THE FORWARD VIEW INTO ACTION:

New Care Models: support for the vanguards

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The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Contents

Making sense of the programme

i. The new care models programme was launched in January 2015 with individual organisations and partnerships invited to apply to become vanguards, one of the first steps towards delivering the NHS Five Year Forward View and supporting improvement and integration of services.

ii. This document 'New care models: supporting the vanguards' updates the initial support package published in July for the first 29 vanguards, and now reflects the needs of all 50 vanguards across England.

The vanguard story so far

iii. More than 380 partnerships during 2015 put forward their ideas to redesign care and in March, the first 29 new care model vanguards were chosen. These were selected to develop three new care model types – integrated primary and acute care systems (PACS); enhanced health in care homes; and, multispecialty community provider (MCPs) vanguards.

iv. In July 2015, eight urgent and emergency care (UEC) vanguards were announced. This was followed in September with a further 13 vanguards known as acute care collaborations (ACC).

v. The 50 vanguards were selected following a rigorous process, involving workshops and the engagement of key partners and patient representative groups.

vi. Each vanguard site is taking the lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system. The aim is for the locally-led new care models - built by patients and those affected by change - to be rolled out across England within the next five years.

Update and initial support

vii. During April and May 2015, the new care models team carried out two-day visits to each of the first 29 vanguards to understand their aims in more detail. Building on these visits, the team developed thematic reviews, which were shared back with the vanguards. Following their support for these reviews, the key areas for transformation were summarised into eight areas for support that would maximise their chances of success and to enable replicability across the NHS and social care. These enablers formed the basis of the initial programme of support that was published in July 2015.

Extended support

viii.   The support package has been updated to reflect the needs of the ACC and UEC vanguards. To understand their aims and specific support needs, we held workshops, intensive diagnostic site visits and ongoing discussions. Based on what they told us they need, a further two areas of support have been added. We have also incorporated the learning to date from the first 29 vanguards.

ix.   The support package is built on ten key enablers to maximise the vanguards' chances of successful local delivery and to enable national spread. They come directly from the issues raised by the vanguards, the thematic reviews arising from the visits and the views of a wide range of stakeholders including patients and clinicians.

x.   Through the joint national and local work outlined in this document, we are making commitments about what will be developed and achieved during the

remainder of 2015/16 and in 2016/17. At the same time, the programme will evolve and develop.

xi.   Each vanguard system is rooted in its local diverse community. The national new care models programme draws together these individual local threads into explicit patterns to exploit common opportunities for radical care redesign and remove barriers to change.

xii.   Our focus is on creating simple, standardised approaches and products, based on best practice and co-produced with vanguards. These are to be designed from the outset for national spread, with the ability to respond to the needs of diverse population groups of all ages.

xiii.   This document covers support for the five types of new care models. In summary, the first three new care models will demonstrate the reinvention of out of hospital care, with PACS and MCP vanguards organising this for the whole population, and enhanced health in care homes targeting their approach to a care home setting. It will shift the integration agenda much further, aided by the dissolution of existing funding, contractual and provider organisational silos.

xiv.   Whilst the enhanced health in care home model will focus on the needs and preferences of a targeted and diverse population, MCP vanguards will deliver an expanded version of core and improved general practice, based on larger, more resilient multi-disciplinary teams. They will bring a broader range of specialist and generalist care closer to all patients and citizens in diverse communities. Similarly, the PACS model will also deliver an expanded version of core general practice, but will go much further by joining with acute hospitals to create a single provider system.

xv.   The UEC vanguards will accelerate the implementation of the Keogh Urgent and Emergency Care Review[1] to improve the coordination of urgent and emergency care as a whole system, so that people can access the most appropriate service first time. The ACC vanguards will develop new clinically and financially sustainable models for acute hospital services. As part of this, the ACC vanguards will take forward Lord Carter's recommendations for improving the productivity of NHS hospitals[2]. Summaries of the aims and support for the ACC and UEC vanguards accompany this document.

xvi.   Rather than launching several additional types of vanguard, the New Care Models Board and national bodies will focus on delivering useful, practical support for these five vanguard groups.

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[1] Published August 2015 http://www.nhs.uk/nhsengland/keogh-review/Pages/urgent-and-emergency-care-review.asp

[2] Published June 2015 https://www.gov.uk/government/publications/productivity-in-nhs-hospitals

The vanguard approach to change

xvii.   Four core values underpin the new care models programme and the way we work. Our values are fundamental to the way that the programme has worked to date, the way the support has been developed and the way we will work to deliver it.

Clinical engagement	Patient involvement
Local ownership	National support

xviii. Building on these core values, four design principles frame the support package.

Design principle 1 – we solve problems through joint national and local leadership

xix.   Many of the local issues that the vanguards face stem from the adverse and often unintended consequences of the national rules, systems and behaviours within which the local NHS operates.

xx.   The programme has been organised through ten enabling areas of support. Twelve joint workstreams are taking these forward and are jointly-led by a vanguard leader and national subject matter expert. Together, the national and local leads are deciding how the work should be progressed, including the experts they want, and ensuring strong input from a range of different vanguards and other bodies, in line with the values of the programme and the aim of national replication. Through their work, national bodies and vanguards are jointly accountable for identifying and fixing specific problems, and taking advantage of common opportunities.

xxi.   In an inversion of the traditional hierarchy, the vanguards are commissioning the national bodies to support them. They are holding us to account for how well we deliver for them. The role of the national bodies is to help remove burdens, rather than add more through programme reporting that will not aid learning. In turn, the national bodies expect the vanguards to engage fully with the programme; to collaborate with each other; to be open to doing things in

common wherever that makes sense; and to deliver demonstrable value for any national investment across the triple aims: improving health and wellbeing; care and quality; and delivering financial efficiency.

Design principle 2 – we create simple replicable frameworks, built for spread

xxii.   From the start of the programme, we have built in the principle of national replicability and spread to the design of what all vanguards deliver locally. The success of the programme and the value to the taxpayer will not be defined by successful local delivery in the vanguard systems, but the extent to which they have made it easy to spread learning across the wider NHS and social care.

xxiii.   This means the job of the joint leaders and supporting groups is to develop the simplest possible standardised solutions wherever that makes sense – designed to meet the needs of multiple existing vanguards and future followers. For example, we are developing: model role definitions for new types of worker; common evaluation metrics; a common simple method for setting a population budget for the PACS and MCPs for testing by vanguard sites in 2016; a new voluntary standard MCP contract for testing by vanguard sites in 2016; common new organisational forms that will be able to deliver integrated health and care services across a whole population; "rights of return" for GP practices; and common standard operating models that will reduce avoidable variation in the cost and quality of care. These simple solutions will be voluntary, and vanguards and other local health systems, will be able to tailor them to suit their own local circumstances.

xxiv.   The NHS will own the intellectual capital for all the work of the vanguards. The programme will minimise duplication of wasted financial resource and avoid two or more local systems paying for what is in essence the same piece of work that can be developed once.

xxv.   Together, the national bodies and vanguards, working with the Academic Health Science Networks (AHSNs), the royal colleges, NHS Confederation, NHS Providers, Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA), will be responsible for sharing learning across the NHS and social care.

Design principle 3 – we encourage and support radical innovation

xxvi.   We are encouraging all vanguards to become more radical in their thinking. It has not always been clear to local systems what is and is not "on the table". Through the programme, we are allowing and enabling existing silos to be dissolved – for example through new approaches to commissioning, contracting, and payment and provider forms.

xxvii.   These are all necessary enablers of transformation but there is no point in pursuing these changes in isolation. Through the support package, we will help vanguards to transfer power to all patients and their diverse communities; to re-design the health and care workforce; and to re-think how care is delivered by harnessing digital and other technology.

Design principle 4 – we work and learn at pace, demonstrating that change is real

xxviii.   The NHS is looking to the new care models programme to create a better and more sustainable future. At the same time, the vanguards and the national bodies know that achieving transformational change is very difficult. The vanguards are telling us that their work has to improve the interaction between individual patients and carers.

xxix.   The vanguards want to deliver improvements for patients as quickly as possible. Our collective task is for the joint national and local leads to work at the pace of the fastest vanguards, and to develop quick wins along the way. Progress and impact will be measured and evaluated using common approaches as described in this document.

xxx.   We know collectively that we need to work at pace. Unless we can start to see demonstrable, quantified change occurring in 2016/17, it will become harder to justify significant national investment.

National support package

1. Designing new care models

1.1. While vanguards have told us how they want to redesign care models locally, they also recognise that they need support with developing more tightly defined overarching models of care, and to understand key components which add the greatest impact and value for people using services. In this way, vanguards will help the national team to identify the active ingredients for each care model that can be replicated in other local health systems.

