and accompaniment. Telemedicine could realise a significant saving both to the prisons service and the local CCG, which is responsible for transport costs to the hospital.

Learning and advice

Involving patients and clinicians from the outset was key for the Morecambe Bay team. Engaging operational managers in a structured way was also crucial, planning for conversations that look at tariffs and inter-organisation working at an early stage.

The technology itself was the easy part; it is the process and business change that required the most effort and are important learning points.

Tackling information governance at the start of the project cycle is crucial. That includes considering physical information governance issues such as curtains and headsets for the telemedicine units, and ensuring all parties are fully engaged and signed up to the relevant standard operating procedures.

The Morecambe Bay team also feels that investing time in training staff to use technology and to understand differences in consultation style when using a video

link has paid dividends. Preparing staff for the change includes engaging admin teams to agree on clinic set-up, management of communication with patients, letters and patient consent.

What do health and care professionals say?

Paul Charnley, CIO at University Hospitals Morecambe Bay: *"Video conferencing has moved from complex, expensive technology occupying large meeting rooms, to cost-effective desktop solutions that are much simpler to deploy."*

Dr Adam Joiner, Consultant Psychiatrist: *"It was simple and easy; I would be happy to do all my clinics through this technology. The nurses and social workers will particularly benefit as they may have to travel to see just one patient, so there could be a lot of time saved."*

What do patients say?

"I found my appointment was just as good as when it's in the same room as the doctor," says Jacqueline, one of the patients in the outpatient trial. *"Doing it this way saves a lot of time when you're just having a catch-up about results."*

Another patient, Lynn, commented: *"It's brilliant! I don't feel like it's taken anything away. If it means I can see the same doctor and get continuity, and faster care, then I am happy."*

Appendix 14: Case study – Erewash Multispecialty Community Provider

Workforce planning framework

Erewash has utilised the SWiPE[1] framework which considers skill level requirements to plan its future health and social care workforce based on a population of 70,000 people. The framework is based on analysis carried out by the Derbyshire strategic workforce implementation group in collaboration with HEE East Midlands, focusing on the frail elderly population initially. The overall concept underlying the tool centres on local demand for care and using this to determine the skill-mix required to meet that demand at different stages of the care pathway.

Initial work has focussed on using the tool to plan the workforce around the frailty care pathway. Firstly, analysis of the prevalence of frailty-related conditions across the local population was undertaken to determine the health and social care need at different stages of the care pathway. This need was then aligned with the skills and competencies of the workforce required to meet the demand.

Mapping population need against the skill-mix required to provide appropriate care allows an understanding of the common skills required for the care plan pathway and which roles are interchangeable across health and social care. Erewash's focus on the link between skills and interventions is enabling them to create a very different workforce model and allowing a clear vision of the percentage shift in workforce terms. Another of the advantages of this framework is that it can be used in the absence of reliable risk stratification data.

The framework is being utilised iteratively across Derbyshire, with the children's workforce being mapped in 2016. Currently the plan of work is to undertake a whole population approach to map the workforce in specific places. Going forward, Erewash is keen to work with other vanguards to trial the framework in their own localities in order to determine the replicability of the approach and to benchmark resource use.

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[1]SWiPe stands for Strategic Workforce integrated Planning and evaluation (Whole System Partnership Trademark)

Appendix 15: Case study – Northumberland Accountable Care Organisation (integrated primary and acute care systems)

Developing an integrated pharmacy service

Traditionally there has been little integration between primary and secondary care pharmacy teams. The Northumberland vanguard team created an integrated pharmacy team that now works across primary and secondary care. This is helping to remove organisational barriers and ensure clinical decisions about medicines optimisation are made in the best interests of patient care, and with the full support of GPs and hospital consultants.

