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Our core values

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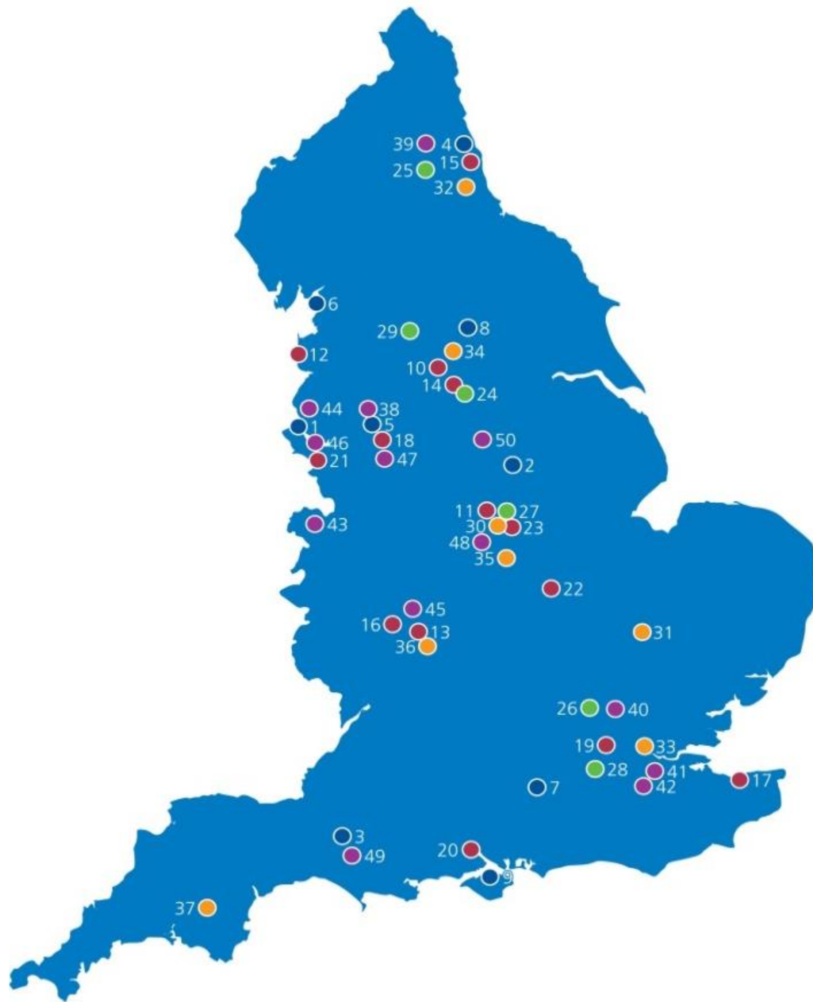
50 vanguards selected