1.2. To share this with the wider NHS and social care, the national team will work with the vanguards to develop and publish a common framework for each care model; PACS, MCPs, enhanced health in care homes, UEC and ACCs.

1.3. Vanguards have identified the need for support at different phases of design and implementation, involving continuous evaluation, refinement and improvement. Alongside this support, they want help to clearly convey components of the care model to their staff, patients and citizens, and to engage them on defining local outcomes and determining factors for success.

Learning from other countries and sectors

1.4. Leaders from the vanguards will have access to international experts who have successfully implemented new care models across Europe, Australasia and North America. The vanguards are hearing first-hand how in each country the care model was transformed through changes in organisational form, accountability and digitalisation of care, and how the workforce has adapted around their care model. In addition, vanguards have been invited to join the integrated care pioneers on a programme provided by the NHS Confederation to understand innovative models of care across the European Union (EU).

1.5. From December 2015, the vanguards will have access to learning about approaches to transformational change from successful public, private and third sector organisations outside the health sector.

Supporting identification of the right care for the right groups of patients

1.6. The first 29 vanguards have been given early access to a version of NHS England's Right Care programme. Right Care is working with many clinical commissioning groups (CCGs) to support their approach to integrated care. This starts with an analytical approach to understand unwarranted variation in outcomes and costs, followed by identifying priorities for action in the services where the opportunity for improvement is greatest. The ACC and UEC vanguards will have access to the emerging lessons and learning from this programme, and we are exploring with them how the programme will support the delivery of their care models.

1.7. Vanguards are developing new care models focused around their population as a whole, ensuring that across diverse communities all patients get access to the right care and treatment which is personalised to them. Vanguards want evidence-based analytical support to segment the local population and then match tailored interventions to suit each group of patients. For example, the ACC accountable clinical network vanguards will bring groups of providers together to consider how best to serve a wider population rather than focusing on the services provided by their individual organisations. To realise the full benefits of this approach, detailed analytical work is needed to understand the needs of their population and the costs of meeting those needs in different ways and settings.

1.8. In other countries, successful integrated health systems such as Geisinger have targeted their efforts on the relatively few patients who are most likely to incur greatest cost. This requires accurate predictive analytical tools that take account of the fact that the cohort of people at greatest risk of avoidable hospital admissions is dynamic. Vanguards requiring help with this can access commissioning support services accredited under the lead provider framework.

1.9. Vanguards want to know how variations in the design of a core component of their model will influence outcomes and the overall impact. The evidence base can be inconsistent and choosing the optimal design can be challenging. For example, some vanguards are choosing to risk stratify their population at the top 2%, others at 5%.

1.10. Therefore, from January 2016, vanguards implementing variations of the same component will be asked to participate in 'action research'. This will allow each component to be refined through continuous measurement of benefits and system-wide impact.

Accessing national clinical and programme expertise

1.11. Vanguards are able to draw on a range of clinical and technical experts in different pathways, disease and patient groups. This includes: care planning for people with long-term conditions; delivering the new five year strategy for mental health (to be published in early 2016); ensuring routine integration of mental health into physical health care pathways and vice versa; new models of elective care and diagnostics; improving cancer services in line with the recommendations of the Independent Cancer Taskforce; and care models for children and young people.

1.12. Alongside this, experts who already support over 30 CCGs nationally will work with vanguards who are ready to take a "commissioning for outcomes" approach to their model. Vanguards will have an opportunity to understand its implementation from the quality and outcomes working group.

1.13. Fourteen of the first 29 vanguards are already developing new approaches to extended access to primary care, through the Prime Minister's GP Access Fund. We are working with all vanguards to explore whether similar approaches for improving access to services could be taken in their local health systems. The Government has made seven day working a top priority for the

NHS in this Parliament across all geographies, and the vanguards will have the opportunity to be at the forefront of this work. For example, the ACC care model type is pursuing seven day consultant led services for key services.

Whole system approach to urgent and emergency care

1.14. Vanguards share a common set of objectives to deliver safe, efficient and high quality care. To be able to achieve this, vanguards will need to work beyond and across organisational boundaries to provide care for people in a joined up way.

1.15. For the UEC vanguards, this will require whole system and networked approaches to designing and developing services for large and diverse populations of all ages. This includes hard-to-reach groups and people with learning disabilities. Urgent care will be delivered in a more integrated way, not just in hospitals but also by GPs, pharmacists, mental health practitioners, community teams, ambulance services, NHS 111, social care, and through people managing their own conditions.

1.16. We will commission expertise to help the vanguards model and understand the system-wide costs and implications of changing their urgent care models. This, in turn, will feed into the development of local commissioning strategies for urgent and emergency care as well as whole system escalation plans.

1.17. The UEC vanguards asked for support with modelling to predict and coordinate demand, capacity and resource across their local health system. An important step will be to map the interactions between emergency departments, walk-in centres, urgent care centres, NHS 111, GPs, pharmacists, and out-of-hours services. North East Urgent Care Network has already made progress on this front through their 'flight desk'. This is a region-wide, whole system capacity management tool reporting on provider capacity and demand.

1.18. One of the core aims of the UEC vanguards is to ensure that people receive and access the right care, first time. To achieve this, practical support and expertise will be available to support the development of clinical advice hubs that integrate NHS 111, ambulance services and out-of-hours primary care.

1.19. From December 2015, the UEC vanguards will also receive support to develop further their existing service finder or directory of services which staff can use for appropriate referral. Some vanguards have made significant progress. For example, Greater Nottingham System Resilience Group has developed an innovative approach to clinical navigation and referring people to appropriate settings. They offer an alternative to an urgent hospital admission by promoting GP to consultant conversations and providing direct access to advice. Following this intervention, an 8% reduction in total emergency admissions has been reported.

Building local capability for quality improvement

1.20. Evidence suggests that embedding good quality improvement methods at the outset of transformation leads to greater success[3]. It builds continuous improvement into implementation and avoids repetitive cycles of planning, and should feed into both local and national evaluation. Some vanguards have got to their state of readiness because locally they have good improvement methodologies in place, and backing from system leaders to use them.

1.21. Stockport Together has adopted principles of improvement methodology by focusing on benefits realisation. Themes that they make use of include: encouraging collaborative leadership at all levels; helping people to increase their knowledge and confidence in tools and techniques that create innovation and support change; encouraging people to make some decisions on intuition; and focusing everyone on the joint vision and outcomes whilst engaging large numbers of volunteers to help take ownership of change.

1.22. Many vanguards have asked for support to strengthen their approach including advice on best practice methodologies. Vanguards will be supported to build "trial, learn and refine" into their local delivery approach, and the national team will encourage prototyping on the basis of strong evidence and clinical consensus. Quality improvement support will be tailored according to the needs of each vanguard.

1.23. Where vanguards need to develop local expertise, we will match them to experts in the improvement community who will signpost them to best practice tools and guidance. The national team will facilitate a quality improvement network for vanguards, pioneers and the wider NHS so that methods can be shared and for common problems to be solved collectively.

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3 The Health Foundation – *Safer patients initiative: lessons from the first major improvement programme addressing patient safety in the UK*, Feb 2011

2. Evaluation and metrics

2.1. The new care models programme is complex in its breadth and depth. It also combines experimental discovery with standardisation. This calls for a sophisticated and multi-faceted approach to measurement and evaluation. Working closely with the vanguards, we will identify the impacts they are having on patients, staff and the wider population. We need to understand how and why these impacts are arising so that the learning about what works, and what does not work, can be shared rapidly amongst vanguards and spread throughout the NHS and social care.

2.2. At its heart, this is about identifying the active ingredients for each care model to establish nationally visible patterns that will support replication across different local health systems. These will include the interventions themselves, the local context, and the process by which change occurred.

Development of logic models as a foundation for evaluation

2.3. Logic models originate from the field of programme evaluation, and are simply diagrams or flow charts that convey relationships between the resources being put into a programme, the interventions, the activities and processes, the outputs from these and the short-term, intermediate and longer-term outcomes. Logic models provide a visual means of showing complex chains of reasoning and are a means of representing the new care models.

2.4. Experience from other large-scale programmes suggests that having a clear logic model is one of the active components for successful change. Logic models can also be used as a planning tool, helping to clarify thinking and reduce the scope for programme failure owing to poor design and untested assumptions.

2.5. Drawing on the diagnostic visits and thematic analyses, we are co-developing draft logic models for every vanguard as a basis for further discussion and refinement.

2.6. All vanguards will receive intensive one-to-one support to develop and refine their logic models. By March 2016, the learning from these sessions will have been shared not just across cohorts but across the NHS and social care. We will aggregate the logic models so that we can begin to understand the totality of the vanguards, and their common activities, outputs and outcomes.

