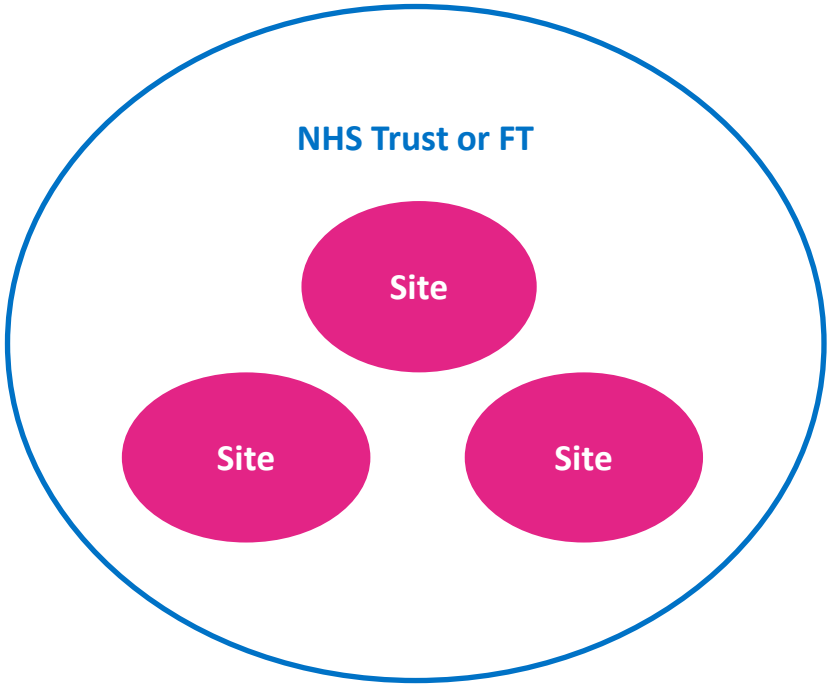
Accelerator Support Pack 1
Module 1: Understanding New Care Models and Workforce Implications

Appendix 1: Case Studies

Option 1: Multi-Site Trust



Case Studies:

Royal Free London NHS Foundation Trust's acquisition of Barnet and Chase Farm Hospitals NHS Trust

Merger between Bart's and The London NHS Trust, Whipps Cross University Hospitals NHS Trust and Newham University Hospital NHS Trust

Option 1: Multi-Site Trust
Case Study 1: Royal Free London NHS Foundation Trust

Background: The Royal Free London NHS Foundation Trust, acquired Barnet and Chase Farm Hospitals NHS Trust in July 2014, becoming one of the UK's largest trusts. The trust delivers care to more than 1.6 million patients each year. It has three main hospitals: Barnet, Chase Farm and the Royal Free, as well as more than 30 satellite sites delivering care within the community. The trust employs more than 10,000 staff from more than 100 nationalities.

Why the trust wanted to change culture across the workforce: In 2012 the Royal Free London developed its world-class care values. Data has shown that the organisation is heading in the desired direction, slowly but steadily delivering a culture change. The hospitals had come together from a previous merger and initial research indicated that this merger had not been entirely successful. There were many signs that they had integrated by name but not completely by working practices. One hospital had also lost services (A&E and maternity) in an earlier re-configuration so felt 'dis-invested'. The senior leadership team felt that the issues identified required a focused attention on culture which had perhaps not been the case before. As a result, a Culture Steering Group was formed, prior to acquisition, to focus on the successful integration of the organisations.

Challenges

- Geography - Three main hospitals with more than 30 satellite sites and a patient population the size of Birmingham.
- Integration of process, systems and people into a single, cohesive and effective organisation.
- Cost improvement programmes and major transformation programmes.

OD practices that have helped change culture: "Successful integration and transformation of services is dependent on the quality of leadership at all levels." The organisational development (OD) team is at the forefront of supporting the culture work. At present the trust is focusing on three key OD supported interventions: leadership and talent, world class care values and patient and staff experience.

Top tips for others

Ensure you have genuine commitment from the senior leadership. Set up a Steering Group and develop a good sounding board that is reflective of the organisation. Include some of the dissenting voices if possible, as they are very helpful. Use internal and external networks and resources to gather as much information about best practice and learning, as possible. Focus heavily on developing the right workforce strategy to ensure employees feel supported.

Option 1: Multi-site Trust
Case Study 2: The Bart's Health NHS Foundation Trust merger

Background

This case study describes the merger between Bart's and The London NHS Foundation Trust, Whipps Cross University Hospitals Trust and Newham University Hospital NHS Trust

An Outline Business Case (OBC) for the proposed merger was approved by the three legacy Trust boards and NHS London.
The perception was that Whipps Cross and Newham were in significant financial difficulties, but Bart's was a stronger hospital. The merger was strongly encouraged and supported implementation from local and regional commissioners.
Other key factors driving the change were the local demographics, with large and growing population and high levels of deprivation, and the chance of FT status.

The clinicians produced a Health and Healthcare benefits document which outlined some of the broad range of improvements that could be made from the merger, and how they could be delivered, whilst keeping services sensitive to local needs. A merger clinical benefits video is also available to view online.

Following an extensive 16-week stakeholder engagement programme and decision-making process in December 2011, a Full Business Case (FBC) was then approved by the three legacy Trust boards, the two commissioning clusters (NHS East London and The City and NHS outer north east London) and NHS London.

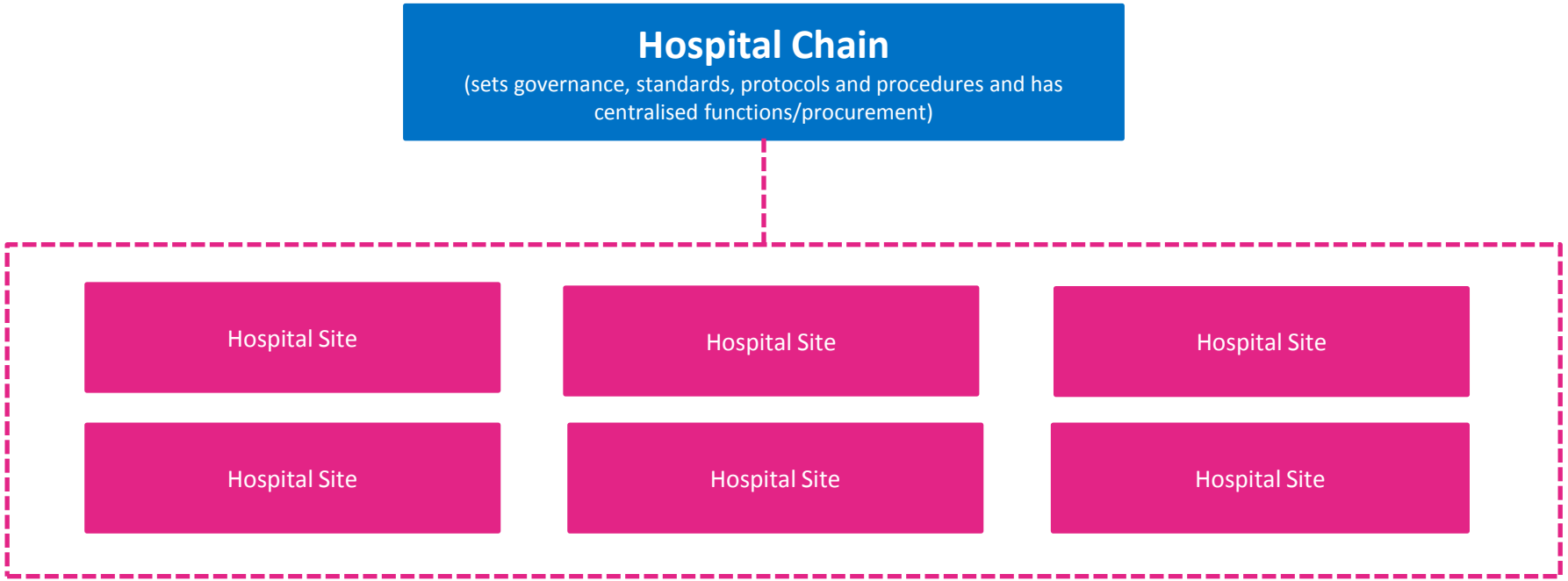
The Department of Health Transaction Board and the NHS Co-operation and Competition Panel (CCP) recommended to the Secretary of State for Health that the merger should proceed. Following consideration of all the evidence and recommendations, the Secretary of State for Health approved the merger and the new Trust – Bart's Health.

Learning:

The merger has improved some patient outcomes, reduced deficits, and some clinical benefits have been achieved such as streamlining outpatient pathways. However not all the benefits have been realised, and Bart's has experienced significant financial problems and some of the contracting arrangements with commissioners are complex.

In March 2015 Bart's Health was selected alongside Tower Hamlets GP Care Group Community Interest Company (representing primary care); East London NHS Foundation Trust (local mental health trust) and London Borough of Tower Hamlets (local council and social care) to deliver a Multispecialty community vanguard under the Tower Hamlets Integrated Provider Partnership.

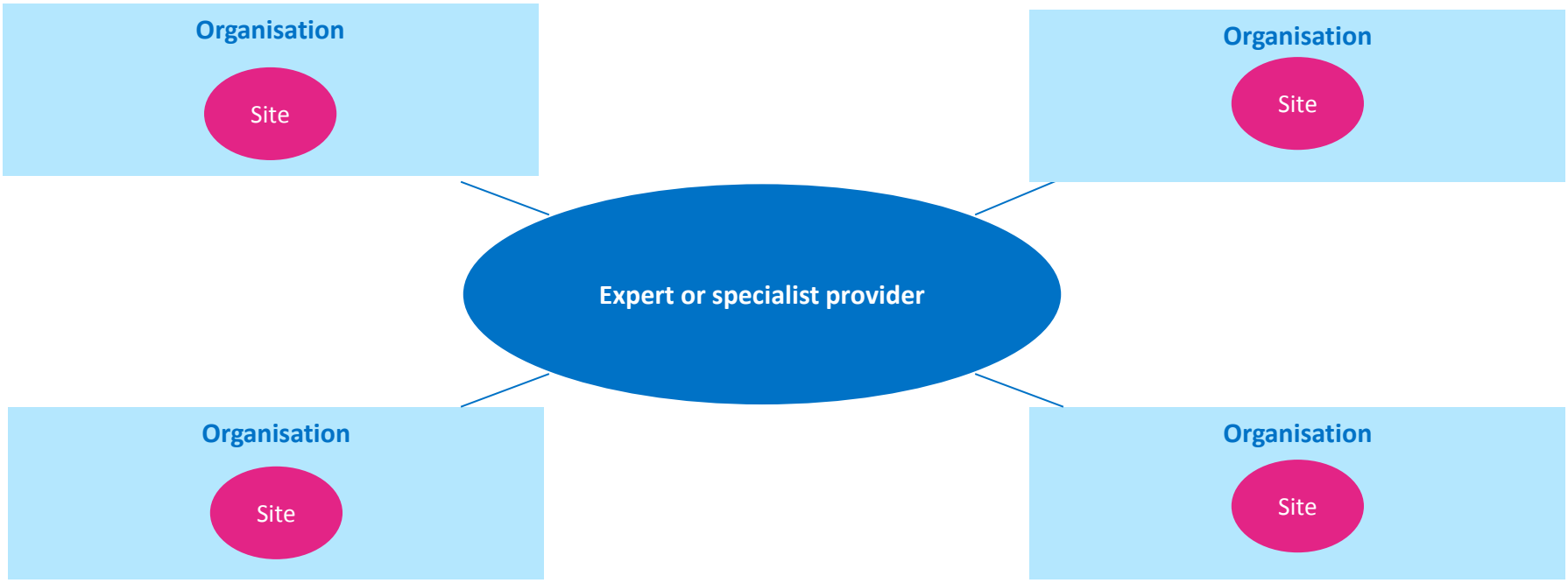
Option 2: Hospital chain



Case Studies:

To follow as develop case study

Option 3: Multi-Site Speciality Franchise



Examples:

Moorfields Eye Hospital

Alder Hey Children's NHS Foundation Trust

Neuro Network

Option 3: Multi-Site Speciality Franchise
Case Study 1: Moorfield Eye Hospital

Background: Moorfields Eye Hospital is the largest provider of ophthalmology services in England, providing more than 33,000 episodes of inpatient treatment and more than 470,000 outpatient appointments each year. It operates a networked model of care across 23 locations in and around London. Apart from the hospital in central London, these locations are grouped into four distinct categories in discrete geographical clusters: District Hubs, such as Moorfields Eye Centre at Ealing, co-located with general hospital services; Local Surgical Centres; Community-based Outpatient Clinics, offering predominantly outpatient and diagnostic services; and Partnerships and Networks, where Moorfields offers medical and professional support to eye services managed by other organisations. Approximately 50% of their total activity is delivered away from the central London hospital.

Premises: Partnership working for other service offers. Uses leased premises at host hospital and community locations.

Commissioned vs. subcontracting: Delivers commissioned and subcontracted services – prefers to be directly commissioned (e.g. have strategic negotiations and influence) and have a contract with the hospital to lease space while providing Moorfields staff.

Branding: Has a strong brand that is the key selling point for Moorfields service-level chain. Do not rent out their name as per a franchise, but prefer all components (staff and systems) to be under their control – key concerns relate to quality assurance and clinical governance.

Patient preference: Hub vs. spoke: Some patients prefer to be seen at the hospital in central London (City Road) as they associate this with high-quality research, and are worried that other locations may not provide the same quality services. Thus Moorfields may find it challenging to deliver geographically far-reaching service-level chains as long distances between the central research centre brand and the Moorfields satellites might lead the satellites to lose some of the brand benefit.

Workforce: Only uses own staff for directly commissioned activity. Moorfields have a clear 10 Year Strategy and have placed great emphasis on developing their workforce to ensure they have the right workforce, skills and capacity to implement their clinical model and strategy. They have also developed a clear leadership and organisational design to ensure they have the right leadership and culture.

Option 3: Multisite Specialty Franchise
Case Study 2: Alder Hey Children's NHS Foundation Trust

Background: Alder Hey is one of Europe's busiest children's hospitals and care for over 270,000 young people and their families every year. It is a Centre of Excellence for cancer, as well as spinal, heart and brain conditions and a Department of Health Centre for Head and Face Surgery. In addition it is the Centre of Excellence for Muscular Dystrophy and the first UK Centre of Excellence for Childhood Lupus, one of four national centres for childhood epilepsy surgery, a joint service with the Royal Manchester Children's Hospital and a designated Children's Major Trauma Centre. Alder Hey have Europe's only intra-operative 3-T MRI scanner which is a pioneering technology for neurosurgery, reducing repeat operations in 90% of cases.

Multisite Specialty Franchise: Alder Hey currently delivers over 600 of paediatric specialist clinics in North-West England and North-Wales. These clinics offer a wide variety of services from specialist clinics to full service paediatrics. Currently the clinics are operated within DGHs paediatric departments. Alder Hey has good reputation in the region and expertise in children's services. They are now looking to expand their service form, and are exploring different arrangements with regional hospitals in delivering care at local communities.

Workforce Objectives: In common with other Trusts Alder Hey faces a range of challenges to ensure that suitable workforce is maintained. With an aging population comes an aging workforce, with attrition coming through retirements and a constrained pipeline of suitably qualified staff. The workforce strategy highlights how the impact of retirement can be absorbed as well as an active recruitment strategy. Alder Hey is committed to:

- 7 day working
- Exceeding the minimum nurse to patient thresholds
- Robust succession planning for suitably qualified doctors
- Providing major, regional nurse training
- Addressing the shortage of Allied Health Professionals through education, learning and development

The Alder Hey Strategic Plan for 2012-16 describes the following workforce objectives:

- Regional, national, and international institutional partnerships which enhance the very best translational and applied clinical research
- A recruitment strategy that will attract the best researchers internationally
- Develop the full potential of the expert multidisciplinary workforce within Alder Hey to lead and contribute to research based knowledge in child health care

Option 3: Multisite Specialty Franchise
Case Study 3: Neuro Network

Background
In September 2015 the Neuro Network was selected as one of the Acute Care Collaboration Vanguards.

The Neuro Network aims to develop a high quality and cost effective neuroscience service chain. It is a partnership between the Walton Centre NHS Foundation Trust; Warrington and Halton Hospitals NHS Foundation Trust; Liverpool CCG; Warrington CCG and NHS England Specialised Services Commissioning Team (North).

The programme is built on partners' extensive experience in developing the network models for neurology and spinal services in Cheshire and Merseyside. It aims to strengthen the neurological support provided by the Walton Centre to local hospitals, GPs and patients, and look to extend the spinal model in partnership with The Royal Liverpool and Broadgreen University Hospitals and Aintree University Hospital. This approach enables patients to have rapid access, locally, to high quality care from a regional specialist centre.