The integrated vanguard pharmacy team benefits from access to information across hospital and primary care settings. Rotas allow pharmacists and pharmacy technicians to be based at one of Northumberland's community hubs, as well as to have a clinical role in hospital at The Northumbria, in general hospitals and at five community hospitals. By basing pharmacy teams across the system in this way, staff are able to communicate effectively with colleagues in primary and secondary care and make better decisions to support medicines optimisation. Staff are also more aware of where pharmacists are working directly with GP practices.

Where teams have had access to a single system for viewing primary care records – called Systm1™ – they have also been able to undertake additional tasks to improve interventions and flow from hospital. For example, updating GP records, arranging prescriptions, and supporting primary care staff when communicating complex information.

Other staff groups (for example consultants and occupational therapists) have also found this enhanced access to primary care records helpful for managing medicines.

Having an integrated working culture has helped improve patient flow and follow-up on discharge. Working across organisational barriers means that the patient is cared for by a single team, no matter where they present within the vanguard geography.

The approach helps to reduce spend on healthcare by supporting a switch from non-formulary to formulary alternatives – saving GP time and money.

For hospital pharmacists, there is a deeper understanding of decisions about medication and they can prescribe repeat medication when a patient is discharged. From a primary care perspective, the benefits include being able to ensure discharge information on medication is accurate, access to hospital notes to check medication details and a better understanding of the rationale for decisions about medicines and duration of treatment.

What do health and care professionals say?

Scott Barrett, Hospital Pharmacist: *"I now have more information to support patients in hospital and can discharge them safe in the knowledge that someone will be there to support them."*

What do patients/carers say?

The pharmacy team in Blyth recently helped an elderly lady who was her husband's main carer. He had recently been discharged from hospital and she was confused as to what medication he should be taking.

She did not recognise some of the medications and could not make sense of the discharge letter.

The pharmacist noted that the patient had been inappropriately discharged with chlorpromazine (an antipsychotic originally started for hiccups), despite this being discontinued by the hospital team. They also noted that metoclopramide was prescribed in hospital but not given on discharge.

Working with hospital colleagues, the pharmacist corrected the medication list and updated the GP records. A corrected discharge letter was sent to the patient's wife along with a medication reminder chart. A new prescription was sent to the community pharmacist and a home visit was arranged to explain the medication changes. This visit also resulted in some medicines being stopped that were no longer having any benefit.

Access to the hospital team and the ability to follow up the patient in their own home, allowed a timely intervention, preventing any unnecessary use of GP time, or potential readmission to hospital.

Appendix 16: Case study – Stockport Together (multispecialty community provider)

Breaking down communication barriers between GPs and consultants

- Population served: 305,000

Background

Stockport Together is one of 14 'multispecialty community provider' vanguards that will move specialist care out of hospitals into the community. To achieve this each of Stockport's 42 GP practices now sits within one of eight core neighbourhoods, each responsible for aligning local health, social and voluntary teams to deliver care closer to home.

New advice and guidance technology, spearheaded by the CCG's primary care development team, supports care closer to home by breaking down the barriers in communication between GPs and consultants. The software enables one clinician to seek counsel from another via a trusted telephone network. It means GPs can now get instant treatment advice from a specialist and check whether a referral is necessary.

It's a simple solution that's already contributed to 520 referrals avoided in just six months.

The approach

This project started as so many NHS change initiatives do – by looking at unwarranted variation in outpatient referral rates. The project team visited the highest referring practices, conducting an audit of referrals where patients had been discharged after their first outpatient appointment.

Alongside process issues for the CCG to resolve, they uncovered a common thread – every GP the team spoke to felt that if they had easier access to consultant specialities, then they wouldn't refer as many patients.

This feedback linked directly to one of the vanguard work streams. The 'acute specialist interface' aims for better connections between acute and primary care and is an area of work that is seen by the vanguard as crucial to the delivery of their core neighbourhoods model.

Online research found a handful of potential technology solutions that might help to connect GPs and consultants, but it was the Consultant Connect system that "really felt like a no brainer", says project lead Julie Ryley.