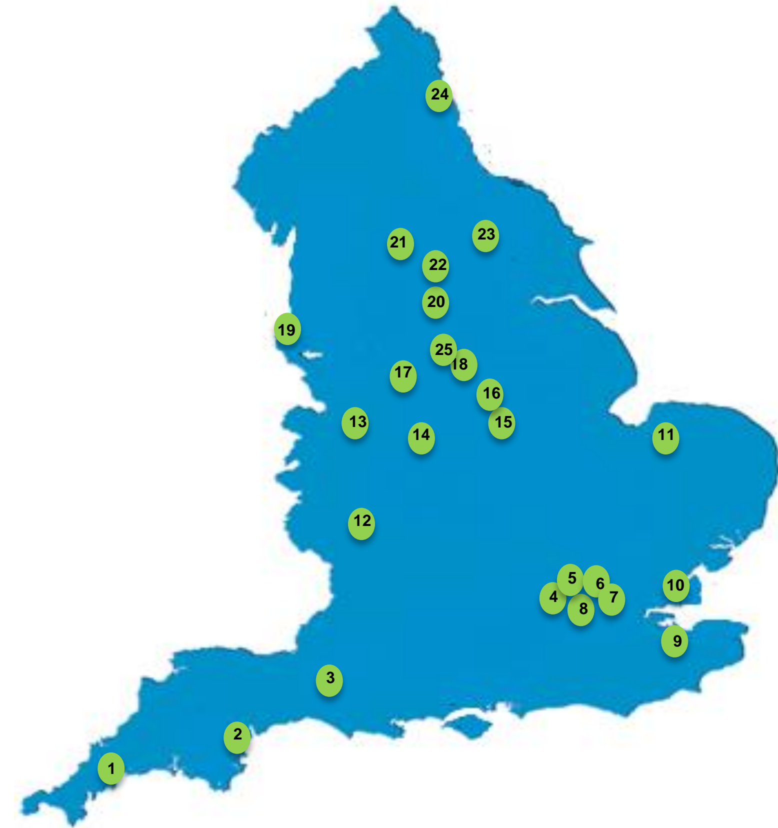


5 new models of care with a total of **50 vanguards**:

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**

Integrated care pioneers sites

- The 25 integrated care pioneer sites are developing and testing new and different ways of joining up health and social care services across England
- Utilising the expertise of the voluntary and community sector, with the aim of improving care, quality and effectiveness of services being provided
- Shared goal is to put the needs and experiences of people at the heart of the health and care system
- Collective learning and collective commitment between pioneer, vanguards and national partners



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

Addressing the key enablers of transformation

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Common components of successful new care models are emerging

While all vanguards are working in response to their different local needs, we are learning that there are common components across each of the first wave of care model types.

Core characteristics in the emerging **PACS** framework:

A. **A population health** and wellbeing care model
B. **Accountability** for the whole population
C. **Integrated governance and organisational form** to support population health
D. **System leadership** to support population health
E. **Contracting and payment systems** that support population health

Core components to the emerging **MCP** framework:

A. **A population health** and care model focused on **proactive and preventative care** tailored around the needs of the individual
B. **Empowering** patients and local people to support each other and themselves in their health and care
C. **Multi disciplinary health care** professionals working within an organisation that has **accountability** for the delivery of health and care services for their population;
D. **Contracting and payment systems** that incentivise and enable the delivery of services for population health

Core themes to the framework emerging from the **enhanced health in care homes** vanguard community:

A. **Enhanced primary care support** for care home residents
B. **Multi-disciplinary team** in-reach support:
C. **Re-ablement and rehabilitation** to promote independence and living at home
D. **High quality end of life** care and dementia care
E. **Joined up commissioning** between health and social care
F. **Workforce** training, development and shared planning.
G. **Data, IT and technology** – shared data, records and new technology.

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What is the EHCH model about?

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- Providing joined-up primary, community and secondary, social care to residents of care/ nursing homes and Extra care Living Schemes (ECLS) via a range of in-reach services.
- To deliver person-centred integrated preventative care that promotes independence and supports individuals in an appropriate housing option of their choosing

Why are we doing this?

- To improve the quality of life, healthcare and planning for people with LTCs - in both care/ nursing homes, ELCS and the community

"I want to live as normal a life as possible"

"I get the best clinical outcomes possible"

"I want to feel part of a community"

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What appears to make the difference for care home residents?

- **Enhanced primary care support for care home residents**
  - Access to consistent, named GP
  - Medicines reviews
  - Hydration and nutrition support
  - Out of hours/emergency support
- **MDT in-reach support**
  - single point of access to primary, community, acute, social and other specialist advice
  - Expert advice for those with the most complex needs
- **Re-ablement and rehabilitation to promote independence and living at home**
- **High quality end of life care and dementia care**
- **Joined up commissioning between health and social care**
  - Shared contractual mechanisms to promote integration
  - Co-production with providers and networked care homes
  - Access to appropriate housing options
- **Workforce**
  - Training and development for care staff
  - Shared workforce planning
- **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

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Routes to spread

1. Across health and care economies- using the planning process in 15/16 to identify where the model will be adopted
2. Through the vanguards and pioneers- ensuring that the EHCH vanguards are adopted across the other vanguard sites
3. Through the trade- through trade associations and providers either as individual elements or in their entirety

How are the vanguards improving care?