Overview
The Walton Centre operates a 'hub and spokes' model that makes tertiary centre neurology services available to more than three million patients across Merseyside, Cheshire, north Wales and the Isle of Man. Currently 13 NHS trusts are included in that model, covering all 15 district general hospitals in the region. Patients are able to access outpatient consultations and a range of tests close to where they live; services are also provided from health centres and other community settings.

The Walton Centre also oversees the Cheshire and Merseyside rehabilitation network.

The Cheshire and Merseyside rehabilitation network is an example of a genuine partnership between NHS organisations in that area. The Walton Centre acts as the host with the hub being at the Walton centre and the spokes in two other district general hospitals, extended and community services are also available to provide stepped down care as the patient progresses.
Admissions are taken across a range of units, depending on the needs of patients, with opportunities with outpatient consultant and therapist appointments to manage ongoing support needs.37 Hyper acute and level 1 rehabilitation is provided at the Centre, networking with three level 2 spokes in district general hospitals, plus community rehabilitation services.

The service has impressive results:
- 96 per cent of patients and families are very satisfied with the models of care
- All national waiting times targets for assessment and admission for specialist rehabilitation care are being exceeded
- 81 per cent of patients admitted with critical illness are discharged within 70 days

Admissions, transfers and discharges across the network are coordinated from a central office, based at the Walton Centre. This ensures that the tertiary centre has a good sense of length of stay within the network and can identify any blocks in the pathway.

Continued on next page

Option 3: Multisite Specialty Franchise
Case Study 3: Neuro Network

Workforce

Consultant neurologists provide general and some specialist neurology clinics and ward referral services at the general hospitals. The model enables the consultants at the same time to provide specialist services at the Centre, so facilitating access to specialist care for the full range of neurological conditions. The focus is on multidisciplinary working, with the full team of specialists.

Patients with long-term conditions and complex needs are also supported by Advanced Neurology Nurses. These nurses liaise with other specialists including physiotherapists, occupational therapists, speech and language services, dieticians, social services, mental health teams and carers. The coordination of multiple professionals ensures that patients have all the support they need, close to home. They act in the role of key worker.

All neurological activity is co-ordinated from the Walton Centre thus ensuring standardisation of booking processes and outcomes. All district general hospitals and community centres have access to specialist advice from the Walton Centre at all times via the emergency line managed by the consultants for one hour per day or via the nurse advice line manned Monday to Friday from 8am until 5pm.

Challenges

The main challenge so far has been for clinicians working across multiple organisations with various clinical systems. Access to records is restricted and the clinicians are required to create local records as well as centre notes. The only system which is regional and easily accessible for all is the Radiology PAC's.

The spoke units are managed locally with some of the neurology services being commissioned under local CCG's and with the specialist services being commissioned by NHS England. Given the different commissioners involved it is difficult at times to identify financial benefits.

Outcomes data is currently reported by local providers to the centre.

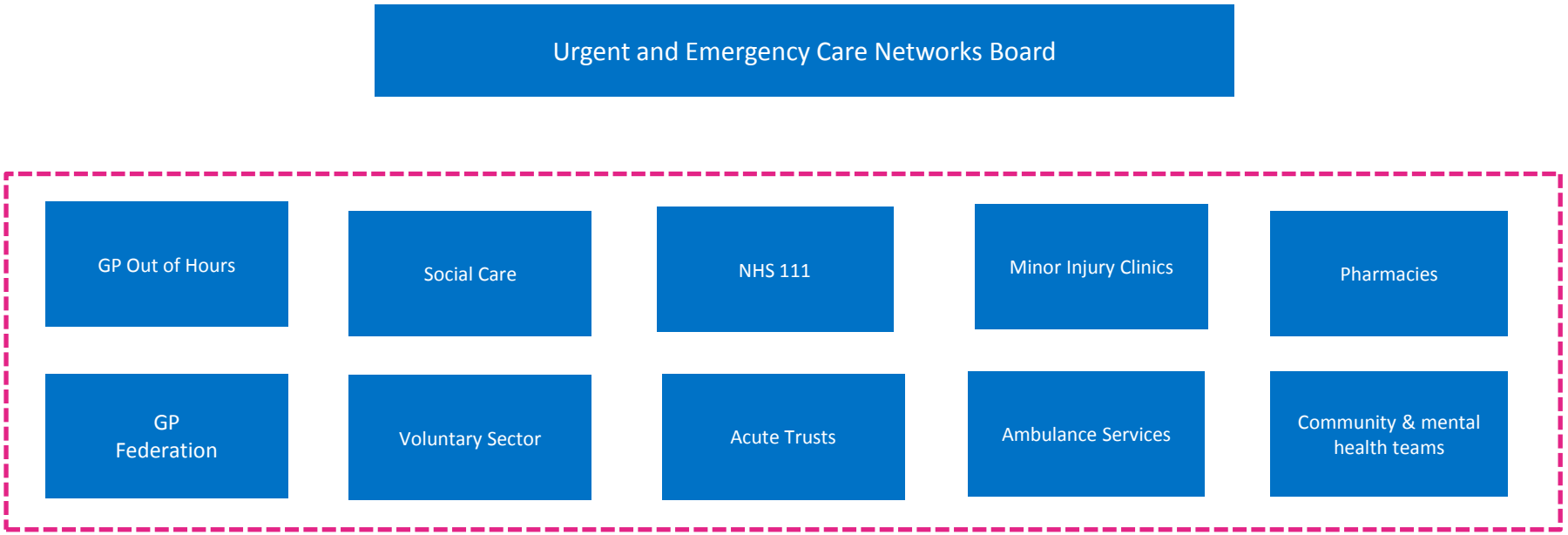
The spinal musculoskeletal lead assessment process has faced challenges in the integration of services due to the varying levels of qualified staff across organisations as well as demand for this type of service.

Next Steps

The Network is exploring the possibilities for common commissioning agreements which would enable the standardisation of terms and conditions as well as providing a more overarching governance structure.

The Network would like to employ more Advanced Neurology Nurses if training and budget allocation will allow.

Option 4: Urgent and Emergency Care Networks



Case Studies:

Barking, Dagenham, Havering and Redbridge system Resilience Group

North East Urgent Care Network

Option 4: Urgent and Emergency Care Networks
Case Study 1: Barking, Dagenham, Havering and Redbridge System Resilience Group

Which organisations are involved:
The Barking and Dagenham, Havering and Redbridge (BHR) System Resilience Group (SRG) is an urgent and emergency care network Vanguard consisting of local CCGs, GP Federations, acute hospitals Trust, NELFT - the community and mental health services provider and local councils across the three London boroughs. The Vanguard application described an ambitious plan to make it easier for the public to find and get help when and where they need it.

Barking and Dagenham, Havering and Redbridge System Resilience Group aims to simplify access, supported by a digital platform that will recognise patients and personalise the help they get. This includes a 'click' online support and information service to book urgent appointments and self-care, a 'call' telephone service for more advice, reassurance or to book-in, and a 'come in' option for patients who really need emergency care

Geography and how it will be different for patients:
The SRG covers 750,000 residents (see next page for full demographics). The aim is to ensure patients have access to excellent urgent care services when they need it by doing things differently. Through working together the SRG aims to remove confusion about where to go in an emergency or where to access urgent care or advice from the various options including A&Es, walk-in centres, urgent care centres, GPs, pharmacists and GP access 'hubs'.

The vision for the future is to offer three choices for accessing urgent and emergency care – supported by a digital system that will recognise patients and tailor the help they get as soon as they make contact. It is hoped patients will go online for support and information to 'self-care' with more confidence and to book urgent appointments direct if needed. They will phone a customer service centre if they need more in depth advice or reassurance from a clinician, or if it's a real emergency or they need hospital tests, they will go to hospital, to one of two ambulatory care centres, eventually sharing a single ED at Queen's Hospital in Romford. The three options are 'Click', 'Call' or 'Come in'.

Quotes from the team developing the new model of care:
"It's an ambitious plan," says **Dr Ed Diggins, Healthbridge GP Federation lead** and part of the SRG's presentation team. "We made that very clear in the Vanguard application and in the team's presentation. We can only do this because we already have true partnership working here in BHR between NHS and social care organisations with a proven track record of great success. That's how we've managed to improve the 4-hour emergency access performance by nearly 20% in the past year, get patients home more quickly through our new joint assessment and discharge service, care for more than 20,000 patients at home with new intermediate care services and launch six GP access hubs offering evening and weekend appointments in recent months, with more to follow."

John Brouder, NELFT Chief Executive, says: "Critical to the whole system is the work that NELFT does in caring for people at home and the community and keeping them out of hospital which is better for the patient, better for their recovery and a better way of managing services."

Cheryl Coppell, Chief Executive of the London Borough of Havering, says: "The success of our joint application is a ringing endorsement of the work by all partners locally to improve care for our residents by working together across organisations. Social care has a major part to play in this by helping to assess those people who do need a stay in hospital and arranging vital care packages to get them back home from hospital quickly once they are well enough."

Option 4: Urgent and Emergency Care Networks
Case Study 1: Barking, Dagenham, Havering and Redbridge System Resilience Group

2

Our context

Data source:

Population data: Local authority population projections 2015 - based on GLA 2014 Round of Trend-Based Demographic Projections, Short-Term Migration Scenario

GP data: Primary Care Web Tool http://www.primarycare.nhs.uk/default.aspx

Social Care Clients source: Health and Social Care Information Centre, 2014/15

Redbridge

ONS: Population: 300,473
Population aged under 5: 23,573
Population aged 75+: 17,266

Life expectancy male: 80.72
Life expectancy female: 84.21
Healthy life expectancy male: 62.7
Healthy life expectancy female: 63.0

ONS projections 2015:
Population growth 5 years: 8.9%
Population growth 10 years: 17.2%

GP practices: 46
List size: 300,100

Social care clients: 6,525 total
18-64 : 1,760
65+ : 4,765

Barking and Dagenham

ONS: Population: 202,358
Population aged under 5: 19,894
Population aged 75+: 9,629

Life expectancy male: 77.66
Life expectancy female: 82.36
Healthy life expectancy male: 61.1
Healthy life expectancy female: 55.5

ONS projections 2015:
Population growth 5 years: 9.7%
Population growth 10 years: 18.4%

GP practices: 40
List Size: 213,104

Social care clients: 3,865 total
18-64 : 1,135
65+ : 2,730

Havering

ONS: Population: 246,998
Population aged under 5: 15,489
Population aged 75+: 22,874

Life expectancy male: 79.78
Life expectancy female: 83.85
Healthy life expectancy male: 63.4
Healthy life expectancy female: 65.8

ONS projections 2015:
Population growth 5 years: 5.7%
Population growth 10 years: 11.8%

GP practices: 48
List size: 262,199

Social care clients: 7,095 total
18-64 : 1,550
65+ : 5,545

BHR Summary

ONS: Population: 749,829
Population aged under 5: 58,956
Population aged 75+: 49,769

GLA: Population: 747,565
Population aged under 5: 59,632
Population aged 75+: 48,779

ONS projections 2015:
Population growth 5 years: 8.1%
Population growth 10 years: 15.7%

GLA projections 2015:
Population growth 5 years: 7.8%
Population growth 10 years: 14.8%

GP practices: 134
List size: 775,403

Social care clients: 17,485

NELFT

Primary community and mental health provider for B&D, Havering, Redbridge and Waltham Forest (also provides community health services for people in south west Essex)

Annual budget: **£300 million est.**
Staff: **6,000**

BHRUT

Number of Hospitals: 2
Population served: 750,000

Annual budget: **£500 million est.**
Staff: **6,000**

GP FEDERATIONS

3 GP Federations in BHR:

Havering Health (Havering)
43 practices signed up (90%)

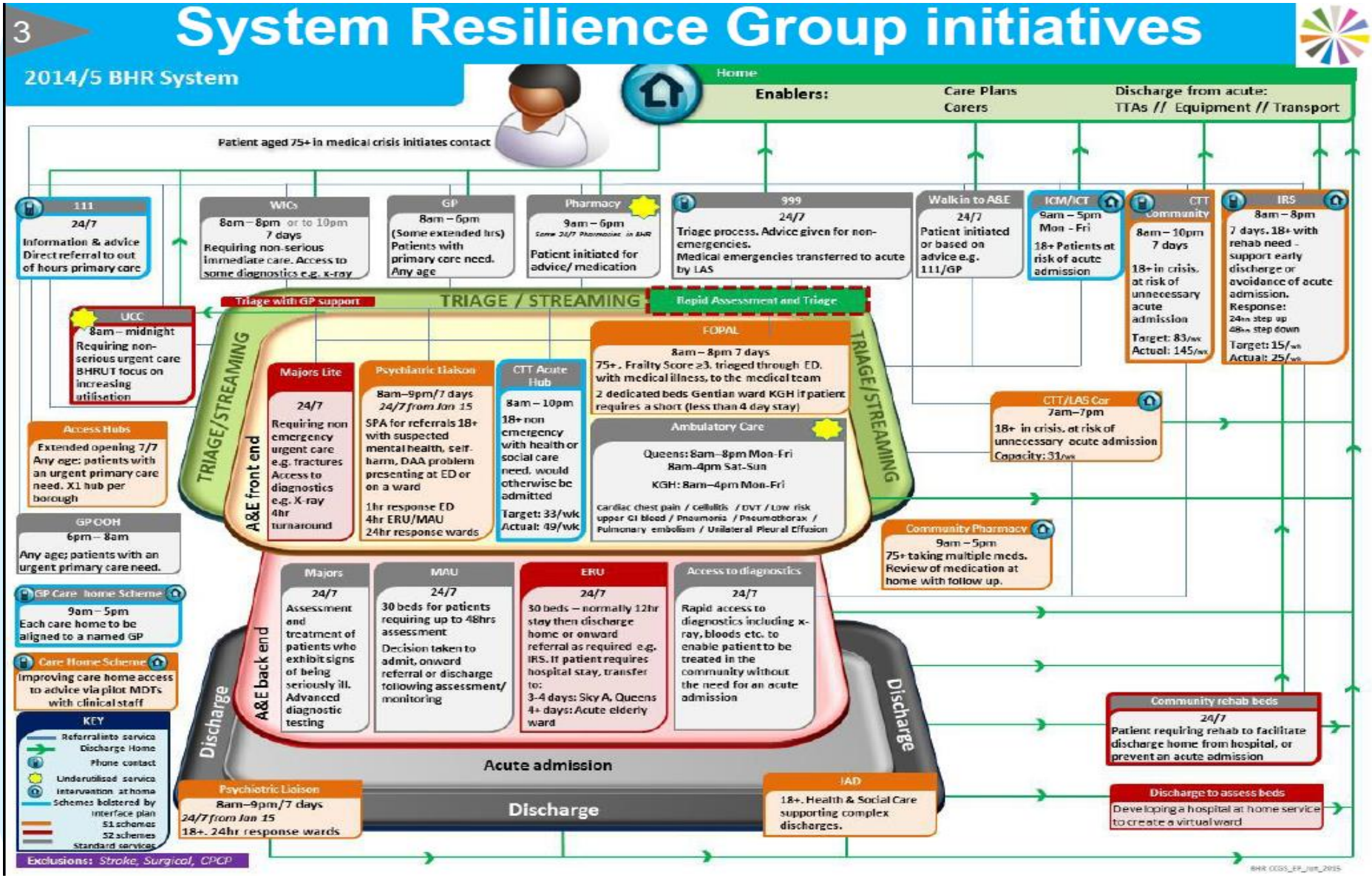
Together First (B&D)
20 practices signed up (50%)

Healthbridge Direct (Redbridge)
23 practices signed up (50%

Option 4: Urgent and Emergency Care Networks
Case Study 1: Barking, Dagenham, Havering and Redbridge System Resilience Group

Stage 1 by April 2016	Stage 2: by October 2016	Stage 3: by April 2017	Stage 4: by October 2017
We will establish two **new ambulatory care centres** at both hospital sites (Queen's and King George) and **integrate all "front door" services** including rapid response. We will develop our **overarching service model** with staff, patient and carer engagement setting out how to access urgent care, services available, branding and the changes needed by providers and others to deliver our model. Stage 1 is critical to building trust and confidence as we develop the new pathways.	We will **align current capacity to the new model**, closing multiple front doors, including King George Hospital* and opening primary care hubs to ensure effective patient flow. We will deliver the full new **digital platform** for practitioners. We will start to see the system achieving the new clinical, quality and productivity standards. We will have agreed **new provider arrangements** based around a single integrated pathway including **payment models and funding flows**.	Our **new urgent care system** will be delivered through a single ED*, two ambulatory care centres, 10-12 integrated primary care hubs and rapid response services with our **commissioning and contracting arrangements in shadow form**. Patients will have full access to the new **patient digital platform** for shared care record, directory of service and direct booking. The system will **deliver new standards** around clinical, quality and productivity including length of stay, readmission rates and lost bed days per 100,000 population.	The **new urgent and emergency care model** is delivered across BHR with simplified access and a consistent offer to patients across services and locations. There is a **single urgent and emergency care pathway and payment**.