Evidence-based interventions

2.7. The diagnostic visits and thematic analyses highlighted variation in both the type and application of planned interventions.

2.8. The national team and vanguard leads are working with key partners to co-produce evidence summaries for the interventions being implemented across each care model. National partners include, amongst others, the Health Services Research Network (HSRN), AHSNs, National Institute for Health

Research (NIHR), Collaborations for Leadership in Applied Health Research and Care (CLAHRCs), NHS Confederation, NHS Providers, the Nuffield Trust, Health Foundation, the King's Fund and the commissioning support units (CSUs). From December 2015, this evidence will be made available to the rest of the NHS and social care.

The vanguard approach to evaluating new care models

2.9. During our discussions with vanguards on evaluation and measurement, we were asked to set out details of our approach to evaluation including: national and local roles; the common metrics to be used across care models; and how progress will be reported for the vanguards and the rest of the NHS.

2.10. Using a set of high level metrics, co-produced with the vanguards, the national evaluation team will monitor the progress being made to address the gaps in health and wellbeing, care and quality, and efficiency.

2.11. The local evaluations will identify the active ingredients of each care model. These will include: the local health system context; specific interventions and how change has been implemented. Through the local evaluation, vanguards will track progress and performance in real-time which, in turn, will support the ongoing design and delivery of the new care model.

2.12. As an example, Salford Together has developed a detailed approach to evaluation. The Comprehensive Longitudinal Assessment of Salford Integrated Care is an evaluation framework designed to provide a rigorous test of the ability of their care model to deliver through measuring improved user and carer experience, improved wellbeing and quality of life and reduced costs of care and improvements in cost effectiveness.

2.13. This will focus on areas which pose common challenges, or areas where there is benefit from standardisation. These will include measuring patient-centred care. For example, Northumberland Accountable Care Organisation is building on the strong patient-centred narrative co-developed with the health and care system by National Voices. They capture feedback from more than 50,000 people every year and measure what matters most to patients in a variety of ways and at different points of care. There is a mechanism of real time measurement feedback to clinical teams within 24 hours.

2.14. We developed an evaluation strategy for MCP, PACS and enhanced health in care home vanguards in October 2015. This was co-produced with vanguards and subject-matter experts from the research community. This will continue to evolve over the life of the programme as we try things out and adapt on the way. We expect to develop and publish an evaluation strategy with the UEC vanguards by end of January 2016 and we are exploring the approach to evaluation with the ACC vanguards.

Core metrics across all care models

2.15. In October 2015, we published the initial suite of core metrics for the first three new care models. The first two metrics that were selected were emergency

admissions and total bed days. We will be working with the PACS and MCP vanguards to assess the suitability of the following metrics for inclusion into the core set: quality of life for people with long term conditions; indicators from the Quality and Outcomes Framework; the Patient Activation Measure (PAM); patient experience of integrated care; staff experience; and emergency readmissions. For the enhanced health in care home vanguards, we will consider a bespoke health and wellbeing indicator, staff and patient experience and medicine use and review. The Keogh Review team is working with the UEC vanguards to develop and test a suite of whole system outcome metrics.

2.16. To facilitate rapid learning and improvement, these core metrics will be complemented by:

- *enabler metrics*: these will measure progress against the care model building blocks or enablers, such as a single shared care record. We will develop these with care model leads, vanguards and others; and

- *local metrics*: these metrics will be defined by each vanguard, reflect local priorities and be rooted in the logic models. We will be providing guidance to vanguards on developing local metrics. We expect that each vanguard will report to us quarterly against approximately six local metrics, although this will be finalised once the logic models for each vanguard are agreed.

2.17. We intend to develop a set of clinical pathway metrics for particular groups of patients such as people with diabetes, people with mental health problems, and frail older people. These would enable us to look at the impacts of the vanguards on clinical outcomes for these patient groups. Not all pathway metrics will be relevant to all vanguards. NHS England is developing a new assessment framework for CCG performance and progress towards achieving the goals of the Five Year Forward View. The new care models evaluation programme will provide input to this framework.

2.18. Alongside these, we will describe and monitor a set of supplementary metrics, aimed at providing additional information about what is driving change in the core indicators, for example, emergency admissions for particular age groups.

2.19. In October 2015, we produced a standard dashboard for each of the first 29 vanguards. This showed its trajectory compared to a baseline and compared to other vanguards for each of the metrics. This is owned by the vanguards and, as part of this, we will help them measure the difference that their new care model is making by comparison with what would have happened if no changes had been made.

2.20. The contents of the dashboard for the ACC and UEC sites will be developed with vanguards. For the ACC vanguards, we will take into account the variation in types of new care model being implemented. The ACC vanguards will also be encouraged to develop their own metrics. For example, the Accountable Clinical Network for Cancer (ACNC) has developed complementary informatics dashboards, based on agreed national metrics (including a proxy measure of the one year cancer survival rate). This gives an 'at a glance' overview of provider performance, with the ability to identify variation in the quality of care.

3. Integrated commissioning and provision

3.1. Vanguards told us they need support to break down the artificial divisions within local health systems which prevent properly integrated commissioning and provision designed around the whole needs of patients.

3.2. The new care models programme is creating new ways to dissolve these traditional boundaries. The vanguards have asked the national bodies to help them make faster progress. This section of the document considers these key technical enablers: capitated payment; bundled contracts; integrated commissioning; fair procurement; and new provider forms.

New payment models

3.3. The joint local and national workstream on payment design and pricing is co-producing a limited number of simple and standard new payment and incentive models that can be implemented and tested locally. For the enhanced health in care homes vanguards, capitation may not be the preferred payment model and we are also exploring how best to improve incentives.

3.4. The MCP and PACS vanguards are clear they want to move towards capitated payment for a whole population. To support that, the joint workstream will consider budgetary flexibility for merging separate provider funding streams into a single MCP or PACS pot. Development of a capitation methodology will take time. In the shorter term, simple pragmatic methods for setting a population-based budget locally for each MCP or PACS will be developed. Budgetary flexibility may be explored for ACC and UEC vanguards pursuing new payment models. From April 2016, the joint payment team from NHS Improvement[4] and NHS England will work with the UEC vanguards to design a payment model, developed by the Keogh Urgent and Emergency Care Review, which contains a mix of elements for all the providers in the network: fixed, volume based and performance based.

Capitation for PACS providers

3.5. The idea behind a PACS model is that there is a single local system of provision. The implication of that is for a PACS vanguard to take on a single budget for all health care (and potentially social care) for their registered population.

3.6. Every PACS vanguard will be supported by expertise from the NHS England pricing team, the new care models finance team and expertise from NHS Improvement. The joint workstream on payment design and pricing will also help sites to access support from commissioning support services where appropriate.

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[4] In July 2015, the Secretary of State for Health announced that NHS Improvement will be formed (bringing together Monitor and the NHS Trust Development Authority) to drive and support both urgent improvements at the frontline and the long term sustainability of the healthcare system.

3.7. The joint local and national workstream will co-produce direct support for sites to help implement a new payment approach, based on a global budget for a population, as soon as practicable. The feedback we have received suggests that some sites may be able to begin using this approach to payments in 2016/17. More will be ready to move during 2016/17. PACS vanguards will co-design a capitation approach to payment for the longer term with NHS England and NHS Improvement.

3.8. From August 2015, the joint workstream began co-producing support to allow payments to other providers outside the PACS, enabling patient choice.

Capitation for MCPs

3.9. Many of the same principles apply to developing new funding models for MCP vanguards and will require similar support.

3.10. The joint workstream on payment design and pricing is working closely with MCPs and their commissioners to build their new payment structure. The MCP model is based on a GP registered list. The structure will build in additional community and mental health services and social care as appropriate, converting these into an amount that can be combined with core general practice funding.

3.11. We are working directly with those sites that want to go live in April 2016, to help them reshape their existing cost and payment structures into a payment that covers a defined population with appropriate incentives and risk sharing. Over the longer term, we are working with vanguards to develop a capitation payment method using patient costing and linked data.

3.12. As with the PACS model, we envisage that the use of these simple standard payment methods will be voluntary. One of the most complex issues that we are working with the vanguards on is developing simple and attractive options for existing GP practices to migrate from their current funding and contractual arrangements, including ways to enable "rights of return".

Payments and incentives for ACCs

3.13. New payments and incentives will be an important enabler for some ACC vanguards. For example, some of the ACC accountable clinical network vanguards will involve a single provider taking on a budget for the population and services covered by the network. From January 2016, support will be provided by the relevant teams in NHS England and NHS Improvement to help these vanguards further develop those proposals and explore options with respect to prime and alliance contracts and joint ventures.

