New care models programme

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Presenting on behalf of NHS England

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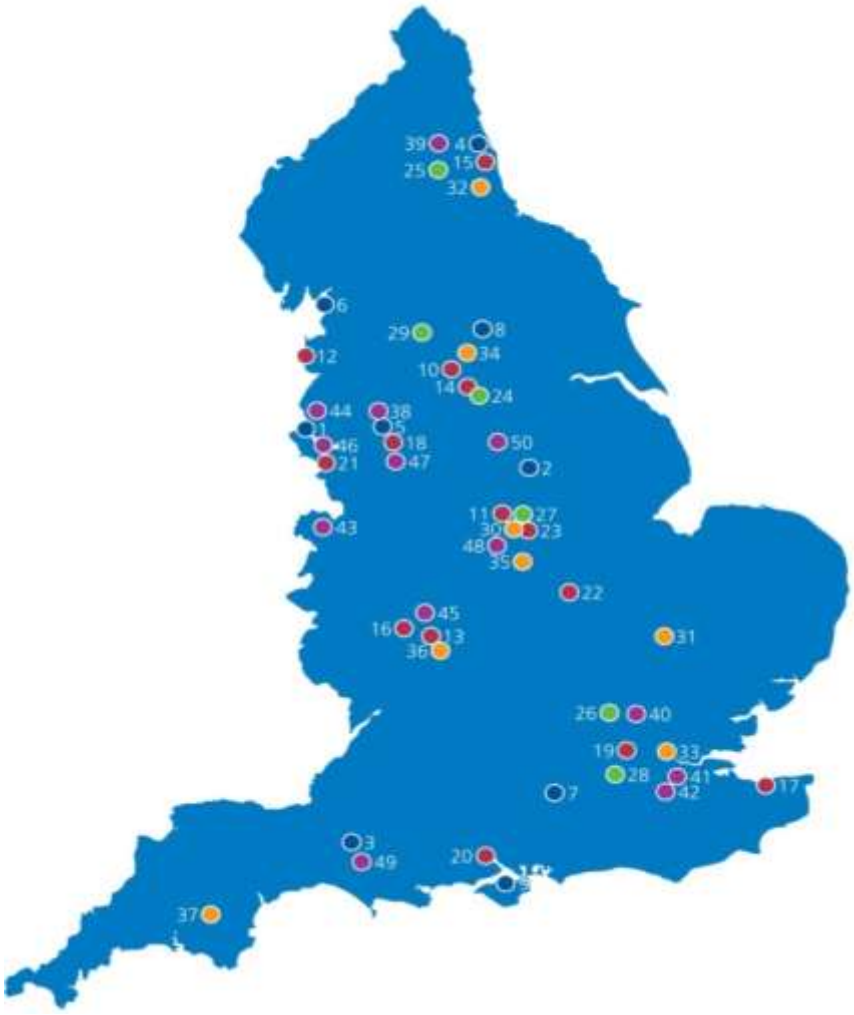
We are realising the NHS Five Year Forward View through the new care models programme

1. **Health and wellbeing gap**
2. **Care and quality gap**
3. **Funding gap**

50 vanguards are developing new care models, and acting as blueprints and inspiration for the rest of the health and care system.

