NEW MODELS OF CARE IN PRACTICE

ACUTE CARE COLLABORATION

EMRAD – EAST MIDLANDS RADIOLOGY CONSORTIUM

The East Midlands Radiology Consortium (EMRAD) aims to deliver timely and expert radiology services to patients across the East Midlands, regardless of where they are being treated. Radiology services include imaging tests like x-rays and scans.

The EMRAD network and its new way of working can save money as well as improve the clinical care offered within urgent services such as major trauma and stroke and in regional acute surgical centres. It also improves the support available to smaller hospitals and outpatient facilities around the region.

The vanguard's work is taking place in two phases. The first is the new technical platform which is used across all of the seven hospitals involved. The EMRAD vanguard has worked with a major international healthcare technology supplier, to create an innovative and scalable radiology IT system, capable of handling millions of patient events.

By working together on the joint procurement of a new shared radiology record, the seven trusts which form the EMRAD network have saved £3 million each year, and expect to save £30 million over the lifetime of the contract.

The new shared technical system allows clinicians to access the complete radiology imaging record for all patients across the East Midlands including scans, reports and clinical opinions, regardless of where they are based. This helps more clinicians provide more care closer to patients' homes and allows clinical expertise to be used flexibly to better match capacity and demand.

KEY FACTS IN NUMBERS

- EMRAD covers over six million patients.
- Joint procurement of a new shared radiology record means the seven trusts which form the EMRAD network have saved £3 million each year and expect to save £30 million over the lifetime of the contract.
- Sharing (rather than selling) supporting documentation will see each subsequent site avoids approximately £170,000 in resource costs.
- Initial evidence suggests that reporting done for EMRAD is being done at a more efficient rate than The Royal College of Radiologists benchmark rates.

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Phase two, offers radiology clinicians an alternative way of working remotely in, non-core hours, across different organisations and sharing their expertise rather than working only within their own trusts.

These new ways of working include allowing remote access to patient data meaning that radiologists can work from home. This has improved patient care, as specialist assessment is available more quickly, as well as improving the working lives of radiologists.

The network will also allow the trusts involved to provide services which make best use of capacity, and help to support both large and small trusts to recruit and retain staff through the formal sharing of expertise.

This use of technology has allowed flexible use of the radiologist workforce, resulting in additional capacity. For example one member of staff (whole time equivalent) was generated by six staff working in this way. This allows NHS staff to undertake work that would previously have been carried out outside the NHS. Initial results show a saving of 25 per cent compared to work carried out outside the NHS.

Further information: To learn more about the work of the vanguards and the new care models programme visit **www.england.nhs.uk/vanguards** or join the conversation on Twitter using **#futureNHS**

A RADIOLOGIST'S STORY

"On extremely busy days it has allowed me to get home in reasonable time and not have to stay on site until 9-10pm preparing for multidisciplinary teams as I can now prepare from home.

"I am more easily available to give opinions or help colleagues when needed. For example, last Friday evening (prior to another trust 'go live' and so a planned system downtime) I was able to help the on-call team from home when we had a major trauma with six to eight trauma cases, including two children. I was called by the operational management team lead by the MRI manager as he was concerned about the two children being brought in with trauma.

"Although I was not on call that night as I have a workstation at home, it meant that I could reassure him that between him, the on-call consultant radiologist and me, we could cope with this. I reported on the head (brain) scans for the trauma cases while they could concentrate on the body imaging."

NEW MODELS OF CARE IN PRACTICE

INTEGRATED PRIMARY AND ACUTE CARE SYSTEMS VANGUARD

BETTER CARE TOGETHER (MORECAMBE BAY)

Better Care Together (Morecambe Bay) has put listening to its local community and supporting their wellbeing at the heart of its vanguard work. Self-care and prevention are vital to helping people to avoid hospital admissions and live longer, happier lives.

The partnership between social care, health services and the voluntary sector is working with the local community to make positive changes that can help them to stay healthy and avoid illness in the future. The vanguard understands that listening to local people and understanding what is important to them, rather than imposing goals on people, is the key to finding new ways to help them to be in charge of their own health and to look after themselves better.