3.14. Where a network overlaps with an MCP or PACS vanguard, the budget for the networked services may need to be carved out of the overall budget for the population served. This will be supported by the joint pricing team made up of experts from NHS England and NHS Improvement.

3.15. Unlike MCP and PACS vanguards, the budget for ACC accountable clinical network vanguards is unlikely to include primary care services, so providers in the network will need to work with GPs to enable greater integration along the entire patient pathway, especially when, as in the case of the Accountable Clinical Network for Cancer (ACNC), a core component of the vanguard's ambition is to shift resources from late stage treatment to prevention and early intervention.

Aligning incentives across UEC systems

3.16. UEC vanguards want similar support to the other vanguards in aligning incentives across a large number of providers and commissioners of services. From December 2015, the joint workstream on payment and pricing will support UEC vanguards to develop payment and incentive mechanisms that are built around shared measures of success across different services and organisations. This will also be underpinned by shared UEC quality standards. For instance, 'internal professional standards' (IPS) will be developed on key areas such as response times between clinical teams and departments. From February 2016, each UEC vanguard will receive direct support from the emergency care intensive support team (ECIST) to achieve best practice in line with the NHS England guide: *'Safer, Faster, Better'*[5]. This includes peer-to-peer reviews.

3.17. A number of UEC vanguards told us that their contracts for out-of-hours care and provision of NHS 111 services are coming to an end from April 2016. We will support vanguards to reshape and integrate those services based on the recently published guidance on integrated urgent care commissioning standards[6].

Quality payments

3.18. Existing quality payments such as Commissioning for Quality and Innovation (CQUIN), Quality and Outcomes Framework (QOF) and the Quality Premium, will need to be reimagined and simplified, in order to create aligned, whole-system incentives that support new care models.

3.19. From September 2015, the joint workstream on payment design and pricing will take learning from these existing schemes and academic research to start developing new pay for performance schemes. For example, East and North Hertfordshire Clinical Commissioning Group have introduced a care premium payment to reward care homes signed up to provide enhanced care for complex conditions in care homes.

3.20. A short menu of standard options will be co-designed with the vanguards. The work will also examine how the current system of sanctions might operate contractually in a PACS, MCP, UEC or ACC vanguard. These will be published during 2016.

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[5] Published August 2015, https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf
[6] Published September 2015, https://www.england.nhs.uk/ourwork/pe/nhs-111/resources/

Bundled contracts

3.21. In November 2015, we established the MCP Voluntary Contract Advisory Group. This group includes vanguards and other key partners who are working together to develop a voluntary MCP prototype contract during 2016. The ambition is for the first MCP vanguards to operate under the new contractual provisions from April 2017. This group will help to identify and address the barriers, as well as explore the freedoms and flexibilities which MCP vanguards might benefit from in line with national expectations.

Model provider-to-provider sub-contract

3.22. Many vanguards are moving towards more integrated forms of provision. Others are developing lead provider arrangements. In any event, lead providers are likely to need to sub-contract the provision of some services.

3.23. Through our joint local and national approach, the vanguards are telling us whether an updated model form of sub-contract will help them to deliver their care model. The new model sub-contract, co-produced with the vanguards, will be available during 2016 based on the new hybrid commissioning contract for the MCP and PACS vanguards.

3.24. As a potential alternative, the non-mandatory model alliance agreement can be adapted for local use where appropriate as a means of binding together and aligning parallel commissioning contracts. This model agreement will continue to be available for vanguards, as well as other local health systems, and will be reviewed and further developed as necessary.

3.25. Alliancing principles are already being explored and adopted by some NHS commissioners and providers. We will identify the national support that can be provided to vanguards, building on the experience gleaned from existing projects as a starting point for local discussions.

Integrated commissioning

3.26. Developing a bundled contract, based on a bigger sum, requires pooling of different commissioner budgets. Working closely with providers and local commissioners in vanguard systems, the joint workstream leads will co-produce practical support for vanguards to plan for and manage the changes needed to bring about integrated commissioning.

3.27. For enhanced health in care homes vanguards this will mean creating commissioning and contracting arrangements across health and social care to enable shared accountability for care home residents.

3.28. The ACC vanguards want to work in partnership with commissioners and other oversight bodies to develop and deliver a multi-year transformation plan.

Options for new integrated organisational forms

3.29. Vanguards have asked for help to work through the different options for new integrated organisational forms. Different provider forms, such as partnerships, social enterprises, staff-owned mutuals and limited companies, each have benefits and limitations. Vanguards want support to understand their options including identifying the most appropriate for each vanguard to achieve their objectives.

3.30. For example, South Somerset Symphony Programme have set up a joint venture board with their local GP federation to hold a single budget for the population and allocate resources in a way that makes the most difference to their patients' care. The hospital trust and GP practices will be working together to develop the appropriate contractual arrangements. Under the new model, a patient with multiple long-term conditions will see improvements in the way different professionals will work together to meet their needs. By early 2016, the new care models team will set out the organisational forms being looked at by the vanguards and the key considerations.

3.31. Where appropriate, we will co-commission legal advice centrally to address common issues and ensure that the learning is available nationally for the rest of the NHS and social care. Support will include helping the vanguards understand their options for different provider forms and the associated risks and benefits.

3.32. All vanguards need support to understand and navigate existing information governance rules. Work is currently underway at a national and local level to develop practical and workable solutions. This is set out under the harnessing technology enabler in section seven.

Procurement, patient choice and competition

3.33. The vanguards have asked for practical support on commissioning, contracting and procurement. Working with the joint local and national workstream, NHS Improvement is leading on procurement support and NHS England is leading on co-producing new contracts.

3.34. The Five Year Forward View made a commitment that the NHS would make good on its longstanding commitment to offer patients choice and the planning guidance for 2015/16 made a clear commitment to a major expansion in personal health budgets. The promise and subsequent delivery of personalisation is a core part of the programme. We also expect commissioners to insist on creating additional local choices where the quality of services is not as good as patients have the right to expect.

3.35. While in some cases collaborative arrangements have already started to develop, progress has been slowed down by questions around national rules and regulations. This was raised by many of the ACC vanguards. Support will be provided by NHS Improvement to help all vanguards understand the relevant regulatory frameworks and how they can demonstrate that their

collaborations will bring real and sustained benefits to the people using their services.

4. New operating models

4.1. ACC vanguards have asked for support to develop the right operating model. For example, those ACC vanguards aiming to become a foundation group have asked for support to develop a 'group model' for NHS hospitals. This is not a simple extension of traditional hospital mergers that result in large multi-site trusts. Instead, these vanguards want to develop a flexible membership model that allows a number of hospitals to operate as part of a single group with a central headquarters.

4.2. Consistent with the recommendations of the *Lord Carter review of operational productivity in NHS providers*[7] and the *Dalton review: Examining new options and opportunities for providers of NHS care*[8], these vanguards will be supported to explore standard operating models from December 2015. The operating models will enable participating hospitals to standardise best practice, measure performance and flexibly deploy their managerial, clinical and physical resources to best use across the group. Detailed supporting evidence packs were made available alongside the Dalton review on a broad range of aspects including joint ventures, contractual forms, integrated care organisations and service chains.[9]

4.3. Similarly, the UEC vanguards are exploring their operating models to ensure that organisations are working together effectively as integrated communities, with standard operating procedures and standards.

4.4. Whilst group models are not common in acute healthcare settings nationally, they are more common internationally. For example, Intermountain Healthcare is a non-for-profit integrated system based in Salt Lake City, Utah (US). We will support the vanguards to identify, work with, and learn from, international healthcare models as well as from other industries. We will hold a networking and learning event next year that brings together vanguards with organisations from across the UK and internationally.

4.5. We will support the vanguards, and the rest of the NHS, to learn from each other's approaches to developing new operating models. For example, the Salford and Wigan Foundation Chain vanguard is developing a novel approach for replicable standard operating procedures. This includes implementing three tiers of clinical services. Tier 1 is protocol driven patient care, which is always the same (such as venous thromboembolism (VTE) risk assessment; choice of perioperative antibiotics). Tier 2 is clinical guidelines (such as choice of surgical

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[7] Published June 2015 https://www.gov.uk/government/publications/productivity-in-nhs-hospitals
[8] Published December 2014, https://www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care
[9] Pack A: collaborative forms - see
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385835/2903219_Dalton_Pack_A_interactive-accessible.pdf
Pack B: Contractual forms - see
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385836/Dalton_Pack_B.pdf
Pack C: Consolidation forms – see
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385837/Dalton_Pack_C.pdf

technique, analgesic ladder). Tier 3 is non-codified individual care (such as ceiling of care decisions, cancer genomics).