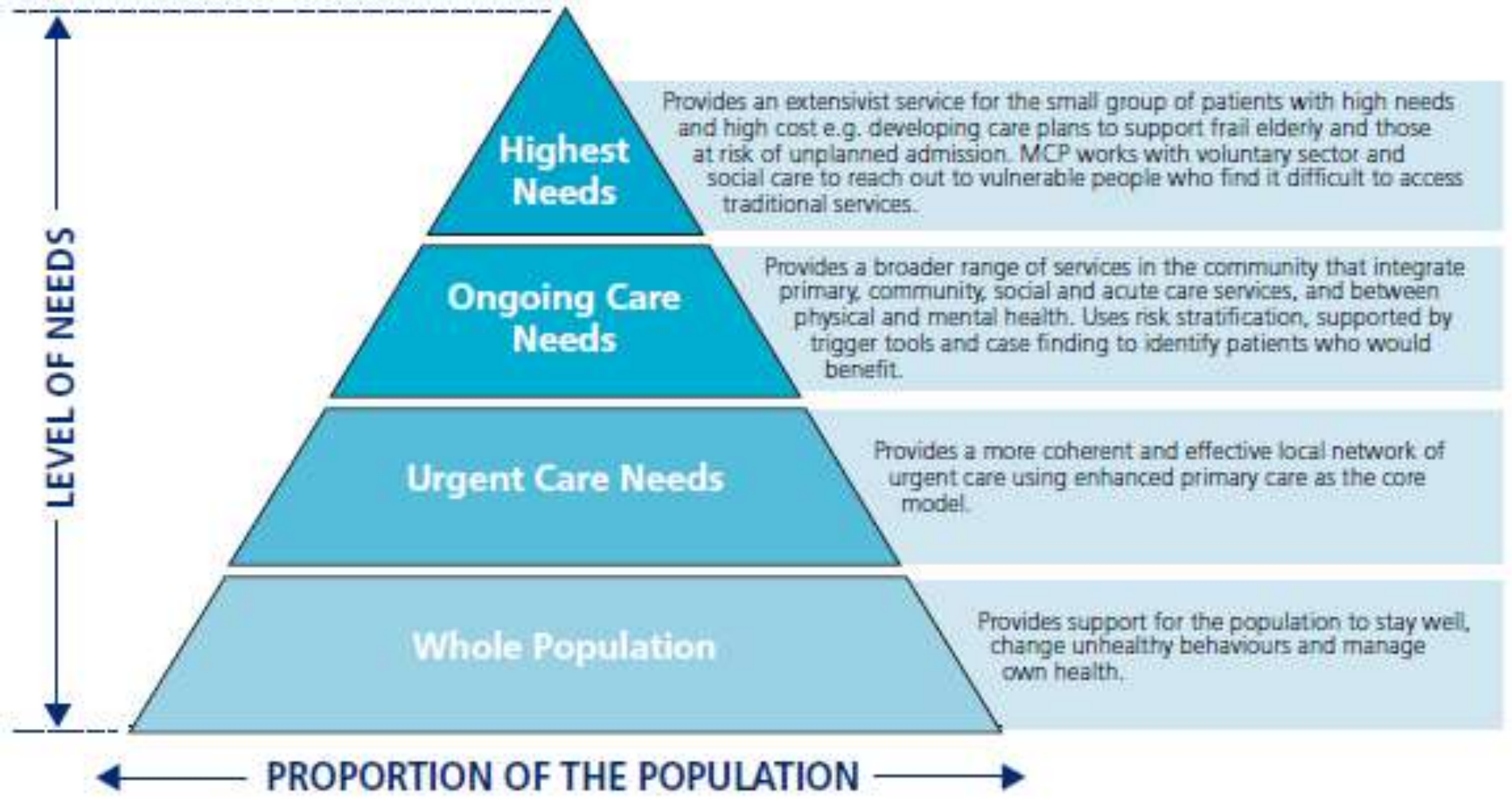


9	Integrated primary and acute care systems
14	Multispecialty community providers
6	Enhanced health in care homes
8	Urgent and emergency care
13	Acute care collaboration