Using a whole population health approach, patients, carers and the wider community have worked together to identify solutions to community-wide issues recognising that being healthy is much more complex than just physical health alone but also includes mental, social and systemic health.

As part of this work the vanguard has introduced health champions, community connectors and health trainers who are making significant contributions to promoting health and wellbeing in their local communities.

The vanguard is also working closely with schools. One project which is having an impact is Let's Get Moving and involves getting local school children in Carnforth to take regular exercise. Some 1,500 children are now running a mile a day or taking part in an alternative form of exercise every day, and this is being rolled out in other areas, e.g. Morecambe.

These children are reaping the mental and physical benefits of regular exercise and learning at a young age how to take control of their own health and stay healthy. Since the initiative began last year children, parents and teachers are reporting improvements to sleep, concentration levels at school and behaviour in the classroom.

The children are also getting fitter, with more able to run the whole mile instead of walking and running. There has also been feedback that teacher wellbeing has also improved in the participating schools.

Working with the wider Lancashire sustainability and transformation partnership (STP) the success of this initiative means it is now likely to spread to other areas within the region.

The vanguard's work with schools has also included developing a play all about 'big sick and little sick' to help children understand the type of illness which requires a hospital visit and the type which you can manage at home. The play has been seen by over 1,000 local school children in town and rural locations, and feedback suggests that those who saw it were engaged with the subject and went on to have further discussions about self-care and appropriate places to get care.

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NEW MODELS OF CARE IN PRACTICE

URGENT AND EMERGENCY CARE VANGUARD

CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP

A vanguard in Cambridgeshire and Peterborough has focused on helping people who are experiencing mental health crisis and demonstrating how, with the right support, they can get the help they need at home or in the community and avoid a trip to A&E. This is improving patient care as well as providing savings for the local health system.

As part of the vanguard, Cambridgeshire and Peterborough NHS Foundation Trust, the local mental health and community services provider, introduced a new system for people to access urgent mental health support 24 hours a day, seven days a week.

People of any age can contact the First Response Service, by calling 111 and selecting option 2. The phone line is answered by trained mental health professionals who can offer advice over the phone, refer people to crisis services, or refer them to a sanctuary – safe places run by mental health charity, Mind. The sanctuaries offer short-term practical and emotional support between 6pm and 1am, seven days a week. They also offer an outreach facility for rural areas.

By bringing together all of the services that support people in times of crisis and introducing new ones, the vanguard has made a significant difference to people living in Cambridgeshire and Peterborough.

Within the first four months of having all the elements in place, 4,000 calls were triaged through the First Response Service and only three per cent required further emergency service input. This means that 97 per cent were able to get the support they needed without going to hospital.

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KEY FACTS IN NUMBERS

Within the first four months of the full model service:

- 4,000 calls were triaged through the service and only three per cent required further emergency service input.
- There was a 34 per cent average weekly reduction in trips to A&E across the four hospitals and a 20 per cent reduction in admissions.
- There has been a reduction in A&E mental health attendances brought in by ambulance by 15 per cent.
- There has been a 16 per cent reduction in the number of overdoses.

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NEW MODELS OF CARE IN PRACTICE

MULTISPECIALTY COMMUNITY PROVIDER VANGUARD

WELLBEING EREWASH

Wellbeing Erewash is a multispecialty community provider vanguard which brings together local health and social care organisations to work as one team. It has shaped a new group of services which are closer to home with patients being supported by a group of professionals working together to prevent ill health, rather than being seen by lots of different professionals individually.

This approach is known as integrated person-centred community care and it allows issues to be picked up and treated earlier and reduces patients' reliance on services. In addition, through the emphasis on developing personal and community 'resilience' local people are empowered to better support themselves and others.

This vanguard has made changes at a population level, meaning that where new roles or services are developed they tend to work across all the GP practices in the area, not just one. This is consistent with the local sustainability and transformation partnership (an overarching plan which sets out how the wider area will manage health and care together in the future). This means that primary care is now much more joined up in helping to keep patients out of hospital.

By listening to the public, patients, carers and health and care professionals, the vanguard has introduced a variety of changes which are making a real impact on people's lives.