4.6. The operating models developed by the vanguards will need to be replicable at scale and deployable to multiple organisations including over dispersed geographical footprints. We will work with the vanguards to consolidate and assist the spread of learning.

5. Governance, accountability and provider regulation

5.1. We will provide support to vanguards to help them develop the right organisational form and governance model for their care model, and to understand the impact these forms have on how they are regulated (by both the Care Quality Commission and NHS Improvement). Whilst all vanguards will need to consider these areas, the ACC vanguards identified this as a more pressing area of support.

Governance and accountability

5.2. ACC vanguards are exploring a variety of potential partnership arrangements. For example, Royal Free London is considering different levels of membership within the group including full or partial ownership, affiliate (group member for certain services) and management contracts. They are in discussion with existing international companies that use a group structure to understand how they develop decision architecture, for example, to determine what is decided at group versus operating unit level.

5.3. Likewise, a core component of the ACC accountable clinical network vanguards will be establishing harder-edged accountability, with a single organising intelligence with decision rights. This contrasts with the looser collaborative arrangements which underpin many existing clinical networks. The vanguards will be encouraged to link with the strategic clinical networks (SCNs), for example, the stroke and trauma SCNs to learn from their experience of developing the accountability structures.

5.4. New accountability structures need to be underpinned by appropriate governance structures. For example, Dartford and Gravesham together with Guy's and St Thomas' are creating a Foundation Healthcare Group underpinned by a partnership based on principles of cooperation, system leadership, member value and shared resources. They are exploring alternative governance models that can support NHS trusts to continue to provide high quality locally delivered care under the brand of a larger organisation. In their case, Guy's and St Thomas' will be acting as system leader. Currently they are looking at corporate arrangements for large commercial organisations to see what they can learn.

5.5. As an extension of the work on integrated organisational forms, the new care models team, together with NHS Improvement, will provide support to vanguards to understand where accountability and control would lie, and what good governance would look like under different arrangements. For those taking a whole system approach such as the UEC vanguards, they will have access to clinical expertise to consider how clinical responsibility, governance and accountability is distributed and shared across their system.

5.6. We will also provide the vanguards with support to understand the accounting treatment and tax implications associated with their new operating models.

Provider regulation

5.7. Vanguards have asked for help to understand how their new collaborations will be regulated. The ACC foundation group vanguards have raised this question most explicitly, and from December 2015 will work closely with NHS Improvement to understand and overcome existing barriers to forming and expanding foundation groups. These include:

- Developing a tailored transactions assessment process that swiftly reveals the underlying operational and structural challenges faced by a prospective group member along with the potential impact on the whole group's financial and governance risk ratings;

- Guidance and support on any merger or competition issues at an early stage in the development of their plans;

- Support to develop options for group membership arrangements, and a programme of policy development work to understand:

  I. how accountability, governance arrangements and regulation (by both CQC and NHS Improvement) would vary across different 'levels' of group membership – including whether it might be possible to apply some licence conditions at group level while leaving others disaggregated across participating group members; and

  II. approaches to incentivising foundation groups to accept challenged providers as new members.

5.8. From December 2015, a working group comprising vanguards, NHS Improvement and the Care Quality Commission will be established to understand and address the range of questions relating to provider regulation for all vanguards.

5.9. The lessons from this work will be swiftly shared with other NHS providers who are exploring the development of new forms of collaboration such as foundation groups, accountable care organisations and other similar arrangements.

6. Empowering patients and communities

6.1. New care models and the priorities of the Five Year Forward View are achievable only by fundamentally changing the relationship that the NHS and social care have with patients, people and communities. Vanguards want to deliver care that is personalised, coordinated, tackles inequalities and provides effectively for the whole population. They want to work in partnership with patients, local people and their community, empowering them and enabling choice through the use of personalised budgets, care planning and peer support.

6.2. Fully harnessing the energy of patients, local people and diverse communities requires a new model of partnership. In order to support this new relationship, the Five Year Forward View People and Communities Board, working with patients, the voluntary sector and vanguards, has set out six principles for new care models:

- Care and support is person-centred: personalised, coordinating and empowering
- Services which are created in partnership with citizens and communities
- Focus on equalities and narrowing health inequalities
- Carers are identified, supported and involved
- Voluntary, community, social enterprise and housing sectors are involved as key partners and enablers
- Volunteering and social action are recognised as key enablers

6.3. The way in which vanguards implement these will vary. The new care models team will work in partnership with each vanguard to deliver the six principles.

6.4. Working with the vanguards, we will recruit a team of expert advisors to support the vanguards to undertake a baseline review of the way they are currently meeting the six principles, identifying strengths and weaknesses. The advisors will also support the vanguards to deliver the six principles, building on their existing expertise and the work they have done to date. This includes supporting them to share their learning across the NHS and social care, and to unlock the expertise within the third sector.

6.5. The vanguards have preferential access to all tools and resources being developed by NHS England and its partners to empower, support and engage patients, including: Realising the Value, personal health budgets, integrated personal commissioning, building health partnerships, carers programme and a collaborative programme to support volunteering, social movements and social action.

6.6. Where there is potential for service change, vanguards want support to work in partnership with patients, staff and other local stakeholders to redesign services. From January 2016, vanguards will have access to practical advice and toolkits to ensure they comply with statutory duties and follow best practice.

6.7. We have published a call to action for a directory of support, with a view to publishing a full directory of support services for vanguards and the wider NHS in April 2016.

6.8. Vanguards will be able to access support from expert advisors at the Institute for Health Equity as they develop their care model. They will be provided with evidenced-based approaches to tackle health inequalities, provide outreach services for targeted groups and improve digital literacy.

6.9. All vanguards want to improve access to the right care at the right time for their diverse communities. This includes supporting the wider community and harder to reach groups to access the most appropriate services. For example, the UEC vanguards are addressing the issue highlighted in the Keogh Urgent and Emergency Care Review[10] that people too often go to A&E for minor injuries and other ailments, rather than more appropriate and convenient services, such as urgent care centres, community pharmacies, ambulance 'see and treat' or general practice. The UEC vanguards will be supported to develop 'click, call or come-in' models to simplify and improve access to the most appropriate services. Work is also underway at a national level to link NHS 111 with NHS Choices.

6.10. Evidence suggests that persuading people to change established behaviours and habits can be difficult. All vanguards will be given access to behavioural insight expertise and tools to help them do this. Such techniques can offer low cost and effective ways of "nudging" people into new ways of acting by going with the grain of how people tend to think and act[11]. Vanguards will also be supported to use technological solutions, social media and public health data to target specific interventions for specific population groups on how best to access services.

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[10] Published August 2015, http://www.nhs.uk/nhsengland/keogh-review/Pages/urgent-and-emergency-care-review.asp
[11] http://www.behaviouralinsights.co.uk/publications/mindspace/

7. Harnessing technology

7.1. Vanguards have asked for our support to rethink how care is delivered given the huge potential of digital technology to offer care in radically different ways. Vanguards will be provided with dedicated expert resource to put them at the forefront of digital delivery. We will align with upcoming test bed sites which, together with the work of the National Information Board (NIB), will accelerate adoption and the spread of digital health care. They will be supported to develop a local digital strategy identifying how they can transform access and delivery of care through technology solutions. This will include: extended GP access and seven day NHS services; prevention and self-care; and enabling personalised care.

Connected digital solutions and information systems

7.2. Full interoperability ensures that all local information systems can 'speak with each other' and information can flow between them seamlessly. Across the NHS, many sites are struggling because key information systems do not allow them to share essential patient information throughout the health and care system.

7.3. A good example has been established in West Yorkshire, where Airedale & Partners currently provide 24 hours a day, seven days a week telemedicine (clinical consultation via secure encrypted video links) to 133 care homes in Airedale, Wharfedale, Craven, Bradford and East Lancashire. This provides homes with access to an established clinical team in the telehealth hub based at Airedale Hospital. Wireless connectivity across the home allows video consultations from residents' rooms and the team has access to the full patient record.

7.4. Building on the NIB commitment that all patient and care records will be digital, real-time and interoperable by 2020, we have started to provide dedicated technical and strategic support for vanguards to produce their roadmap to interoperability.

7.5. From December 2015, we will publish examples of digital successes so other vanguards and the wider NHS can see what good looks like. Vanguards will also be expected to share their digital strategies, learning and any technical solutions or designs within cohorts and with the rest of the NHS through the Code for Health initiative.

Information governance

7.6. Successfully delivering the new care models will require significant information sharing for direct patient care as well as for evaluating and managing the local health and care system.

7.7. The work underway nationally and locally seeks to understand the issues that prevent progress as well as to develop practical and workable solutions. The summit for Integrated Care Pioneers in early 2015 produced a framework of

aims, issues and potential solutions. These were tested and discussed with four pioneer sites. The key lessons, including the approaches to resolving the issues, have been made available to the vanguards.