Option 4: Urgent and Emergency Care Networks
Case Study 1: Barking, Dagenham, Havering and Redbridge System Resilience Group



Option 4: Urgent and Emergency Care Networks
Case Study 2: North East Urgent Care Network

The North East Urgent Care Network spreads across both rural and urban areas, including Northumberland and County Durham and has a total population of 2.71 million. It aims to provide consistent and seamless care in terms of access and quality across its three major conurbations. A total of £1,543,000 was secured to the North East Urgent and Emergency Care Vanguard.

The funding will be used to speed up implementation of elements of the Urgent and Emergency Care route map and will focus on:
- Information sharing (SCR or MIG) linked to NHS 111 accessing GP bookings directly
- Information-sharing agreements to allow anonymous data sharing
- Development of the clinical hub
- Develop self-care
- Developing the clinical model
- Development of the DOS for NHS 111
- Scoping of mental health projects

Workforce

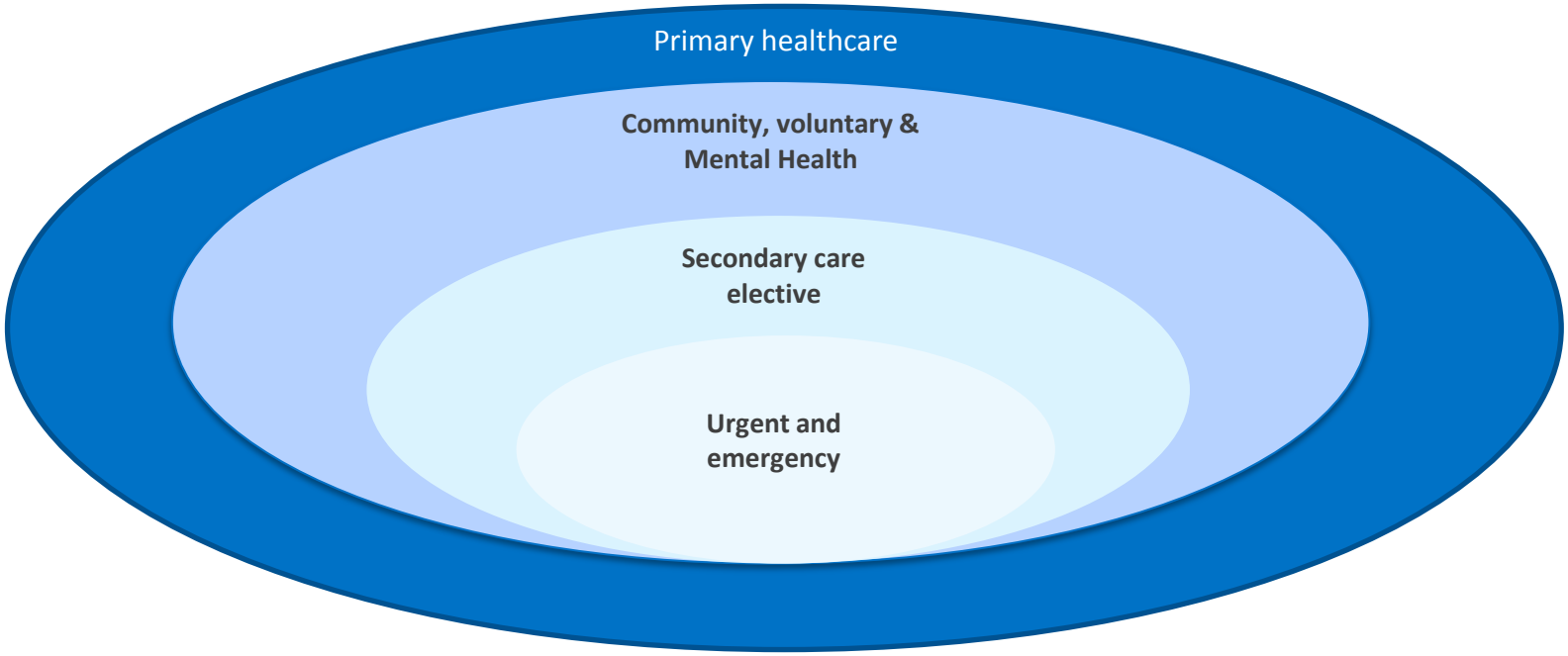
The CCG recognises that the details of service delivery in terms of the necessary workforce will be ultimately determined by the Provider of the service. However, it is clear from the pre-engagement feedback that there are some core skills and inputs that the future service model will need to incorporate.

It is also clear that there is currently a wide range of excellent staff currently deployed in the delivery of urgent care services. The CCG envisages that all of these staff groups would be deployed in the future service configuration. TUPE implications for staff will be thought through in detail after the consultation is completed and once a decision has been made about the future configuration of urgent care services.

Potential workforce for urgent care services in the future are:
- GP's
- Urgent care doctors (SPR and specialty doctors)
- Nurses (of all bands, from HCA to modern matron)
- Prescribing nurses
- Nurse Practitioners, specialising in (for example): Emergency care, Paediatrics, Minor injuries
- Radiographers
- Administrative staff e.g. Receptionists, wards clerks

The clinical model describes a single site scenario as well as a 'hub and spoke scenario. The same resource would be available to establish both scenarios, and as such, with the 'hub and spoke' model, the resource would be spread more thinly across a number of locations. Therefore it should be noted that that it will not be viable to establish a full compliment of staff described above in every point of delivery. For example the 'spokes' will not provide a full range of specialist nurse practitioners or radiographers . This skill mix would be centralised in the 'hub'.

Option 5: Accountable Care Organisation or Integrated Care Organisation (ACO/ICO)



Case Studies:

Salford Together

Greenwich Co-ordinated Care

Cambridge Accountable Care Organisation

Virginia Mason Accountable Care Organisation

Alzira Accountable Care Organisations

Option 5: Accountable Care Organisation/Integrated Care Organisation
Case Study 1: Salford Together

Background: In common with the rest of the UK, Salford has a growing elderly population, it is predicted to increase by **22 per cent by 2030**. A joint learning disability service was initially piloted 12 years ago. This had a pooled budget and an integrated health and social care head of service was appointed, they then recruited people with a shared vision. The strategy and vision for the service was governed by the valuing people report by the Department of Health (2001). This became the template for recruiting people, with the focus furthermore on those who were "person-centred".

Salford is committed to finding new and better ways of providing services and so for the last two years health and social care partners have been working together to look at new ways of caring for and supporting older people in the district. The learning from the joint learning disability service was used in the creation of the Salford Older People's Integrated Care project – Salford Together – a partnership of Salford City Council, NHS Salford Clinical Commissioning Group, Salford Royal NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundation Trust.

Workforce: The management team consists of the Head of Service/Head of Provision, Head of Assessment Services, Joint Health and Social Care Commissioning Officer, both community team members (one from a nursing background, one from a social work background), a Learning Disability Psychiatrist, a Clinical Psychiatrist and a special behaviour nurse therapist. The Older People's team now has a team of Integrated Care Co-ordinators, managed by two integrated care managers based in and co-located in one office. Although they are from either a nursing or social care background they are still responsible for managing all roles. The risk stratification tools in place and regular reviews mean that new ways of working are encouraged via a different means that the usual organisational response. The MDT in place looks at key points for peoples well being and recovery, sharing of information means prioritising people and identifying those most at risk to make the greatest impact through integrated, co-ordinated care.

Building on The Success: Winning hearts and minds has been key to the success of the earlier developments and work now taking place. Key success factors:

- The importance of using the term "we" rather than "us" or "them"
- A fully integrated budget, patient centred rather than "health" or "social care" money
- Appointment of a key worker with ability regardless of role to co-ordinate all care
- Joint working with all organisations involved
- Agreeing shared care plans
- Sharing information across all agencies
- Regular reviews to change plans as required
- Risk stratification tools

Option 5: Accountable Care Organisation or Integrated Care Organisation (ACO/ICO)
Case Study 2: Greenwich Co-ordinated Care (Building the Team Around the Person)

Royal Greenwich Coordinated Care - developed by the Royal Borough of Greenwich, NHS Greenwich Clinical Commissioning Group, Oxleas NHS Foundation Trust and the local voluntary sector

Background: Greenwich is divided into four areas with, four geographical clusters of GP practices called syndicates. Greenwich Coordinated Care has successfully been tested in one syndicate area and is now being expanded. Greenwich Co-ordinated Care teams ensure that care to residents with complex health and care needs is well co-ordinated and personalised. The team has a consistent focus on what patients and their families want to achieve. The care facilitated by the team is shaped by each individual's 'I' statements through which patients describe what would truly make a difference to their lives. This collaborative approach has proved to be very successful and has helped people to turn their lives around. Indications are that people and their families appreciate this approach and are happy with the plans that are put in place for meeting their care needs and aspirations.

Workforce: Each syndicate has a core team consisting of GPs, a clinical integration specialist, care navigators, social workers and a psychologist. Working closely with GPs, this core team around the person lies at the heart of the Greenwich coordinated care model which aims to support people with multiple long term conditions or complex needs. Greenwich Coordinated Care is an approach underpinned by intensive work of the core team involving the Care Navigators who then draw on a wider array of services specific to the needs of the individual person's care such as District Nursing, Community Matrons, Continence Team, Podiatry Team, IAPT, memory services, Social Care, Housing, Telecare/Telehealth, Domiciliary Care, Physiotherapists, Occupational Therapists, Community Psychiatric Nurses and Voluntary Sector.

Pooling resources and bringing together teams of therapists, other health care professionals and social care staff into one service, with shared management arrangements, allowed a previously complicated system to be streamlined into a clear pathway with shared aims and outcomes.

In addition, the core team has named links with the patient's established specialist services for example diabetes, **chronic obstructive pulmonary disease** or mental health. They also work closely with a range of well-established integrated health and social care teams focusing on rapid response in the community for clinical deterioration; community assessment and rehabilitation; hospital discharge; support for learning difficulties and reablement services.

Option 5: Accountable Care Organisation or Integrated Care Organisation (ACO/ICO)
Case Study 3: Cambridge Accountable Care Organisation

Vision: Partnership between primary and secondary care providers to deliver the best possible clinical outcomes within a fixed budget

Core objectives: Clinical teams moving seamlessly from home to community centre to hospital, shared electronic patient record with patient access, financial alignment and risk sharing of a capitated budget and to transforming academic excellence and research into on-the-ground achievements for our population

Clinical Care: to develop a shared care model from the [patients home thought to tertiary care enabling care with the most suitable professional

Accountable Care model: A single **provider** organisation crossing primary/secondary care boundaries, commissioned by NHS; accountable for outcomes, registered primary care population with a capitated whole population budget and financial risk held on provider side.

Accountable Care Structure: A Community Interest Company run for the benefit of the community, working in and with the community, jointly owned by primary and secondary care, board-level representation of patients, local authority & both primary and secondary care clinicians and accountable to commissioners for outcomes, not processes

ACO Priorities: Living within a finite budget, relentless focus on quality of care, safety, outcomes, patient experience and careful use of resources, flexibility around service provision and local accountability and shared decision making

Vision for patients: Local easy access to quality-assured health care, extended opening of primary care facilities, full range of diagnostics provided at local level, ability to manage most conditions on-site, using specialist knowledge when needed and rapid access to specialist opinion using shared record

Option 5: Accountable Care Organisation or Integrated Care Organisation (ACO/ICO)
Case Study 4: Virginia Mason Accountable Care Organisation

When: The hospital itself has existed for some time, but in 2002 Virginia Mason embarked on a system-wide program to change the way it delivers care and in the process improve patient safety and quality. It did so by adapting the Toyota Production System (TPS) for application to the care they deliver, calling it the Virginia Mason Production System (VMPS).

Population/ Coverage: No information available on fixed coverage; patient volume in 2011 included over 800,000 physician visits, just over 16,000 in-patient hospital admissions and 18,000 surgical procedures.

Type of Model: A multi-speciality group ACO, Virginia Mason is a fully integrated healthcare system. In its own literature regarding the Federal ACO programme Virginia Mason note that they decided not to take part in the formal initiative "given the complexity and cost of participation"9 and primarily because as an organisation they were already providing fully integrated care, focused on quality outcomes.

Summary: Its a non-profit organisation offering a system of integrated services including the following:

- A large multispecialty group practice of 460 physicians who offer both primary and specialty care.
- An acute-care hospital licensed for 336 beds with a Research Institute at Virginia Mason.
- A network of medical centres throughout the region.
- A nursing residence and chronic care management centre for people living with AIDS and other chronic or terminal illnesses.

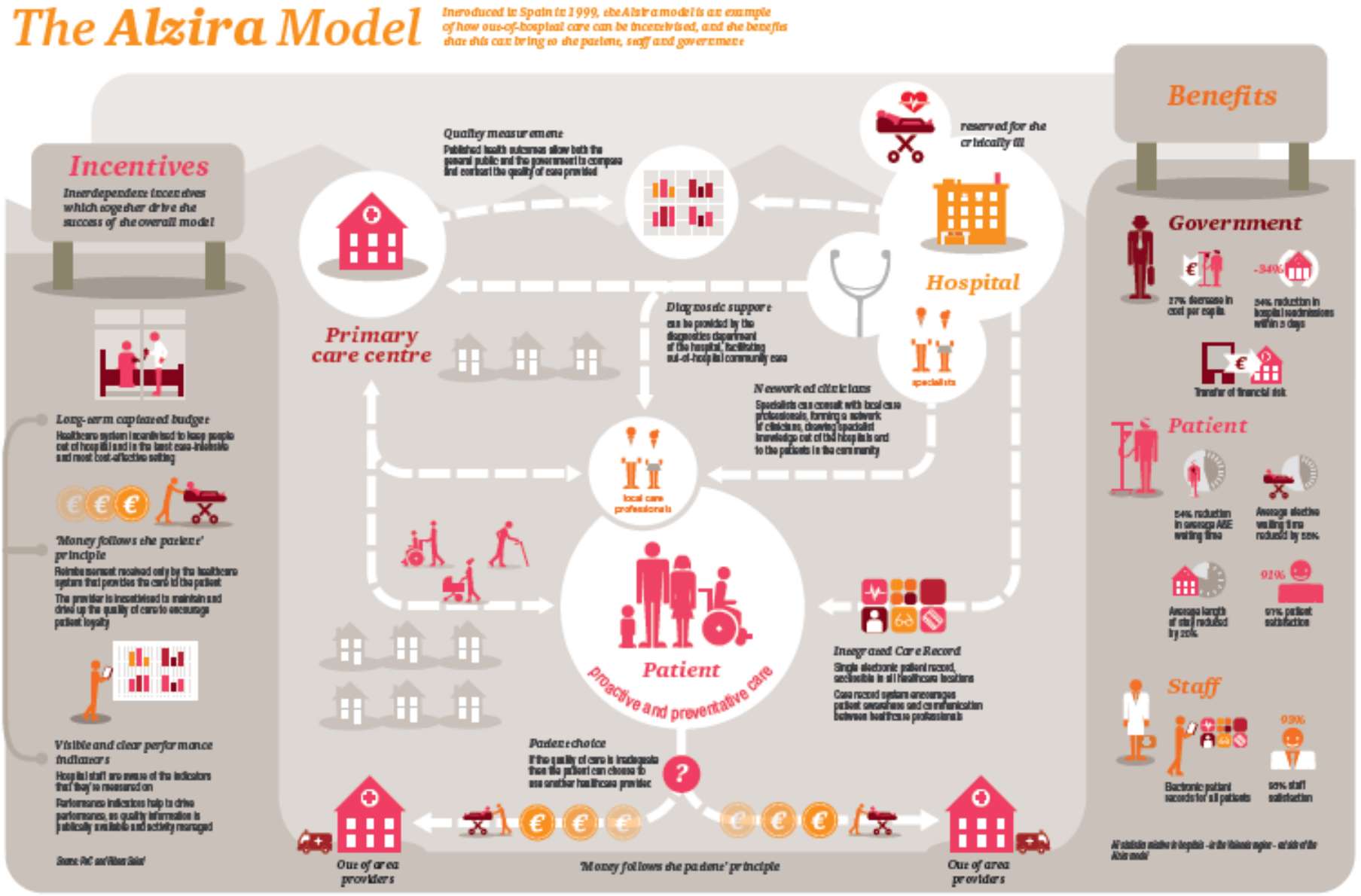
Finance and contract: The Affordable Care Act changed the system for paying for care in the USA, in an effort to reward higher quality care through value-based purchasing and holding providers accountable for health of a population. Providers are held accountable across quality care measures. Virginia Mason described value-based purchasing as "good for patients because it will help improve the quality and safety of care they receive by providing financial incentive for hospitals to provide the best possible care. It's good for Virginia Mason because our attention to quality and extraordinary service should help us receive the maximum payment levels from Medicare, which is important for us to remain financially strong. Virginia Mason is a non-profit health care provider governed by a board of community volunteers. The Medical Centre is a tax-exempt organisation and savings from continuous improvement are reinvested to support patient health and wellbeing.