New care coordinators are able to identify patients who might be at the most risk of having to go to hospital, either to A&E or being admitted, or who might need frequent follow-ups and support due to complex ongoing conditions or needs. These patients are then managed by a multidisciplinary team which contains expertise from the right professionals across all the different health and care organisations in the area. This team includes GPs, community nurses, social care professionals, mental health specialists and other allied health professionals (such as physiotherapists or occupational therapists).

KEY FACTS IN NUMBERS

- In November and December 2016, an 'on day service' in Long Eaton, had 3,586 attendances – 566 potentially avoiding A&E attendance, saving £50,000.
- Between April and December 2016, the Erewash Hub had 3,039 attendances – 494 potentially avoiding A&E attendance, saving £44,000.
- Between April and December 2016, the home visiting service recorded 3,039 attendances – 494 potentially avoiding A&E attendance, saving £44,000.

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The vanguard is working to keep lower risk patients out of hospital. A new acute home visiting service prevented 494 A&E attendances and 49 potential hospital admissions saving around £140,000 in just nine months in 2016/17. This is reducing financial pressures as well as improving care for patients. Advanced nurse practitioners (senior nurses) lead this service meaning that patients can be visited and treated more quickly, often freeing up GP time elsewhere.

Patients who need care quickly are benefiting from an 'on day' service which allows them to get same day appointments in both the Ilkeston and Long Eaton areas. This is helping prevent hospital attendances and admissions and improving the experience for patients.

The vanguard has implemented a number of personal and community resilience projects in support of this work on developing integrated care and primary care services. The personal resilience work helps support individuals to be as healthy as they can be, looking after themselves and knowing where to get help when they need it. The community resilience work helps make sure support is available and easy to find in the local community, and encourages people to look out for each other. Examples of these projects include Erewash Time Swap – bringing individuals together to 'trade' skills, Brilliant Erewash – developing the self-confidence of school children, and the Petersham project – working with people in an area of Long Eaton to strengthen their social networks.

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JOHN'S STORY

John, a patient, who had been diagnosed with cancer was in a lot of pain and recognised that he may be approaching the end of his life. His GP visited him at home and discussed with him and his family his wishes. John made the decision that he wanted to die in a nursing home.

Having services like the acute home visiting service in place meant that John was able to have his own GP providing support for the last stages of his life. The service releases clinical time for GPs so that they can provide continuity of care for patients with complex conditions.

The care co-ordination team supported the GP to find and arrange a care home bed for John quickly so that he could die in his place of preference. Previously, the arrangement of the bed would have been left to the GP and it may have been that the GP would not to be able to organise a bed in time. This would have made it more likely that John would have been admitted to an acute care bed.

NEW MODELS OF CARE IN PRACTICE

MULTISPECIALTY COMMUNITY PROVIDER VANGUARD

TOWER HAMLETS TOGETHER

Amongst many other initiatives, this vanguard has established a new community kidney service which uses technology to help identify and treat patients either at risk of kidney disease or already living with the condition.

This is an important area for the vanguard as high rates of hypertension and diabetes in east London's population are associated with higher than UK average progression to end stage kidney disease, and higher rates of mortality and morbidity due to associated cardiovascular disease.

A new consultant-led weekly e-clinic has been set up specifically for kidney disease. If a GP suspects a patient may have issues with their kidney function, they now have immediate access to a specialist in a virtual online clinic who can provide instant feedback on the best way to manage the patient either in the community or with more specialist care where needed. Technology is also used to identify patients who are at risk and they are also treated by the new service.

This is reducing the need for patients to be referred to the hospital service to get advice and dramatically reducing the time patients wait for treatment.

KEY FACTS IN NUMBERS

In 2015, the average wait for a renal clinic appointment was 64 days, using the new e-clinic, the average wait has dropped to five days.

Since the e-clinic was introduced in December 2015, a high number of referrals are managed without the need for a hospital appointment and where patients do need to attend a renal clinic at the hospital the wait has been reduced from 64 days to just five days.