7.8. Further work is now being undertaken with stakeholders, led by the Department of Health, to understand the remaining issues including how best to address them. A review is being undertaken by the National Data Guardian and by the Care Quality Commission on key information governance issues that require clearer guidance. These findings are due in January 2016 and they will be shared with the vanguards and the pioneers as well as other programmes such as Integrated Personal Commissioning and the Better Care Fund.

7.9. Some vanguards are already well on their way to resolving this locally. For example, North East Hampshire and Farnham have provided staff with access to an integrated digital care record. The Hampshire Health Record (HHR) combines patient data from a range of health and care settings, and is now being used to support more targeted provision of care. Mid Nottinghamshire Better Together, through their links to the multi-agency 'Better Together' programme, is close to implementing an agreed data sharing and consent model, defining how they will handle different types of information safely.

7.10. This builds on the suite of resources being developed by the pioneers throughout 2015/16 which includes: guidance on real-life clinical scenarios and the information governance approaches taken; and nationally agreed standard templates that can be adopted by the wider system.

7.11. From December 2015, we will develop practical support with vanguards to establish information sharing agreements and guidance on how to manage risks for different purposes including direct care, case finding, profiling, and stratification.

7.12. The East Midlands Radiology Consortium (EMRAD) has made significant progress and has developed collaborative information governance and data sharing agreements across the seven EMRAD trusts. This has been enabled by a shared technical solution, which is creating a virtual single imaging record for each patient in the East Midlands. The solution has been procured by the EMRAD Trusts in consortium, and is estimated to have saved £1m in procurement costs alone; with an ongoing yearly saving of £3m for the technical solution across the region for the life of the new solution.

Digital strategy

7.13. The NIB framework published in November 2014 sets out the vision and approach to accelerating the use of data and technology across the NHS. Support for vanguards will build on this by providing vanguards with dedicated expert and technical resource. Vanguard digital strategies should include ways of caring for patients using mobile and assistive technologies.

Managing system vendors

7.14. To deliver better outcomes and value for taxpayers, vanguards have told us that they need support to navigate a rich and dynamic technology supplier market, which includes both national and international suppliers. Vanguards are receiving support, co-produced with national bodies, to collate technology requirements, create shared frameworks and enable collective market engagement and procurement at scale. The EMRAD example outlined demonstrates the benefits which can be achieved.

7.15. We will co-produce and publish a toolkit setting out the key stages of effective procurement and contracting.

8. Workforce redesign

8.1.   A modern flexible workforce is needed to organise networks of care around patients and local populations – reflecting the diversity of the communities served. Multi-disciplinary team working will be at the centre of this.

8.2.   From August 2015, the joint workstream for workforce redesign will co-produce practical support for vanguards, working closely with Health Education England (HEE), the royal colleges, regulatory bodies, NHS Employers and trade unions. This will include work with Public Health England (PHE) to help vanguards build a workforce based on population health needs, focusing on prevention and early intervention.

8.3.   This section explains how the joint workstream leads will co-produce support for vanguards to help them: develop an effective local workforce strategy; introduce new and extended roles; enhance the skills of existing staff; and build an engaged, satisfied and healthy workforce.

Local workforce strategy

8.4.   Vanguards have told us that they want support to map and profile their existing workforce across the local health and care system. By January 2016, vanguards will be supported to develop local workforce strategies that identify the training needs of existing staff, the new roles they need to create, and the number of staff needed with different skills to deliver their new care models.

8.5.   For example, the UEC vanguards want to profile their workforce to ensure the right mix of skills and multi–disciplinary roles to provide urgent and non-urgent care across whole populations. Vanguards will also be supported to engage closely with local education and training boards (LETBs) through the annual planning process to ensure that local and national investment reflects the shape of the future workforce.

8.6.   Over the next three months, vanguards will be provided with a self-assessment tool to assess their capacity and capability for workforce redesign, helping to identify gaps in local expertise. This tool, which has been co-produced with Health Education Yorkshire and the Humber, has already been successfully piloted in Wakefield. Building on this, vanguards will have access to further analytical support and input from workforce experts to help profile the workforce.

New and extended roles, skills and training

8.7.   Vanguards told us that they want practical support to develop new and extended roles. Some local health systems have already piloted new roles, including physician assistants, care navigators, pharmacists in GP practices and mental health leads in CCGs. The regulators and HEE have an explicit responsibility to ensure that new roles, and the training and development programmes that underpin them, are based on a clear understanding of relevant skills and associated scope of practice.

8.8. Sutton Homes of Care is enhancing the skills and expertise of care home staff and managers. A targeted development programme has been developed for care home managers so that they can deliver care to their residents proactively, and work together as a key member of the local multi-disciplinary team.

8.9. Northumberland Accountable Care Organisation is developing a new type of band 4 community care practitioner role and is testing this out on behalf of other vanguards and the rest of the NHS. The learning will be used to develop a model job description as quickly as possible.

8.10. The Working Together Partnership (South Yorkshire, Mid Yorkshire, North Derbyshire) is collaborating closely with Health Education York and Humber (HEYN) to support workforce redesign and develop new professional roles within radiology for capturing and reporting images. They are also working with a national group co-chaired by the Chief Scientific Officer, NHS England and Head of Workforce Transformation (HEYN) to review sonography training.

8.11. From September 2015, the joint workstream on workforce redesign will start to co-produce common skill and job descriptors for new and extended roles so that all local health and care systems can start training and recruiting the people they need. To take this forward, workstream leads will work closely with HEE and the regulators, as well as the royal colleges, Skills for Care, Skills for Health, NHS Confederation and other professional groups.

8.12. We will help vanguards build training and development into local programmes, especially in areas where there are specific shortages such as paramedics and in mental health crisis care services, such as liaison mental health services. The joint workstream on workforce redesign will also work closely with a range of organisations, including the voluntary sector and carers, to understand how they could play a greater role in early identification and prevention of crises. Age UK in London has developed a primary care navigator role to support patients who are over 75 to access community support services which helps them to stay well and at home for longer. Through the programme, work is underway with National Voices and a consortium of leading patient and care charities to enhance these roles across the country. This consortium will also be offering the opportunity for the vanguards to work with them to ensure true local integration including with voluntary sector services.

New ways of working

8.13. Too often, our current system has incentivised different parts of the health and care system to work separately from each other. This can mean that vulnerable people with more than one health or care need, such as older people with dementia, are not always getting the high quality care they deserve.

8.14. Changing the workforce culture to a more collaborative approach between different sets of clinicians, health and social care professionals, and across all frontline staff will be crucial. For instance, building on the Mental Health Taskforce recommendations, lead vanguards will be supported from December 2015 to take forward new ways of delivering 24/7 all-age integrated mental

health crisis care and ensuring that there is 'parity of response' between urgent and emergency mental and physical healthcare.

8.15. A specific aim of the UEC vanguards is to break down boundaries between physical and mental health and improve access to urgent and emergency care for people of all ages. This means ensuring that mental health services, particularly those dealing with people in crisis, are a core part of the UEC system. For example, the West Yorkshire Urgent and Emergency Care network, working with mental health providers and the police, has created mobile treatment services including rapid crisis response and street triage services. Vanguards will have access to clinical and professional expertise in mental health to help them do this. This includes support to build improved models for all age liaison mental health services in acute hospital settings**.**

8.16. All vanguards will receive support to manage change at scale, and to overcome the organisational and cultural barriers that can prevent seamless care for people using services. The joint workstream on workforce redesign will provide expert advice on organisational development. In addition, vanguards have asked for specific support with technical and HR issues to enable and attract staff to work flexibly across different settings and organisations. These include new employment contracts, professional indemnity and understanding clinical risk.

8.17. All vanguards will be offered facilitated simulation exercises to understand better the challenges of multi-professional working and the culture change required. For example, the ACC vanguards want to make best use of their combined clinical workforce in achieving key service standards and to maintain clinical dependencies in a way that preserves local access for people using services (in both urban and rural locations). The simulation exercises build on the work we have done with the pioneers and will be tailored to the specific contexts, organisational interactions and professional skill mix of all the new care models.

9. Local leadership and delivery

System leadership

9.1. A number of vanguards have asked for targeted support for leaders to partner across their local health and care system.

9.2. System leaders from MCP vanguards are taking part in a targeted leadership programme, or 'community of practice', and a similar programme for PACS vanguards began in September 2015. Through expert national and international facilitation, executive level participants will explore factors which support effective system leadership for each care model, reflecting their local context and experiences. Participants will be able to have open and honest conversations and debate with peers about challenging the status quo in their health and care economy. System leaders from the ACC and UEC vanguards will also benefit from taking part in targeted leadership programmes. These programmes will commence in early 2016, starting with a diagnostic to fully capture the specific needs of ACC and UEC vanguards.