Successes: At the forefront of the application of continuous improvement with the result of improving patient care and driving up quality; ranked in the top 1% of hospitals for quality and efficiency, liability claims reduced and patient waiting times cut. Specific examples across the system are on large and small scales i.e. developed a 'one stop care point' for cancer patients, including a laboratory and pharmacy, saving cancer patients having to walk around the building/ to different departments. In a local team example, surgery teams redesigned the equipment cart for anaesthesia tools by using a shadow board to show where the tools belonged, so that gaps immediately revealed missing supplies and instruments. Developed electronic dashboards to remind clinicians of specific issues such as automatic reminders to undertake a quality review for every critical care patient. In July 2015 awarded contract from the Department of Health to work as the long term partner of the Trust Development Agency (TDA) to develop and implement a large scale Health Improvement Service change programme in the NHS.

Enablers: Adoption of the Toyota Production System: Application of a range of continuous improvement techniques to clinical and non-clinical settings, with a particular focus to improve safety and quality. Leadership: Chief Executive and leadership have been stable and dedicated to the change - in place and driving the process since it began, having decided that a new approach was needed for safe care and financial stability.

Vision and Mission: Virginia Mason have a clear mission to be the quality leader and transform health care in 'pursuit of the perfect patient experience' including a commitment "to providing a broad range of services that improve one's health and well-being and which prevent illness." Embedded in the culture: Emphasis underpinning the vision and mission is that staff who do the work know what the problems are and have the best solutions. Staff are fully trained in VMPS fundamentals and staff engagement and ownership are key features of the model.

Option 5: Accountable Care Organisation or Integrated Care Organisation (ACO/ICO)
Case Study 5: Alzira Accountable Care Organisation, Valencia



Option 5: Accountable Care Organisation or Integrated Care Organisation (ACO/ICO)
Case Study 6: Cheshire Pioneer Programme

Background
Connecting Care in Cheshire was selected in November 2013 as one of 14 Integrated Care and Support Pioneer sites. Connecting Care in Cheshire covers the geographic area of Cheshire, as covered by the Cheshire East and Cheshire West Health and Wellbeing Boards.

The Programme is fully supported by the two Local Authorities of Cheshire West and Chester Council and Cheshire East Council, along with the four Clinical Commissioning Groups working in the borough (NHS Eastern Cheshire CCG, South Cheshire CCG, Vale Royal CCG and West Cheshire CCG. These areas are covered by our hospitals – Countess of Chester NHS Foundation Trust, East Cheshire NHS Trust, Mid Cheshire NHS Foundation Trust, and Cheshire and Wirral Partnership NHS Foundation Trust. With an estimated combined health and social budget of £1.3 billion, there is a clear commitment from all partners, including providers and third sector agencies to work together in a joined up way.

Vision
The vision for the Connecting Care in Cheshire Programme is that within three years the residents of Cheshire will enjoy a better standard of health and wellbeing. It is hoped it will place less demand on more costly public services through the implementation of ground-breaking models of care and support based on integrated communities, integrated case management, integrated commissioning and integrated enablers.

Aims
The aim is to ensure that individuals in Cheshire stop falling through the cracks that exist between the NHS, social care and support provided in the community, and in the future avoid:

- duplication and repetition of individuals experience, with people having to re-tell their story every time they come into contact with a new service;
- people not getting the support they need because different parts of the system don't talk to each other or share appropriate information and notes;
- the "revolving door syndrome" of older people being discharged from hospital to home not personalised to their needs, only to deteriorate or fall and end up back in A&E;
- home visits from health or care workers are not coordinated, with no effort to fit in with people's requirements, and;
- delayed discharges from hospital due to inadequate coordination between hospital and social care staff.

Programme Approach
The programme identified 5 key workstreams: Integrated community, Mental health, Continuing Health Care, Empowering Cheshire (linked to workforce as an enabler) and the Digital care record. Some of the workstreams are applied across all the organisations and some were adapted locally with common elements.

Continued on next page

Option 5: Accountable Care Organisation or Integrated Care Organisation (ACO/ICO)
Case Study 6: Cheshire Pioneer Programme

Workforce

The workforce developments have included working with the Pioneer National Programme and leadership centre looking at whole systems organisational development. The challenges include patients regularly moving out of area into other trusts including those in Wales. The programme is looking to mitigate this risk and overcome any barriers by working towards a joint health and wellbeing board.

The programme is supported by three areas identified in conjunction with the North West Education Network (Health Education England West and NHS England). The three areas are:

- Academic health and science research into funding feasibility of the way learning is shared across organisations, what happens currently and possible improvements to be identified by the Steering Group
- Health Education England North West looking at careers and engagement. The aim is to improve the uptake of training from schools and colleges and working together across organisations to ensure that rather than have a constantly moving workforce they take a more collaborative approach to resourcing vacancies
- The NHS England Intensive Support Bid: 1 of 6 successful bids in the country. Working with Skills for Health and Skills for Care. The first objective was identifying a common narrative of change for informing the workforce what change will require from them and are working towards agreement through a consensus workshop soon to be organised. The second objective is utilising the RAP software focusing on workforce data. The challenge has been overcoming data sharing agreements which is still under negotiation.

New Roles

The programme has employed 8 new Care Navigators under East Cheshire. The navigators plays a key role in the community, identifying local family networks for providing support and communicating what support the service can provide. The roles are connected to GP practice managers in the relevant areas. The programme has Integrated Team Managers employed under local circumstances.

Next Steps and Challenges

The next step is to identify what new organisational form they could take. The contracts will remain as individual contracts working in a collaborative arrangement until the new care model is identified. The challenges are financial constraints and the plans are to identify existing capacity whilst trying to address the tensions between transforming services and creating sustainability. The programme is looking into co-locating services although this remains a challenge due to the rural geography covered.

The programme have organised a sharing and learning event for members from all the relevant services to discuss the next steps and actions on key topics like information governance and new ways of working.

Option 6: Multi-specialty Community Providers (MCPs)

Acute care specialists including Consultants and Extended Scope Practitioners

Primary Health Care Team

Extended Primary Care Team
GP's, nursing, therapy, mental health, learning disabilities, children's, social care, pharmacy

Localities (30-50,000 population)

Community Hospitals

Localities (30-50,000 population)

Case Studies:

Tower Hamlets Integrated Partnership

Worcestershire Well Connected Programme

Dudley Multi-specialty Community Provider

Option 6: Multi-specialty Community Providers (MCP's)
Case Study 1: Tower Hamlets Integrated Provider Partnership

Tower Hamlets Integrated Provider Partnership (THIPP) was set up in December 2013 to bring the providers of health and social care in Tower Hamlets together to improve the delivery of integrated care to adults with complex health and social care needs, as well as those in the last years of life.

The partnership is between Bart's Health, East London Foundation Trust, London Borough of Tower Hamlets and the GP Care Group (a community interest company of all 36 practices in Tower Hamlets). The partnership has grown over the last 2 years from a loose grouping of the providers to a multispecialty community provider Vanguard site (THIPP and Tower Hamlets CCG), and now the joint holders of the contract for community health services in Tower Hamlets.

The focus of THIPP has also changed from complex adult care to prevent hospital admissions, expedite discharge and (most importantly) improve the well-being of the residents of Tower Hamlets, to now include public health initiatives and how we look after the health and well-being of children in Tower Hamlets though new models such as The Bridge virtual ward for children.

Successes so far include the Community Geriatrician post which has reduced admissions from local nursing homes to Bart's Health by supporting the GPs who provide the enhanced service to the nursing homes. The community Chronic Kidney Disease (CKD) clinic where GPs can ask for advice from a renal physician via EMIS (the GP computer system) and get feedback as to whether a person needs to be seen in clinic or not. The wheelchair services are looking at different seating for service users to improve independence and quality of life and not need a chair at home and a separate wheelchair. The Home Support Pathway piloted this winter which has reduced admissions to the inpatient rehabilitation beds (and reduced readmissions to the Royal London).

As THIPP is the preferred provider for the Community Health Services in Tower Hamlets (with GP Care Group as the prime contractor) we will jointly be able to develop new services in the community around the extended primary care team (including mental health and social care workers), pilot the Buurtzorg model for community nursing, set up a complex needs assessment clinic encompassing Mental Health for Older People (from East London Foundation Trust), Older People's Services (from Bart's Health) and Community Health Services, as well as develop new models for the care of children with complex health needs in the next year.

All of this work has been led by "frontline" staff in the separate organisations and will continue to grow and develop in the future.

Option 6: Multi-specialty Community Providers (MCP's)
Case Study 2: Worcestershire Well Connected Programme

Overview

Worcestershire is a large county in the west of England, with a population of around 800,000. It has both urban centres of population and also widely scattered rural communities. It has a higher than average elderly population (19.3% over 65), of whom a higher proportion live in rural areas than in urban, adding to the challenge for health and social care services. The health of the people of Worcestershire county is generally better than the England average. The rate of hip fractures, however, in older people is higher than the England average.

Health and wellbeing priorities include older people and management of long-term conditions, mental health and wellbeing, obesity and alcohol.

Background

Well Connected was a pioneer programme. The aim of the collaboration of all the health and care partners in Worcestershire was to manage whole-system change in health and care delivery. The collaboration included three clinical commissioning groups (CCGs), an acute NHS trust, a health and community NHS trust, Worcestershire County Council, NHS England, Local Healthwatch and representation from the voluntary and community sector.

Vision

A transformation vision was established between the stakeholders, adopting the National Voices 'I statements' on integrated care. The vision for improved and integrated care covers all people in Worcestershire with a focus on older people and adults and children with multiple long-term conditions or complex problems. The integrated care programme was rebranded as the Well Connected Programme. A five-year strategy was developed to transform the commissioning and delivery of care.

Objectives

The objectives and outcomes anticipated were:

- Securing additional years of life for people in conditions amenable to healthcare
- All people over 65 and those under 65 with long-term conditions have their own personalised integrated care plan
- Reducing emergency admissions and length of stay by managing care more proactively in other settings
- Increase in safe and effective care and the proportion of people having a positive experience of care in all settings
- A fall in the need for long-term residential and nursing care for all age groups by people being healthy and living independently
- Parity of esteem between people with mental health conditions and those with physical health conditions

The Worcestershire five-year health and care strategic plan defined five transformation programmes, including:

- **Future Lives:** The major change programme for adult social care, including new models of care for integrated health and social care working
- **Out of hospital care:** Developing new models for primary care at scale and care closer to home, including enhanced services for prevention and early intervention
- **Urgent Care:** This encompasses 14 projects to improve urgent care and manage increasing demand

New Models of Care

Following the success of the previous programme the organisations are now moving towards a "hybrid multi-specialty community provider model".

Continued over page

Option 6: Multi-specialty Community Providers (MCP's)
Case Study 2: Worcestershire Well Connected Programme

Overall Challenges

- It is hard work laying the foundations of partnership working and maintaining this during challenging periods. Sometimes behaviours do not match the rhetoric of integration – it can be difficult always to put the needs of service users above the needs of organisations
- Like other areas, have struggled with information governance and progressing work on capitated budgets until it is resolved at the national level. Membership on the national information governance working group to help take this forward
- In general, there is a lack of resources for the large-scale change needed; for example for 'double running' to invest in community services before down scaling the acute sector. The work is also influenced by the cuts in the social care budget and the rapidity of changes required to implement the Care Act
- The attempts to communicate the vision of integrated care and care out of hospital and closer to home is not helped by national messages about the NHS – these still give the impression that health is all about hospitals

Workforce Highlights

- There are currently 22 Physician Associates in training at Worcester University
- Consultant input provided to the integrated recovery inpatient unit on a SLA basis
- Enhanced care teams and care home project utilising advanced nurse practitioners
- Working with Health Education England and Skills for Health on the approach to the Care Navigator type role but instead of opting for recruitment discussion is taking place on the skills which exist within the team to identify the best approach to having a Care Navigator function
- Working on technology solutions to enable flexible working and the ability to connect I.T systems, exploring options such as EMIS web

Workforce Challenges

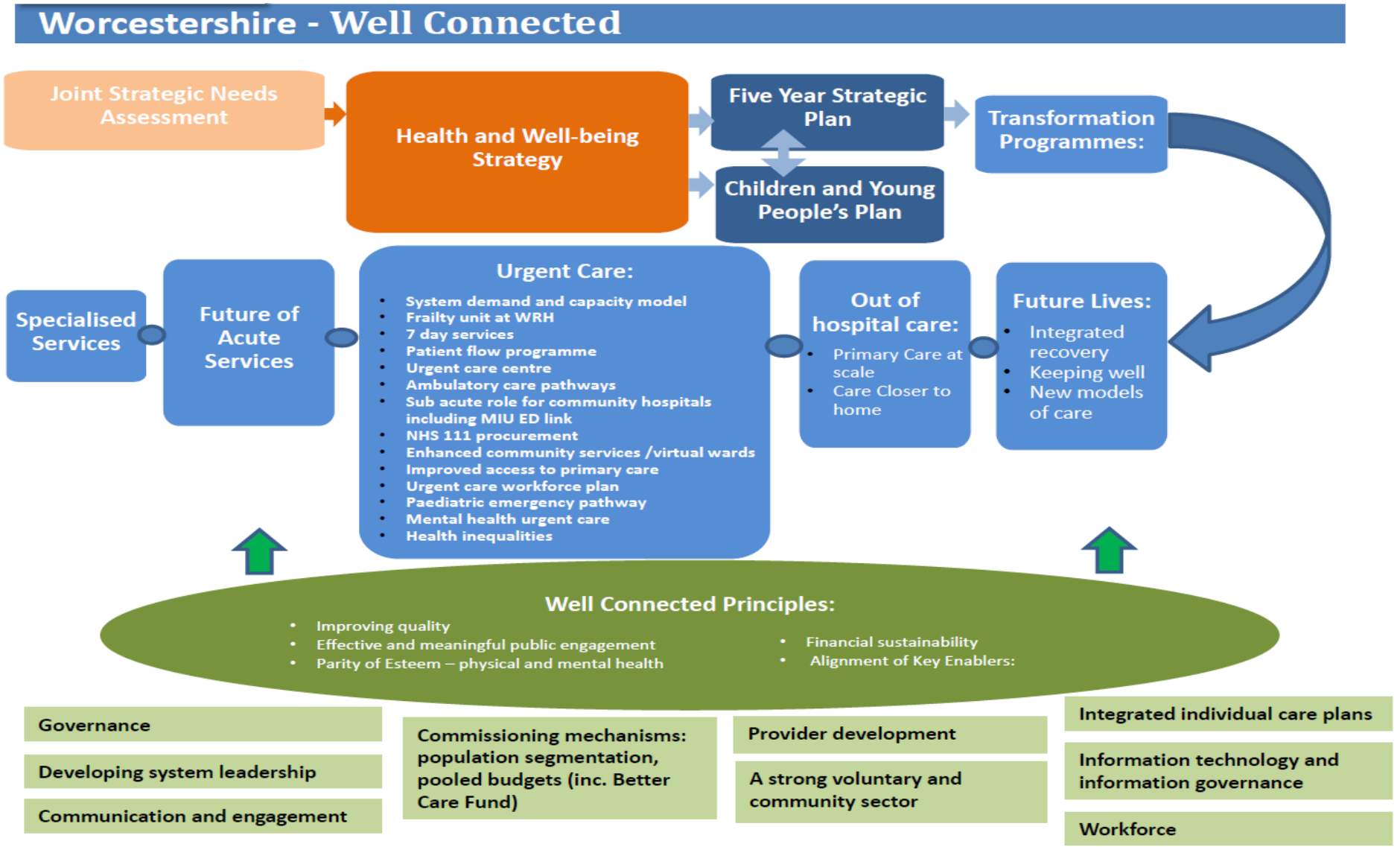
- Workforce planning is challenging and new ways of working can have unintended consequences, for example recruiting high-quality staff to the care home project has left workforce gaps elsewhere in the system
- Finding the resources and time to carry out evaluation has been challenging and concerns that there are pressures to evaluate too early before being in a position to assess long-term outcomes of the changing models of care
- Reducing agency and locum costs in line with national policy causes further pressures
- Staff TUPE arrangements have experienced issues with pensions, have undertaken a procurement exercise which addresses this through bidders liability
- Continued issues with the recruitment of Consultant Geriatricians and GP's
- Different bursary arrangements between different areas make one area more attractive than another

Option 6: Multi-specialty Community Providers (MCP's)
Case Study 2: Worcestershire Well Connected Programme