Consultant Connect provides a trusted clinician-to-clinician telephone network that bypasses switchboards and department secretaries to create a direct connection between GP and consultant. Working patterns and direct dial details are managed centrally in the system to ensure accurate routing of calls and remove the need for clinicians to share personal contact numbers.

To use the system GPs simply dial a local-rate number from a phone, key in the patient's NHS number and the speciality required, and their call is routed to the first available consultant. If a call remains unanswered after 20 seconds, the system

automatically routes the call to the next available consultant on the rota for speciality and clinical session.

Once connected, the call between GP and consultant is recorded and the call outcome logged. Both clinicians can access the encrypted call recording online to attach it to the patient record, or for future clinical review or medicolegal reasons. In addition, real time reports display call outcomes, average waiting times and system usage data for commissioners and hospital managers to review.

With no interface to clinical systems, a rapid roll-out model and low configuration costs, Stockport CCG selected the Consultant Connect system for a 12-month pilot in February 2016.

The challenges

No matter how easy a system might be to deploy, human behaviours can often get in the way of success. For instance, the current 61 per cent call pick-up rate in Stockport is explained by a change in mobile number for a specialist IBD (inflammatory bowel disease) nurse that wasn't notified and entered on to the system and initial inaccuracies in entering and maintaining rotas, which meant that calls weren't being routed correctly.

As a result of this, a directorate rota secretary now administers the system – a simple, web based drag and drop interface – and the project team expect to see an increase in numbers of calls answered because of this process improvement. Other issues have proved more challenging to resolve, in particular how to persuade people with a high workload to learn about and use 'yet another system'. However, by taking the time to talk with colleagues and demonstrate the solution and benefits, Stockport has found that even the busiest departments are willing to come on board.

Impact on staff and patients

The system has the potential to benefit a population of 300,000 people. Six months into the pilot and the results are impressive.

- 1,657 calls made across all specialities, of which 1,029 were answered – a 62 per cent first time pick-up rate across all specialities (haematology, endocrinology, paediatric, cardiology, elderly medicine, gastroenterology, and IBD specialist nurses)
- Of the calls answered: 51 per cent of call outcomes were referral avoided; 33 per cent referral made; nine per cent diagnostics requested; four per cent admission avoided; and three per cent admission made
- Average time of 46 seconds before a consultant answers the call
- Average call duration time of three minutes, 55 seconds

Reducing healthcare spend

Stockport CCG has funded the initial pilot and there is no cost to GP practices for using the system, other than the cost of the standard local-rate telephone call. Year one set-up and license fee costs were £64,800 (inclusive of VAT) and it's important to note that the cost structure isn't linked to call volumes – the more calls clinicians make, the more cost-efficient the system becomes.

It is too early for a formal ROI but the team is clear on the business case – unnecessary outpatient appointments are neither a good use of resources, nor a good patient experience.

In Stockport there is a block contract in place for outpatient activity. This means that the project is already helping the hospital to drive efficiencies and it may be helping the system to meet 18-week targets.

Learning and advice

The advice from the Stockport team is to see a project like this as a business-led change programme. Know your audience, understand the challenges they are facing and have a stakeholder management plan in place. Taking time to demonstrate and communicate the benefits to the system is crucial.

Also key to the success of a project like this is information governance (IG). As part of the rapid deployment methodology, Consultant Connect comes with a standard information governance pack that can be adapted for local use. This includes a governance framework overview and data processing agreement, together with a schedule of IG roles and responsibilities.

The project team took time to pre-empt possible queries and concerns. For instance, they called the medical defence union, which wrote an open letter assuring clinicians about the medicolegal benefits of the system, and made sure GPs were engaged and having their voice heard throughout the project.

There were the usual delays in getting the business case through several committees, and, inevitably, some specialities were initially quite hostile about taking on what they saw as more work. By taking time to talk with them and demonstrate the solution, even the busiest departments are now saying they are willing to come on board.

What do health and care professionals say?