9.3. In December 2015, vanguards will also have the opportunity to learn from international partners to gain insight and knowledge from leaders elsewhere. This has been a successful scheme for the pioneers, and vanguards will be invited to take part in a series of study tours to the EU. The first of these will take place in Spain to learn from the Alzira care model. Alongside this, vanguards will be invited to join an international seminar programme where leaders from across the world will discuss their innovative models of care.

Integrated and flexible leadership

9.4. To deliver integrated services, frontline clinical and professional leaders need to be willing and able to work together across different care settings and share their expertise across organisational boundaries. This has not been achieved at scale before.

9.5. Enhanced health in care home vanguards have told us that to deliver their care model, clinical, care home and social care leaders will need to develop side-by-side. Some have already begun to do this, but others have asked for additional support.

9.6. We are working with enhanced health in care home vanguards and the NHS Staff College to co-design a leadership programme, which will begin in October 2015. The programme will support clinical and non-clinical leaders to enable multi-disciplinary and multi-agency working across health, social care, housing, independent and third sectors.

9.7. All vanguards recognise that clinical and social care leaders will need to support generalists and specialists to work together, and decide how responsibility and accountability will be shared across multi-disciplinary teams.

9.8. We will support clinical and social care leaders to work out the best way of working together, breaking out of traditional hierarchies, while maintaining clear lines of delegation.

9.9. Given the significance of primary care across the care model cohorts, the National Association of Primary Care (NAPC) and NHS Alliance has developed a learning community for primary care and community professionals, where participants can share insights and concerns with peers.

9.10. In conjunction with key partners, for example NHS Confederation (encompassing the breadth of their membership base including NAPC and NHS Providers), the LGA and the royal colleges, we are offering multi-disciplinary learning sets for clinical and professional leaders. These will include facilitated discussions on: improving patient safety; improving access to voluntary sector services; and harnessing skills and experience of Allied Health Professionals. The work here will tie in closely with plans to commission the NHS Confederation to support the spread of innovation to non-vanguard sites, including work led by the Chief Allied Health Professional Officer.

Leadership at all levels

9.11. Leadership development should not be limited to system leaders and experienced clinical and professional leaders. Dudley Multispecialty Community Provider, for example, has placed a strong emphasis on the leadership and cultural change process needed to support their multi-disciplinary team model. This will encompass frontline leaders, whilst also identifying emerging leaders for their talent management programme.

9.12. Similarly, Better Local Care (Southern Hampshire) leaders are creating an environment that supports collaboration and enthusiasm for change. This includes development of the next generation of leaders, by creating clinical fellowships that could support backfilling and give emerging leaders a range of experiences.

9.13. The national NHS bodies will take into account the leadership challenges and responses identified above when considering the future priorities of the Leadership Academy.

Supporting local delivery

9.14. Many vanguards already have strong programme delivery arrangements in place with local teams working across organisations to design and drive change in a coordinated way. For instance, Better Health and Care for Sunderland's programme management has been integral in bringing their partners together and building momentum to drive the programme forward.

9.15. To support local delivery and help create additional capacity, all vanguards are supported by a dedicated account manager. Account managers provide help in problem-solving and facilitate access to the relevant expertise when required.

Use of local health and care assets

9.16. Implementing new care models across vanguards will in many cases require a different approach to the use of NHS assets and other estates. For example, moving care out of hospitals needs modern and suitable local primary and community care facilities. Vanguards have asked for support to take a view across the local health system about how to manage, develop and rationalise estates and assets.

9.17. Vanguards identified four areas where support is needed. The first area is to understand and plan their future estate needs including identifying the right options for meeting those needs. From February 2016, we will support vanguards to explore these options and develop estates strategies in the short and longer term. We will create a national estates network, led by estates experts, for vanguards to access advice and share learning with peers.

9.18. The second area is utilising their existing estates and assets. We will make tools available to enable vanguards to benchmark their estates utilisation and cost as well as develop a complete picture of the public assets within their area. We will help vanguards bring together local organisations to explore opportunities for sharing NHS owned estates as well as sharing assets across other public sector organisations. Working with the vanguards, we will develop a list of high impact actions that can improve estate utilisation that draws on best practice across the country, and spread this through the national estates network. We will also co-design a standardised leasing and licensing agreement with vanguards that can act as a starting point for local negotiations.

9.19. To help vanguards refurbish and repurpose buildings, we will work with them to overcome contractual obstacles, for example, if services are to be provided from buildings with multiple owners and landlords. Vanguards will also receive support and advice to develop variations in private finance initiative (PFI) schemes and local improvement finance trust (LIFT) contracts as a means to make best use of these resources.

9.20. The third area is realising value from surplus land and estates. This could be through the sale of surplus land but also through developing surplus land and estate for income generation. We will work with vanguards and partners to explore the rules around income generation and capital receipts.

9.21. The fourth area is support for developing new and/or redeveloping facilities that better support delivery of their new care models. Together with the vanguards, we will develop a simpler and quicker procurement process for doing so within the constraints of existing law. We will also provide advice and support to vanguards on how to access capital and develop capital business cases.

Transformation funding

9.22. The vanguards have had access to the bulk of the £200 million Transformation Fund in 2015/16. Every vanguard has been given the opportunity to submit value propositions demonstrating delivery against the triple aims: improving health and wellbeing; care and quality; and delivering financial efficiency. Efficiency requirements are core to this, and vanguards are demonstrating through their propositions how they will deliver the requirements of additional efficiencies by the end of 2017/18.

9.23. Following the publication of the Autumn Statement on 25 November 2015, we are working with the vanguards to finalise the process for allocating transformation funding in 2016/17 and beyond.

10. Communications and engagement

10.1. To be successful, the new care models will be designed and delivered by a strong collaboration of partners where staff, patients, carers, local people and other stakeholders are engaged and committed to the vanguard's vision.

10.2. Evidence shows that effective communications play a key role in improving the performance of NHS organisations. Many vanguards are leading the way in some elements of communications and engagement such as involvement of patients, public or staff. For instance, Northumberland Accountable Care Organisation has received significant praise from their local Healthwatch about the way they have involved patients and local people in the development of their new emergency care hospital.

10.3. The support explained in this section is designed to enable all vanguards and pioneers to be exemplars, demonstrating best practice in the way they communicate and engage with local diverse communities.

Local communications and engagement strategy

10.4. As discussed in the empowering patients and communities' chapter, co-designing the models hand-in-hand with local people and staff will mean that the needs of all involved, including those who are vulnerable or from hard-to-reach groups in the community, will be the focus of the new care model. This will involve comprehensive targeted strategies for a wide external audience including patients, carers, politicians, local charities and support groups, and the media. To harness the renewable energy of local diverse communities, vanguards will act as a catalyst for social movements.

10.5. Successfully breaking down traditional boundaries of health and social care will involve well-planned clear strategies. Many of the vanguards have multiple partners and sites. For example, the Mid Nottinghamshire Better Together has 14 partners and, the Better Care Together (Morecambe Bay Health Community) vanguard comprises 11 organisations.

10.6. All vanguard sites will receive support from independent experts to develop, review and provide feedback on their communication and engagement strategies. There will also be opportunities for peer review, whether across all of the vanguards or within their care model type.

10.7. A new evaluation tool – developed in partnership with leaders in the field – has been made available to enable vanguards to assess the impact of their strategy and compare results with their peers. This will allow them to undertake an assessment of their communications and engagement to date, providing a baseline for comparison as they move forward.