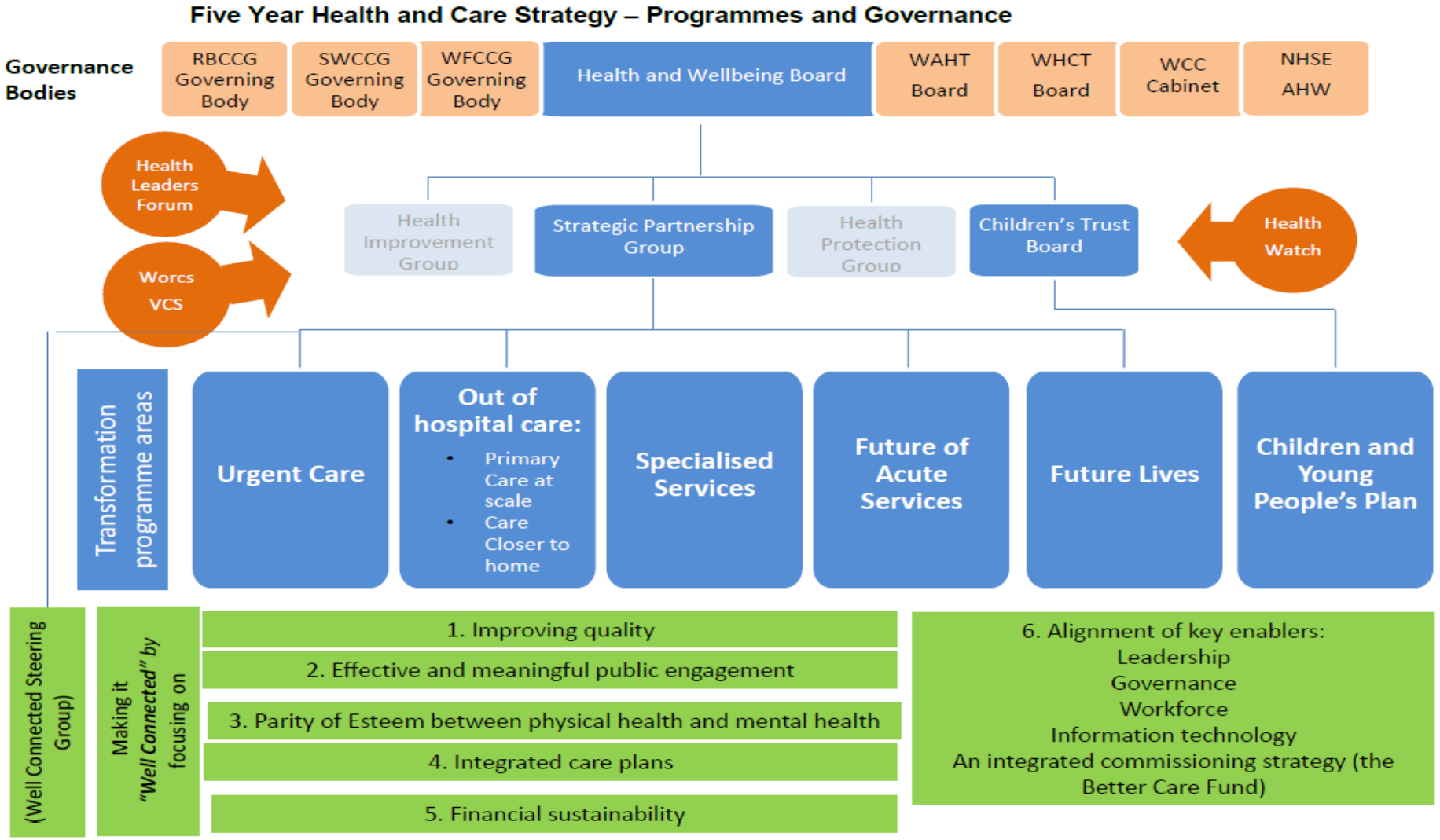
Outcomes

- Implementation of a patient flow centre that collects, reviews and acts on all whole-system data related to bed and service capacity and demand
- Setting up a clinical navigation unit at the front door of Alexandra Hospital A&E and locating GPs in A&E at Worcestershire Royal Hospital
- Developing a new sub-acute model in community hospitals, building on virtual wards
- The further development of enhanced care teams and a care home project utilising advanced nurse practitioners
- Managed to stem the flow of increasing emergency admissions with numbers holding steady compared to last year. At 31 December 2014 the total number of A&E attendances across Worcestershire was up 7.22% on the previous year. Over the same period emergency admissions stood at 36,366. This is compared to 36,277 in 2013/14 – a decrease of 0.09%
- Profiling the health and care needs of half of Worcestershire's population to enable the population to be divided into segments with the aim of designing new models of care to meet their different needs, delivered by a collaboration of providers through the mechanism of a capitated budget
- Setting up an integrated commissioning unit to build on the previous joint commissioning for mental health and learning disabilities, strengthening its governance and incorporating the necessary capacity for integrated commissioning for older people and to deliver the Better Care Fund proposals
- Buy-in from all partners in the county. The senior leaders from all the organisations meet regularly within a clear governance structure (see next 2 pages)
- Even when things have been difficult the commitment to attendance and resolution of problems has been maintained
- Finance and governance: Population segmentation to develop capitated budgets, development of the integrated commissioning unit
- Information technology and information governance: A roadmap developed with support from Health and Social Care Information Centre to implement the vision for sharing service user information through IT. This is supported by a multi-organisational information governance group
- Workforce: Development of an integrated workforce strategy across health and care, with an initial focus on urgent care
- Communications and co-production: Development of a website and newsletter, presentations at many groups about the vision and plans, development of a co-production strategy, supported by Healthwatch

Option 6: Multi-specialty Community Providers (MCP's)
Case Study 2: Worcestershire Well Connected Programme



Option 6: Multi-specialty Community Providers (MCP's)
Case Study 2: Worcestershire Well Connected Programme Governance



Option 6: Multi-specialty Community Providers (MCP's)
Case Study 3: Dudley Multi-specialty Community Provider

Background

The team behind the Vanguard application from Dudley is led by Dudley Multispecialty Community Provider and includes Dudley Metropolitan Borough Council, Black Country Partnership NHS Foundation Trust, Dudley Group NHS Foundation Trust, Dudley and Walsall Mental Health Partnership NHS Trust, Dudley Council for Voluntary Services and Future Proof health Ltd.

The Multispecialty Community Provider model proposed by the partnership in Dudley aims to develop a network of integrated, GP-led providers across health and social care, each working at a level of 60,000 people, reaching a total population of around 318,000 across Dudley. This system will see the frontline of care working as "teams without walls" for the benefit of patients, taking shared mutual responsibility for delivering shared outcomes.

Aim

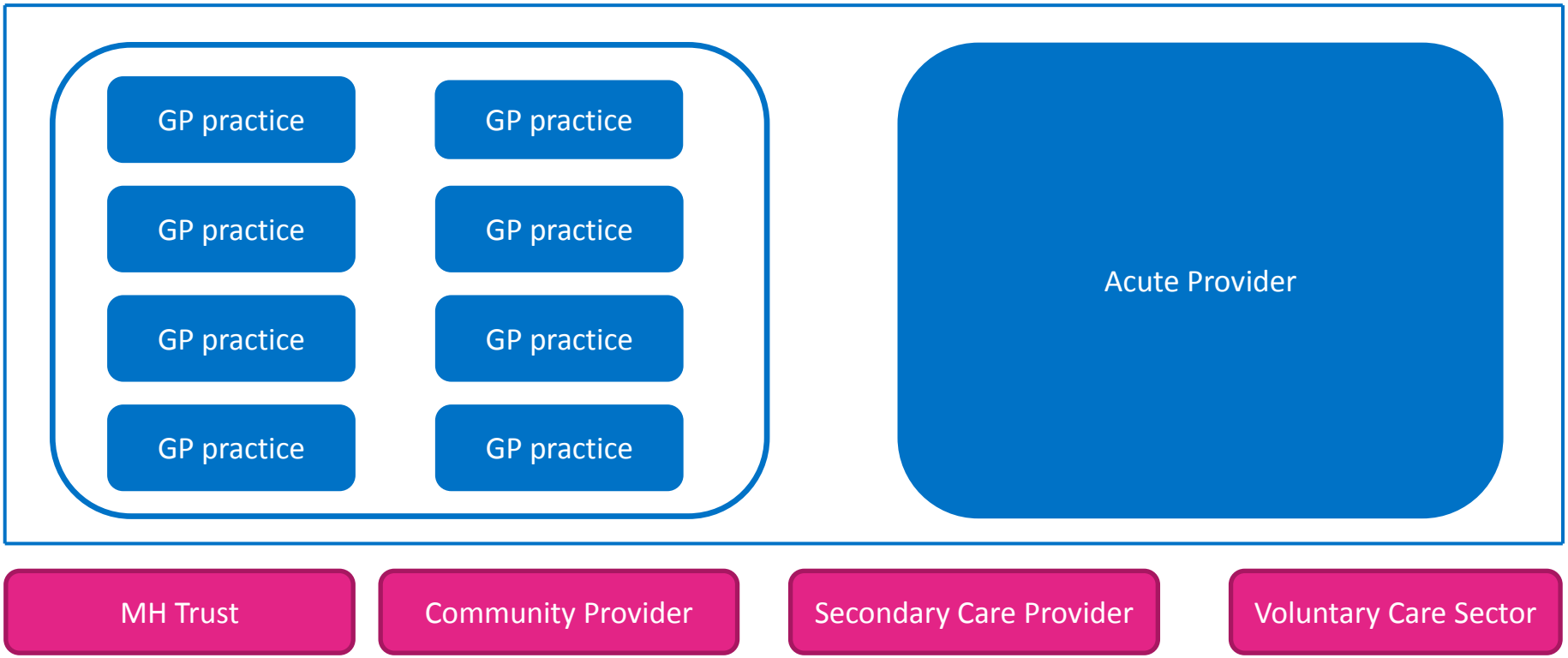
Under the new provider system patients, for example a lady with frailty & long-term conditions & registered with a GP in Dudley, will have her care overseen by a multi-disciplinary team in the community including specialist nurses, social workers, mental health services and voluntary sector link workers.

This will ensure holistic care that better meets all of her medical and social needs at one time in one place, but allows her to access advice and support for the isolation she can feel at living alone far from her family, and combatting her episodes of anxiety.

When she needs help urgently there is a 24 hour rapid response and urgent care centre which provide a single coordinated point of access for her so she doesn't need to call 999.

As a result of the health and care system working better together in this way, patients are not only receiving the coordinated support necessary for their health needs but they are also linking to the wider network of care and social interaction in their community to help them to live more independently for longer.

Option 7: Primary and Acute Systems (PACS)



Case Studies:

Healthy Wirral

Northumbria Primary Care (NPC) Project

North East Hampshire and Farnham Vanguard

Option 7: Primary and Acute Systems (PACS)
Case Study 1: Healthy Wirral

Healthy Wirral (a PACS model Vanguard site) is aiming to improve education and diabetes care across the health and social care economy, and in turn to improve detection and patient-led-control of diabetes, using Puffell.com

Diabetes prevalence is higher in Wirral compared to England (6.5% or 17,504 patients in Wirral, compared to 6.2% of the England population aged over 17 in 2013/14) and is increasing year on year due to an ageing population and levels of obesity.

At the centre of Healthy Wirral's vision around diabetes care and prevention is the ground-breaking digital platform and behaviour change tool 'Puffell': a free online interactive resource built around behavioural economics and social communications.

Puffell is a self-care ecosystem and provides advice, tools and trackers, combined with an online community of support, for people to self-manage their health and wellbeing. As part of a wider transformational plan around the management of diabetes in Wirral led by the Healthy Wirral team, a special diabetes app (or 'deck') within Puffell is being developed to help citizens reduce their risk of developing diabetes or, for those already diagnosed, to self-manage their condition through education and lifestyle changes. The deck will also act as a helpful resource for patients' partners, families and wider peer groups to find out more about the condition and ways to support people with diabetes. Users will be able to gain useful advice on healthier living through diet and exercise and create their own online support and social groups.

One of the key features of the diabetes deck is the tracking function, where users can record both clinical information, such as blood glucose levels, medical appointment reminders, weight and exercise as well as setting more personal goals and aspirations. These tools have been developed with patients to ensure the deck provides them with all the support they need.

The Healthy Wirral team have been working with patients and carers to identify what matters most to them about their diabetes and are developing person centered outcome measures which are also to be included in the deck.

Puffell has been designed in line with the wider social determinants of health and with the New Economics Foundation's 'Five Ways to Wellbeing'. It helps people to connect, to be active, take notice of 'their world', to keep learning, and to give. By supporting users to self-manage and take greater responsibility for their diabetes and overall health and wellbeing, Puffell aims to reduce the number of hospital admissions and GP appointments across Wirral. As an integral part of Healthy Wirral, it also aims to reduce instances of type 2 diabetes, and type 1 diabetes related health complications, improving self-esteem as people feel more in control and in better health. Puffell is available for anyone to try to manage their own health and wellbeing. See more at puffell.com.

For more information on the Healthy Wirral programme, please visit healthywirral.org.uk or follow @Healthy_Wirral

Option 7: Primary and Acute Systems (PACS)
Case Study 2: Northumbria Primary Care (NPC) Project

Background

Northumbria Healthcare NHS Foundation Trust ("Northumbria") has created a single legal entity, Northumbria Primary Care Limited in response to a request from the local primary care market for support, creating a new model for the delivery of primary care. In March 2015 Northumbria was selected as a Vanguard to integrate primary and acute care systems (PACS) for Northumberland, with the aim of creating closer ties and working relationships with primary care medical services. The success of NPC will help to facilitate the progress of the PACS vanguard project.

The Northumbria Primary Care (NPC) project was built on a foundation of years of successful collaboration between primary and acute care in Northumberland and North Tyneside, with fully engaged local GPs. NPC provides strong clinical leadership and support to help GPs with meeting the everyday challenges facing local practices. This support allows for bespoke packages to be created, meeting the individual requirements of different GP practices, which includes:

- **Management support**: providing general practices with back office support, expertise and resources to reduce practice costs and place the practice in a stronger position to win contracts and generate new income streams, allowing the practices to focus on their clinical provision and improved outcomes for patients. This includes quality governance and compliance, payroll management, financial services, human resources and organisational development and estates maintenance; or
- **Full support:** providing the full clinical service under the practice's primary care commissioning contract by way of a sub-contract between the practice and NPC, with the consent of NHS England.

Benefits

NPC allows GPs to access substantial corporate expertise from Northumbria as a successful Foundation Trust, but also retain control over the level of service they need in order to run their practice effectively.

As a result of the management support provided by NPC, early results have been very impressive with one member practice recording a 76 % improvement in routine access times. Another practice has saved £6,000 in monthly expenditure.

Creating this model has required Northumbria to:

- Set up a wholly owned subsidiary
- Navigate through the highly regulated primary medical care environment
- Design the governance of Northumbria Primary Care in order that it interfaces with Northumbria's own Foundation Trust governance requirements

Overcoming the challenges

A key challenge within the project was the fact that NPC is not an eligible body to hold a GMS Contract, therefore the design of a contractual structure that complied with the GMS Contracts Regulations was key.

Northumbria and NPC had to work hard on the perception challenge in the region to ensure that GP Practices did not view NPC as a route for secondary care to "take over" primary care. It is very much a partnership and collaborative approach. It was also crucial to ensure NHS England were involved in the journey and were on board with the concept.

It was essential to clearly and concisely set out the "employment deal" for staff once GPs and practice staff transferred to the employment of NPC. GPs in particular required detailed information about the impact on income tax and national insurance contributions, and any impact on pensions.

The governance aspects were significant in terms of arrangements for delegation, reporting, holding to account and decision making between Northumbria as parent and NPC as subsidiary. Escalation of risk management issues and the management of conflicts of interest were also key governance areas to tackle.

Option 7: Primary and Acute Systems (PACS)
Case Study 3: North East Hampshire and Farnham Vanguard

Background

The Vanguard programme in North East Hampshire and Farnham is made up of clinicians and services managers from NHS North East Hampshire and Farnham Clinical Commissioning Group (CCG), Frimley Health NHS Foundation Trust, Southern Health NHS Foundation Trust, Surrey and Borders Partnership NHS Foundation Trust, South East Coast Ambulance Service NHS Foundation Trust, Virgin Care, North Hampshire Urgent Care and Hampshire and Surrey County Councils. NHS North East Hampshire and Farnham CCG are the lead organisation for the programme.

The programme has four workstreams which are:
- designing and implementing a new model of care;
- creation of a new commissioning model;
- introducing a new provider model; and
- a number of enablers including co-production, intra-operability, evaluation and workforce redesign

Co-production – putting people at the heart of Vanguard is crucial for the success of the project. This will involve people in the co-production of the programme and they will be engaged at every point in the design and implementation of the new model of care. The programme features a communications and co-production enabler ,which will ensure that co-production is weaved into all workstreams.