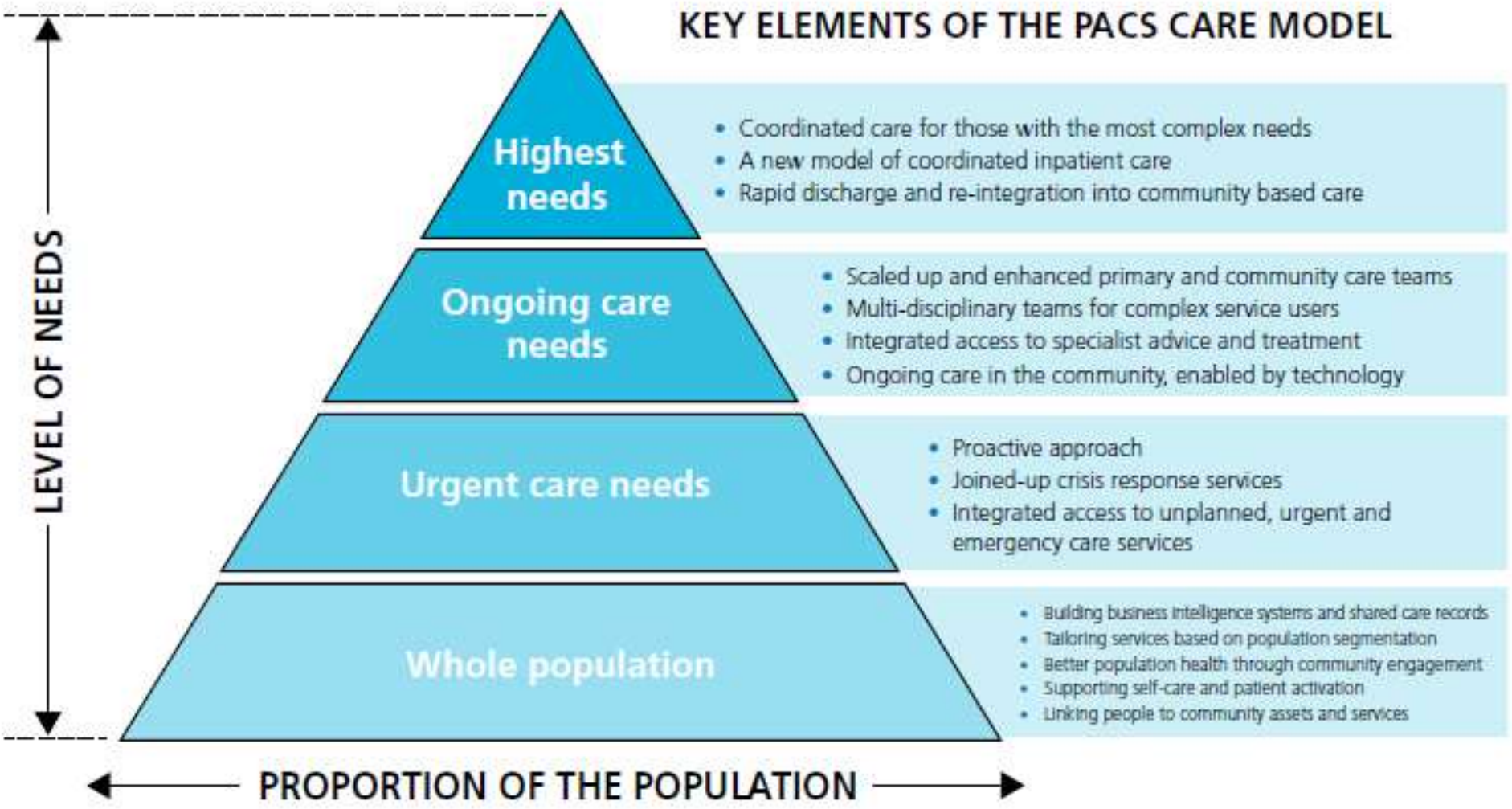
The national programme is supporting the vanguards through the key enablers of their new care models

The last year we have worked with vanguards to develop and deliver new care models, and signs of impact are emerging

With the vanguards, we have developed the full MCP care model.



Whole population models of care - PACS & MCP



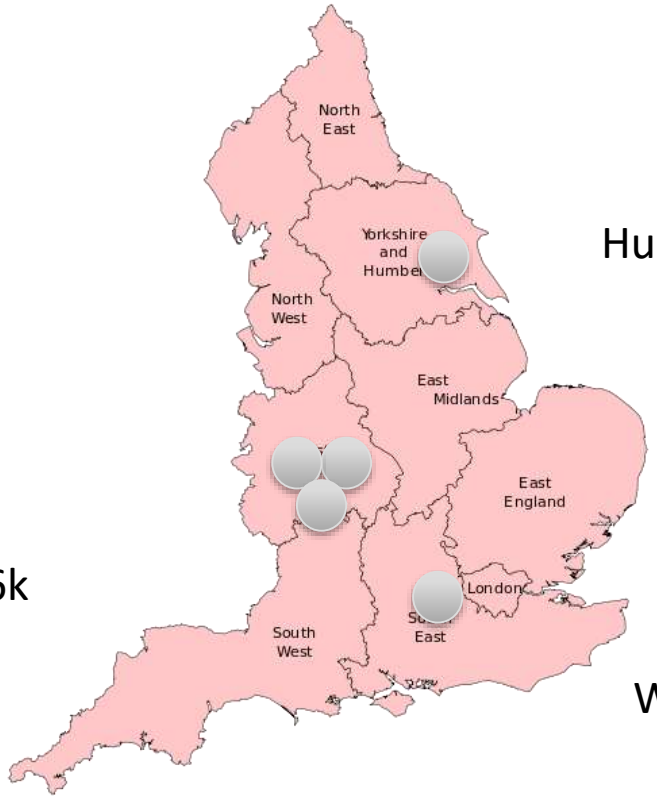
Whole Population Model (PACS/MCP)