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ROBERT'S STORY

This service is improving the lives of patients like Robert who is being treated with lithium for a bipolar disorder and ramipril for diabetes. He also suffers high blood pressure. Robert went to see his GP feeling unwell and blood tests showed his lithium level was too high and his renal function was deteriorating. The GP was able to link with the community chronic kidney disease clinic where a renal consultant reviewed Robert's patient records before advising changes to his medication. The GP made the changes and Robert's kidney function rapidly improved and he felt much better. Without the seamless sharing and reviewing of medical records it is likely Robert's condition would have continued to deteriorate. The rapid action taken by his GP meant he avoided an outpatient appointment or hospital admission, which also reduced the pressure on the wider health system.

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NEW MODELS OF CARE IN PRACTICE

INTEGRATED PRIMARY AND ACUTE CARE SYSTEMS VANGUARD

MID NOTTINGHAMSHIRE BETTER TOGETHER

Mid Nottinghamshire Better Together vanguard is working towards the local health and care system being more joined up, and together partners have been reducing unnecessary hospital admissions for the area's highest risk patients.

This means getting doctors, nurses, other health professionals and social care staff to work more closely together in a multidisciplinary team to support the needs of patients, their families and carers.

This joined-up approach is better for patients as their care is better coordinated with the different people who look after them all sharing information and making sure that they are communicating effectively with each other. This means that they can more effectively spot patients who need extra help and allows issues to be identified earlier, preventing health from deteriorating or complications which require a hospital stay from arising.

The model the vanguard uses to identify and support the patients who are at the greatest risk of needing to be admitted to hospital in the future is known as the PRISM model of care.

This stands for three core elements:

- Profiling risk, which is looking at those who are most likely to end up in hospital soon due to complex conditions or other factors.
- Integrated care, which is everyone working together to support these people.
- Self-management and teaching patients to manage their ongoing conditions and health needs with support in the community.

The idea is that extra support is given to those most likely to require a hospital admission to keep them well and prevent an admission being needed.

KEY FACTS IN NUMBERS

- The system has seen 22 per cent fewer breaches of the national four hour emergency target in 2015/16, compared to the previous year.
- As a result of the urgent and proactive work, Sherwood Forest Hospitals has been able to reduce bedstock by over 100 adult medical beds.
- The number of patients staying in hospital for more than 14 days has halved.
- The area is now one of the top performing in patients returning to their usual place of residence after a hospital stay.

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The team identify the patients using a process called risk stratification and then work together to review their needs and decide on a course of action which will help to keep them happy at home instead of unwell in hospital.

As a result of initiatives like this the vanguard has managed to reduce the number of days its population is spending in hospital by 10 per cent.

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IAN'S STORY

The team helps patients like Ian, 68, who had a brain injury 13 years ago which affects his memory and means that sometimes he neglects his other health issues: diabetes, deep vein thrombosis and associated liver and kidney problems. Prior to being on the team's at risk register, Ian unnecessarily attended the local A&E three times over a two month period. However, since offering Ian extra help and support with his care needs and diabetic medication he has avoided a further four hospital admissions in a four month period.

NEW MODELS OF CARE IN PRACTICE

ACUTE CARE COLLABORATION

ROYAL FREE LONDON

Royal Free London is one of four foundation trusts developing a 'group model' – a new way of working across organisational boundaries to improve the quality of patient care, while also reducing the cost to the healthcare economy as a whole.

Royal Free London believes that improvements to patient health outcomes, a better patient experience, a more engaged and higher skilled workforce and cost improvements can be achieved by creating a group of hospitals which can operate on a larger scale.

Hospitals in the group develop common processes, governance and back office systems such as human resources. Each hospital within the group continues to function as a hospital unit and with support from the group centre.

The long-term ambition of the vanguard is to create a group which will eventually contain between ten and 15 NHS trusts and bring the benefits of the group structure to around five million patients.

Royal Free London's early work is focusing on standardising the most common patient pathways, so that we can reduce the largely unwarranted variation in care that many patients currently receive which will improve overall quality of care and reduce costs.

For example, a potential 10-20 per cent cost saving has been identified in treating patients with gallbladder disease. Implementing standardised ways of doing things across the group will also mean earlier interventions, which improves the experience for patients. These improvements are achieved through a rapid delivery of appropriate tests, eliminating repeat and unnecessary scans or tests and timely operations scheduled as day-case procedures, where possible.