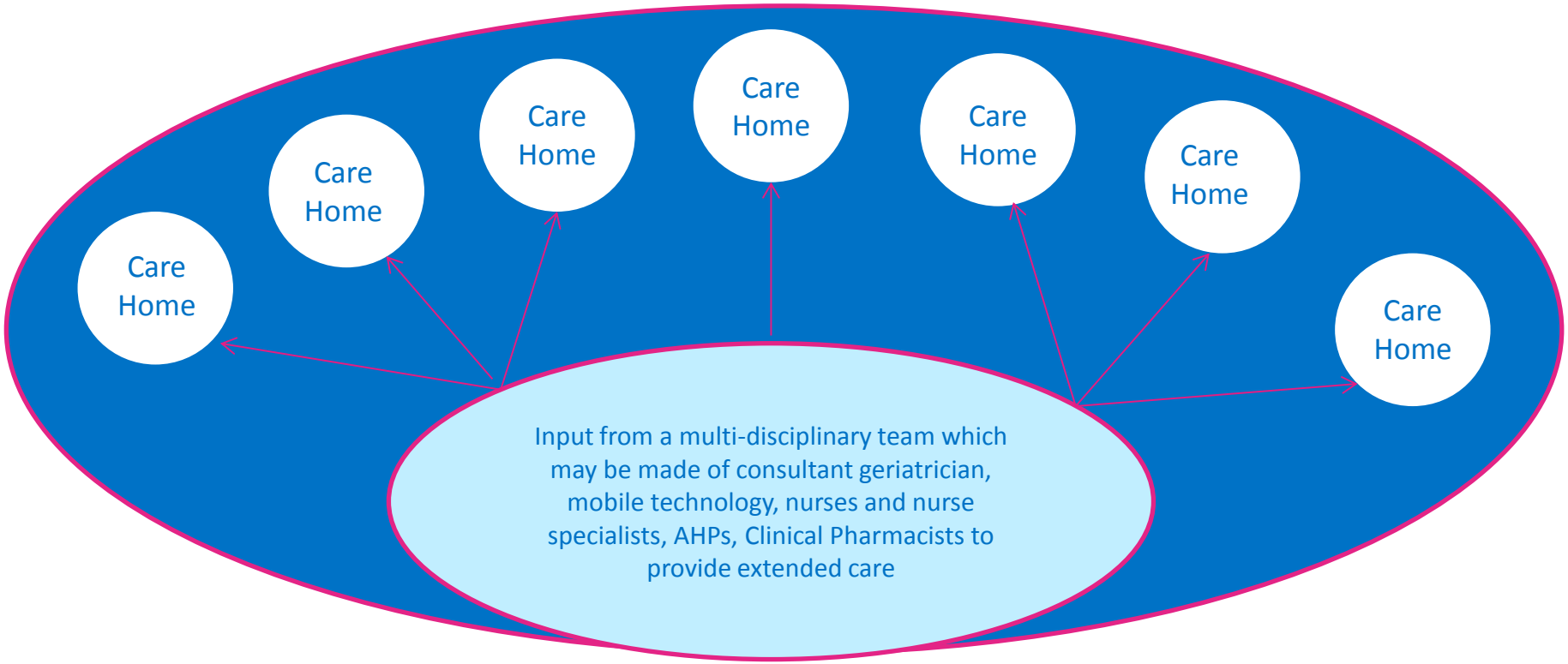
Programme overview

The new model of care, designed by health and social care professionals and local people, will look and feel different. It will:
- result in better outcomes and experience for local people – helping them to be happy, healthy and wherever possible, supported at home; and
- provide better value for money, helping to close the gap between the available resources and the costs of providing services to meet need.

The work underway with the new model of care includes:

- Multi-disciplinary teams in all five localities
- Preventing ill health, enabling self care and supporting wellbeing
- Services to avoid hospital admission and enable earlier discharges
- Design of the overall new model of care
- A new commissioning model
- A new provider model

Option 8: Enhanced Health in Care Homes



Examples:

Sutton Homes of Care

Gateshead Vanguard Care Home Programme

Option 8: Enhanced Health In Care Homes Model
Case Study 1: Sutton Homes of Care

Background
Sutton Homes of Care Vanguard covers a registered GP population of 180,000 and 27 GP practices, over 6% of the 75+ population live in care homes. Sutton CCG currently commissions 74 Care Homes, this encompasses nursing homes, residential care of the elderly homes, mental health and learning disability homes. The Vanguard application was made in partnership with London Borough of Sutton, AgeUK Sutton, the Alzheimer's Society, Epsom & St. Helier Hospitals NHS Trust, South West London & St. George's Mental Health Trust and Sutton and Merton Community Services (the Community division of the Royal Marsden).

Sutton Homes of Care (SHOC) has three key components:
- Integrated Care
- Care Staff Education and Development
- Quality Assurance and Safety

The programme aims to:
- Improve the quality of care
- Support staff and improve confidence
- Improved recruitment and engagement

The Vanguard programme will be developed and implemented in phases over a period of four years, during which it is anticipated that we will see the following results:

A reduction in:
- 999 calls
- Ambulance attendances – 10%
- A&E attendances – 35%
- Non Elective Admissions – 8.6%
- Length Of Stay in the acute care setting – One day per admission
- Delayed transfers of care (supporting local BCF target)
- Staff turnover to below 17%

Increases in:
- Preferred Place of Death (PPD) from 33% to 35%
- 111 calls (targets to be determined)
- Length of stay in care homes (targets to be determined)
- Staff, resident and family satisfaction (metrics and targets to be determined)

Option 8: Enhanced Health In Care Homes Model
Case Study 1: Sutton Homes of Care

NHS
Sutton Clinical Commissioning Group

Overview of Our Sutton

74 Care Homes

1077 Care Home Beds

594 residents in NHS Funded Nursing Home placements

203,048
Residents in Sutton
14166 aged **75+**
4450 aged **85+**

2014/15
106
Health funded home care packages

2014/15
319 Fully funded nursing home placements

£6,25 M

2014/15
1008
A&E presentations from Care Homes

2014/15
702
Emergency Admissions

2014/15 £1.1M
275 people were eligible to receive Funded Nursing Care

Option 8: Enhanced Health In Care Homes Model
Case Study 1: Sutton Homes of Care

The three main workstreams are:

1. Quality and Assurance:
A joint intelligence group meets monthly consisting of commissioners, the council, the CCG, CQC and the Ambulance Trust. The group focus on reviewing data such as monthly admissions and trends to identify local issues. The focus has included admissions due to catheters and other continence issues. In response to this the programme has organised bespoke continence training delivered by the community continence nurses free of charge for nursing staff. This has been provided for 2 nurses per home with the expectation that they disseminate the learning to the other staff.

2. **Workforce, education and development:**
A range of strategies have been identified to address workforce challenges, education and development:

- An e-learning tool with 3 modules including dementia and continence. The tools are available on the local authority platform to ensure all relevant staff are able to access them
- Link nurses providing short bespoke training for staff during lunch times
- Development of a podcast by the Challenging Behaviours Team describing topics like end of life care
- Resource cards in the style of credit cards have been designed to educate staff on subjects like urine analysis, falls, sepsis and signposting on alternative options to calling an ambulance
- Bi-monthly forums for link nurses, managers and staff to meet to network and access educational sessions

3. Integrated Care
The relevant community nurses are linked to the care homes for areas such as continence. The health and wellbeing reviews are undertaken by a link GP in 6 homes as part of a pilot scheme. The GP visits each home once a week working alongside two senior nurses who act as care co-ordinators. The link GP role has two approaches; reactive care where residents are seen urgently as required and proactive care where each resident has a holistic MDT review each 6 months. The review focuses on functionality, mobility, patterns in falls, infections and initiating end of life care. The pilot has been extended by another six months until October to allow for the appropriate evaluation to take place.

Workforce Structure
Across the London Borough of Sutton, there are approximately 5,000 staff working in care homes, 74% of these working in direct care work. These staff are paid marginally above the national average, however this figure remains below both the London and UK living wage, leading to increased risk of staff turnover. The turnover of staff is slightly below the national average of 21.7%, at 19.2% and with an ageing workforce (average age 45, with 6% below the age of 25) a review of the staff population, including their rationale for remaining employed within the sector is required, as well as new ways to encourage junior staff into care of the elderly as a long term career in order to ensure a sustainable workforce moving forward.

The management of the homes varies between the owners being managers, having separate managers and having nurses who may also be the manager of the home. The workforce in the home normally consists of managers, qualified nurses, support workers, activity co-ordinators and administrative staff.

Option 8: Enhanced Health In Care Homes Model
Case Study 1: Sutton Homes of Care

Workforce Challenges

The pay structure is not guided by Agenda for Change meaning various pay structures and various job descriptions particularly in the absence of any chains within Sutton.

The GP pilot has experienced issues with GP capacity and interest in the scheme.

Permanent nursing staff are difficult to recruit and there are capacity issues related to maternity cover arrangements. The nurses are professionally registered but there are no further registrations under the umbrella of care home service delivery.

Training is varied and attendance at training is normally outside of working hours with the expectation being that staff should finance training personally and attend in their own time.

Successes

Key Success in 15/16 have included:

- Investing in an integrated workforce wrapped around the resident to deliver proactive care and an equitable approach
- Investing in and developing existing care home staff
- Co-designing innovative ways to help prevent residents being admitted to hospital through a new hospital transfer pathway
- Continuing to deliver bimonthly care home forums with the local authority to support engagement
- Strengthening the joint intelligence across health and social care as early as possible to identify potential risks in the system
- Improving the overall programme management to ensure our evaluation is robust, our communication and engagement techniques are effective and the benefits from the programme can be shared

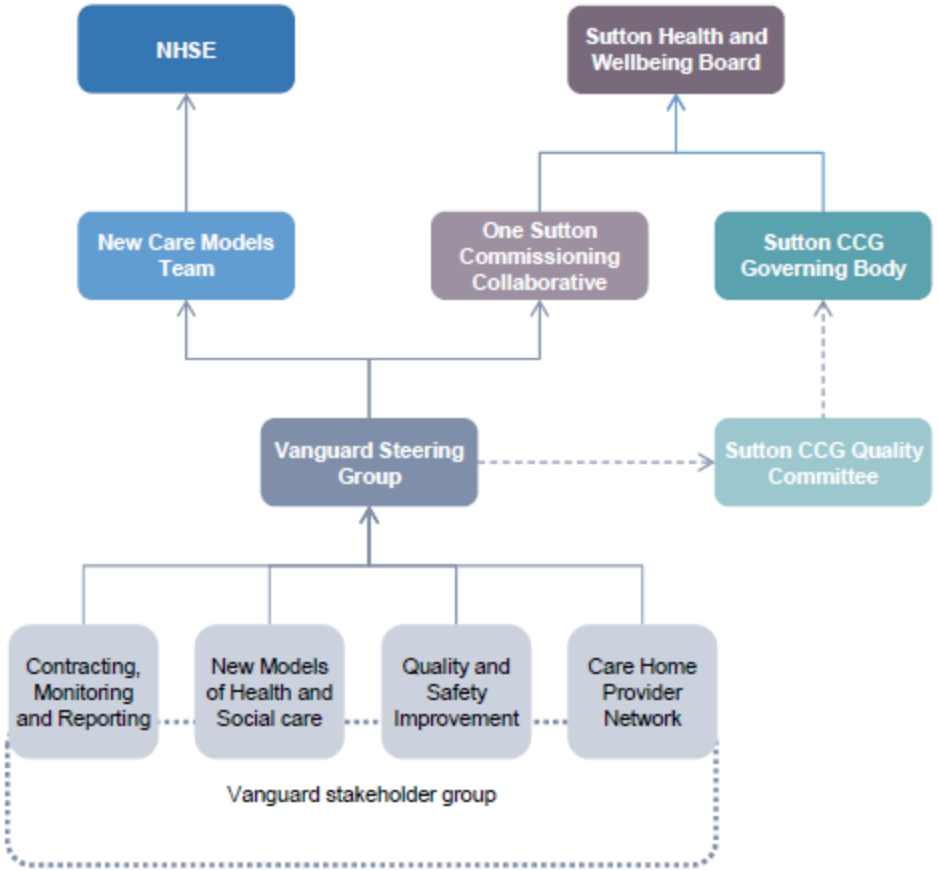
Initial feedback on the GP pilot scheme has been positive. The scheme has enabled continuity of GP and good working relationships between the GP and nurses, enabling them to build a good rapport.

In addition to the GP and link nurse schemes, the programme has lead to the employment of a pharmacist.

Next Steps

The programme has extensive plans for the next four years. Workforce plans include focusing on student nurse placements to offer nurses a placement within care homes and looking at the role of Allied Health Professionals in care homes.

Option 8: Enhanced Health In Care Homes Model
Case Study 1: Sutton Homes of Care – Programme Governance



The Vanguard workstreams are formed out of subject matter experts and key stakeholders from our wider stakeholder groups. They are responsible for delivering a number of key elements of the programme, be they through ongoing pieces of work, or task and finish programmes.

The workstreams are accountable to the VSG, who will provide the opportunity for our partners to oversee the work that is being undertaken, but also to ensure that risks to the delivery of the programme are flagged early, and will aid with mitigations.

The work products will be shared with the Sutton CCG quality Committee, and subsequently the Sutton CCG Governing Body to ensure a level of quality assurance throughout the work, however this process will not serve to govern or impede the process, and the VSG will not be accountable to this group.

The VSG will be accountable to both the New Care Models team (NCM) and the One Sutton Commissioning Collaborative (OSCC), however decision making power of the OSCC is deferred to the VSG. The VSG will work closely with the NCM, and will request their support through a sitting member on the VSG

Option 8: Enhanced Health In Care Homes
Case Study 2: Gateshead Vanguard Care Home Programme

Background
The aim of the partners is to work together to enhance health within care homes are Gateshead CCG and Gateshead Local Authority. Gateshead has a population of around 206,000.

Aim
A new organisation will be created called the Provider Alliance Network (PAN) which is to deliver the Gateshead Integrated Community Bed and home-based care service. PAN will provide holistic care and seamless support across the traditional health and social care boundaries. PAN will also oversee and connect healthcare for a population who are cared for and supported in long and short term stay community beds as well as helping those individuals in their family home undertaking reablement, rehabilitation and recovery services at home.

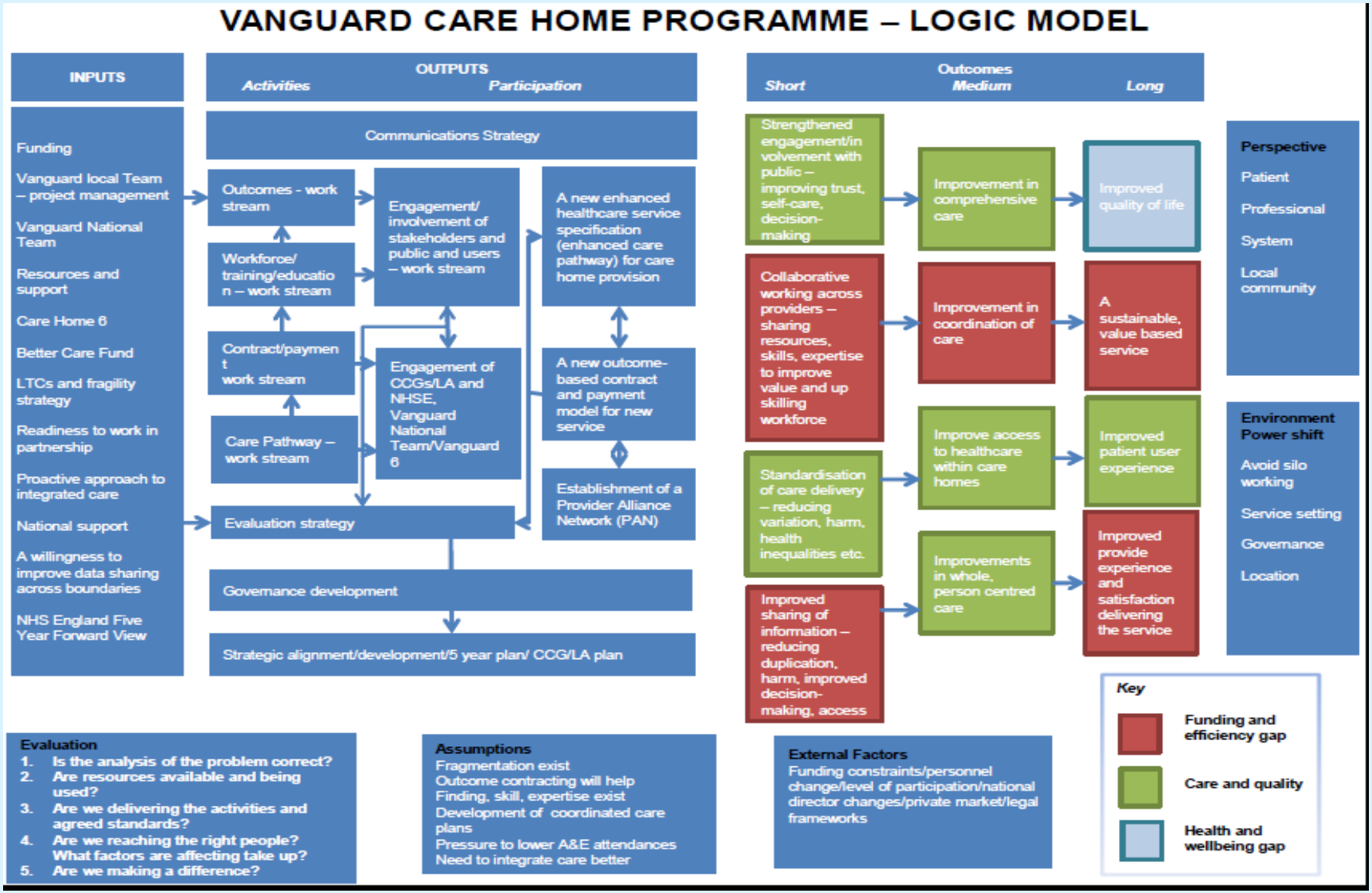
Objectives
The principal changes that are planned to the delivery of care include the development of co-commissioning of all community-bed and home based care; capitation-based payment system based on need; and outcome-based contract in place. By 2016, PAN and its commissioners expect to see: co-commissioning of all services except those in the private sector; completion of the analysis around health-related and public sector social care costs; and completion of the milestone metrics and outcomes.