Selected work the care home six are implementing:

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1. Newcastle & Gateshead

- Homecare/Community beds
- Virtual Ward MDT / Ward Rounds – GP, Community team & Care Home Staff weekly ward rounds for care planning and MDT for complex decision making
- Outcome Framework based on 'I' statements and Local Metrics
- New care pathway for frail elderly, encompassing homecare/community beds, supported by a growing Provider Alliance Network, and development of outcome-based contractual / payment model.

2 . Airedale

- A Dementia-focused social movement, working with the Alzheimers' association and Yorkshire's Cricket clubs - building resilience in communities through sport to support people with dementia.
- Using technology to support care home residents by providing a secure video link to senior nurses.

3. Wakefield

- MDT - a proactive care homes support team will provide person-centred care planning and co-ordinated input to the care home staff and residents
- **Community Anchors** - trained individuals helping those in care/nursing homes & ECLS access community assets & networks to reduce social isolation
- Introducing holistic assessment tools such the LEAF 7 assessment and Portrait of a life to increase wellbeing and health for those in care homes

4. Nottingham City CCG

- Joint commissioning with local authority as lead contractor, using an NHS-standard contract. Underpinned by robust quality monitoring processes.
- Person-centred outcome measures developed with Age UK and local citizens
- Dementia outreach team is commissioned to provide dementia care, case management and training and support for care home staff. The team also run care home managers' and care coordinators' forums

5. East and North Herts

- Health and social care data integration
- A complex care framework: Supporting care home staff to be confident in their care for their patients
- GPs aligned to specific care homes
- An integrated rapid response team which offers a timely assessment and alternative model of care to hospital admission for appropriate patients who are in a 'crisis'.

6. Sutton

- Hospital Transfer Protocol (red bag)
- Standard Assessment Form
- End of Life Care
- Engagement with care homes

What can MCPs and PACS adopt or adapt?

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How to implement elements of the model will depend on your locality – but here are some examples

	Workforce - training and development for care home staff	**Enhanced Primary Care**	***Better use of technology in care homes***
Description	Up-skilling staff within the care home to enable them to care for increasingly complex patients with more confidence. Delivered via a complex care framework – various levels of premium according to training mix and care home capacity / rating	Aligning GP teams and community teams with care homes staff , to support 'care and support planning'. Proactive care with focus on best practice around End of Life, medicines, dementia care, nutrition and Hydration etc. In-reach MDT – complex decision making and proactive and responsive care and support	A Telehealth model that delivers an immediate telemedicine service that provides a secure video link to care homes. Particularly useful in care homes, whereby there are a high proportion of staff who are not medically trained; hence the clinical team are able to provide extra support. Other examples include linked health and social care datasets Secure email i.e. nhsmail
Potential benefits	• Better care in the care home • Supports residents to die in their preferred place of death • Reduction in number of emergency attendances and admissions from homes • Reduced vacancy rates and improved motivation of staff	• Continuity of care • Reduction in number of emergency attendances and admissions from homes • Reduction in number of ambulance calls • Savings on medicine prescribing	• Reduction in hospital as place of death for palliative care patients • Reduction in number of emergency attendances and admissions from homes • Reduction in number of ambulance calls • Reduction in inappropriate GP call • Patient information can be shared securely across the health system

How might this relate to housing

- The challenges the sector has articulated are similar to those the care homes work is seeking to address
- Several sites are already extending their schemes to extra care housing and homecare
- Technology means that the model could be delivered across a building footprint
- Some of the care model requires system change but other elements can be adopted standalone