NHS England

Core components of a successful whole population model are emerging

- Systematic approach to population health management
- Engaging the population in their own health and wellbeing
- A new model of enhanced primary care &integrated community teams
- A person-centred approach to delivery of care and support
- Shared care records and digital technology
- Specialist advice and treatment in the community
- A whole pathway approach to long term care
- Integrated access to acute and emergency care
- A new model of inpatient care
- A whole-system approach to workforce and leadership

Modality Partnership- the First National GP Partnership in the NHS



Hull 60k

Walsall 27k

Sandwell 26k

Birmingham 85k

Wokingham 25k

Primary Care Working Together

Clinical Contact HUB	Practice Level	Back Office Support
• Website Optimisation • Patient Apps • NHS symptom checker • Re-routed NHS 111 • Video consultations • Twitter/Facebook • Digital NHS F&F Test • E consulting • Care Navigation • Call/Recall	• Standardised clinical templates • Patient Interaction Initiatives • Extended Access • Enhanced Services • Specialist Services Delivery • Enhanced Primary care teams • Physio/pharmacy/ANP/PA/EP • MDTs with community	• HR • Governance • Finance /Payroll • IT Support • Group Purchasing • Training

The Modality Platform

Change Management

Lean Processes

Continual Improvement

Our MCP Vision

Based on our registered population, our collective vision is to develop a true population health model that provides the right services by the right team at the right time and place based on individual needs and acuity

Together, we will:

- Increase access to our services and ensure the right care and support at the right time and place by the right professional team, delivered in the way people want according to their needs
- Make the best use of available resources and work together to provide integrated and seamless care closer to home
- Harness our collective skills, capabilities and expertise to deliver excellent quality and experience and value across the system and improve long-term outcomes of our population

Working Together

ICOF

modality Partnership

Birmingham Community Healthcare NHS
NHS Trust

healthcare without boundaries

NHS
Sandwell and West Birmingham Clinical Commissioning Group

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Birmingham City Council

Vision for Patients/Service Users by Risk Cohorts

	Well population (80%)	Moderately complex population (18%)	Most complex population (2%)
THE NEED	• Enhanced multi-channel access to core primary care services • Support to manage unforeseen events and return to health • Support to manage wellness and achieve positive health outcomes	• Personalised care planning to manage and maintain risk • Access to person-centred condition management programmes, delivered in a primary care setting • Regular pro-active contact • Social support/social prescribing • Timely access to step-up support in the case of unforeseen events or exacerbation in order to stabiles condition(s), maintain independence and achieve the best health outcomes possible • Socially isolated – Wellbeing coordinator • Frailty care managed	• Personalised care planning to manage and maintain risk • Streamlined access and delivery of a coordinated, multi-disciplinary care plan, tailored to individual needs and preferences, delivered in a combined primary and community care setting (including home-based care) • Timely access to step-up support in the case of unforeseen events or exacerbation in order to stabilise decline, maintain independence for as long as possible, and achieve the best health outcomes possible • EOL/Advanced Illness • Socially isolated – Wellbeing coordinator • Frailty care managed
	Access, wellness and engagement	Prevent escalations, unplanned hospitalisation and avoidable admissions	Manage goals, empower, prevent avoidable decline, and treat in least restrictive setting
THE SERVCIE	**Focus on delivery of core services plus appropriate referrals to specialist services, prevention and wellness – delivered at practice level** • **Core GMS/PMS services** • **Community-based wellness services** • **Engagement and wellness** • **Self-care**	**Focus on condition and disease management – delivered at enhanced primary care level** • **Condition-specific care management delivered through EPC** • **Remote monitoring** • **Self-care**	**Focus on goal setting and care planning, supported by MDT teams working proactively and cross functional across care settings – coordinated at EPC level** • **Complex care management** • **Nursing home/residential care** • **Advanced illness/EOL**

Enhanced health in care homes care model.