KEY FACTS IN NUMBERS

- Early work on pathway standardisation, for example in gallbladder disease, suggests that a 10-20 per cent or more cost saving is possible.
- A standardised process for gallbladder treatment could reduce the cost of delivering specified parts of the service by around £500,000.
- A set of standardised pathology tests for patients visiting A&E with common symptoms is saving the Royal Free site approximately £8,000 per month.

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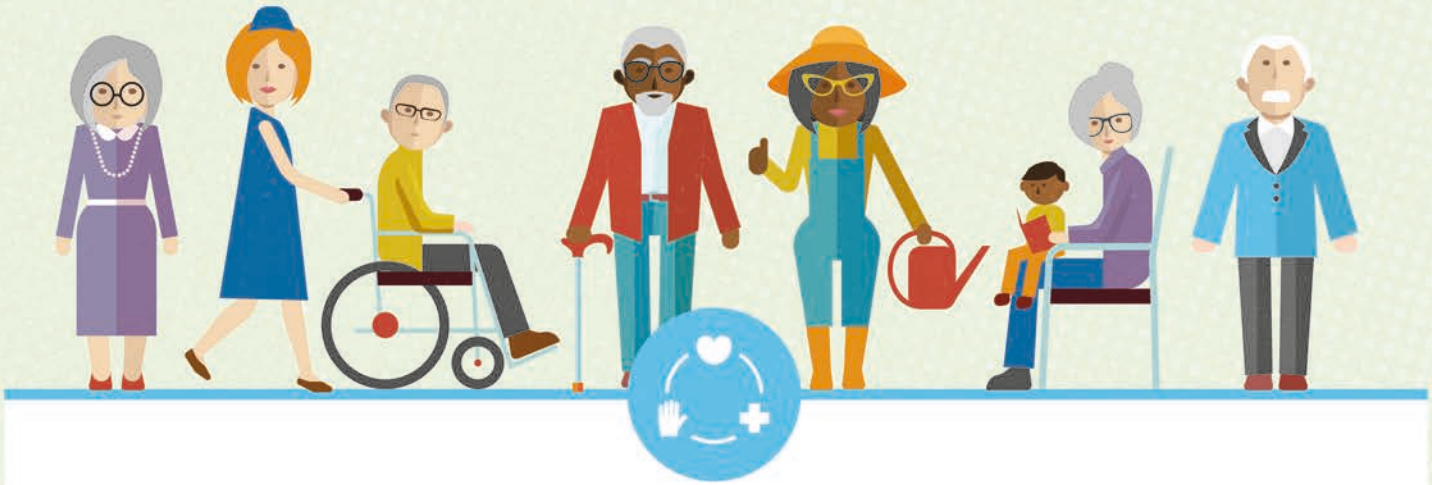
For example, it is estimated that a more standardised process for gallbladder treatment could reduce the cost of delivering some parts of the service by around £500,000. These savings would be achieved through earlier use of definitive treatments, a reduction in post-operative follow up attendances, a reduction in trips to A&E and patients spending less time in hospital.

Royal Free London has also developed a set of standardised pathology tests for patients visiting A&E with common symptoms. This is improving patient experience by reducing unnecessary tests and making it easier for staff to order the correct tests.

The next step for Royal Free London is to develop the membership model for other organisations and continuing to develop at least 20 standardised clinical pathways in 2017/18.

Further information: To learn more about the work of the vanguards and the new care models programme visit **www.england.nhs.uk/vanguards** or join the conversation on Twitter using **#futureNHS**



NEW MODELS OF CARE IN PRACTICE

ENHANCED HEALTH IN CARE HOMES VANGUARD

CONNECTING CARE – WAKEFIELD DISTRICT

Connecting Care – Wakefield District vanguard has been focussing on improving the health and wellbeing of local care home residents.

Connecting Care – Wakefield is bringing the right professionals from health and social care services and care homes together and establishing new ways of working to prevent ill health and deliver better care when residents do fall ill. New multidisciplinary teams, encompassing professionals from all the partner organisations including GPs, community nurses, social care workers, mental health practitioners, therapists, volunteers and pharmacists are now able to support the team working in a care home in a variety of important ways.