Dr Simon Woodworth, GP: *"It's proved to be really quick and an efficient use of time. Each contact with the consultant has stopped the need for a referral, which meant that the patient left the consultation with clarity of their management plan. This is particularly useful for patients with complicated needs, who might normally have to wait for a chain of letters between the GP and consultants or a formal appointment secondary to a referral."*

Dr Richard Bell, Endocrinology Consultant: *"Consultant Connect makes it very easy to communicate with GPs and improve patient care while cutting out pointless backwards and forwards letters and inappropriate patient appointments. We can use our time seeing the most appropriate people. Many patients do not need a physical hospital appointment but their GP may need a consultant opinion about their care."*

Julie Ryley, Project Lead: *"Consultant Connect is helping us to build relationships, and that's so important in this environment. We want to make hospital smaller and see primary care taking on more activities, but we can't do that without specialist advice and the right relationships in place."*

For this particular vanguard project it seems that the keys to success have been solid stakeholder management, coupled with a willingness to get in front of clinicians by an energetic, business-led project team. Consultants and GPs are talking to one

another once again, and the benefits beginning to be realised are indeed ‘a no-brainer’.

What do patients say?

Mrs Hamilton, 77, from Romiley, had been suffering for some time from low blood pressure, which had led to two emergency visits to A&E at Stepping Hill Hospital during the last year, including a fall where Mrs Hamilton hit her head.

After her health deteriorated further, Mrs Hamilton booked an appointment to see Dr Woodworth at Chadsfield Surgery, who used the new Consultant Connect system, which had just launched that week. He spoke to endocrinology consultant Richard Bell and adjusted her blood pressure and steroid medication based on his opinion.

Mrs Hamilton said: *“I thought it was excellent, a superb way for the GP to hear from a consultant without having to refer me to the hospital, with the wait that entails.*

“My health had been getting worse for a while and at one point, I passed out and hit my head and had to be taken to A&E. My blood pressure was very low, which was why I didn’t have any energy and felt dreadful all the time.

“Now after the change to my medication, I feel so much better and everyone says I look a different person. We have been on a lovely day trip to Arnside on the train which would not have been possible previously and I would probably still be waiting for a hospital appointment now.”

Appendix 17: Case study – Barking and Dagenham, Havering and Redbridge (BHR) A&E Delivery Board

The challenge

The Barking and Dagenham, Havering and Redbridge area is one of the most challenged in the country in terms of quality of care and money available to deliver. The system was frequently tested with too many patients attending at the wrong location for the care they needed. Services were overstretched and struggling to meet demand.

Patients were confused as to what service or location to use to get the care they wanted and staff were under pressure to deliver and frustrated that many felt they knew the solution that was needed but lacked the opportunity to make any changes.

What was the approach and what happened?

1. Core to the vanguard approach was talking to clinicians to get real examples of how care was not working properly and what could be done about it.
2. Clinicians and managers from different partner organisations met with Healthwatch and agreed the approach to the problem.
3. The group agreed that research with patients was needed to get to the root cause of what made them make their choices on where to access care.
4. 3,000 telephone surveys, 900 one-to-one interviews and ten focus groups were carried out to build the evidence database.
5. To give a level playing field the results and research were released to everyone at the same time; staff, patients, managers, Healthwatch and other parties all had the same opportunity to contribute to the way forward.

Impact on staff and patients

The vanguard had a clear belief that patient and staff engagement had to be at the heart of what the vanguard wanted to achieve. Staff and patient feedback was to be used to shape the work and ideas and energise the process of change.

Involving staff and patients in the process and presenting research and evidence to them, has helped enhance staff understanding of the problems and reasons for patient flows. This has helped staff think through the process and offer ideas and solutions.

Where patients were engaged and involved, it helped ensure their story was part of the process and the reasons for their choice of care location were taken note of. They were then given the opportunity to understand why their choice of care might not be the best option and encouraged to make a change.