1. Enhanced primary care support

- Access to consistent, named GP and wider primary care service
- Medicine reviews
- Hydration and nutrition support
- Out of hours/access to urgent care when needed

2. Multi-disciplinary team support including coordinated health and social care

- Expert advice and care for those with the most complex needs
- Helping professionals, carers and individuals with needs navigate the health and care system

3. Reablement and rehabilitation

- Rehabilitation / reablement services
- Developing community assets to support resilience and independence

4. High quality end of life care and dementia care

- End -of -life care
- Dementia care

5. Joined up commissioning and collaboration between health and social care

- Co-production with providers and networked care homes
- Shared contractual mechanisms to promote integration (including Continuing Healthcare)
- Access to appropriate housing options

6. Workforce development

- Training and development for social care provider staff
- Joint workforce planning across all sectors

7. Data, IT and technology

- Linked health and social care data sets
- Access to the care record and secure email
- Better use of technology in care homes

Early evidence from the vanguards shows some encouraging indicators of progress and impact.

- **Against 2014/15 baseline both PACS and MCP vanguards have seen lower growth in emergency hospital admissions and emergency inpatient bed days than the rest of England.**
- **The Care Homes vanguards are also reporting lower growth in emergency admissions than the rest of England, and meaningful savings from reducing unnecessary prescribing costs.**

We are working with the individual vanguards to test and evaluate their local findings, which often show even greater quality and activity improvements for specific groups…

The new care models programme is also supporting the development of NAPC's Primary Care Home model

The PCH sets a vision for the future of primary care, and empowers the workforce to deliver change locally through:

- Providing care to a defined, registered population of 30,000 to 50,000
- Combined focus on personalisation of care with improvements in population health planning, provision and outcomes
- An integrated multi-disciplinary workforce spanning primary care, community care, secondary care, mental health, social care and voluntary sector
- Financial drivers aligned with the health needs of the population

As well as the 15 intensive sites supported, a further 148 sites are now part of the PCH community of practice. The full 163 sites cover a registered patient population of over 7 million people across more than 730 GP practices.

Our challenge for the year ahead will be to cement the improvements, and spread successful new care models

With the vanguards, we have learned about the key requirements for developing, delivering, and spreading new care models

- Build collaborative system **leadership** and relationships around a shared **vision** for the population.
- Develop a system-wide **governance** and programme structure to drive the change.
- Undertake the detailed work to design the **care model, the financial model and the business model**. This includes clinical and business processes and protocols, **team design and job roles**.
- Develop and implement the care model in a way that allows it to **adapt and scale**.
- Implement the appropriate **commissioning and contracting** changes that will support the delivery of the new care model.

Sustainability and Transformation Plans (STPs) will be key to the future delivery of health and care services

STPs will consider how to implement (or scale up) new care models, drawing on the lessons from the vanguards. The specifics of the care models, and the mix between them, will be for the STP areas to determine.

Some geographies will go further faster, with the creation of integrated (or 'accountable') health systems.

Accountable Care Systems will agree to:

1. Become exemplars in delivering the NHS's top priorities: mental health, cancer, primary care, UEC, elective, hospital productivity & standardisation.
2. Take responsibility for living within a combined system financial control total.
3. Act together to improve operational performance including, for example, the A&E four hour wait, referral-to-treatment times, diagnostic and cancer waiting times.

For further information…

More details can be found on the NHS England website:

www.england.nhs.uk/vanguards

You can email the programme at: england.newcaremodels@nhs.net

Or join the conversation on Twitter using the hashtag:

#futureNHS

Or contact Jane Mcvea jane.mcvea@nhs.net