Most importantly, this more joined-up approach has allowed the partners to help care home staff to develop their own skills in dealing with the complex medical needs of their residents. This means issues are being identified early and resolved before they develop into an emergency which can be distressing for the resident and require an emergency call out from a medical team or admission to hospital.

The vanguard is also sharing information between the different professionals involved in a resident's care. They have developed shared personalised care plans for residents which means that a resident who has multiple needs is having these addressed in a coordinated way to ensure that their overall health is improving. These simple shared care records are also helping care home staff to understand their residents better and increasing the confidence of staff to do the things which can dramatically improve the quality of life of residents, like being more aware of their personalities and histories.

Through talking to residents and their families about what really matters to them and would make a difference to their lives, the vanguard has put in place a range of measures to promote residents interacting together and feeling connected to their local community. Social isolation and loneliness are known to have a significant impact on health and wellbeing, therefore this is an important area of work.

KEY FACTS IN NUMBERS

- In 2016/17, the vanguard care homes reduced emergency admissions by 13 per cent and reduced ambulance call outs by 5 per cent. This was compared to an increase of 18 per cent in call outs to other non-participating care homes in Wakefield District.
- In 2014/15, 38 per cent of residents in an extra care scheme terminated their tenancies to move into residential care. By 2016/17 with the vanguard in place, this has been reduced to none.
- Loneliness and social isolation are harmful to our health: research shows that lacking social connections is as damaging to our health as smoking 15 cigarettes a day (Holt-Lunstad, 2015).

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Care homes have developed programmes which see residents getting into their local community for activities like health walks, visiting a local church or going to a tea dance, as well as activities which see the community coming into a care home, for example bringing a choir or a dog in to visit. The programme also includes activities which encourage residents to share their memories with each other and staff to help them get to know each other better and form social relationships and networks within their care home.

The vanguard has also been working with people before they have to go into care homes. Working with extra care settings, for those who need a bit of extra support but do not require to be in residential care, has enabled the vanguard to prove that with the right interventions in place the process of moving into residential care can be slowed down and in some cases be stopped altogether. In an extra care setting, residents can retain an independent lifestyle, while still living within a larger secure scheme.

In 2014/15, at Croftlands Extra Care scheme managed by Wakefield District Housing, 38 per cent of tenancies terminated were due to residents moving into residential or nursing care. When this was reviewed in 2016/17 following the support of the vanguard, it was established that residents terminating their tenancies to move into residential or nursing care had fallen to 0 per cent.

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NEW MODELS OF CARE IN PRACTICE

INTEGRATED PRIMARY AND ACUTE CARE SYSTEMS VANGUARD

NORTH EAST HAMPSHIRE AND FARNHAM

North East Hampshire and Farnham vanguard is focussing on bringing local primary, community, acute, mental health and social care services together to work as one team to keep the local population healthier.

Working more closely across services has helped North East Hampshire and Farnham vanguard to develop new services and initiatives which support people to self-care where possible and to be treated more often in their local community instead of hospitals.

One service is the Safe Haven in Aldershot for people with mental health problems. This jointly run service has crossed traditional agency boundaries and geographical borders and provides a real alternative to A&E for those in crisis. Early data showed a 33 per cent reduction in acute psychiatric admissions locally in the first six months.

Seven days a week, with no appointment needed, service users can go to the Safe Haven to talk to staff who can support them when they are in crisis by helping them to access community information on mental health and wellbeing, get peer support and feel more integrated with their local community and learn self-management skills to break the cycle of crisis.

This has been viewed very positively by service users who have described the importance of being able to access help when they needed it and that the Safe Haven has helped them to avoid further crisis, self-harm or going to A&E.

One service user said: "If I hadn't come in tonight I would have self-harmed, but talking to someone has relieved my crisis and helped me understand my situation and what I need to do."

Services working together more closely in North East Hampshire and Farnham vanguard has also resulted in GP practices collaborating to develop urgent care hubs. The hubs allow them to offer an enhanced service for patients with same-day urgent needs and also take them out of the routine practice system.

This has freed up more time to deal with patients with complex needs, putting in place a holistic care plan to meet all of their needs and sharing information between professionals to allow more proactive care.

This sharing of resources and skills is resulting in a better service for patients and a more efficient service which will reduce hospital admissions.

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