Impact on quality and cost

The research study provides robust evidence of local people's awareness and behaviour. This is shaping initiatives that provide the right care in the right place, and reduces pressure on the busy A&Es.

The re-direction of adult walk-in patients at Queen's Hospital emergency department (July to September 2016) saw patients receive a clinical assessment by a senior GP on arrival at the emergency department. Results showed that up to 30 per cent of patients attending the emergency department did not have emergency care needs, and were redirected to community urgent care services or given self-care advice.

Co-designed by hospital clinicians and GPs, it means the local hospital has aligned their staffing and required skills mix, releasing emergency care clinicians for emergency cases. Community services focus on supporting people at home, reducing A&E visits and avoiding admittance.

Learning and advice

The vanguard strongly believes that getting input from frontline staff is a serious challenge, but the reward can be a rich database of information from which to develop options for the way forward.

Having a stepped approach to engagement and implementation has allowed everyone involved to come on board with the project and move forward together.

A robust evidence database has informed the programme of work and provided real evidence of how staff and patient engagement has helped shape the model of care for the future.

The approach taken served to break down assumptions about A&E usage and gave a real focus to the actual problems that needed to be solved.

5. Resources

- Workforce Redesign WebEx – Population Health Workforce Planning #1 (January 2017)
- Workforce Redesign WebEx – Population Health Workforce Planning #2 (February 2017)
- Workforce Redesign WebEx – Population Health Workforce Planning #3 (March 2017)
- Workforce Redesign WebEx – Integrated Workforce Models – Sharing examples of the successful implementation of MDTs (February 2017)
- The Academy of Fabulous Stuff – Multidisciplinary team working
- The Point of Care Foundation – Staff care: How to engage staff in the NHS and why it matters (January 2010)
- King's Fund 'Supporting integration through new roles and working across boundaries' (June 2016)
- Health Foundation's 'Fit for purpose? Workforce policy in the English NHS' (March 2016)
- NHSE and the LGA joint integrated personal commissioning emerging framework (May 2016)
- Carter report
- Nuffield Trust 'Reshaping the workforce to deliver the care patients need'
- Skills for Care – The principles of workforce integration (2014)
- Centre for Workforce Intelligence – Think integration, think workforce (2013)
- The King's Fund and Nuffield Trust – The evidence base for integrated care
- The Better Care Fund - How to... work together across health, care and beyond (May 2015)
- The King's Fund – Place-based systems of care: A way forward for the NHS in England (November 2015)
- NHS Institute for Innovation and Improvement – Joined-up care: A practical guide to making change happen (2010)
- International Federation of Integrated Care (IFIC) – Effectiveness of teamwork in an integrated care setting for patients with COPD (2016)

6. References

[1] Sikka R, Morath JM, Leape L. The Quadruple Aim: care, health, cost and meaning in work. BMJ Qual Saf published online first: 2 June 2015. doi: 10.1136/bmjqs-2015-004160

[2] Five Year Forward View

[3] Institute for Healthcare Improvement Triple Aim initiative

[4] New care models support package

[5] Skills for Care, Think Local Act Personal, Skills for Health, Local Government Association, NHS Employers and the Association of Directors of Adult Social Services, The principles of workforce integration (2014)

[6] Workforce redesign workstream new care models, integrated workforce models – useful literature, 12 August 2016/updated 2017

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[43] The six new care model sites include:

- One pioneer – Barnsley
- Two PACSs – Salford Together; North East Hampshire and Farnham
- Three MCPs – The Connected Care Partnership (Sandwell and West Birmingham), Wakefield Connecting Care Multispecialty Community Provider (MCP), Better Local Care (South Hampshire)

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[47] Patients who take the PAM questionnaire/survey are given a PAM 'score' from 0-100 based on the answers given. Based on the PAM score the patient is then identified as being at a PAM 'level' 1, 2, 3 or 4. Note an increase in a patient's PAM 'score' may not cause an increase in their PAM 'level'.