The model is a joint approach by NHS Newcastle Gateshead CCG and Gateshead Council. In Gateshead, there has been a long successful history of developing integrated support for patients in community beds (i.e. care homes) to improve patients' experience and reduce unnecessary admissions to hospital through collaborative working. Although, the component parts are in place, there is still work to do to bring these parts together, into a whole system sustainable model. The Gateshead model will build on a well-established proactive 'ward round' based service that sees GP practices and community nursing teams aligned to care homes across the borough.

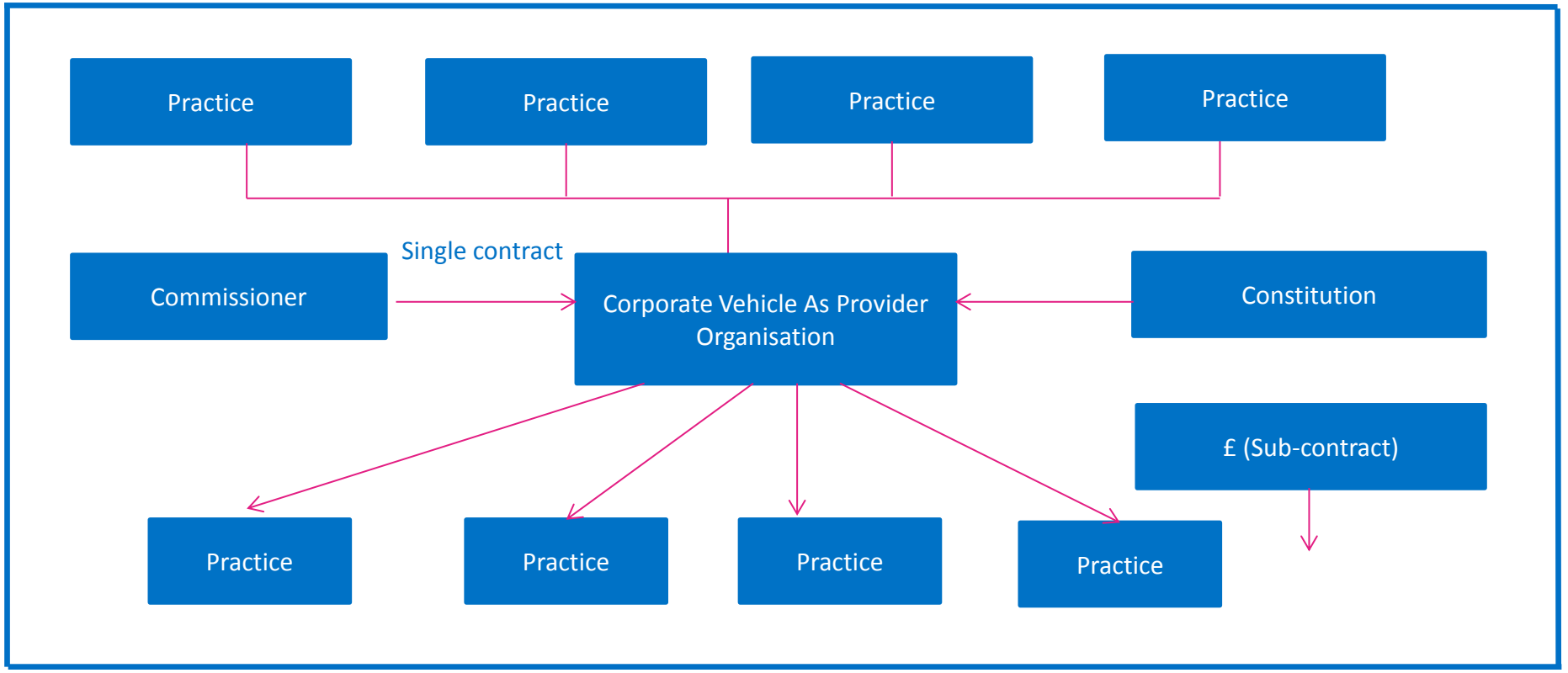
Outcomes
Personalised care delivery and multi-disciplinary working is starting to see successful reductions in avoidable hospital admissions, together with an improvement in the quality of care delivered.

Next Steps
The next steps through Vanguard acceleration will focus on cementing these principles for a wider cohort of patients and families who currently access home services (e.g. intermediate care). Above and beyond the care provision, the vanguard will support the development of a sustainable model through establishing an environment of co-commissioning and co-provision of services with an outcome-based payment system, that promotes value for the health and social care economy.

Option 8: Enhanced Health In Care Homes
Case Study 2: Gateshead Vanguard Care Home Programme



Option 9: GP Federations



Examples:

Tower Hamlets GP Care Group CIC

Brent GP, Middlesex

Healthbridge Direct, Redbridge

Option 9: GP Federations
Case Study 1: Tower Hamlets GP Care Group CIC

Tower Hamlets GP Care Group CIC is a federation of 37 member practices in Tower Hamlets CCG, London.

Background

In 2008-9, the then Tower Hamlets PCT asked GP practices to form geographically-aligned networks to implement the borough's vision for better integrated care. Networks were formed based on Local Area Partnerships (LAPs) with 4-5 GP practices coming together to form each network.
There were 8 networks formed. Upfront funding to set up these networks was delivered by the PCT, and spend went towards upgrading IT infrastructure, employing network administrators, and contributing to an education budget.
In January 2014, the eight networks chose to come together under the umbrella of a new organisation, the Tower Hamlets GP Care Group, a Community Interest Company (CIC). The organisation formally became an entity in September 2014 and is owned by the 37 practices which compose the eight networks, each of them owning one share.
Each network nominates one Board member on behalf of their practices. In addition, two network managers, a practice manager, and a practice nurse, amongst others, sit on the Board.

What prompted change?

- The initial formation of eight networks came about to influence better GP collaboration. There was a sense that GP practices working independently needed to come together to improve quality of care in Tower Hamlets, and take advantage of possible economies of scale from pooling resources.
- Rather than tendering traditionally enhanced services to individual practices, services were contracted with practices, but packaged together as Network Improved Services (NISs), providing the network as a whole with targets, and consequently payment at the network level. The network's members therefore shared financial risk incentivising a drive in quality by working together.
- A shifting policy climate and the introduction of the Health Care Act 2012 steered the case for a borough-wide provider group for GPs.

What advice was provided?

- Initial support to form networks was provided by McKinsey & Company, a health consultancy company. Assistance included developing and agreeing the Terms of Reference for the management arrangements, as well as helping to tabulate governance structure, constitutions, membership arrangements, and roles and responsibilities.
- There was also support provided around discussions about what legal form/entity the network should take.

How is this funded/commissioned?

The Tower Hamlets GP Care Group was successful in wave 2 of Prime Minister's Challenge Fund and granted £3.3 million.

- It has also successfully bid for phlebotomy, transport services and surgical aftercare contracts since its inception.
- In March 2015, the Tower Hamlets Integrated Provider Partnership (THIPP), of which the GP Care Group is a key partner agency, was successfully chosen as multispecialty community provider vanguard site. GP Care Group is the preferred lead provider the THIPP for an on-going community health service tendering process.
- In January 2016, the GP Care Group was appointed the provider of Health Visiting service in Tower Hamlets (from April 2016).

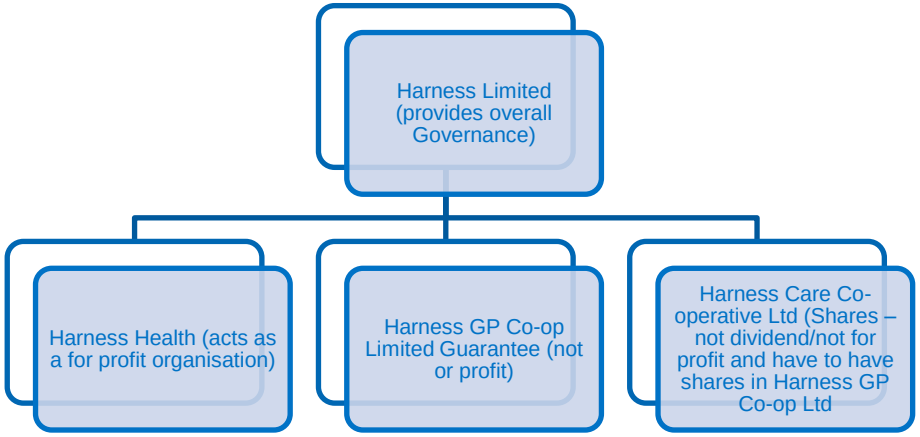
Option 9: GP Federations
Case Study 2: Brent CCG/Harness GP Co-operative Federation

Overview of Harness GP Co-operative Ltd

- Harness, work under the principles of a co-operative non-profit making social enterprise , commissions Health and Social Care for Harlesden, Willesden and Wembley residents, ensuring they receive value for money, good clinical and social care. Any profits generated from its trading activities are available for reinvestment back into the organisation, or for health benefit of the local community.
- Harness Co-operative Ltd Guarantee is made up of 21 practices and covers 115,000 patients.
- Now expanded and has 4 organisations which include both for and not for profit, with an overarching holding company above to provide governance to all companies.
- Recently developed this model to prevent all assets being asset locked. Worked closely with Employment and Corporate Solicitor to ensure organisational form works for them.
- Developing into a super-partnership similar to Vitality, Birmingham.
- Harness operates on a mutual co-operative basis, and aim to work collaboratively with all their staff and shareholders in order to drive forward our vision for improving services in the local area.
- Harness has been established for many year since 2006 and already is responsible for running Harlesden Medical Practice and the GP Led Health Centre under contract with NHS Brent.
- Developed HR Practice and risk sharing agreements to support inter-practice ways of working.

Highlights and barriers overcome

- Harness has been successful in its bid to NHS Harrow for running a new GP Led Health Centre under an APMS contract. It now offers 8-8 walk in service 7 days per week, holds 3 APMS contracts and provides LA public health contracts and is an integrated care pioneer. Provide specialist nursing to GP practices and each practice purchase level they need for their population.
- Provide wholes system contracts for quality and performance management. Been able to provide all employees with access to the NHS pensions scheme therefore ensuring competitive terms. This is provided by the not for profit organisation.
- They also key roles to support them with deliver and enable them to provide contracts at a network level e.g. Head of GP Contract Support , Project Manager to support quality and performance improvements and review mechanisms
- Mapped all of the current competencies across primary care and completed a skills gap analysis.
- Developed apprenticeships for 40 employees and won 4 awards for the programme. No difficulty attracting people given scope and diversity of roles.
- Developing new roles for HCAs and to support social isolation working with Age UK/HENWEL



Option 9: GP Federations
Case Study 2: Brent CCG/Harness GP Co-operative Federation

Developing systems and processes to support high quality care

Harness passionately believes that strong clinical and managerial leadership, effective teamwork and a focus on patient-centred care are central to ensuring the delivery of high quality services and continuity of care for patients. This is achieved through:

- a rigorous recruitment and selection process
- a process of continuing personal and organisational development
- supervision and mentorship
- ensuring adherence to best practice

The process of ensuring high quality care is reflective of the culture in which all members of the clinical and administrative functions are able to communicate quickly and effectively. All practices are on the same shared record provided by EMIS and they have developed:

- Clear policies and procedures are in place to guide the actions of all clinical and non-clinical employees.
- All clinical and non-clinical staff undertake a comprehensive induction to the policies and processes which govern the services. This will be reinforced and supported by a programme of continuous professional development.
- Each individual medical record is immediately updated during both clinical and administrative uses and can be subject to audit.

Benefits for the Harness workforce

HARNESS due to its co-operative roots provide a sensitive approach to the employment of their practice teams in both clinical and non-clinical roles. they provide a wide range of incentives for our staff, including:

- Access to the NHS pension scheme
- Continuing skills development and training for all levels and grades of staff
- Incentives that encourage improved performance and meeting the PCT's agreed KPIs
- Meeting all TUPE requirements as appropriate.

Working With The Local Health Economy

Harness with GP Practice members has a strong history of providing primary care services in the Brent area and understand and prioritise the need for seamless integration with other providers and stakeholders in the local healthcare economy by:

- Working with local acute Trusts & other provider services to drive down progressively inappropriate A&E attendances in a managed and sustainable way.
- Coordinating with the local Out of Hours providers in order to ensure that there is no duplication of services.
- Working with other GP Practices in the whole of Brent in a supportive fashion. This includes directing immediately necessary/urgent patients back to their registered practice for ongoing follow-up care after any treatment or consultation.

Option 9: GP Federations
Case Study 3: Healthbridge Direct

Background

HealthBridge Direct is a formal GP federation for the London Borough of Redbridge. The area incorporates 46 GP practices with a growing registered population of 289,293 registered patients.

The federation of practices have joined together to help one another provide the best possible care for patients. The GP Federation share ideas and resources and seek ways to provide high quality services to patients close to their homes.

Healthbridge Direct was established to deliver:

- EFFICIENCY – the benefit of shared expertise and economies of scale
- QUALITY – a common and ever-enhancing level of service across the borough
- PROFIT – the way to respond to and bid for opportunities individual practices could not easily do

Key Relationships and Networks

At HealthBridge one of the key functions is to represent members at the many meetings and partnerships of the local health economy. The relationships include The Community Education Provider Network (CEPN), The Primary Care Transformation Board, The Barking, Redbridge and Havering System Resilience Group meetings, The Integrated Care Steering Group, The Prime Ministers Challenge Fund Steering Group, Health 1000 steering committee, BHRUT and local federations strategic meeting and Bart's Health and local federations strategic meeting.

Services

Evening and Weekend GP Service

Healthbridge Direct has now been running a GP service on evenings and weekends since September 2014. It began with one centre at the Newbury Group Practice and they have just opened a second centre at Fullwell Cross Medical Centre. The hope is to eventually have one centre open in each of the four localities of Redbridge. The centres are for problems needing treatment on that day rather than long term condition reviews and they are open for appointments from 6.30pm to 10pm on weekdays and from 9am to 5pm on Saturday and 9am to 1pm on Sunday. Patients are given appointments to come in and are seen either by a **GP** or a **nurse practitioner**. After seeing the evening GP, details of the consultation and any medicines prescribed are sent to the patient's own GP by 9am the next morning, so the family doctor knows what has happened and what, if any, treatment has been provided. The Federation are working on a system which will allow them to see the patient's own records from the centres and write directly into their notes.

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Option 9: GP Federations
Case Study 3: Healthbridge Direct

Queens Hospital Urgent Care Centre

Healthbridge, along with the neighbouring two federations in Barking and Dagenham and Havering, have now been working in partnership with Queens Hospital to run an Urgent Care Centre within their Emergency Department since February 2015 (see case study on Barking, Dagenham and Redbridge System Resilience Group). This is a very exciting project in many ways. There's already an excellent team of **Emergency Nurse Practitioners, experienced GPs** and **dedicated receptionists** working there. By working to support and supplement this team we will be able to:

- Strengthen the partnership between the hospital trust and the local GPs in a way which will afford many opportunities to work together in the future
- Create a space in which to develop a workforce which can help and support both GPs and the hospital
- Greatly enhance the experience of patients using the hospital
- Join up the urgent care services in the local area with the same records being used across the GP practices and the urgent and out of hours GP services across the whole area. This is another step towards a joined up local health service in the future.

Workforce Developments

The Federation are still looking to supplement the staff at the UCC and are looking for **GPs, nurse practitioners** and **HCAs**. The approach to recruitment is:

- Staff who have some time free and would like to work sessions at the UCC as and when available
- Staff with more time available and would like to dedicate a number of sessions to the UCC on a regular basis on a sessional or salaried basis but still keep current practice arrangements
- Staff who would like to begin a new job working in a specially created salaried post in urgent and primary care – spending 4 or 5 sessions in the UCC, 3 or 4 sessions in a General Practice surgery and 1 session of CPD dedicated to developing specific training in urgent primary care

General Practice Support Programme

Healthbridge Direct takes part in the General Practice The Practice Support Program (PSP) fosters transformation in patient care by helping physicians build capacity in their practices through the use of innovative clinical and practice management tools and strategies.