Sharing best practice and methods

10.8. In the NHS we have not always sufficiently shared and learnt from each other. Working in partnership with NHS Confederation, NHS Providers, the LGA, NHS
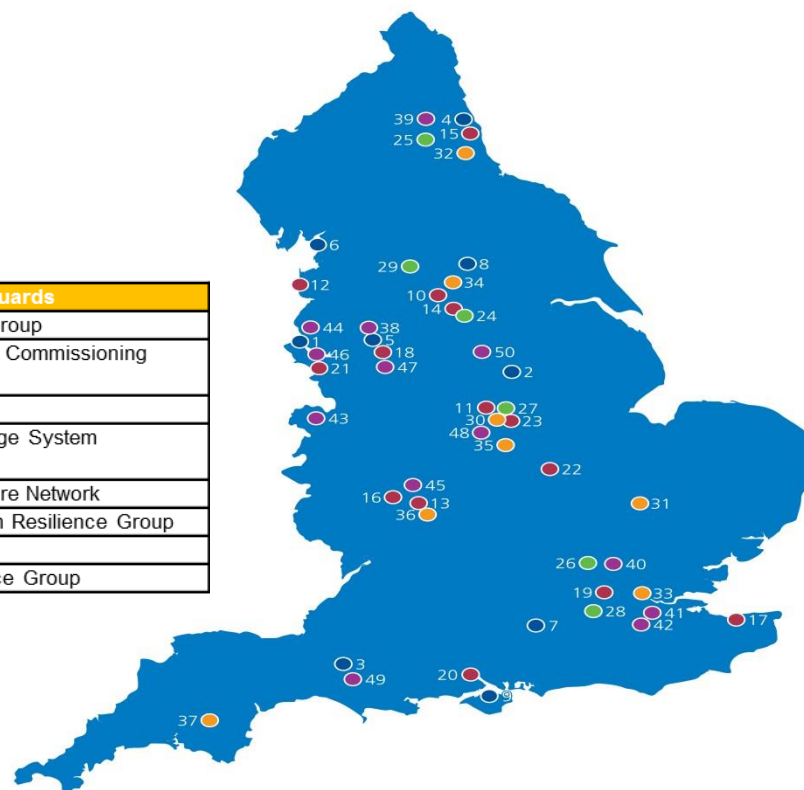
Clinical Commissioners and others, vanguards are being offered a range of tools to share the learning from the programme as part of a detailed collaboration plan, including conferences, events, visits, publications and the ambassadors' programme. The ambassadors' programme will harness the energy of staff to individually and collectively champion their own emerging models and the difference it is making to patients.

10.9. A simple online platform has been launched so that vanguards can share learning and information. From early 2016, a more extensive tool will enable this learning and information to be disseminated to the NHS and social care as well as support real-time conversations between peers to help solve problems.
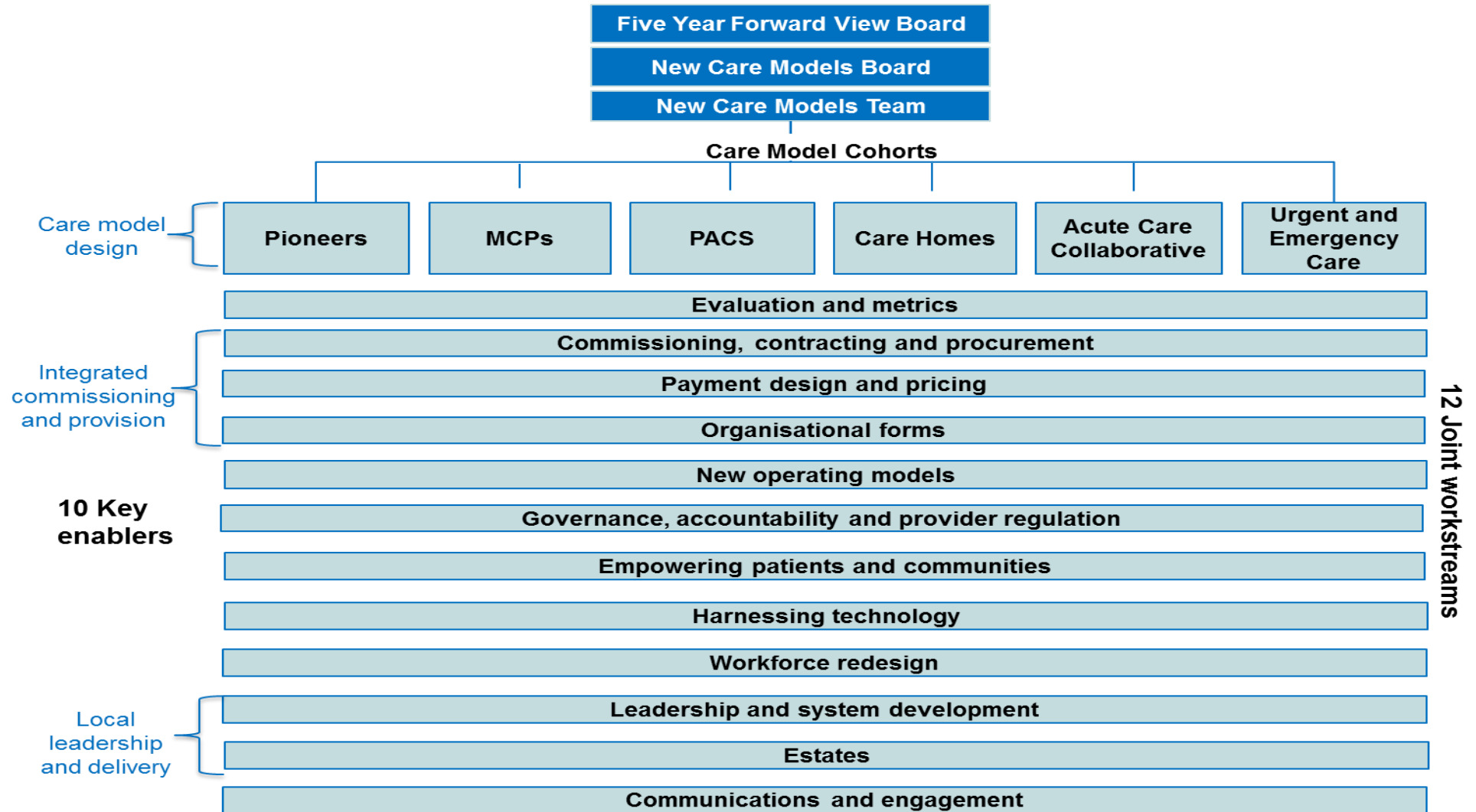
Annexes

Annex A: Vanguard sites

Urgent and emergency care (UEC) vanguards

30	Greater Nottingham Strategic Resilience Group
31	Cambridgeshire and Peterborough Clinical Commissioning Group
32	North East Urgent Care Network
33	Barking & Dagenham, Havering & Redbridge System Resilience Group
34	West Yorkshire Urgent and Emergency Care Network
35	Leicester, Leicestershire & Rutland System Resilience Group
36	Solihull Together for Better Lives
37	South Devon and Torbay System Resilience Group

Acute care collaboration (ACC) vanguards

38	Salford and Wigan Foundation Chain
39	Northumbria Foundation Group
40	Royal Free London
41	Dartford and Gravesham
42	Moorfields
43	National Orthopaedic Alliance
44	The Neuro Network (The Walton Centre, Liverpool)
45	MERIT (Mental Health Alliance for Excellence, Resilience, Innovation and Training) (West Midlands)
46	Cheshire and Merseyside Women's and Children Services
47	The Royal Marsden, Manchester Cancer and UCLH
48	East Midlands Radiology Consortium (EMRAD)
49	Developing One NHS in Dorset
50	Working Together Partnership (South Yorkshire, North Derbyshire and Mid Yorkshire)

Integrated primary and acute care systems (PACS) vanguards

1	Wirral Partners
2	Mid Nottinghamshire Better Together
3	South Somerset Symphony Programme
4	Northumberland Accountable Care Organisation
5	Salford Together
6	Better Care Together (Morecambe Bay Health Community)
7	North East Hampshire and Farnham
8	Harrogate and Rural District Clinical Commissioning Group
9	My Life a Full Life (Isle of Wight)

Multispecialty community providers (MCPs) vanguards

10	Calderdale Health and Social Care Economy
11	Erewash Multispecialty Community Provider
12	Fylde Coast Local Health Economy
13	Vitality (Birmingham and Sandwell)
14	West Wakefield Health and Wellbeing Ltd
15	Better Health and Care for Sunderland
16	Dudley Multispecialty Community Provider
17	Whitstable Medical Practice
18	Stockport Together
19	Tower Hamlets Integrated Provider Partnership
20	Better Local Care (Southern Hampshire)
21	West Cheshire Way
22	Lakeside Surgeries (Northamptonshire)
23	Principia Partners in Health (Southern Nottinghamshire)

Enhanced health in care home vanguards

24	Connecting Care – Wakefield District
25	Gateshead Care Home Project
26	East and North Hertfordshire Clinical Commissioning Group
27	Nottingham City Clinical Commissioning Group
28	Sutton Homes of Care
29	Airedale and partners

Annex B: Joint workstreams

Five Year Forward View Board

New Care Models Board

New Care Models Team

Care Model Cohorts

Care model design

Pioneers	MCPs	PACS	Care Homes	Acute Care Collaborative	Urgent and Emergency Care

Evaluation and metrics

Integrated commissioning and provision

Commissioning, contracting and procurement

Payment design and pricing

Organisational forms

10 Key enablers

New operating models

Governance, accountability and provider regulation

Empowering patients and communities

Harnessing technology

Workforce redesign

Local leadership and delivery

Leadership and system development

Estates

Communications and engagement

12 Joint workstreams