The PSP offers a flexible service delivery model that works in collaboration with increased partnerships with divisions of family practice and health authority Regional Support Team (RST) Leadership.

Continued over page

Option 9: GP Federations
Case Study 3: Healthbridge Direct

Pharmacists In Clinical Settings

The Federation was successful in being selected for the NHS England Clinical Pharmacists in General Practice Pilot. The Pharmacists are employed through the GP Federation and deployed into practices.

Nurses

The Federation employs Advanced Nurse Practitioners. The Advanced Nurse Practitioners undertake training together. In addition there are 12 nurses working under the new to nursing programme in conjunction with Health Education England. The nurses are placed into 4 practices to allow to shadowing and training to take place.

The Federation would like to create a staff bank for GP's and Nurses and are looking into the indemnity arrangements for this to take place. The success of this will depend on the response from the medical defence unions and Royal College of Nursing particularly around the anticipated costs.

Challenges

Indemnity costs can be challenging particularly if a GP would like to provide a small number of sessions and the indemnity costs for doing so are too expensive. The NHS England Winter Indemnity Scheme did not apply as the Federation is not a recognised Out of Hours Provider. In addition, indemnity costs for nurses to undertake triaging became so great that many nurses left.

Lessons Learnt

The Federation found that adopting the hub model can be expensive and in hindsight believe that integrating the hub services into local practices may have had a greater impact.

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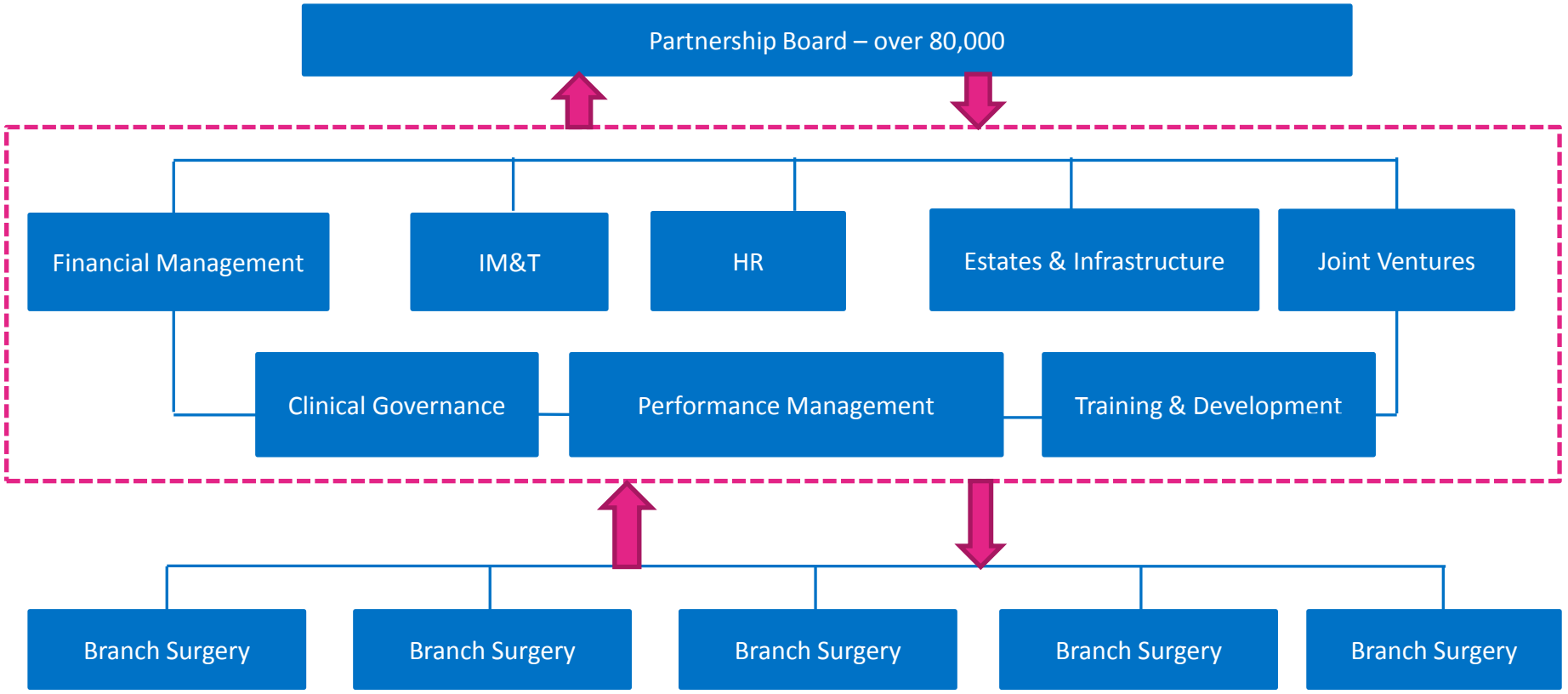
Option 10: Super-Practices



Examples:

Hurley Group, London

The Vitality Partnership, Birmingham

Whitstable Medical Practice

Option 10: Super-Practices
Case Study 1: Hurley Group, London

Background

Prior to 2006 the Hurley Group ran a 12,000 patient surgery in South London proudly achieving a 100% quality points score, providing a substance misuse service and a willingness to go the extra mile for their patients.

Commissioners approached the practice to ask if they could support two local single handers with recruitment and premises issues which led to starting a new practice in Vauxhall.

Southwark PCT decided to divest itself of a PCT-run practice in Peckham and the staff there encouraged the Hurley Group to apply. The clinical and operational turnaround of this troubled practice took a year. The Nuffield undertook an analysis of the positive impact, and this led to caretaking a neighbouring practice at short notice. A few months later they were awarded the contract for the practice and a Walk-in Centre at the same site. They soon developed a passion for the satisfaction derived from taking a struggling service and transforming the care for patients, and just kept going – always keeping a focus on London's most deprived communities.

Current Day

Hurley Group now run 13 practices in 10 London Boroughs with 100,000 registered patients and 350,000 minor illness and injury cases from nine locations, across 9 CCG's. The team has grown from 25 to nearly 400 in this period, but remains a traditional NHS GP Partnership model. Along the way, they have branched out into providing substance misuse services, a sick doctors service, developing several premises schemes, and delivering a school health education and anti-bullying programme (provided by the six school teachers employed by Hurley). They have developed partnerships with social enterprises to impact the wider determinants of health in for the population e.g. Chapel Street, Praxis and Turning Point.

Further developments are taking on a 111 GP call handling and Out of Hours services, as well as developing technology for use in Primary Care. These include an online platform called webGP for patient self-management and eConsults, and another allowing clinicians and managers to source online advice and share best practice. Evidence has shown that these not only improve the patient experience, but also improve practice capacity for more complex patients.

Continued over page

Option 10: Super-Practices
Case Study 1: Hurley Group, London

Monitoring

The Hurley Group have developed a set of metrics to monitor performance using a comprehensive dashboard which tracks performance by site every month. The set of metrics include 10 quality metrics including QOF and immunisation rates, 10 patient questions utilising both national and local surveys, 10 business efficiency metrics including sickness rates, budget and DNA rates.

Workforce

The model is heavily influenced by the quarterly staff barometer, ensuring morale remains high and they remain focused on the organisational purpose – delivering the best care to the most deprived communities in London. There is a robust organisational development programme for nurturing talent and attractive career pathways for all clinical and non-clinical staff. They invest in education, training and research and are developing the Hurley Academy to host the in house mentoring, leadership and skills training programmes.
They also plan to create internal fellowships for individuals to operationalise solutions to frontline problems.

During the years growing as an organisation, they have found themselves recruiting staff and using TUPE to maintain terms and conditions under agenda for change (a third of staff) , moving to one Hurley contract.

GP recruitment and retention of full time GP's continues to mirror the national struggle. The Hurley Group has employed 6 Physician Associates. They have recruited nurse practitioners and find them of great benefit although they are hard to retain. The receptionists have been trained and developed into HCA's providing services such as phlebotomy. The next step for the group is to look at recruiting a clinical pharmacist.

Having influenced the Primary Care Standards and the initial design of networks in Tower Hamlets in 2007, we now find ourselves in an emerging world of cross-practice provision. We are members of numerous Federations and involved in several discussions about capitated and pooled budgets with others. The next challenge will be navigating our way to a model that is right for patients, general practice and the wider sustainability of the NHS.

The Executive Team meets once a week meaning that all urgent matters are addressed quickly. Please see the next page for the governance and organisational structure.

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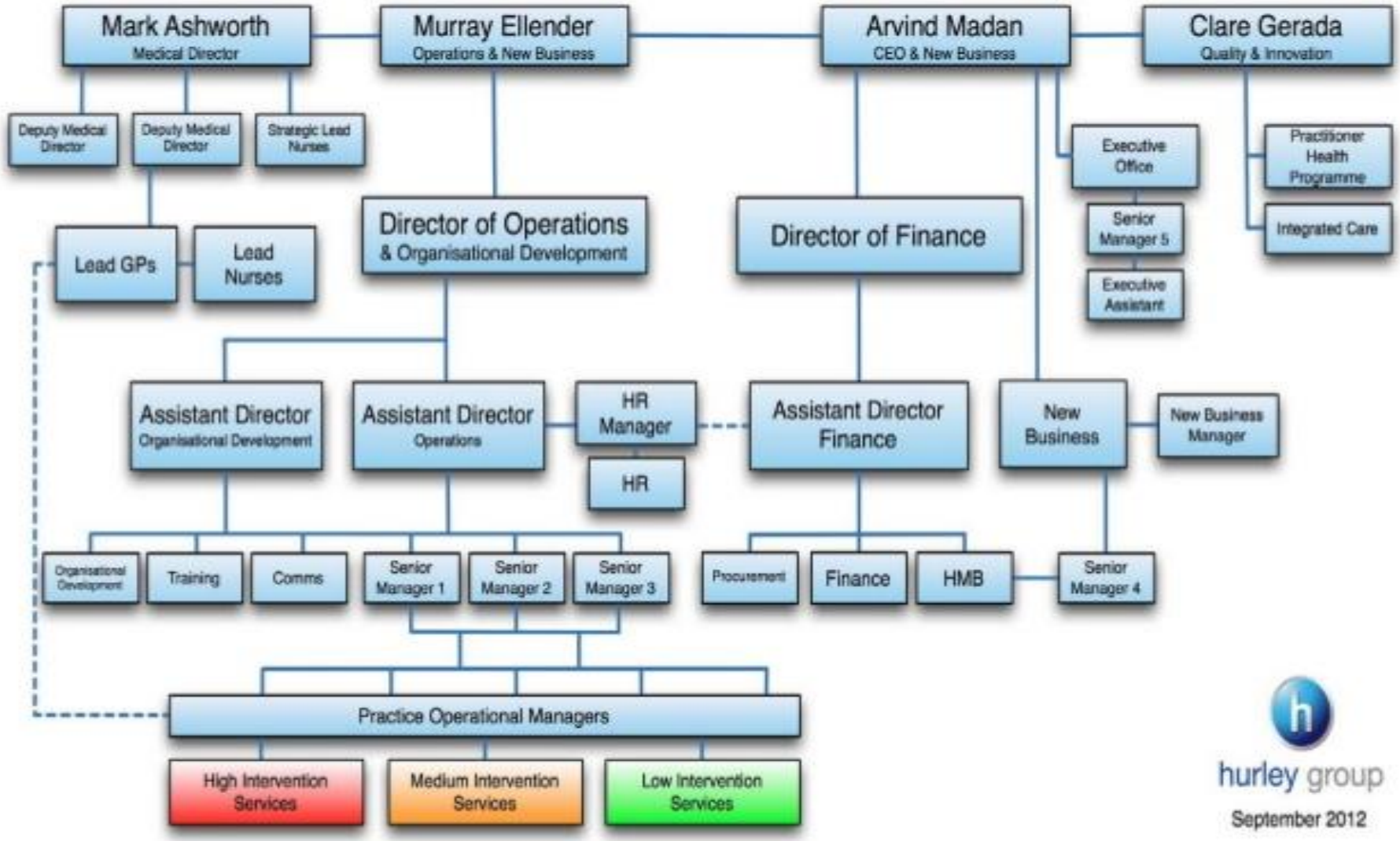
Option 10: Super-Practices
Case Study 1: Hurley Group, London – Governance Structure



Option 10: Super-Practices
Case Study 2: Vitality Partnership, Birmingham

Background

The Partners of Handsworth Wood Medical Centre and Laurie Pike Health Centre established the Vitality Partnership in Birmingham in June 2009. At the time, both practices were large, well-established and high quality achieving in their own right. The motivations of the partners to create a large 'super-partnership' were varied: to provide better general practice to a larger population; to offer a broader range of patient services; to transform the local NHS landscape; to diversify into other business areas; and to protect incomes.

Since the inaugural partnership was established, they have expanded further and now cover additional practice sites across Birmingham and Sandwell, serving over 50,000 patients and employing over 180 people. The five-year strategic business plan set out to become a GP-led integrated care organisation serving more than 120,000 patients by 2016. The practices currently operate fairly independently, under the umbrella of the Vitality Partnership, but are going through a major process of 'back-office' centralisation to realise economies of scale and build efficiencies.

Challenges

It has been a very steep learning curve. Each of the mergers has been unique. All have been time consuming and required a partner to devote the necessary energy and time to make it happen. It also required good management support to ensure all the diligence documentation is robust. Post-merger, it doesn't end there: the first single-handed practice merger took over 12 months to turn around and required considerable resource (partner time and monetary investment). Nevertheless, seeing such a previously under-performing practice improve on quality metrics (such as QOF or public health targets) has been extremely rewarding and makes it all worthwhile.

Key Lessons

As they have grown, one of the key lessons learned has been ensuring effective communication, both amongst the partnership, and the staff and their patients. In the early years, they relied on partners cascading information to staff via practice managers. However, the level of information received by the staff varied from practice to practice. Things improved after setting up a monthly email newsletter to all staff and regular email updates. Each practice has its own patient participation group (PPG) group, which is a sub-group of the larger Vitality-wide Patient Participation Group. This has worked well to ensure patients are involved in and shape the services currently being delivered and wish to deliver in the future.

Vitality has continued to modify the partnership agreement and structure to reflect the expanded partnership and the new services on offer, which any good organisation should do. Moving to a more corporate partnership structure (to deliver on our business plan) is a very new concept for general practice. This has proved to be challenging to articulate to potential incoming practices and some local practices have been put off merging as a result. However, those GPs, especially the single-handed practices, that have joined have found the clinical and administrative support has meant they are able to enjoy general practice once again without having to worry about administrative burdens. It can be intimidating coming into a large partnership, especially in terms of clinical exposure, if you have been practising as a single-handed GP for many years. A significant part of the Executive Partner role has been to ensure these GPs are welcomed, settled in and made to feel an integral part of the partnership.

Another key lesson has been to ensure that staff contracts are harmonised sooner rather than later. It took a great deal of time to go through the organisational change process so all staff were on standardised Vitality contracts. We also understand some of the local commissioning issues/tensions and see ourselves as active contributors to the solutions, being a significant local provider of health services. We have started to build upon historical working with our local acute trust and are forming relationships with the local authorities to integrate across health care and social care for our practice population. Size really does matter in this context.

Option 10: Super-Practices
Case Study 3: Whitstable Medical Practice

Main drivers

- Provide a better patient experience
- Deliver higher quality of care for less money
- Improve integration between GPs, community services and specialists
- Improve access to wider range of local services
- Reduced waiting times
- Improve management of long-term conditions

Local Levers

- Practice vision to provide community integrated health care in order to enhance the patient experience, and health care outcomes at less cost
- An acceptance by GP partners that there would need to be personal financial investment
- Good patient and public engagement.

Workforce

- 130 (34 nurses, no salaried GPs), 19 partners

Identified Benefits

- Savings on tariff for specialist services
- Improved access; some services available out of hours
- Improved coordination of care through joint care planning
- Improved and more efficient care pathways
- Increased continuity of care
- Single patient record
- Tangible increased job satisfaction for partners and staff
- Improved patient and public engagement
- Enhanced patient satisfaction. Savings on tariff for specialist services
- Improved access; some services available out of hours
- Improved coordination of care through joint care planning
- Improved and more efficient care pathways
- Increased continuity of care
- Single patient record
- Tangible increased job satisfaction for partners and staff
- Improved patient and public engagement
- Enhanced patient satisfaction

Get involved…..

Telephone: 0113 807 0161

Email us: England.LondonWorkforce@nhs.net

Post: Healthy London Partnership, 4th floor, Southside, 105 Victoria Street, London, SW1E 6QT

You can also follow us on Twitter at www.twitter.com/#healthyldn

Get involved with the Working Group

Visit the new website and you'll find all of the support packs https://www.myhealth.london.nhs.uk/healthy-london/workforce